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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the	F 159		2/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/22/2016

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 159	Continued From page 1 SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review, the facility failed to make resident funds available to 1 of 2 residents reviewed for personal funds. (Resident #66). The findings included: Resident #66 was admitted to the facility on 05/17/13. Her diagnoses included Huntington's Disease, anxiety and depression. The annual Minimum Data Set dated 11/18/15 coded her with intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status. Review of resident fund accounts revealed Resident #66 had a personal fund account managed by the facility. Review of the transactions revealed Resident #66's social security check was deposited into her account the beginning of each month and she withdrew $30.00 out monthly. During an interview on 01/26/16 at 11:22 AM, Resident #66 stated she was unable to always get her $30.00 when she asked for it out of her personal fund account. Resident #66 said the office told her they didn't have any money to give her and she would have to wait three to four days	F 159	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F159- Manage Personal Funds Resident # 66 will continue to have resident funds available for personal use. All residents with personal funds are at risk of the alleged deficient practice. On 02/26/2016 the Administrator reeducated alert and oriented residents who have personal funds that they may request monies from the business office Monday through Friday from 8:00am-5:00pm and after hours and on weekends from the charge nurse. Newly admitted residents will receive written notice of the Resident Funds policy upon admission. On 02/15/2016 the Administrator reeducated the charge nurse and the	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 159	Continued From page 2 for the corporation to send money. On 01/29/16 at 9:09 AM the Human Resource (HR) staff was interviewed. HR stated that the receptionist was responsible for giving residents money out of their personal fund account. HR stated that the facility maintained $300.00 in cash for residents with personal fund accounts to access. She further stated that around the third of the month, this cash fund becomes low because of residents getting money from their accounts. The Receptionist was interviewed on 01/29/16 at 9:16 AM. The Receptionist stated that she distributed money to residents from the facility cash fund which was maintained at $300.00 for resident use. When this money got low, she sent the residents' signed receipts to the corporate office who then sent a check to the facility to reimburse the cash fund up to $300.00. The Administrator then cashed the check sent from corporate and replenished the resident's cash fund account. Upon further interview, the Receptionist stated that a few residents had complained about not having access to their money when they requested it. She stated Resident #66 had "fussed" when she did not have cash to give her upon request. The Receptionist confirmed that Resident #66 had money in her account when she came to withdrawal all her $30.00 out at the beginning of each month, however, the cash fund did not always have the cash available to give her. The interview further revealed there was not someone in the business office every day since the business office manager position had been vacant for several months.	F 159	receptionist on the policy of ensuring resident funds are available in the medication room lock box after hours and initialing every shift to validate balance and availability. Newly hired charge nurses will be educated upon hire. The charge nurse will be responsible for notifying the Assistant Business Office Manager (ABOM) if available resident funds are low and the Human Resource Director will replenish funds weekly and notify the Administrator of additional funds needed as appropriate. The ABOM and/or the Administrator will monitor the medication lock box weekly for 6 months to validate the charge nurse is initialing availability and usage every shift and that ample funds are available to meet residents needs. The Administrator will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 159	Continued From page 3 During an interview with the Administrator on 01/29/16 at 4:09 PM, the Administrator stated that there was $300.00 maintained in a cash fund for residents' use. She stated when the money was gone, it may take 1 to 2 days for the cash to be replenished depending on when the resident asked for money that was not available. She further stated that she had asked the corporate office for a cash fund of $500.00 but that corporate would only agree to having $300.00 in cash available to residents.	F 159		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interviews and staff interviews, the facility failed to knock on resident doors when passing meal trays to 5 out of 6 residents observed during 2 meal observations. This occurred on 1 of 6 hallways in the facility. (Residents #25, #59, #85, #129 and 157). The findings included: 1. Resident #129 was admitted to the facility on 12/24/15. The admission Minimum Data Set dated 12/31/15 coded him with intact cognition. On 01/26/16 at 12:21 PM, Nurse Aide (NA) #2 entered Resident #129's room without knocking	F 241	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F241- Dignity- Resident Preferences Employee # 2 was educated by the Director of Clinical Services (DCS) on 01/26/2016 on promoting care for residents by knocking on the resident doors while passing meals.	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 4 or announcing her presence to deliver the meal tray. Interview with NA #2 on 01/26/16 at 1:08 PM revealed she had been trained to knock on doors before going into resident rooms. She stated she did not knock, gave no reason why she failed to knock on resident doors during tray delivery and just stated she just didn't knock. During interview on 01/28/2016 at 11:45 AM with Resident #129, he stated it was his expectation for staff to knock on his door before they entered his room. He said sometimes staff came in and didn't knock but he would expect for then to knock on his door every time they entered his room. He further stated he did not let anyone come in his home without knocking and he didn't like it when staff just walked on in. Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected staff to knock on resident doors and ask for permission to enter before entering a resident's room. Interview with the Director of Nursing on 01/29/16 at 4:52 PM revealed he expected staff to knock or make eye contact when entering a resident's room. 2. Resident #157 was admitted to the facility on 01/18/16. The admission nursing assessment dated 01/18/16 stated Resident #157 was alert, oriented to person, had long and short term memory impairments and modified independence for decision making. On 01/26/16 at 12:24 PM Nurse Aide (NA) #2 proceeded with a tray and entered Resident #	F 241	All Residents have the risk to be affected by of the alleged deficient practice. On 02/24/2016 the DCS reeducated staff on residents rights to include honoring and promoting care for residents in a manner and environment that maintains dignity and respect in full recognition of his or her individuality by knocking on door before entering. Newly hired staff will be educated upon hire. The DCS and/or Nurse Supervisor will monitor 5 random employees promoting dignity by knocking on door before entering residents room 3x/week for 3 months, then 1x/week for 3 months. The DCS will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 5	F 241		

