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	01/30/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 00924 Based on observation, interview and record review conducted during a Complaint (#NY00338861) investigation completed on 1/30/25 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 #2) of three resident reviewed. Specifically, Resident #2 did not receive weekly and comprehensive wound assessments and received applied dressings without a physician's order for a chronic left lower leg vascular ulcer (a chronic skin wound that develops due to poor blood circulation). In addition, the Minimum Date Set (MDS, resident assessment tool) was inaccurately assessed for the chronic left lower leg vascular ulcer. The finding is: Review of the facility's policy entitled Documentation of Pressure Ulcers and Chronic Wounds revised in June 2023 revealed weekly skin assessments are documented to include type of area (Pressure Ulcer, Stasis Ulcer, venous wound, arterial or diabetic), site, stage for pressure/stasis Ulcer, only, length, with and depth measurements, description/characteristics, treatment, debridement, exudate, pain management, and progress toward healing. Resident # 2 diagnoses included diabetes mellitus (condition where the body's blood glucose (blood sugar) levels are higher than normal), schizophrenia and a past medical history significant for a right above the knee leg amputation (a surgical procedure where a part of the body, usually a limb, is removed). Review of the Minimum Data Set, dated dated dated [DATE] revealed the resident is cognitively intact and understands and is understood. Indicates the resident has one unstageable pressure ulcer and no other ulcers, wounds, or skin problems. During an observation on 1/14/25 at 9:45 AM Resident #2 was lying in bed with a white gauze dressing secured with paper tape that encircled the left lower leg in the calf region and was approximately 8 inches in height; the dressing was not dated or signed. During the observation Resident #2 stated they had the left lower leg wound for quite a while, staff performed dressing changes on the wound daily, and said the surveyor could observe the treatment later. An additional observation on 1/14/2025 at 11:55 AM revealed Resident #2 refused the left lower leg dressing change when the nurse approached them for the procedure and the left lower leg dressing remained in place. During an observation on 1/15/25 at 10:00 AM Resident #2 was in lying bed and a left lower leg dressing was visible and in place. The resident stated the surveyor could watch the treatment; however, they later refused the observation of the wound treatment. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a hospital discharge summary dated 9/5/24 revealed discharge diagnosis of a chronic non-healing wound of the left lower extremity with recommendations for the resident to return to the facility's wound care regimen that was in place prior to the hospital admission. Review of a Nursing Admission Assessment, performed by Registered Nurse #1 dated 9/5/24 revealed when the resident re-entered the facility after a hospital stay Resident #2 had a vascular skin abnormality on the left lower leg without any other assessment characteristics noted. Review of the 9/10/24 History and Physical performed by the Medical Doctor revealed Resident #2 was a long-term resident with a previous right above the knee amputation and a full skin examination was not completed and to refer to nursing documentation for the skin assessment. Review of the Comprehensive Care Plan revealed a problem of impaired skin integrity related to venous ulcers of the left lower extremity initiated on 7/31/24 and revised on 1/13/25 with plans to evaluate and measure skin/wound site(s) at least weekly, document outcome and treatment progress/changes, and administer treatment per physician's orders. Review of the Physician Orders dated 1/2/25 revealed check the skin/wound every shift for visible redness, swelling or saturation and follow up and document accordingly. Mupirocin External Ointment 2 % (Mupirocin-topical antibiotic) application to the left lower extremity topically each day shift for a venous ulcer. Review of the Nursing Weekly Skin Status Documentation revealed on 7/30/24 the re-emergence of an old vascular ulcer of the left lower extremity. The assessments documented on 7/30/24 describe the left vascular wound as diffuse open areas with surrounding redness to the anterior of the left lower extremity without providing any measurements or any other characteristics of the wound. In addition, documentation from 7/30/24 to 1/13/25 documented the resident had a left lower front vascular wound with diffuse open areas with surrounding redness to the anterior left lower extremity without providing any measurements and complete characteristics of the wound. Documentation on 8/13/24, 9/30/24, 10/14/24, 11/25/24, 12/9/24 documented improvement of the wound. During a telephone interview on 1/24/25 at 11:45 AM Licensed Practical Nurse #1 stated they have provided many wound treatments for Resident #2's left lower leg vascular ulcer which Resident #2 has had for a long time. During the interview Licensed Practical Nurse #1 while referring to Resident #2's medical record, stated there was no specific order for the daily wound dressings because the nurses know to put it on with the treatment. In addition, Licensed Practical Nurse #1 stated that the vascular wound is open at times, other times it is scabbed with some redness, and sometimes there is drainage on the bandage when it is removed. The wound nurses document the wounds weekly, so the floor nurses typically don't document on the wound other than signing the resident's treatment records. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/16/25 at 8:55 AM Registered Nurse #1, Unit Manager stated they provide the weekly wound assessment for the left lower leg wound and stated sometimes the left lower leg wound is scabbed and other times it's open. Registered Nurse #1, Unit Manager stated Resident #2 has had the wound for quite a while, it's chronic and has been there over two years. During the interview the Registered Nurse #1, Unit Manager referred to their 12/30/24 documentation of the left lower leg and stated the documentation of the wound with a foul odor with purulent (consisting of, containing, or discharging pus) drainage was not correct, it was an error, and no wound culture of the vascular wound was obtained. In addition, the Registered Nurse #1, Unit Manager stated the left lower leg diffuse area was approximately 5-7 centimeters, but it wasn't all open and stated they did not document the size because they were taught not to by wound specialists when the affected area is diffuse. During an additional telephone interview on 1/27/25 at 2:21 PM the Registered Nurse #1, Unit Manager stated they performed the 9/10/24 skin assessment on Resident #2 upon re-entry into the facility post hospitalization . Once a treatment order is placed in the electronic medical record, the computerized system automatically populates an order to check the wound. When asked why the location of the wound was not indicated on the wound check entry in the treatment administration record, the Registered Nurse #1, Unit Manager stated they didn't know. During the interview the Registered Nurse #1, Unit Manger stated there was not a current order for the leg dressings although there is a treatment order and stated the nurses have worked with it so long, they know when to put a dressing on the wound which is usually done when the wound is open. When asked if the wound dressing required a physician's order the Registered Nurse #1, Unit Manager did not answer the question. During the interview the Registered Nurse #1, Unit Manager stated it is the responsibility of the floor nurses and the Unit Manger to check order for accuracy and completeness. During an interview on 1/22/25 at 4:06 PM, the Adult Nurse Practitioner stated they serve as a wound consultant for the facility and evaluates wounds upon request by nursing staff and had not received a request to evaluate the left lower leg vascular wound for Resident #2. The Adult Nurse Practitioner stated since October 2024 they have been evaluating a wound on the buttocks and was not even aware that the resident had a vascular wound on the left lower extremity. The wound consultant stated that vascular wounds, require weekly assessments with the same detail of a pressure ulcer; however, they are not usually stated; this would include length, width, depth, color, odor, and area of the surrounding skin. During a telephone interview on 1/22/25 at 5:45 PM the Medical Doctor stated that the wound team is responsible to assess all wounds weekly and should include the type of wound, size, depth, treatment, and signs of infection. During the interview the physician read Resident #2's documented wound notes and stated staff should never document a wound is improving without providing all the required wound characteristics; the measurements should be documented. The Medical Doctor stated each treatment including dressings require an order from the provider in the medical record. During a telephone interview on 1/29/25 at 4:16 PM the Director of Nursing stated that after they checked with corporate staff, they determined that open vascular wounds require measurements and that dressings require physician's orders. 10 NYCRR 415.12