

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 335634	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2025
NAME OF PROVIDER OR SUPPLIER Garden Gate Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Union Road Cheektowaga, NY 14227	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview, and record review during a complaint investigation (NY00353368 & NY00369586) conducted during a Standard survey completed on 3/19/2025, the facility did not ensure that housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior for three (A Unit, C Unit, and D unit) of four resident units observed. Specifically, there were issues with walls in disrepair or spackled and not sanded or painted (C Unit); floors in resident rooms and common areas with black debris (C and D Units); an over the bed light that was not functioning and accessible to the resident (C Unit); and soiled and rusty commode chairs (C Unit).</p> <p>The findings are:</p> <p>The policy titled Basic Floor Care Definitions dated 6/1/2000, documented that dust mopping will remove approximately 90% of the soil and debris bound most hard and resilient floor surfaces.</p> <p>The policy titled Frequency of Types of Floor Care for Resilient Floors dated 6/1/2000 documented that flooring will be maintained in a clean state.</p> <p>The policy titled Maintenance Electronic Work Order System dated 9/2024 documented that the facility will utilize an electric work order system to better facilitate maintenance repairs/requests. The use of the system will further enable Maintenance to address any issues that affect the safety, comfort and dignity of the residents.</p> <p>The policy titled Room and Equipment Cleaning Procedures dated 11/2024 document that cleaning of every resident room is done daily; that sinks and toilets are cleaned with a disinfectant cleaner inside and out; that flooring is dust mopped and then wet mopped with the appropriate cleaner; and that a resident room will be thoroughly cleaned not less than every 90 days.</p> <p>The facility job title Housekeeping Aide documented that housekeeping aides are responsible for mopping rooms daily and once weekly with a disinfectant cleaner; and reports maintenance repairs, problems, or needs to their supervisor.</p> <p>Observations on 3/12/2025 from 9:00 AM to 1:00 PM revealed the following:</p> <p>A Unit</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] - there was brown debris in the bathroom sink and on the toilet.</p> <p>C Unit</p> <p>room [ROOM NUMBER] - the light over the bed did not turn on.</p> <p>room [ROOM NUMBER] - multiple areas of missing paint on the bathroom door; multiple brown and black debris on the floor at the foot end of bed and next to bed; wall behind headboard a spackled area, not sanded or painted approximately 2 1/2 feet x 6 inches wide.</p> <p>room [ROOM NUMBER] - toilet bowl and back edge of toilet with scattered brown debris; commode chair with brown debris on back of it in between the metal frames of the chair; approximately 2 feet long of the baseboard behind the toilet was falling off the wall exposing crumbling drywall; the tray table had debris from spilled items.</p> <p>B Unit</p> <p>room [ROOM NUMBER] - a urine-soaked hospital gown and linens remained on the floor for 40 minutes as staff walked by.</p> <p>room [ROOM NUMBER] - the bathroom had a soiled gown and washcloth on the floor; black stains on the floor and black residue on the floor around the toilet; the residents room floor had multiple areas of black debris next to the chest of drawers and bed.</p> <p>During an observation of room [ROOM NUMBER] and interview on 3/12/2025 at 12:47 PM, Licensed Practical Nurse #7 Unit Manager stated the linens were foul smelling and soiled with urine. Soiled linens belonged in the receptacle in the soiled utility room, not on the floor where people walk, and it was unsanitary.</p> <p>During an interview on 3/12/2025 at 1:03 PM, Certified Nurse Aide #7 stated they did not know how the soiled linens ended on the floor and stated they left them in the middle of the bed in a bundle and somehow, they ended up on the floor. The linens should have been disposed of in the soiled utility room down the hall.</p> <p>During an interview on 3/12/2025 at 1:05 PM, Certified Nurse Aide #6 stated they looked in room [ROOM NUMBER] as they walked by at 12:45 PM, saw the linens on the floor and left them there at the foot of the bed. They stated they were busy transporting other residents to lunch and had no excuse for leaving soiled linens on the floor. They stated it was against infection control practices and could cause cross contamination.</p> <p>Observations on 3/13/2025 from 7:00 AM to 12:00 PM revealed the following:</p> <p>A Unit</p> <p>room [ROOM NUMBER] - brown debris on the toilet and in the sink; soiled incontinence pad on the bathroom floor.</p> <p>C Unit</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>room [ROOM NUMBER] - multiple dark brown/black debris spots on the floor; multiple used tissues on the floor on the left side of the bed.</p> <p>Observations on 3/14/2025 from 7:45 AM to 12:00 PM:</p> <p>C Unit</p> <p>room [ROOM NUMBER] - the light over the bed did not turn on. At the time of the observation, the resident stated that they told someone about the light not working but could not remember who. The resident attempted to reach the light to pull the cord, but they could not reach it.</p> <p>room [ROOM NUMBER] - multiple areas of missing paint on the bathroom door; multiple brown and black debris on the floor at the foot end of the bed and next to the bed; wall behind headboard a spackled area, not sanded or painted approximately 2 1/2 feet x 6 inches wide</p> <p>room [ROOM NUMBER] - commode chair with brown debris on back of it in between the metal frames of the chair; baseboard behind the toilet falling off wall approximately 2 feet exposing crumbling drywall; tray table had debris from spilled items.</p> <p>Observation of room [ROOM NUMBER] on 3/14/25 at 1:10 PM, with the Housekeeping/Laundry Supervisor present, revealed the over the toilet commode chair had rust along the front bar in the bathroom. The rusted area measured five inches wide and was located on the horizontal bar that would be in contact with the back of the user's legs. The Housekeeping/ Laundry Supervisor stated the chair needed to be replaced due to the rust.</p> <p>During an observation of room [ROOM NUMBER] on 3/17/2025 at 9:12 AM, a bag of briefs and a roll of paper towel were on the floor next to the toilet; a blackish/brownish stain was noted around the floor of the toilet. At the time of the observation, Licensed Practical Nurse #3 stated that resident supplies should not be stored on the bathroom floor and should be put away in a resident's drawer. Licensed Practical Nurse #3 stated that the floors were dirty and needed to be mopped.</p> <p>During an interview on 3/17/2025 at 9:30 AM with Housekeeper #1, they stated that the floors were a lot dirtier last Friday on Unit D. They stated that the floors were waxed by accident as the floors should have not been waxed and that's why the dirt sticks to the floor. They stated that they are removing the wax to get the floors clean.</p> <p>During an interview on 3/17/2025 at 10:56 AM, Housekeeper #2 stated that housekeepers were responsible for cleaning the toilets and floors. They stated that if there were maintenance issues with a resident's room, they verbally reported it to maintenance or to their housekeeping supervisor.</p> <p>During an interview on 3/17/2025 at 12:23 PM the Housekeeping/Laundry Supervisor stated that they expected their housekeeping staff to clean the sinks and the toilet bowls daily. They stated that if there were any issues about cleaning or removing debris from a sink or toilet bowl, staff should be notifying them. They stated that staff should notify them if there were any maintenance issues so they can be fixed. They stated that they would notify maintenance by using an internal system so maintenance can have a work order to fix an issue in a resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/18/2025 at 10:30 AM, Resident #92 stated they stated that it bothered them they didn't have a light that worked over their bed, and it had not worked for a month. They stated that it would be nice to have a light that worked.</p> <p>During an interview on 3/19/2025 at 9:15 AM, the Administrator stated they expected the housekeeping staff to clean resident room floors, sinks, and toilets every day. They stated that they expect staff to report any maintenance issues to maintenance or to their supervisor so the issues can be addressed. They stated that they were working on getting the floors replaced so they can be easily maintained.</p> <p>During an interview on 3/19/2025 at 11:58 AM, the Director of Nursing stated that dirty linens on the floor can cause cross contamination. They stated dirty linens should be put away right away after care. They expected the staff to put dirty linens into the soiled linen room right after care.</p> <p>10 NYCRR 415.5 (h)(2)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 3/19/25, the facility did not ensure that residents who were unable to carry out activities of daily living, received the necessary services to maintain good grooming and personal hygiene for two (Residents #6 and #63) of eight residents reviewed for activities of daily living. Specifically, Resident #6 had a moderate amount of chin and upper lip hair and Resident #63 had long fingernails on both hands with dark brown debris underneath on multiple observations. Staff did not offer or provide shaving or nail care during care observations.</p> <p>The findings are:</p> <p>The policy titled Activities of Daily Living, last revised 10/2023, documented each resident would receive and the facility would provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. This included the facility ensuring that the resident was given the appropriate treatment and services to maintain or improve his or her ability to carry out activities of daily living, including hygiene (bathing, dressing, grooming, and oral care). Certified Nurse Aides would follow the Kardex (guide used by staff providing care), if a resident refused care or had a change in condition requiring a level of care differing from the Kardex, the Certified Nurse Aide would alert the licensed nurse/nurse supervisor.</p> <p>The policy titled AM (morning) and HS (evening) Care, last revised 1/2024, documented all residents were provided with morning and evening care on a daily basis. Morning care procedure consisted of oral care, washing face, neck, under arms and under breasts. Washing resident's genital areas and buttocks if resident was unable to do so. Provide assistance with shaving using disposable razor or electric razor. Shaving cream used based on resident preference/need.</p> <p>The policy titled Nail Care, last revised 10/2011, documented routine nail care was to be completed following bathing/showering and whenever possible to ensure cleanliness and prevent infection.