157's room without knocking or announcing her presence.

Interview with NA #2 on 01/26/16 at 1:08 PM revealed she had been trained to knock on doors before going into resident rooms. She stated she did not knock, gave no reason why she failed to knock on resident doors during tray delivery and just stated she just didn't knock.

On 01/28/16 at 11:32 AM Resident #157 was interviewed and she stated she would like staff to knock before entering her room.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected staff to knock on resident doors and ask for permission to enter before entering a resident's room.

Interview with the Director of Nursing on 01/29/16 at 4:52 PM revealed he expected staff to knock or make eye contact when entering a resident's room.

3. Resident #25 was most recently admitted to the facility on 11/11/15. She was coded on her quarterly Minimum Data Set dated 10/30/15 with long and short term memory impairments and having severely impaired decision making skills.

On 01/26/16 at 12:26 PM Nurse Aide (NA) #2 entered Resident #25's room without knocking to deliver a tray to her bedside. NA #2 entered again without knocking on 01/26/16 at 12:27 PM and left a sippy cup at her bedside. On 01/26/16 at 12:31 PM without knocking or announcing her presence, NA #2 entered Resident #25's room, set her tray up and began to feed her.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 6	F 241		

Interview with NA #2 on 01/26/16 at 1:08 PM revealed she had been trained to knock on doors before going into resident rooms. She stated she did not knock, gave no reason why she failed to knock on resident doors during tray delivery and just stated she just didn't knock.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected staff to knock on resident doors and ask for permission to enter before entering a resident's room.

Interview with the Director of Nursing on 01/29/16 at 4:52 PM revealed he expected staff to knock or make eye contact when entering a resident's room.

4. Resident #85 was admitted to the facility on 12/21/15. The admission Minimum Data Set dated 12/28/15 coded her with long and short term memory impairments and moderately impaired decision making skills.

On 01/26/16 at 12:28 PM, Nurse Aide (NA) #2 entered Resident #85's room without announcing herself or knocking and left the lunch tray at her bedside. NA #2 reentered Resident #85's room on 01/26/16 at 12:39 PM and set the tray up and began to feed her without any knocking or announcing her presence.

Interview with NA #2 on 01/26/16 at 1:08 PM revealed she had been trained to knock on doors before going into resident rooms. She stated she did not knock, gave no reason why she failed to knock on resident doors during tray delivery and just stated she just didn't knock.

