STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335649	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Gate Health Care Facility	7264 Nash Road North Tonawanda, NY 14120

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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 22485 Based on interview and record review conducted during an Abbreviated survey (complaint #NY00322899) completed on 5/30/24 the facility did not ensure that residents who had an indwelling (foley) catheter (tube inserted into the bladder to drain urine) received the appropriate care and services to manage catheters for one (Resident #1) of three residents reviewed. Specifically, there was lack of a provider order for the indwelling catheter (tube placed in bladder to drain urine), lack of documented urine outputs, and catheter care provided. The finding is: The policy titled Clinical Records revised 4/01 documented the medical record would be complete and accurately documented. The medical record would contain information pertinent to resident care and planning. The policy titled Catheter Drainage Bag Care revised 5/13, documented urinary drainage bag care was performed appropriately to prevent complications caused by the presence of an indwelling urethral catheter. Output was to be recorded every shift. Resident #1 had diagnoses including post laminectomy syndrome (chronic back pain following surgery), depression, and colitis (inflammation of the colon). The Minimum Data Set (a resident assessment tool) dated 8/16/23 documented Resident #1 was cognitively intact, did not have a foley catheter, and was occasionally incontinent of urine. The Nursing Admission Evaluation dated 8/9/23, completed by Licensed Practical Nurse Unit Manager #1, documented Resident #1 did not have a foley catheter. Review of the Kardex (guide used by staff to direct care) dated 8/9/23 and 8/10/23 documented to monitor bowel movements each shift and the resident used a bed pan for toileting with total assistance. There was no documentation the resident had an indwelling catheter or that staff were to provide catheter care. Review of provider orders dated 8/9/23-8/17/23 revealed there were no orders to address use of or discontinuation of the foley catheter. (continued on next page)

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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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Medical Visit Notes dated 8/10/23 to 8/14/23 revealed no evidence the resident had a foley catheter. Review of the OT (occupational therapy) Evaluation dated 8/10/23, completed by Occupational Therapist #1, documented Resident #1 had a foley catheter. Review of nursing Progress Notes dated 8/9/23 to 8/14/23 revealed the following: -On 8/11/23 at 2:11 AM, the resident's foley was intact -On 8/13/23 at 4:51 AM, the resident's foley was intact There was no documentation of urine outputs, urine characteristics, or any catheter care was provided. Review of the 24-hour Nursing Services Supervisor Report dated 8/9/23 to 8/14/23 revealed the following: -On 8/10/23 11:00 PM-7:00 AM shift documented the resident was confused and had a foley -On 8/13/23 the 7:00 AM-3:00 PM shift, documented the foley output was 850 cc (cubic centimeters-unit of measurement) and the 3:00 PM-11:00 PM shift documented the resident had a foley, no output was documented -On 8/14/23 the 7:00 AM-3:00 PM shift documented the resident's foley was discontinued and a urine sample was obtained and sent Review of the Treatment Administration Record dated 8/1/23-8/31/23 revealed no documentation the resident's urinary output was measured from their admission on 8/9/23 until the catheter was documented as discontinued on 8/14/23. Review of the Lab Results Report dated 8/16/23 documented a urine culture (urine test done to detect bacteria) was collected on 8/14/23 at 1:30 PM and was positive for Escherichia coli (bacteria commonly found in the lower intestine). The facility was unable to provide certified nurse aide task documentation related to urine output or catheter care. Review of the hospital History and Physical dated 8/17/23 at 3:30 PM, revealed the resident was admitted with sepsis as evidenced by leukocytosis (increased number of white cells in the blood, especially during an infection), tachycardia (rapid heart rate), and hypotension (low blood pressure) secondary to a urinary tract infection. During a telephone interview on 5/28/24 at 12:59 PM, Licensed Practical Nurse #2 stated if they documented a resident had a foley catheter on 24-hour report, it meant the resident had a catheter. Licensed Practical Nurse #2 stated that sometimes they emptied the foley catheter drainage bags and would document the output, but sometimes rehab people emptied them and didn't report the output to them. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/24 at 3:19 PM, Licensed Practical Nurse Unit Manager #1 stated they didn't know if the resident had a foley catheter and could only refer to their note. The Licensed Practical Nurse #1 stated they didn't know why other staff members documented the resident had a foley and if a resident did have a foley on admission, they usually automatically wrote orders for it, then a provider would figure out of the resident needed to keep it or discontinue it. During an interview on 5/29/24 at 9:25 AM, the Occupational Therapist #1 stated they didn't remember the resident. They reviewed the Occupation Therapy Evaluation dated 8/10/23 and stated they assume at the time they wrote the note that the resident had a foley catheter because it was documented. During an interview on 5/29/24 at 12:16 PM, the Registered Nurse Unit Manager #1 stated if someone was admitted with a foley, they would do a set of admission orders and would be up to the providers to decide if the foley was discontinued. The Registered Nurse Unit Manager #1 reviewed the record and stated they saw where some staff have documented the resident had a foley and others didn't. The Registered Nurse Unit Manager #1 stated there should be an order for the foley catheter and catheter care every shift should have gone onto the care plan and Kardex. They stated resident's with foley catheters were at risk for urinary tract infections. During an interview on 5/29/24 at 1:59 PM, the Director of Nursing stated they could not say whether the resident had a foley catheter or not based on the medical record. They also stated they could not determine if catheter care was provided. The Director of Nursing stated they should have been able to determine all of that that from the medical record. The Director of Nursing stated it was possible the foley was missed by nursing upon admission. 10 NYCRR 415.12(d)(1)(2)