</p> <p>1. Resident #6 had diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease (body has trouble controlling blood sugar and using it for energy), unspecified dementia (loss of memory) with other behavioral disturbance, and essential tremor (a nervous system disorder that causes rhythmic shaking). The Minimum Data Set (a resident assessment tool) dated 1/3/25 documented Resident #6 was severely cognitively impaired, was usually understood, and usually understands. Required supervision or touching assist of one staff member with personal hygiene and substantial/maximal assist of one staff member with bathing.</p> <p>The comprehensive care plan dated 3/30/21 documented Resident #6 required a minimal assist of one staff member for personal hygiene and a moderate assist of one staff member with bathing upper extremities related to impaired balance, limited mobility and limited range of motion.</p> <p>The Kardex (a guide used by staff providing care) with a printout date of 3/14/25 documented Resident #6 received their showers Saturdays during the 7:00 AM - 3:00 PM shift.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of nursing progress notes dated 2/1/25 - 3/14/25 revealed no documented evidence that Resident #6 was offered or refused shaving.</p> <p>During an observation and interview on 3/12/25 at 1:01 PM, Resident #6 was sitting up in their bed eating lunch, with 1/2 inch to 1-inch long, gray, curly facial hair on their upper lip and chin. Resident #6 stated they minded having facial hair and no one had ever offered to shave them.</p> <p>During follow up observations on 3/13/25 at 9:23 AM and 4:05 PM, Resident #6 was lying in bed sleeping and the facial hair remained. Photographs of Resident #6 were on the wall of their room. No facial hair was observed on the resident in those photographs.</p> <p>During an observation and interview on 3/14/25 at 10:58 AM, with the Clinical Educator present, Certified Nurse Aide #1, with assistance from Certified Nurse Aide #2, washed Resident #6's face, arm pits, under breasts and completed incontinent care and assisted with dressing. Certified Nurse Aide #1 discarded the soiled linen on the barrier, dumped the soiled water into the toilet and stated they were completed with care. Shaving was not offered to Resident #6 and their facial hair remained.</p> <p>During a follow up interview on 3/14/25 at 11:10 AM, Certified Nurse Aide #1 stated morning care for residents typically consisted of incontinent care, brushing hair and teeth, applying deodorant and shaving if needed. Certified Nurse Aide #1 stated Resident #6 had tons of facial hair, and they should have offered the resident to be shaved during care, but they did not. Certified Nurse Aide #1 stated morning care for Resident #6 had been completed on their first rounds at the beginning of the shift and they had not offered to shave Resident #6 then either. They stated Certified Nurse Aides were responsible for shaving residents whenever facial hair was noticed, it was important for dignity reasons.</p> <p>During an observation and interview on 3/14/25 at 11:13 AM, Licensed Practical Nurse #1 stated morning care included a half bed bath: wash face, hands, arm pits, incontinent care, oral care, brush hair, and shaving on shower days or whenever facial hair was noticed. They walked into Resident #6's room, observed the facial hair on the resident's upper lip and chin, then stated Certified Nurse Aide #1 should have offered to shave Resident #6 because they had long facial hair. It needed to be addressed, it was important to keep the resident feeling and looking nice.</p> <p>During an interview on 3/14/25 at 11:30 AM, Licensed Practical Nurse #2 Unit Manager stated morning care consisted of washing hands, face, arm pits, arms, incontinent care, oral care and shaving whenever it was noticed. There were no specific times that shaving should be offered or completed, it could be completed any time throughout the shift, not just with morning care. They would have expected Certified Nurse Aide #1 to shave Resident #6 during incontinent care, or at least have offered. It was important for dignity reasons.</p> <p>During a follow up interview on 3/17/25 at 10:27 AM, Licensed Practical Nurse #1 and Licensed Practical Nurse #2 Unit Manager stated the Certified Nurse Aide assigned to the resident was responsible for ensuring shaving was offered and completed whenever they noticed facial hair.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/17/25 at 11:28 AM, Licensed Practical Nurse #6 Clinical Educator stated shaving should be offered whenever facial hair was noticed, it did not matter if care was being provided or not. The Certified Nurse Aide assigned to the resident was responsible for ensuring shaving was completed. They stated Certified Nurse Aide #1 should have offered to shave Resident #6 and they did not. It was important to shave dependent residents who had facial hair for dignity reasons, so they can feel good, fresh, and clean.</p> <p>During an interview on 3/19/25 at 9:13 AM, the Director of Nursing stated Certified Nurse Aides were responsible for offering and providing shaving to dependent residents. Nurses could offer and help if they had the extra time. The Director of Nursing stated Certified Nurse Aide #1 should have offered to shave Resident #6 during morning care, or whenever the facial hair was noticed. Shaving should be completed by Certified Nurse Aides first thing in the morning with first rounds, or whenever time was available throughout the shift. It was important to keep residents looking good, for integrity and dignity purposes.</p> <p>During an interview on 3/19/25 at 11:58 AM, the Administrator stated they expected Certified Nurse Aides to offer shaving to residents in need of it at some point throughout the day; during morning care, on shower days and anytime it was needed or noticed. The Certified Nurse Aides were responsible for ensuring activities of daily living were carried out for residents, team leaders were to ensure they were completed. It was important for dignity purposes.</p> <p>2. Resident #63 had diagnoses including unspecified dementia with psychotic disturbance, depression and anxiety disorder. The Minimum Data Set, dated dated [DATE], documented Resident #63 was moderately cognitively impaired, no behaviors were exhibited and did not reject care. Resident #63 required partial/moderate assistance with personal hygiene.</p> <p>The comprehensive care plan last revised 3/13/25, documented Resident #63 had a personal hygiene activities of daily Living self-care performance deficit related to activity intolerance, limited mobility and impaired balance with interventions including nail care on bath day and / or as needed.</p> <p>Review of the Visual/Bedside Kardex Report, undated, documented nail care on bath day and/or as needed.</p> <p>During observations on 3/12/25 at 11:46 AM and 3/13/25 at 10:26 AM, all fingernails on Resident #63's right hand were long with dark brown debris beneath.</p> <p>During an observation at 3/14/25 at 1:00 PM, Resident #63 was in the dining room feeding themselves. All fingernails on their right hand were long with dark brown debris beneath.</p> <p>During an observation on 3/17/25 at 10:04 AM, with Licensed Practical Nurse #6 Clinical Educator present, Certified Nursing Assistant # 5 provided morning care to Resident #63 while they were in bed. The resident's fingernails on their right hand were long with dark brown debris beneath all nails and the 2nd,3rd, 4th and thumb fingernails on their left hand were long with dark brown debris beneath the nails. Certified Nursing Assistant #5 completed care and exited Resident #63's room.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/17/25 at 10:34 AM, Certified Nursing Assistant #5 stated they had completed Resident #63's morning care and they were finished. They stated Resident #63 refused their shower that morning therefore all their care was provided while they were in bed and stated they did not observe Resident #63's fingernails while providing care and they should have. They stated fingernail care included trimming and cleaning beneath the fingernails and was completed on shower days and as needed. Certified Nursing Assistant #5 and Clinical Educator Licensed Practical Nurse #6 reentered Resident #63's room and observed Resident #63's fingernails. Certified Nursing Assistant #5 stated Resident #63's fingernails were long with dark brown debris, and they needed to be trimmed and cleaned. They stated they should have provided nail care during morning care. Certified Nursing Assistant #5 stated Resident #63 used their hands to feed themselves therefore it was important to keep their fingernails clean and trimmed for infection control purposes.</p> <p>During an interview on 3/17/25 at 10:35 AM, Clinical Educator Licensed Practical Nurse #6 stated Certified Nursing Assistant #5 did not offer fingernail care during AM care and should have. Upon observation of Resident #63's fingernails Clinical Educator Licensed Practical Nurse #6 stated Resident #63's fingernails are long with dark brown debris.</p> <p>During an interview on 3/18/25 at 1:19 PM, Unit Manager Licensed Practical Nurse #4 stated Certified Nursing Assistant #5 should have cleaned Resident #63's fingernails during morning care. They stated resident's fingernails are to be trimmed and cleaned on shower day and any time when they are long or noted with brown debris beneath them. They stated all nurses and certified nursing assistants are responsible to ensure resident's fingernails are clean and trimmed during care.</p> <p>During an interview on 3/19/25 at 12:05 PM, the Director of Nursing stated they would have expected Certified Nursing Assistant #5 to have trimmed and cleaned Resident #63's fingernails during morning care. They stated it was important to have resident's fingernails trimmed and clean for infection control purposes and dignity. They stated it was the responsibility of all nurses and certified nursing assistants to observe resident's fingernails whenever providing care and would have expected them to have been cleaned and trimmed.</p> <p>10NYCRR 415.12(a)(3)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>36415</p> <p>Based on observation, interview, and record review conducted during the Standard survey completed on 3/19/25 the facility did not ensure that residents receive treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan for one (Resident #120) of three residents reviewed for nutrition. Specifically, weekly weights recommended by the dietician were not obtained consistently by the dietician as planned and Resident #120 had a continued weight loss.</p> <p>The finding is:</p> <p>The policy titled Weight Monitoring revised 5/2013 documented a weight record is used to facilitate monitoring of changes in weights on a weekly or monthly basis. Admission/ Re-Admission weights are obtained weekly for the first four weeks, then monthly thereafter unless more frequent monitoring is indicated by the resident's condition. Weekly or more frequent weight checks may be indicated on residents with anorexia, dehydration, obesity, edema, significant change or as indicated by certain medication regimes. Weight frequency will be increased as deemed necessary by Nursing, dietary or a physician. Consistent monitoring of weight gain or loss provides guidance for appropriate intervention in conjunction with the Dietician, as indicated. A licensed nurse monitors the weight sheets and significant changes are reported to dietary and physician as needed. Dietary records the weight in the Electronic Medical Record.