Interview with the Administrator on 01/29/16 at

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 7	F 241		

4:09 PM revealed she expected staff to knock on resident doors and ask for permission to enter before entering a resident's room.

Interview with the Director of Nursing on 01/29/16 at 4:52 PM revealed he expected staff to knock or make eye contact when entering a resident's room.

5. Resident #59 was readmitted to the facility most recently on 11/04/15. Resident #59's quarterly Minimum Data Set (MDS) dated 11/11/15 coded her with long and short term memory impairments and having moderately impaired decision making skills.

On 01/26/15 at 12:25 PM Nurse Aide (NA) #2 entered Resident 59's room without knocking and proceeded to set up her meal tray, which had been previously delivered, and feed her without knocking or announcing her presence.

Interview with NA #2 on 01/26/16 at 1:08 PM revealed she had been trained to knock on doors before going into resident rooms. She stated she did not knock, gave no reason why she failed to knock on resident doors during tray delivery and just stated she just didn't knock.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected staff to knock on resident doors and ask for permission to enter before entering a resident's room.

Interview with the Director of Nursing on 01/29/16 at 4:52 PM revealed he expected staff to knock or make eye contact when entering a resident's room.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 8	F 241		

6. Resident #59 was readmitted to the facility on 11/04/15. A review of the most recent quarterly Minimum Data Set (MDS) revealed diagnoses of dementia, anxiety and depression and Resident #59 had long and short term memory impairments and was moderately impaired in cognition for daily decision making.

An observation on 01/26/16 at 5:35 PM during the evening meal service revealed NA #9 picked up a tray off the meal cart in the hallway and walked into Resident #59's room without stopping at the doorway of the resident's room and did not knock on the door. She placed the tray on an over bed table in front of Resident #59 and asked if she needed anything else and walked out of the room back to the meal cart in the hallway.

During an interview on 01/26/16 at 5:49 PM NA #9 stated she was so nervous and confirmed she did not knock on Resident #59's door. She stated she had been taught to knock on resident's doors, take the tray into the resident's room and set it up for the resident but sometimes she got so busy she forgot to knock. She also stated she had been taught to address residents by name and engage them in conversation but she forgot to knock on the resident's door before she entered the room.

During an interview on 01/29/16 at 4:09 PM with the Administrator she stated she expected for staff to knock on resident's doors and ask for permission to enter the room before they entered the room.

During an interview on 01/29/16 at 4:52 PM with the Director of Nursing he stated it was his expectation for staff to knock on resident doors

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 9	F 241		

before they entered the resident's room.

7. Resident #25 was admitted to the facility on 11/11/15. A review of the most recent quarterly Minimum Data Set (MDS) dated 10/30/15 revealed diagnoses of Alzheimer's disease and Resident #25 had long and short term memory impairments and was severely impaired in cognition for daily decision making.

An observation on 01/26/16 at 5:38 PM during the evening meal service revealed NA #9 picked up a tray off the meal cart in the hallway and walked into Resident #25's room without stopping at the doorway of the resident's room and did not knock on the door. She placed the tray on an over bed table in front of Resident #25 and asked if she needed anything else and walked out of the room back to the meal cart in the hallway.

During an interview on 01/26/16 at 5:49 PM NA #9 stated she was so nervous and confirmed she did not knock on Resident #59's door. She stated she had been taught to knock on resident's doors, take the tray into the resident's room and set it up for the resident but sometimes she got so busy she forgot to knock. She also stated she had been taught to address residents by name and engage them in conversation but she forgot to knock on the resident's door before she entered the room.

During an interview on 01/29/16 at 4:09 PM with the Administrator she stated she expected for staff to knock on resident ' s doors and ask for permission to enter the room before they entered the room.

During an interview on 01/29/16 at 4:52 PM with

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 10	F 241		

the Director of Nursing he stated it was his expectation for staff to knock on resident doors before they entered the resident's room.

8. Resident #129 was admitted to the facility on 12/24/15. The admission Minimum Data Set (MDS) dated 12/31/14 revealed diagnoses of high blood pressure and diabetes and Resident #129 was cognitively intact for daily decision making.

