STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 08/31/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to use a mechanical lift to transfer one (1) of one (1) sampled resident. (Resident #1) The findings are: Resident #1 was admitted to the facility with a history of falls and physical immobility. The latest Minimum Data Set (MDS) dated 06/25/11 indicated impairment of memory and cognition and dependence on staff assistance for all care. A Care Area Assessment dated 04/04/11 specified use of a mechanical lift for transfers. A review of a care plan updated 06/30/11 revealed Resident #1 is at risk for falls and injury due to immobility. An intervention on this care plan specified to use a mechanical lift with the assistance of two (2) staff members for transfers. On 08/31/11 at 1:16 p.m. Nursing Assistant (NA) #1 was observed placing a battery on a mechanical lift in the hallway near Resident #1's room. NA #1 left the hall and promptly returned	F 323	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by state and Federal law. F 323 #1 Resident #1 is being transferred with the appropriate mechanical lift. #2 For those residents having the potential to be affected, the facility has reviewed current resident's care plans and care profiles by the nursing management staff as of September 12, 2011and updated as indicated for appropriate lift usage.	9/23/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janet L. Foster — TITLE: Administrator — (X6) DATE: 9-12-11

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.

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F 323	Continued From page 1 to Resident #1's room with NA #2. Resident #1 was observed sitting in a wheel chair. The NAs placed the wheel chair perpendicular to the resident's bed. The NAs lifted Resident #1 by placing their arms under the resident's armpits, raising the resident from the wheel chair and swinging the resident to the bed. An interview with NA #1 on 08/31/11 at 1:20 p.m. revealed the battery she obtained for the lift by Resident #1's room would not work. She stated she solicited assistance from NA #2 to manually transfer the resident from the wheel chair to bed. An interview with the Director of Nursing (DON) on 08/31/11 at 1:33 p.m. revealed the facility keeps batteries for mechanical lifts charging at all times. At this time, the DON pointed out two more batteries in chargers that were available. The DON added the facility has a total of six (6) mechanical lifts, four (4) of which are the type lift required for Resident # 1's transfers. She stated that a working lift is always available. The DON stated she expected staff to use mechanical lifts for transfers. At 3:25 p.m. on 08/31/11 further interview with the DON revealed the facility had a no lift policy. She stated all nursing assistants are informed of this policy when they are hired and sign a statement they had been notified.	F 323	#3 Measures put in place to ensure correction includes the current nursing staff have been re-educated by the Unit Manager, completed by September 12, 2011, on importance of using mechanical lifts as indicated on the resident profile and care plan, where to find the information, and the facility practice of being a no physical lift facility. This information will be reviewed during orientation for any newly hired nursing staff. The Director of Nursing, charge nurses, and Unit Manager will complete a Quality Improvement tool observing 10 transfers daily 5 days per week x 2 weeks to observe use of appropriate mechanical lifts as indicated on the resident care plan and profile, then weekly x 4, then monthly x 4. #4 The Director of Nursing presents the trending of this plan of correction to the RM/QI (Risk Management/Quality Improvement) committee. The Administrator will continue to evaluate this action plan for its effectiveness during the RM/QI meetings weekly for 4 weeks than monthly thereafter for 4 months. Any revision to this plan will be implemented when indicated.	9/23/11