</p> <p>Resident #120 had diagnoses which included Parkinson's disease, depression, and severe protein-calorie malnutrition (reduced availability of nutrients leads to changes in the body). The Minimum Data Set- (a resident assessment tool) dated 1/31/25 documented Resident #120 was cognitively intact, understands and was understood. The Minimum Data Set further documented Resident #120 weighed 125 pounds and had a weight loss of five percent or more in the last month or loss of ten percent or more in the last six months and was not on a physician's prescribed weight-loss regimen.</p> <p>The comprehensive care plan dated 2/19/25 documented that Resident #120 was at risk for alteration in nutrition related to parkinsonism, depression, below the ideal body weight, significant weight-loss, and protein-calorie malnutrition. The plan included to weigh weekly, supplements on meal trays: mighty shakes three times per day and nutritional medication pass which included liquid protein supplement.</p> <p>The Visual/Bedside Kardex Report (guide used by staff to provide care) with the as of date of 3/18/25 documented Resident #120 required maximal assist for meals and ate meals on the unit. Weekly weights were not reflected on the Kardex report.</p> <p>The Dietary Nutritional Screen dated 1/27/25 documented a weight of 124.8 pounds and was a 15.2 pound weight loss since discharged from the facility on 10/16/24 at a weight of 140 pounds. Weekly weights were incorporated into the plan and Resident #120's weight would gradually increase by the next review.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Medical Visit Note dated 3/6/25 Nurse Practitioner #2 documented the most recent weight was 124.4 and was obtained on 2/12/25. Resident #120 had severe protein calorie malnutrition due to chronic disease, and Parkinson's. Nurse Practitioner recommended to continue vitamin/mineral supplementation and was followed by Nutrition.</p> <p>During an observation and interview on 3/13/25 at 9:02 AM, Resident #120 was eating breakfast in bed and stated they preferred no assistance with eating from the staff and wanted to remain as independent as possible. They did not like the food and were unsure how much weight they lost but knew they had lost weight.</p> <p>Review of the meal consumption sheets dated from 2/17/25 through 3/17/25 documented Resident #120's average intakes ranged from 25 percent to 50 percent.</p> <p>The nutrition snack before bedtime consumption sheets from 2/19/25 through 3/17/25 documented Resident #120 refused on 2/19/25 and accepted the snacks on the following evenings: 2/28/25, 3/1/25, 3/4/25, 3/8/25, 3/17/25. It was documented Resident #120 was offered snacks before bedtime on six evenings between 2/19/25 and 3/17/25.</p> <p>Review of the B Unit weekly weight tracking sheets on 3/17/25 at 10:32 AM verified by Registered Dietician # 2 that from 1/28/25 through 3/11/25 revealed Resident #120 had inconsistent documented weekly weight tracking. The weights were blank on 2/18/25, 2/25/25, 3/4/25, and 3/11/25.</p> <p>The Nutrition Weight Audit Tool for B Unit provided by Registered Dietician #2 on 3/18/25 dated 2/27/25 and 3/13/25 the weight column for Resident #120 was blank.</p> <p>During an interview on 3/18/25 at 12:44 PM, Registered Dietician #2 stated they distributed weekly weight sheets on Monday mornings. Certified nursing assistants documented the weights weekly on the tracking sheets. The sheets were collected at the end of the day shift on Wednesdays then documented into the electronic medical record. Nutrition Weight Audit Tools indicated missed weights and were emailed on Thursdays to Registered Nurse Unit Coordinator #2, Assistant Director of Nursing #1 and Director of Nursing #1. Registered Dietician #2 assumed no additional weight loss had occurred for Resident #120 based on meal and bedtime snack consumption but was not definite. The last documented weight was 124.4 pounds on 2/12/25. Weights were monitored weekly for four weeks, then monthly thereafter unless directed by the physician. Weights warranted the need for revisions to resident's daily meal plan and prevented further weight loss.</p> <p>Further during an interview on 3/18/25 at 2:56 PM, Registered Dietician #2 stated Resident #120's current weight on 3/18/25 was 120.6 pounds and was 4 pounds down from readmission on 1/27/25 but was not significant. They would have implemented more protein and prevented further muscle wasting. Registered Dietician #2 stated they would have notified the provider sooner of the downward trend and suggested an appetite stimulant if it would not be contraindicated with their other medications.</p> <p>During an interview on 3/19/25 at 9:36 AM, Certified Nursing Assistant #4 stated they were responsible for Resident #120's weekly weights. Weights were important to monitor fluid balances and health. Certified Nursing Assistant # 4 stated providing care was more important than getting weights.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/25 at 10:51 PM, Nurse Practitioner #2 stated they would have expected the recommendations of Registered Dietician #2 to be followed to catch trends of weight loss or gains. Interventions with additional supplements or vitamins may have been warranted.</p> <p>During an interview on 3/19/25 at 12:02 PM, Registered Nurse #2 Unit Coordinator stated weights were written down daily on the certified nurse aides assignments sheets. The assigned certified nurse aide documented the weight on the weight board kept at the nurse's station. Registered Nurse #2 Unit Coordinator did not know why weekly weights were inconsistently documented for Resident #120, but they should have been completed and documented weekly.</p> <p>During an interview on 3/19/25 at 12:08 PM, Director of Nursing #1 stated Certified Nurse Aide # 4 should have weighed Resident #120 weekly per Registered Dietician #2's recommendation and their plan of care.</p> <p>10 NYCRR 415.12</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>36415</p> <p>Based on observation, interviews, and record review conducted during a Standard survey completed on 3/19/25, the facility did not ensure that the resident environment remained as free from accident hazards as was possible and that each resident received adequate supervision to prevent accidents for one (Resident #115) of three residents reviewed. Specifically, Resident #115 was served regular consistency soup with intact broccoli pieces and the soup should have been pureed.</p> <p>The finding is:</p> <p>The policy and procedure titled Accident/Incident Investigation and Prevention with a revised date of 6/23 documented the facility provides an environment that is free from accident hazards and provided supervision to each resident to prevent avoidable accidents.</p> <p>The policy and procedure titled Eating Assistance revised 3/25 documented that facility staff is responsible for assisting and/or feeding residents as needed. It documented that when the meal is presented to the resident, staff will check the meal ticket for the type of assistance required and to assure the correct diet has been provided, and the prescribed liquid/food consistency are present.</p> <p>The policy and procedure titled Solid and Liquid Consistency revised 9/22 documented that consistency alterations are indicated when residents have difficulty chewing or swallowing due to various problems such as poor dentition, facial paralysis, senility and dysphagia. It documented that for an order of thickened liquids, all soups are served puree and modified to the correct consistency.</p> <p>Resident #115 had diagnoses including aphasia following Cerebral Infarction (a language disorder that impairs a person's ability to communicate, including speaking, understanding, reading, and writing, due to damage to the brain's language center), dysphagia (difficulty swallowing, which can occur due to damage to the brain regions controlling swallowing, leading to potential complications like malnutrition and pneumonia), and dementia (a condition characterized by progressive or persistent loss of intellectual functioning). The Minimum Data Set (an assessment tool) dated 2/7/25 documented Resident #115 had a moderate level of cognitive impairment and was sometimes understood and understood sometimes.</p> <p>Resident #115's Comprehensive Care Plan documented that Resident #115 required verbal cues/encouragement and supervision when eating and was to eat all meals in the main dining room.</p> <p>Resident #115's Kardex (guide used by staff to provide care) dated 3/16/25 documented the resident ate all meals in the main dining room and their diet order was for nectar thick liquids and they required supervision and verbal cueing and encouragement.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an evening meal observation in the main dining room on 3/16/24 all trays were passed by nursing staff at 6:41 PM. At 6:47 PM, Resident #155's meal ticket documented the resident was to receive a pureed soup and have supervision with encouragement and verbal cueing at mealtime. The soup on Resident #115's tray was uncovered, and was of regular consistency and contained pieces of broccoli. Resident #115 had not eaten any of the soup, however was able to pick up their sandwich and eat. There were staff in the dining room supervising at this time.</p> <p>Review of Resident #115's diet order documented that Resident #115 was ordered a house diet, ground texture, nectar thick liquids with large portions, with an effective date 10/25/24.</p> <p>Review of the Swallow Discharge Summary dated 11/1/24 documented Resident #115 was aphasic, dysarthric (difficulty speaking due to damage or dysfunction of the muscles or nerves controlling speech), confused, and lethargic. The resident was able to manage ground food consistency and required nectar thick liquids due to a delayed trigger and coughing persisting with thin liquids. Additional recommendations were to provide supervision during meals, provide verbal encouragement, decrease the rate and amount of consumption, alternate liquids and solids, and alternate hot and cold. The Swallow Discharge Summary noted that Resident #115 was unable to follow the recommendations independently.</p> <p>Review of Section GG (Functional Abilities) of Resident #115's Minimum Data Set (an assessment tool) dated 2/7/25 documented the resident usually required supervision or touching assistance while eating.</p> <p>During an interview on 3/16/25 at 6:48 PM, Food Service Director #1 stated Resident #115 should have received a pureed nectar thick soup with their meal and had they attempted to eat the regular soup, they could have choked.