An observation on 01/26/16 at 5:45 PM during the evening meal service revealed NA #9 picked up a tray off the meal cart in the hallway and walked into Resident #129's room without stopping at the doorway of the resident's room and did not knock on the door. She placed the tray on an over bed table in front of Resident #129 and asked if he needed anything else and walked out of the room back to the meal cart in the hallway.

During an interview on 01/26/16 at 5:49 PM NA #9 stated she was so nervous and confirmed she did not knock on Resident #59's door. She stated she had been taught to knock on resident's doors, take the tray into the resident's room and set it up for the resident but sometimes she got so busy she forgot to knock. She also stated she had been taught to address residents by name and engage them in conversation but she forgot to knock on the resident's door before she entered the room.

During an interview on 01/29/16 at 4:09 PM with the Administrator she stated she expected for staff to knock on resident's doors and ask for permission to enter the room before they entered the room.

During an interview on 01/29/16 at 4:52 PM with

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 241	Continued From page 11 the Director of Nursing he stated it was his expectation for staff to knock on resident doors before they entered the resident's room.	F 241		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record reviews, the facility failed to honor preferences for 7 out of 8 sampled residents related to choices of smoking (Residents #8, #10, #38 and #69), bath type and frequency (Resident #8) and food preferences (Residents #1, #4, #8, #54). The findings included: 1. The facility's undated smoking policy included: *"3. Smoking is only allowed under direct supervision of our staff."; *"4. Each resident is assessed according to our procedures for safety with smoking."; *"5. Each resident must wear a "smoking apron" when they are smoking to ensure their safety." Resident #8 was admitted to the facility on 10/14/14.	F 242	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F242- Dignity- Right to make Choices Resident #8, 1, 4 and 54 food preferences were reassessed by the Dietitian by 02/24/2016 to meet their individual needs. Resident 8, 10, 38, and 69 were re-assessed for smoking safety by the Social Worker on 02/18/2016 for smoking evaluation to reflect residents smoking ability.	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 12 The comprehensive Minimum Data Set (MDS), a significant change assessment dated 05/13/15 coded her with intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status. She was coded as saying it was very important for her to choose between a shower and tub bath. Her most recent MDS, a quarterly dated 11/12/15, coded her with intact cognition, scoring a 15 out of 15 on the Brief Interview for Mental Status. a. Review of the Resident Choices Interview sheet dated 10/14/14 revealed, Resident #8 preferred a tub bath and would like a bath at least 3 times a week. Review of the shower book revealed that Resident #8's room was scheduled for showers twice a week on first shift, Mondays and Thursdays. On 01/26/16 at 5:09 PM Resident #8 stated that when she first came to the facility she was asked about her bathing preferences and she informed the facility she preferred a tub bath three times a week. She stated that she got 3 baths per week when she first came here but when she changed rooms and moved to different hallways, her showers were changed to twice a week. She stated that the last time she asked for a whirlpool about 6 to 8 months ago, she was told the whirlpool was not working. Nurse #1 stated during interview on 01/29/16 at 10:57 AM that there was a form the nurses filled out upon admission to determine preferences for showers. She further stated that staff should give the resident a choice between a shower or bath each time they take the resident to the shower room.	F 242	Resident # 8 was reassessed by the Licensed Nurse Cooridnator on 02/18/2016 for bathing preferences. All Residents have the risk to be affected by of the alleged deficient practice. An audit was completed by Dietitian on 02/13/2016 to identify resident preferences related to food choices. The Social Worker audited on 02/18/2016 current smoking residents deemed safe to smoke at leisure, and the licensed nurse coordinator audited all alert and orientated residents on 02/18/2016 for preferred bathing times. On 02/24/2016 the Director of Clinical Services (DCS) reeducated all staff on residents rights to include honoring and promoting care for residents in a manner and environment that maintains dignity and respect in full recognition of his or her individuality for preferences, smoking assessment, and bathing preferences. Newly hired staff will be educated upon hire. The DCS and/or designee will monitor 5 random residents for smoking preference assessments, bathing preferences and food preferences for 3x/week for 3 months, then 1x/week for 3 months. The DCS will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 13 Nurse Aide (NA) #1 was interviewed on 01/29/16 at 11:59 AM. NA #1 stated she gave Resident #8 a shower yesterday. She did not specifically ask Resident #8 if she wanted a shower or a tub bath, just asked if she was ready for her shower and the resident did not specifically ask for a bath. NA #1 stated she worked all over the facility. Interview with the unit manager on 01/20/16 at 2:19 PM revealed she set up the shower schedules. She further stated Resident #8 had moved halls a couple of times and it appeared her preferences were not communicated when she changed rooms. Review of shower documentation since 12/01/15 revealed Resident #8 has only received showers and no more than twice a week. b. The Quarterly Data Collection tool completed by Nurse #4 on 11/08/15 marked her a a safe smoker. The Safe Smoking Evaluation form was completed on 10/17/14, 1/19/15, 8/13/15 and 11/12/15 by the Social Worker (SW). According to this evaluation, Resident #8 was determined to be a safe smoker and notations on this form stated the resident would continue to follow facility guidelines for smoking. On 01/25/16 at 11:23 AM, Nurse Aide #6 who was supervising the smoking area was interviewed. She stated no resident was permitted to smoke alone as they had to be with staff, family or visitors. If a resident smoked with a visitor they were permitted to smoke anytime otherwise they had to find staff to smoke with them if they have missed the scheduled smoking times. In addition, all residents must wear an apron.	F 242	The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 14 On 01/28/16 at 5:00 PM, the SW stated she completed the smoking evaluations initially and quarterly on all residents who smoked. The SW stated she watched residents smoke when she completed the smoking evaluation to ensure they extinguished their cigarettes appropriately. She stated all residents were informed upon admission that they had to smoke at designated times (unless supervised by family or friends), had to wear an apron and always had to be supervised when smoking. The SW stated she looked at the restrictions as a resident safety issue and not a residents' rights issue. The SW further stated she did not think when she evaluated someone as a safe smoker that meant they could smoke independently. On 01/29/16 at 10:49 AM Resident #8 stated she was a social smoker and did not go outside in the cold to smoke. She stated she was not permitted to smoke when she wanted to, she was required to wear an apron when she smoked and she had to be supervised whenever she smoked. On 01/29/16 at 4:09 PM the Administrator stated the facility's corporation developed the policy which included no smoking without supervision, without aprons, and at specific times. The Administer stated she tried to get the policy changed but the facility's corporation would not change the policy. She further stated she was not aware there were any residents assessed as safe smokers. c. Review of the Resident Profile Details provided 01/29/16 at 8:37 AM by dietary staff revealed her preferences for breakfast included "prefers boiled eggs when available."	F 242		