</p> <p>During an interview on 3/17/25 at 10:56 AM, Speech-Language Pathologist #1 reviewed Resident #115's chart and stated Resident #115's soups should be pureed and nectar thick and they could be at risk of aspiration if they ate regular consistency soup with pieces of broccoli. They stated that supervision at mealtime meant that someone should be checking on the resident throughout the meal.</p> <p>During an interview on 3/17/25 at 12:37 PM, Licensed Practical Nurse #4 stated that to their understanding, supervision was considered nursing staff being present in the dining room during mealtime for Resident #115.</p> <p>During an interview on 3/19/25 at 8:56 AM, Director of Nursing #1 stated that Resident #115 could have aspirated or choked if they had eaten regular consistency soup with pieces of broccoli. The stated that meal tickets and care plans should always be followed.</p> <p>10NYCRR 415.12 (h)(1)(i) (2)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>36415</p> <p>Based on interview and record review conducted during a Standard survey completed on 3/19/25, the facility did not ensure that the pharmacist reported irregularities to the Attending Physician, the Director of Nursing and the facility's Medical Director, and that these reports were acted upon for one (Resident #145) of five residents reviewed for drug regimen reviews. Specifically, recommendations made by the Consultant Pharmacist on 1/17/25 were not reported to the Attending Physician, and the facility's Medical Director. Additionally, these recommendations were not acted upon.</p> <p>The finding is:</p> <p>The policy titled Unnecessary Medications Medication Regimen Review, last revised 10/2018, documented the Consultant Pharmacist conducted a medical record review and assessed the drug therapy of each resident monthly. During routine reviews the Consultant Pharmacist identifies any irregularities or additional identified concerns using the Medication Regimen Review Form. When there were pharmacy recommendations that were routine, the pharmacist would move the medication regime review form to the physician section of the chart. On the next scheduled visit, the attending physician reviewed and documented the irregularity and what/if any action had been taken to address. Should there be no change, the physician documented their rationale. The physician responded/followed up within 60 days of routine recommendations. If physician follow up exceeded 60 days, the Consultant Pharmacist would notify the Director of Nursing Services/facility designee.</p> <p>The finding is:</p> <p>Resident #145 had diagnoses including type 2 diabetes mellitus, dementia without behavioral disturbance, and depression. The Minimum Data Set (a resident assessment tool) dated 12/3/24 documented Resident #145 was moderately cognitively impaired, was usually understood, usually understands, and received hypoglycemic medication (used to lower blood sugar).</p> <p>Review of the comprehensive care plan dated 11/26/24 documented Resident #145 had an alteration in nutrition related to diabetes mellitus with an intervention to monitor for signs and symptoms of hyper/hypoglycemia (high/low blood sugar).</p> <p>Review of Pharmacy Drug Regimen Review form dated 1/17/25 at 6:22 PM, Consultant Pharmacist #1 documented the medication regimen of Resident #145 was reviewed. A recommendation was made to the attending physician.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Note to Attending Physician/Prescriber dated 1/17/25, revealed Consultant Pharmacist #1 identified Resident #145 was receiving a weekly CBC with diff (complete blood count with differential; a blood test that goes beyond a standard complete blood count by providing a detailed analysis of the different types of white blood cells in addition to the standard complete blood count measurements) and a BMP (basic metabolic panel; a blood test that measures electrolytes and blood sugar) and they questioned if it was still required weekly. Additionally, they identified Resident #145 was receiving Lantus (a medication that lowers the blood sugar slowly over a 24-hour period) 100 units/milliliter 8 units injected every morning, Humalog (a medication that lowers the blood quickly over a short period of time) 100 units/milliliter per sliding scale before each meal (which required the resident to have their blood sugar taken by a finger stick three times a day), Metformin (a medication that lowers blood sugar over a 24-hour period) 1000 milligrams twice a day and Ozempic (a medication that lowers the blood sugar slowly over a 7 day period) 2 milligrams/3 milliliters 0.5 milligrams injected once every Wednesday. They documented Resident #145's blood sugar range was between 80-233 from 1/1/25 to 1/17/25 and questioned if the residents sliding scale insulin checks should continue as ordered due to only requiring insulin three times out of fifty finger sticks, and if not how often should blood sugar be monitored. There was no documented follow up, signature, or date on the report by a medical provider.</p> <p>Review of the physicians Order Summary Report dated 3/18/25 revealed Resident #145 had active physician's orders to receive weekly lab work consisting of a complete blood count with differential and a basic metabolic panel and Humalog 100 unit/milliliter inject per sliding scale three times a day before meals.</p> <p>During a telephone interview on 3/18/25 at 11:34 AM, Licensed Practical Nurse #5 Unit Manager stated when they received a pharmacy recommendation, they placed them into the medical providers box to be addressed. The medical provider would write if they agreed or disagreed with the recommendation, sign it, and put in the order if there was a change. The Unit Manager would then approve the order, and the recommendation was then filed in the resident's medical chart. Licensed Practical Nurse #5 Unit Manager stated they could not recall the recommendation or if the medical provider had been updated on the recommendation from Consultant Pharmacist #1 for Resident #145 from 1/17/25.</p> <p>During a telephone interview on 3/18/25 at 11:56 AM, Consultant Pharmacist #1 stated they review all residents' medications and medical record monthly and make recommendations based on their findings. The recommendations were emailed to the Unit Managers and Director of Nursing. The Unit Managers review them and then gives them to the medical providers to address. They expected all recommendations to be addressed based on the severity of them, but no later than the next monthly review. Consultant Pharmacist #1 stated they made recommendations for Resident #145 on 1/17/25 to reduce their finger sticks and injection burden. The recommendations were not addressed so they sent an email on 2/18/25 notifying the facility (Licensed Practical Nurse #5 Unit Manager) that it had not been responded to. During the interview the consultant reviewed Resident #145's medical record and stated the recommendations had not been addressed as of 3/18/25. They had not completed the monthly review for March yet, so that was the last communication regarding the orders.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a facility provided e-mail sent to Licensed Practical Nurse #5 Unit Manager dated 2/18/24 revealed Consultant Pharmacist #1 attempted to follow up on the recommendations for Resident #145. The e-mail was sent to Licensed Practical Nurse #5 Unit Manager with the monthly unit report and documented there were old items that had not been addressed by the medical provider for Resident #145 from 1/17/25. There was no documented evidence the email was replied to, or that the recommendations were addressed.</p> <p>During an interview on 3/18/25 at 12:05 PM, Nurse Practitioner #1 stated the process for monthly medication recommendations was that they were placed in a box outside of their office by the Unit Managers, were then reviewed by the medical provider who would write if they agreed or disagreed with the recommendation, sign them, then enter any changes into the medical record. They stated they do not recall every being given a recommendation for Resident #145 from 1/17/25 regarding weekly lab draws or Humalog sliding scale changes. Nurse Practitioner #1 reviewed Resident #145's medical record and physician notes and stated a medical provider would have put a note in regarding reviewing the recommendations, and there was no note, so they did not think any other medical provider saw the recommendation either. They stated Resident #145 was now long term in the facility so they probably did not need lab work drawn weekly and their Humalog would be appropriate to change to once a day instead of three times a day to lessen the finger sticks, they received. Nurse Practitioner #1 stated it was important to review pharmacy recommendations in a timely manner to make any needed changes to the residents' plan of care.</p> <p>During an interview on 3/19/25 at 9:17 AM, Director of Nursing #1 stated the current process for monthly medication reviews were that the Consultant Pharmacist emailed all recommendations to the Unit Managers and themselves (Director of Nursing), then they were given to the medical providers by the unit managers to address and then given back to medical records to file accordingly. They stated they would have expected the recommendations made for Resident #145 on 1/17/25 to have been given to the medical provider by Licensed Practical Nurse #5 Unit Manager. It was important to ensure recommendations were followed through with in a timely manner so that things did not fall through the cracks like the incident with Resident #145. Additionally, Director of Nursing #1 stated they expected to be included on any follow up correspondence regarding recommendations not being addressed.</p> <p>During an interview on 3/19/25 at 10:49 AM, Medical Director #1 stated their expectations regarding monthly medication regimen reviews sent by the Consultant Pharmacist were that they were given to the medical providers and addressed within a week of the Unit Managers receiving them. There were providers in house daily, so there was no excuse for the recommendations for Resident #145 made on 1/17/25 to not have been addressed. They stated it was important for reviews to be addressed timely for the safety of residents. Additionally, Medical Director #1 stated they valued the Consultant Pharmacist recommendations.</p> <p>During an interview on 3/19/25 at 11:54 AM, the Administrator stated the Unit Managers, with oversight from the Director of Nursing, were responsible for reviewing medication regimen reviews and giving to the medical providers to address.</p> <p>10 NYCRR 415.18 (c)(2)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>36415</p> <p>Based on observation, interviews, and record review conducted during the Standard survey completed on 3/19/25, the facility did not ensure that food and drink was palatable, attractive and at a safe and appetizing temperature for five (B Unit dining room, D Unit dining room, C Unit hallway, A Unit hallway, and Main dining room) of five test trays. Specifically, food and beverages during meals were served at suboptimal temperatures and were not palatable. Residents #38, #54, #60, #79, #87, #92, #101, #104, #118, #120, #127, #143, #145, and #173 were involved. Residents attending the resident council meeting also expressed concerns about food and food temperatures.</p> <p>The findings are:</p> <p>The policy titled Food Preparation, Service, and Distribution effective 7/2008 and revised 10/22 documented that the facility will assure safe and sanitary food preparation, holding, transport and distribution to prevent foodborne illness. It documented that foods would be held at temperatures outside of the danger zone (temperatures above 41 degrees Fahrenheit and less than 135 degrees Fahrenheit) in tray-line and/or alternate meal preparation and service areas that may include steam tables, where hot prepared foods are held and served and chilled areas where cold foods are held and served. The policy and procedure further documented the facility will serve hot foods hot and cold foods cold in accordance with resident preference.</p> <p>a. Review of Resident Council Meeting Notes and Resident Council Concern & Comment Forms revealed the following concerns:</p> <ul style="list-style-type: none"> -December 2024, late mealtimes, sometimes 45 minutes to an hour late and food being cold, as well as no condiments placed on trays, no menus posted -January 2025, late meals, cold food, tea, and coffee; all mostly at dinner time. -February 2025, food continued to be frequently late and cold, as well as incorrect; still issues with condiments; residents have been told they can't have seconds because the leftover food was thrown out; issues with coffee, they questioned if the machine was broken. <p>b. Initial Pool Interviews and Observations</p> <p>During an interview on 3/12/25 at 8:56 AM, Resident #79 stated the kitchen has gotten worse lately and meals were being served way later than the projected times. They were lucky if they received lunch by 1:15 PM in the main dining room. They stated the coffee maker had been broken for a month, so they were not receiving hot coffee or tea. Most of the time food was served cold. They stated they brought up the concerns at Resident Council, so the facility was aware of the issues.</p> <p>During an interview on 3/12/25 at 9:30 AM, Resident #60 stated the food sucks. There was often black residue in their tea and coffee cups and the silverware on the meal trays came dirty often. The meal trays were dirty and did not look like they were washed in between meal services. Resident #60 stated they had spoken with Food Service Director #1 on multiple occasions with complaints of missing items on their tray and inedible, cold, hard food.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/12/25 at 11:08 AM, Resident #92 stated the food temperatures were fair but not hot, meats and vegetables tasted bland.</p> <p>During an interview on 3/12/25 at 12:16 PM, Resident #127 stated food is mushy, it tastes bad, bland and the food is always cold.</p> <p>During an interview on 3/12/25 at 12:30 PM, Residents #79 and #104 stated they always had to ask for hot water for tea or for coffee and condiments at every meal. They stated that the dinner meal was always late, dinner had been served as late as 7:40 PM. Late dinners make it difficult for the nurses on the units to pass out medications in a timely manner, and Certified Nurse Aides on the units have less time to give showers and get residents ready for bed. Residents #79 and #104 stated that the facility's coffee machine had been broken for several weeks now and the quality of the coffee being served, if there was coffee served at all, was bad.</p> <p>During a follow up interview on 3/12/25 at 1:34 PM, Resident #60 stated the ham was just warm, the gravy on the potatoes was barely warm, and they did not receive any tea, sugar or creamer, and that bothered them.</p> <p>During an interview on 3/12/25 at 1:16 PM, in the main dining room, Resident #87 stated they usually try to come to the main dining room at about 5 PM and spend time talking with other residents who are waiting for the meal service. They stated that dinner often did not come out until 7:30 PM and it was usually cold.</p> <p>During an interview on 3/12/25 at 1:39 PM, Resident #143 stated the quality and taste of the food was awful. The ham was too salty and there was no salt in the mashed potatoes. The hot water for tea was not very hot.</p> <p>During an interview on 3/12/25 at 3:24 PM, Resident #38 stated they usually received a cup of water for tea on their meal tray and a lot of the time, the water was too cold to make tea. They stated they usually ate in their room and dinner often did not come until 7:00 PM and lunch sometimes did not come until 2:00 PM.</p> <p>During an interview on 3/13/25 at 9:04 AM, Resident #101 stated that the food was atrocious and always cold. They stated that at times they did not receive meals at all and did not receive a breakfast tray at all on Monday, 3/10/25. They ordered out dinner due to not receiving dinner and they would like to have tea but were not aware if that was available.</p> <p>During an interview on 3/13/25 at 4:46 PM, Resident #137 stated they often received their meal trays with cold food items that are supposed to be hot, which makes them not want to eat the food anymore. They stated they did not bother asking for items to be reheated because staff never came back after asking them for something.</p> <p>During an interview on 3/14/25 at 8:15 AM, Resident #60 stated the dinner meal the night prior had consisted of a meat ball sub and green beans. The green beans were not in a separate bowl, so the juices caused their bun to become soggy and fall apart. It was disgusting and inedible.</p> <p>c. Test Tray Observations and Interviews:</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a tray line observation on 3/14/25 from 11:27 AM to 1:15 PM, temperatures of food items placed on the steam table were taken with a facility thermometer by [NAME] #1 at 11:25 AM, and were as follows:</p> <p>Catch of the Day - regular 179 degrees Fahrenheit</p> <p>Catch of the day - pureed 189 degrees Fahrenheit</p> <p>French fries - 190 degrees Fahrenheit</p> <p>Glazed baked ham 189 degrees Fahrenheit</p> <p>The lunch meal caddies left the kitchen at the following times:</p> <p>B unit caddy left the kitchen with the test tray at 12:18 PM</p> <p>A unit caddy left the kitchen with the test tray at 12:32 PM</p> <p>C unit caddy left the kitchen with the test tray at 12:46 PM</p> <p>D unit caddy left the kitchen with the test tray at 12:57 PM</p> <p>Main dining room caddy left the kitchen with the test tray at 1:13 PM</p> <p>During an observation of a lunch meal test tray on 3/14/24 from 12:10 PM to 12:25 PM, the second tray caddy arrived on B unit in the dining room at 12:20 PM. The test tray temperatures were taken with a facility thermometer. The test tray contained the alternative meal selection in ground consistency. The food was tasted and tested with Registered Dietician #2 at 12:25 PM and the temperatures were as follows:</p> <p>-Ground ham measured 104 degrees Fahrenheit, tasted lukewarm, and was not palatable.</p> <p>During an observation of a lunch meal test tray on 3/14/25 on Unit A, the meal cart arrived on the unit at 12:33 PM, all trays were passed at 12:50 PM. The tray contained the regular meal selection for this service with regular consistency food and regular consistency liquids. The food temperatures on the test tray were taken at 12:55 PM by the Dietician #1, using a facility thermometer and were as follows:</p> <p>-Fish measured 118 degrees Fahrenheit; tasted bland and not warm enough.</p> <p>-French Fries measured 100.0 degrees Fahrenheit; and were bland and not warm.</p> <p>-Hot water measured at 94 degrees Fahrenheit; and was not warm.</p> <p>During an observation of a lunch meal test tray on 3/14/25 at 1:01 PM on C unit, all trays were passed at 1:01 PM. The tray contained a regular meal with regular consistency and regular liquids. The food temperatures on the test tray were taken at 1:01 PM by Food Service Director #1, using a facility thermometer and were as follows:</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Coffee measured 106 degrees Fahrenheit; tasted tart and not warm enough.</p> <p>During an interview at the time of the test tray, Food Service Director #1 stated they believe the coffee sat too long and it cooled down. They stated hot foods should come out of the kitchen at 165 degrees and be palatable to the taste and temperature.</p> <p>During an observation of a lunch meal test tray on 3/14/25 from 11:57 AM to 1:04 PM, the tray caddy arrived on D unit, 5 staff members assisted with passing trays, the doors remained open for a short period, then staff kept one door open at a time while passing trays on that side. At 12:58 PM the second caddy arrived with the test tray on it. Trays were passed to residents seated in the dining room on D unit. The doors remained open, and trays were continuously passed. All trays were served at 1:02 PM, and the test tray temperatures were taken with a facility thermometer. The tray contained the regular meal for this meal service in regular consistency with regular fluids. Food was tasted and tested with Registered Dietician #1 at 1:04 PM and were as follows:</p> <p>-French fries measured 102 degrees Fahrenheit; tasted gritty, lukewarm and dry.</p> <p>-Coffee measured 92 degrees Fahrenheit; was not warm enough, had no flavor, and was not appetizing.</p> <p>During an interview at the time of the test tray, Registered Dietician #1 stated the French fries were hard to take a temperature on and the coffee, and all warm foods, should be over 140 degrees Fahrenheit. Below favorable temperatures could make food less palatable, and it was important to keep temperatures in the safe zone for food safety.</p> <p>During an observation of a lunch meal test tray on 3/14/25 from 1:15 PM to 1:22 PM, the two tray caddies arrived in the main dining room at 1:15 PM, facility and corporate staff assisted with passing trays and all trays were passed at 1:19 PM, and the test tray temperatures were taken with a facility thermometer. The tray contained the Regular meal with puree consistency and regular fluids. Food was tested and tasted with Food Service Director #1 at 1:21 PM and temperatures and taste were as follows:</p> <p>-Pureed fried fish measured 135 degrees Fahrenheit and tasted dry for a pureed diet.</p> <p>-Coffee/water measured 106 degrees Fahrenheit and tasted too cold for coffee.</p> <p>During an interview at the time of the test tray, Food Service Director #1 stated that they thought all food items on the tray tasted good and the coffee was too cold.</p> <p>During an interview on 3/14/25 at 1:12 PM, Resident #60 stated the lunch they received that day was ham and French fries and everything was cold, including their tea. This was upsetting to them.