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 15	F 242		

Interview with Resident #8 on 01/29/16 at 10:49 AM revealed months ago she asked for a fried egg and was told the residents had to have scrambled eggs until further notice.

Interview with the Dietary Manager (DM) on 01/29/16 at 8:31 AM revealed she had several residents who wanted shell eggs. She stated Resident #8 preferred boiled eggs. The DM further stated that there has been an ongoing issue regarding the availability of shell eggs.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected residents to be served the eggs prepared as they requested.

2. The facility's undated smoking policy included:
*"3. Smoking is only allowed under direct supervision of our staff.";
*"4. Each resident is assessed according to our procedures for safety with smoking.";
*"5. Each resident must wear a "smoking apron" when they are smoking to ensure their safety."

Resident #38 was admitted to the facility on 12/18/15.

Her admission Minimum Data Set dated 12/25/15 coded her with clear speech, being understood and understanding but her Brief Interview for Mental Status was not assessed. She was coded with intact short and long term memory and having modified decision making skills. According to the Care Area Assessment for Activities of Daily Living Skills, Resident #38 was alert and oriented.

Review of the Admission/Readmission Data Collection tool completed on 12/18/15 by Nurse

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 16	F 242		

#3 marked her as a safe smoker. The Safe Smoking Evaluation completed 12/25/15 by the Social Worker (SW) marked "NO" regarding able to light cigarette safely with a lighter. She was marked as a safe smoker and included the comments that she would follow the facility guidelines for smoking.