</p> <p>During an interview on 3/14/25 at 1:05 PM, Resident #173 stated they received their lunch tray with cold ham and runny ice cream. They stated after their ham was reheated it was good. Resident #173 stated their coffee was cold and that was typical. They stated the coffee should be warmer.</p> <p>During an interview on 3/14/25 at 1:12 PM, Resident #120 stated their lunch was kinda warm but could have been warmer. They stated the coffee was lukewarm, bland and was usually cold.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 3/14/25 at 1:14 PM, Resident #145 stated their French fries were cold and the coffee was warm, not hot. They stated the coffee should be hot.</p> <p>During an interview on 3/14/25 at 1:17 PM, Resident #118 stated their fish and French fries were cold. Resident #118 stated they didn't drink their coffee because it was cold. They stated the meals and coffee were always cold.</p> <p>During an interview on 3/18/25 at 10:48 AM Registered Dietician #2 and #3 stated they had heard about issues with coffee in the facility and they would expect tea, hot chocolate, and coffee to be available at mealtimes. Registered Dietician #3 stated they expected hot drinks and hot food to get to the residents at 140 degrees Fahrenheit or above, as below that, the items would be in the danger zone. Hot food should be greater than 140 degrees Fahrenheit and cold food should be less than 40 degrees Fahrenheit.</p> <p>During an interview on 3/19/25 at 8:50 AM Director of Nursing #1 (infection Preventionist) stated they could not answer what the correct food temperatures for hot and cold food were and would have to resort to the Registered Dietician's expertise. They stated if food was not cooked enough there was a potential for salmonella, and if food was served too hot, there would be a potential for burns. They stated they were aware there had been issues with the coffee maker and the facility did not allow staff on units to reheat any food items. Unit staff had been instructed to go to the kitchen if a resident requested that something be reheated. Director of Nursing #1 also stated that cold coffee would not taste good and tea water that is lukewarm would not make good tea.</p> <p>10 NYCRR 415.14 (d)(1)(2)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36415</p> <p>Based on observations, interviews, and record review conducted during a Complaint (NY00353368) investigation during the Standard survey completed on 3/19/25, the facility did not store, prepare, distribute, and serve food in accordance with professional standards for food service safety for one of one kitchen. Specifically, the kitchen had unlabeled and undated food items stored in the freezer and coolers. The main kitchen coffee maker was not functioning and kitchen equipment was not cleaned after previous use. There was food and trash debris on the kitchen and dish washing room floors; there were un-covered meal trays with un-eaten food on open carts, on top of tray caddies, on the counters in the main dining room and hallway adjacent to the main dining room. Additionally, there were fruit flies observed on several occasions. Resident #137 was involved.</p> <p>The findings are:</p> <p>The policy and procedure titled Food Preparation, Service, and Distribution effective 7/2008 and revised 10/22 documented the facility would assure safe and sanitary food preparation, holding, transport and distribution. Food contact equipment would be clean, washed and sanitized between uses.</p> <p>The policy and procedure titled Dining Room/Servery Meal Service with a revised date of 3/2011 documented it was to establish the times, methods, delivery, pick-up, supervision and disbursement of resident trays. It documented that dietary staff will be responsible for the delivery and pick up of food carts to and from each station, nursing personnel will be responsible for the disbursement of trays and returning the finished tray to the food cart, that prior to removing the cart from the unit, dietary personnel will check to see that they have all available trays at that time. The dietary and nursing personnel will clear the residents' meal, clean and sanitize the area and re-set the table.</p> <p>During the initial walk-through of the kitchen and food storage areas on 3/12/25 from 8:48 AM to 9:08 AM, the following were observed:</p> <p>There was an open metal cart containing two shallow pans with two tied roasts each (total of 4 roasts) in the walk-in freezer. They were uncovered and not labeled or dated.</p> <p>The floor stand mixer had dried spills on both arms, the soup kettle had dried on spills around the outside and on the base, and the meat slicer had meat pieces stuck at the bottom of the blade and blade guard along with solidified greasy drips in the catch area. At the time of the observation, Food Service Director #1 stated that the meat slicer had last been used during the evening shift on 3/11/25 and should have been cleaned by the cook who used it to slice ham. The slide-out stove drip trays under the cooking surface had four different types of burned-on pasta and various other unidentifiable burned on substances on them. The splash guard at the back of the stove was greasy and the surface finish of it was flaking.</p> <p>The kitchen reach-in prep cooler contained the following unlabeled and undated items: one cut in half tomato wrapped in clear plastic wrap, half of a turkey breast wrapped in clear plastic wrap, and one resealable clear plastic bag appearing to contain chopped cooked turkey breast.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The walk-in cooler contained a metal pan with half of an uncovered/unwrapped liver sausage and a clear plastic resealable bag of cheese. The bag, liver sausage and pan was not labeled or dated and the open end of the liver sausage was dark and dried out.</p> <p>The kitchen and dish washing room floors were littered with food debris and used napkins, plastic covers, single use condiments, single use supplement containers that had been consumed, etc.</p> <p>There was a box of broken ceramic plates on a shelf under the three-part sink. The broken pieces were covered in debris. During an interview on 3/12/25 at 9:08 AM, Food Service Director #1 identified the debris on the plates as herbs and spices and stated they did not know why that box would be there.</p> <p>During the interview on 3/12/25 at 9:08 AM, Food Service Director #1 stated they were working on a cleaning schedule for the kitchen and that they expected cooks to clean any equipment they used when they finished using it. They also expected dietary staff to clean their stations along the tray line when tray line was finished.</p> <p>There were two un-covered large trash cans in use in the kitchen, after morning tray line clean-up.</p> <p>During an observation on 3/12/25 at 9:26 AM, the dish washing room was crowded with serving carts of dirty dishes, there were three full carts of dirty dishes in the main dining area outside of the dish washing room, and the cart containing the four tied roasts observed earlier in the walk-in freezer was now in the dish washing room with the roasts still in the shallow pans on the cart. There was no one working in the dish washing room, at the time of this observation.</p> <p>During an interview on 3/19/25 at 11:26 AM, Food Service Director #1 stated that the roasts observed in the walk-in freezer were roasted turkey that had been prepared the night before and they were overcooked. Dietary staff ended up disposing of the four roasts. All items in the reach-in and walk-in coolers that were unlabeled and undated were disposed of and dietary staff should always dispose of anything that was unlabeled and undated, as there was no way to know when it was opened.</p> <p>During an interview on 3/13/25 at 8:38 AM, Dietary Aide #1 stated that when tray line was finished, all dietary staff cleaned up their areas of tray line and after that they all go on break.</p> <p>During an observation on 3/12/25 at 4:35 PM, there were three open tray carts with uneaten food on lunch trays in the main dining room just outside of the dish washing room.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 3/16/25 at 4:45 PM, in the main dining room, the tablecloths on the tables were soiled, the floor had food debris on it, there were two lunch trays with leftover food in the main dining room, one on a tray table, the other on top of a tray caddy (identified as lunch trays based on the food items and the meal tickets on the trays), there was one meal tray with breakfast leftovers on the counter near the main dining room servery area (identified by the food items and the meal ticket on the tray). A long table where feeding assistance was provided had a pile of soiled clothing protectors on it, and the coffee station had opened and emptied single serve containers of creamer on a tray and the area was littered with what appeared to be spilled sugar or artificial sweetener. There were six insulated tray caddies in the hallway and one of them had a partially eaten plastic yogurt cup with a soiled napkin and spoon placed on top of it. During an interview at this time PM, Food Service Director #1 stated the dishes from the lunch service should have been washed after the lunch service and the tablecloths in the dining room should have been changed. It was dining staff and housekeeping staff's responsibility to clean the main dining room between meals.</p> <p>During an observation on 3/16/25 at 5:44 PM, the dish washing room had several fully loaded carts of dirty dishes, including a cart with a stack of dirty steam table pans, identified by Food Service Director #1 as steam table pans from the lunch meal, the floor was littered with food debris and single use used plastic cup and bowl covers, empty single use ice cream cups, etc. No one was working in the dish washing room. During an interview at the time of this observation, Food Service Director #1 stated they had been onsite since 3:30 PM and work every other weekend and they were unsure who their assigned dish washing dietary staff was for this shift.</p> <p>b. During the initial kitchen walk-through on 3/12/25 from 8:48 AM to 9:08 AM, several small fruit flies were observed in the food preparations area.</p> <p>Fruit flies were also observed at the following times and in the following locations:</p> <p>3/12/25 at 10:03 AM in the hallway outside of the kitchen and main dining room had several small flies hovering around uneaten food on meal trays that had been placed on top of closed insulated tray transport caddies and were stored along the hallway wall. There was no one observed doing dishes at this time.</p> <p>3/12/25 at 3:19 PM in the main dining room just outside of the dishwashing room, several small flies flying around two carts of left over meal trays with uneaten and uncovered food.</p> <p>3/14/25 at 10:31 AM a small fly was observed in the food preparation area of the kitchen during the puree observation.</p> <p>3/18/25 at 3:20 PM a small fly was observed in the main dining room near the dish washing room door.</p> <p>Review of Pest Control Service Reports documented the following:</p> <p>On a report dated 8/9/24: A lot of fruit flies due to poor kitchen cleanliness.</p> <p>On a report dated 9/5/24: Heavy fruit fly activity due to poor cleanliness.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On a report dated 11/20/24: Heavy fly activity, water leak in dishwasher area puddling on floor. Food debris under all equipment. Replaced monitors as needed. Treated floor drains.</p> <p>On a report dated 1/2/25: Activity level was high. Replaced all monitors throughout. Foamed all drains. Replaced all glue boards in fly lights.</p> <p>On a report dated 2/19/25: Inspected kitchen, heavy fly activity found. Sanitation remains an issue as floors have standing water and food debris. Replaced glue boards and treated drains to aid with fly activity.</p> <p>On a report dated 3/5/25: Activity levels are high, especially in the dishwash area.</p> <p>During an observation and interview on 3/13/25 at 4:46 PM, Resident #137 was in their bed conversing with the surveyor, a fruit fly was flying around in the resident's room, and they were continuously swatting it away. Resident #137 stated the fruit flies came in with the meal trays and it was bothersome to them.</p> <p>During an interview on 3/18/25 at 3:47 PM, Licensed Practical Nurse #2 stated they had not seen any fruit flies on the unit recently, but there had been a problem with fruit flies in the summer time and nursing staff had been instructed to clear meal trays left on the unit of leftover food and dispose of it in the trash. They were instructed to return used meal trays to the kitchen, if the caddy was no longer on the unit for transport.</p> <p>During an interview on 3/18/25 at 3:20 PM, the Administrator stated they were aware of fruit flies in the building and the facility was using lights installed by their pest control vendor to combat them. They also stated they had a professional cleaning company come in to deep clean the walls and floors and had ordered lids for the kitchen trash cans. They stated that dining staff were responsible to return used meal trays to the kitchen after meal service and that any trays left on units after that were nursing staff's responsibility to return to the kitchen. The Administrator stated that Environmental Services Manager #1 was responsible to review service reports from the pest control vendor and that issues noted on the reports had been addressed in huddles by Food Service Director #1 with dietary staff.</p> <p>During an interview on 3/19/25 at 8:50 AM, Environmental Services Manager #1 and Housekeeping/Laundry Supervisor #1 stated they were aware of fruit flies in the building and Environmental Services Manager #1 stated they had spoken with the pest control vendor on what to look for that attracts them. They were the person who would power wash floors in the kitchen and dish washing rooms. Things to look for were for dietary staff to be on top of trays when they are returned to the kitchen and there had been some improvement since Food Service Director #1 had started their position in dietary.</p> <p>c. On 3/13/25 at 8:37 AM, Certified Nurse Aide #3 was observed at the kitchen door in the main dining room, requesting kitchen staff to re-heat a cup of coffee that had been served to a resident in A unit. While Dietary Aide #1 took the coffee cup to reheat, Certified Nurse Aide #1, in an interview, stated they often had to bring coffee cups to reheat, per resident requests.</p> <p>During an interview on 3/13/25 at 8:38 AM, Dietary Aide #1 stated the coffee maker was not functioning as it did not heat the water for brewing coffee. Dietary Aide #1 stated that kitchen staff had to heat water up, pour it into the coffee maker, and the coffee maker would then brew the coffee.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation in the main dining room on 3/13/25 at 8:59 AM there was a tray of coffee cups next to a thermal container; when checking the cups for cleanliness, they were visibly wet with water both inside and out.</p> <p>During an interview on 3/13/25 at 8:59 AM, Food Service Director #1 stated the kitchen staff had to do some dishes this morning and the cups should have been left to air dry completely prior to being placed in the main dining room for resident use. Food Service Director #1 stated the coffee maker was no longer heating the water and were waiting for a new machine to arrive.</p> <p>During an interview on 3/13/25 at 9:05 AM, Director of Program Management #1 stated the coffee maker broke on 3/7/25 and was being replaced. They stated the coffee maker was still brewing, but no longer heated the water to the correct temperature and this was the only coffee maker available in the facility.</p> <p>NYCRR 415.14 (h)</p> <p>Chapter 1 State Sanitary Code Subpart 14-1</p> <p>14-1.42, 14-1.43,14-1.95,14-1.110,14-1.170.</p> <p>NYCRR 415.29(j)(5)</p> <p>14-1.160</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>36415</p> <p>Based on observation, interview and record review conducted during a Standard Survey completed 3/19/25, the facility did not maintain an infection prevention and control program designed to provide a safe, sanitary, and a comfortable environment, to help prevent the development and transmission of communicable diseases and infections for one of one facility. Specifically, staff were not wearing face masks in resident care areas and were not immunized with the Influenza vaccine and New York State had declared Influenza Prevalent.</p> <p>The finding is:</p> <p>The policy titled Influenza (Seasonal/H1N1) Program - Employees/ Volunteers/Students documented, employees, volunteers and students are provided with influenza immunization, based on availability, unless medically contraindicated. Control of influenza is increasingly important because the long-term care resident is prone to developing serious complications when they contact the flu. Employees, volunteers and/or students that decline the influenza vaccine will be required to wear asks in all areas of the building except for the main kitchen and service corridor when influenza is deemed prevalent in New York State. Facility records are required to be maintained for employee vaccinations status.</p> <p>New York State Department of Health memo dated 12/18/24 to Article 28, 36, and 40 Healthcare and Residential Facilities and Agencies from the Office of the Commissioner documented, New York State Department of Health Commissioner declares Influenza Prevalent in the State. In accordance with Section 2.59 of the New York State Sanitary Code (10NYCRR 2.59), all healthcare and residential facilities and agencies regulated pursuant to Article 28, 36, or 40 of the public health law, shall ensure that all personnel, as defined in the regulation, not vaccinated against influenza for the current influenza season wear a surgical or procedure mask while in the areas where patients or residents are typically present. This declaration shall remain in effect until the Commissioner declares influenza no longer prevalent in New York State.</p> <p>A facility e-mail dated 12/18/24 at 2:29 PM from the Quality Assurance Corporate Nurse to the Director of Nursing with a subject: Advisory: Influenza declared prevalent in New York State for 2024 - 2025 Influenza season, documented Masks on for those that are not vaccinated.</p> <p>A facility e-mail dated 12/18/24 at 2:38 PM from the Director of Nursing to management nursing personnel including Unit Manager Licensed Practical Nurse #4 with subject: Masks documented, Masks MUST be worn for all staff that have not received the flu vaccination.</p> <p>Review of untitled and undated employee list identified by the Director of Nursing as the current employee list of acceptance/declination of the Influenza vaccine, documented staff members; Certified Nurse Aides #5, #8, #9, #10, Licensed Practical Nurse #9 and #10 were identified as having declined the influenza vaccine. Certified Nurse Aide #11 was not listed on the employee list.</p> <p>Review of the facility forms titled Employee Consent / Declination of Immunizations revealed the following:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Certified Nurse Aide #5 declined the Influenza vaccine on 11/1/24.</p> <p>Certified Nurse Aide #8 declined the Influenza vaccine on 11/1/24.</p> <p>Certified Nurse Aide #9 declined the Influenza vaccine on 11/1/24.</p> <p>Certified Nurse Aide #10 declined the Influenza vaccine on 11/9/24.</p> <p>Certified Nurse Aide #11 declined the Influenza vaccine on 3/13/25.</p> <p>Licensed Practical Nurse #9 declined the Influenza vaccine on 11/11/24.</p> <p>Licensed Practical Nurse #10 declined the Influenza vaccine on 11/14/24.</p> <p>During an observation on 3/17/25 at 10:04 AM Certified Nurse Aide #5 (in the presence of Licensed Practical Nurse Clinical Educator #6) provided hands on morning care to Resident #63 with their face mask below their mouth covering only their chin and neck.</p> <p>During an interview on 3/17/25 at 10:34 AM, Certified Nursing Assistant #5 stated they were wearing a face mask for their own protection in case the resident coughed. They stated they had not placed it over their mouth and nose because the resident had not coughed. Certified Nurse Aide #5 stated they had not had the Influenza vaccine, and did not know they were to wear a mask in resident care areas if they did not have the Influenza vaccine.</p> <p>During an interview on 3/17/25 at 10:35 AM, Licensed Practical Nurse Clinical Educator #6 stated they did not know where the facility's list was that identified the staff members that had declined the Influenza vaccine. They stated Certified Nurse Aide #5 and any staff members who had not received an Influenza vaccine were required to wear a face mask covering their mouth and nose in resident care areas for the resident's safety for infection control because New York State had declared Influenza Prevalent.</p> <p>During intermittent morning observations on 3/17/25 Licensed Practical Nurse #9 was on Unit C and not wearing a face mask in resident care areas. During an interview on 3/17/25 at 11:15 AM, they stated they had declined the Influenza vaccine and had been providing care without wearing a face mask. They stated they were not informed of the need to wear a face mask for resident safety because of the declaration of Influenza prevalence.</p> <p>During an observation and interview on 3/17/25 at 11:15 AM Certified Nurse Aide #8 was sitting in the Unit C resident lounge area with residents and was not wearing a face mask. They stated they had declined the Influenza vaccine, had not been wearing a mask while providing care and did not know they were required to wear a mask.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Garden Gate Health Care Facility		STREET ADDRESS, CITY, STATE, ZIP CODE 2365 Union Road Cheektowaga, NY 14227	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation on 3/17/25 at 10:20 AM Certified Nurse Aide #9 was not wearing a face mask and assisted Resident #63 with positioning in bed. At 11:15 AM Certified Nurse Aide #9 was sitting in the Unit C resident lounge with residents present and was not wearing a face mask. At this time Certified Nurse Aide #9 stated they declined the Influenza vaccine and had not been wearing a mask while providing care unless a resident was specifically on precautions. They stated they were not informed they needed to wear a face mask for resident safety because of the declaration of Influenza prevalence.</p> <p>During intermittent observations in the morning on 3/17/25 Certified Nurse Aide #11 was in a resident area on Unit B and was not wearing a face mask. During an interview on 3/17/25 at 11:28 AM, they stated they had declined the Influenza vaccine and had not been wearing a mask while providing care. They stated it was important to wear a mask during the Influenza season.</p> <p>During intermittent observations on 3/17/25 Licensed Practical Nurse #10 passed medications to residents and was in resident care areas on Unit D and was not wearing a face mask. In an interview on 3/17/25 at 11:37 AM, they stated they were a corporate float staff nurse and had not provided the facility with the Influenza vaccination documentation and should have been wearing a mask in the resident care areas.</p> <p>During an observation and interview on 3/17/25 at 11:28 AM, Certified Nurse Aide #10 was on Unit B in resident care areas and was not wearing a face mask. They stated they should have been wearing a face mask during Influenza season for resident safety.</p> <p>During an interview on 3/18/25 at 1:27 PM, Licensed Practical Nurse Unit Manager #4 of Unit C stated they were not aware that Certified Nurse Aides #5, #8, #9 and Licensed Practical Nurse #9 had not had the Influenza vaccine and were working on the unit without a face mask. They stated they did not know New York State had declared influenza prevalent and should have been informed by the Assistant Director of Nursing or Director of Nursing. They stated had they been made aware, they would have ensured staff members were wearing a face mask while in resident care areas.</p> <p>During an interview on 3/18/25 at 2:06 PM, the Infection Control Preventionist Director of Nursing #1 stated the Assistant Director of Nursing #1 was responsible to ensure the employee Influenza vaccine declination was accurate and inclusive of all current staff and it was not. They stated they did not know New York State has declared Influenza prevalence and should have known.</p> <p>During an interview on 3/19/25 at 9:30 AM, the Assistant Director of Nursing #1 stated they were aware that New York State had declared Influenza prevalence. They were responsible to ensure the employee Influenza vaccine declinations and lists were up to date and current with any changes and they were not. They stated all staff that had not provided documentation of receiving the Influenza vaccine and all staff who had declined the vaccination were required to wear a face mask. They stated they believe all staff were notified of Influenza Prevalence in New York State through verbal conversations and the Unit Mangers were made aware though morning meetings; however stated they did not have any written documentation or formal education that staff were aware. They stated they would have expected any staff member who had not received the Influenza vaccine to have been wearing a face mask while in any resident care area.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 3/19/25 at 11:27 AM, the Administrator stated New York State had declared Influenza prevalence in December and had sent e-mails to the Department Directors, Nurse Managers and had discussed Influenza Prevalence in meetings. They stated they would have expected the Assistant Director of Nursing #1 and Director of Nursing #1 to have ensured they had a current employee Influenza vaccine declination list, and that staff were educated and followed the face mask requirement.</p> <p>NYCRR 415.19(a)(4)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36415</p> <p>Based on record review and interviews conducted during the Standard survey completed on 3/19/25, the facility did not ensure that the facility's infection and control program included antibiotic use protocols and a system to monitor antibiotic use for two (Resident #16 and #52) of two residents reviewed. Specifically, Resident #16 was receiving an antibiotic since 10/30/24 and Resident #52 was receiving an antibiotic since 10/2/21. The use of the antibiotic was not monitored and tracked by the Infection Preventionist (IP) / Antibiotic Stewardship Program.</p> <p>The findings are:</p> <p>The policy and procedure titled Antibiotic Stewardship Program revised 3/2025, documented the antibiotic stewardship program is a component of the facility's Infection Prevention and Control Program. It is a coordinated program that promotes the use of antimicrobials, improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms. The primary goal of antibiotic stewardship is to optimize the treatment of infections and clinical outcomes while minimizing unintended consequences of antibiotic use. The facility has a quality assessment and assurance committee that will review the antibiotic use and resistance data. The Administrator, Medical Director, Director of Nursing Services, and Consultant Pharmacist are responsible for antibiotic stewardship in the facility. The facility will track adherence including but not limited to clinical assessment documentation of signs and symptoms, vital signs, physical examination findings of infection, dose, duration and indication, and adverse drug events.</p> <p>1. Resident #16 had diagnoses which included osteomyelitis (infection of bone), diabetes mellitus, and peripheral vascular disease (poor circulation of lower extremities). The Minimum Data Set (a resident assessment tool) dated 1/3/25 documented Resident #16 had moderate cognitive impairment, was understood, and understands. The Minimum Data Set documented Resident #16 received antibiotics.</p> <p>The comprehensive care plan dated 12/3/24 and revised 2/22/25, documented Resident #16 was at risk for infection related to diabetes, a right foot vascular wound and a right heel wound. Interventions included to apply treatments, administer antibiotics as ordered, and assess for signs and symptoms of infection.</p> <p>The Medical Visit Note dated 1/17/25 documented Resident #16 was evaluated by vascular surgery and refused surgical intervention. The infectious disease physician recommended Cefadroxil (antibiotic) indefinitely.</p> <p>The Order Summary Report printed by the facility on 3/19/25 documented a physician's order with a start date of 10/30/24 and a discontinued date of 3/18/25 for Cefadroxil Oral Capsule 500 milligrams by mouth every twelve hours for suppressive therapy.</p> <p>The Medication Administration Record dated March 2025 documented Resident #16 received Cefadroxil Oral Capsule 500 milligrams by mouth every twelve hours as ordered.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #52 had diagnoses which included multiple sclerosis, acute promyelocytic leukemia (a rare and fast developing blood cancer that affects immature white blood cells called promyelocytes) in remission, and urinary tract infections. The Minimum Data Set, dated dated dated [DATE] documented Resident #52 was cognitively intact and received antibiotics.</p> <p>The comprehensive care plan dated 12/2/24, documented Resident #52 was at risk for infection related to history of urinary tract infections, indwelling medical devices, suprapubic catheter, colostomy, pressure ulcer sacrum, vascular ulcer and right media calf. Interventions included administer antibiotic/medication according to physician's order.</p> <p>The Medical Visit Note dated 11/22/24 documented Resident #52 had neurogenic bladder - suprapubic in place and continue Macrobid for prophylaxis.</p> <p>The Order Summary Report printed by the facility on 3/19/25 documented a physician's order with a start date of 10/2/21 with no end date for Nitrofurantoin Monchyd Macro (Macrobid) Capsule 100 milligrams by mouth one time a day at bedtime for prophylaxis.</p> <p>Review of the following lists provided by the facility as their mechanisms to monitor antibiotic use for Antibiotic Stewardship had no documented evidence Resident #16 and #52 were receiving antibiotics.</p> <p>-Order Listing Report of Active, Completed, and Discontinued antibiotics dated 1/1/25 through 3/17/25 printed 3/17/25.</p> <p>-Detailed list of residents on antibiotics dated 1/1/25 through 3/17/25 printed 3/17/25 from the facility's Data Analyst #1.</p> <p>-Antibiotic Utilization by Resident dated 1/1/25 through 3/17/25 from the facility's Consultant Pharmacist #1, printed 3/17/25.</p> <p>During an interview on 3/18/25 at 11:36 AM, the facility's Pharmacy Client Successor #1 stated they don't know why some of the anti-infectious agents (antibiotics) were not listed on the provided documents and believed this was a computer program error. The information should be analyzed differently to capture that Resident #52 was on Nitrofurantoin Monchyd Macro (Macrobid).</p> <p>During an interview on 3/18/25 at 12:05 PM, Consultant Pharmacist #1 stated Resident #16 and #52 prophylactic antibiotics were not being reported on the lists they provide to the facility and did not know why. They also stated they did not know if the facility had discussed Resident #16 and #52 at the Antibiotic Stewardship/ Quality Assurance and Performance Improvement meetings. Consultant Pharmacist #1 stated they believed there was an Antibiotic Stewardship Program system failure because Residents #16 and #52 were not being identified. They stated it was important to review all antibiotic usage in the facility to ensure antibiotics were being ordered for the appropriate use.</p> <p>During an interview on 3/19/25 at 9:30 AM, Assistant Director of Nursing #1 stated Antibiotic Stewardship was a collaborative effort between them and the Director of Nursing. They stated they had no documented evidence Resident #16 and #52 have been reviewed, monitored and tracked for antibiotic use and the residents should have been, tracked reviewed and monitored.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 3/19/25 at 12:13 PM, Director of Nursing #1 stated the Cefadroxil for Resident #16 and Nitrofurantoin Monchyd Macro (Macrobid) for Resident #52 was not on the facility's monthly antibiotic tracking list therefore was not reviewed for effectiveness, side effects, or resistance during the Quality Assurance meetings. The Cefadroxil and Nitrofurantoin Monchyd Macro (Macrobid) should have been monitored monthly. The Director of Nursing #1 verified the Cefadroxil for Resident #16 was started on 10/30/24 for suppression therapy and had no stop date until 3/18/25 and Nitrofurantoin Monchyd Macro (Macrobid) was started 10/2021 for prophylactic treatment for urinary tract infections with no end date.</p> <p>During an interview on 3/19/25 at 1:09 PM, the Administrator stated they would have expected that Resident #16 and #52's antibiotic use would have been discussed monthly at the Antibiotic Stewardship/Quality Assurance Improvement Program meetings by reviewing the antibiotic medication type, dose, reason, and duration to ensure the antibiotic usage was appropriate.</p> <p>10 NYCRR 415.12(l)(1)</p>		