On 01/25/16 at 4:07 PM Resident #38 was observed smoking with a group, wearing an apron and under supervision of staff. Staff lit all the cigarettes. On 01/28/16 at 11:23 AM, Resident #38 was observed outside smoking under supervision and wearing an apron.

On 01/25/16 at 11:23 AM, Nurse Aide #6 who was supervising the smoking area was interviewed. She stated no resident was permitted to smoke alone as they had to be with staff, family or visitors. If a resident smoked with a visitor they were permitted to smoke anytime otherwise they had to find staff to smoke with them if they have missed the scheduled smoking times. In addition, all residents must wear an apron.

On 01/28/16 at 12:09 PM Resident #38 stated she was told on admission the times she was allowed to smoke and that she had to be supervised. Resident #38 further stated if she had visitors she could smoke with them anytime and she always had to wear an apron. Resident #38 stated that she would like to smoke when she wanted instead of being treated like a 10 year old.

On 01/28/16 at 5:00 PM, the SW stated she completed the smoking evaluations initially and quarterly on all residents who smoked. The SW stated she watched residents smoke when she completed the smoking evaluation to ensure they

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 17	F 242		

extinguished their cigarettes appropriately. She stated all residents were informed upon admission that they had to smoke at designated times (unless supervised by family or friends), had to wear an apron and always had to be supervised when smoking. The SW stated she looked at the restrictions as a resident safety issue and not a residents' rights issue. The SW further stated she did not think when she evaluated someone as a safe smoker that meant they could smoke independently.

On 01/29/16 at 4:09 PM the Administrator stated the facility's corporation developed the policy which included no smoking without supervision, without aprons, and at specific times. The Administer stated she tried to get the policy changed but the facility's corporation would not change the policy. She further stated she was not aware there were any residents assessed as safe smokers.

3. Resident #1 was admitted to the facility on 11/27/12. Her annual Minimum Data Set dated 10/07/15 coded her with intact cognition scoring a 15 out of 15 on the Brief Interview for Mental Status.

On 01/26/16 at 9:05 AM while at the breakfast table in the dining room, Resident #1 stated she disliked scrambled eggs and wanted fried eggs. She stated she would eat 2 eggs if they were fried but had been told the facility cannot get shell eggs due to the bird flu.

On 01/29/16 at 8:55 AM, the Dietary Manager stated she could not always get shell eggs from the food company. The facility had stated the only shell eggs she was permitted to purchase

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 18	F 242		

were pasteurized eggs. She further stated that she could recall the last time she ordered shell eggs.

On 01/29/16 at 11:40 AM, Resident #1 stated not too long ago she asked for fried eggs and was told no because of the bird flu. She stated she never ate scrambled eggs growing up and always ate fried or boiled eggs.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected residents to be served the eggs prepared as they requested.

4. The facility's undated smoking policy included:
*"3. Smoking is only allowed under direct supervision of our staff.";
*"4. Each resident is assessed according to our procedures for safety with smoking.";
*"5. Each resident must wear a "smoking apron" when they are smoking to ensure their safety."

Resident #10 was admitted to the facility on 05/09/15.

The quarterly Data Collection tool completed by Nurse #4 on 10/02/15 noted Resident #10 could not light a cigarette safely with a lighter but marked that the resident was a safe smoker.

The most recent quarterly Minimum Data Set dated 10/28/15 coded him with intact cognition scoring a 15 out of 15 on the Brief Interview for Mental Status.

The Safe Smoking Evaluations dated 09/17/15 and 10/28/15 completed by the Social Worker (SW) marked that he was unable to light a cigarette safely with a lighter. She marked both

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 19	F 242		

entries as Resident #10 was determined to be a safe smoker and he was to follow facility guidelines for smoking.

On 01/28/16 at 8:50 AM, Resident #10 was propelling his wheelchair down the hall and stated he was going to smoke. At 8:59 AM, he was in the activity room waiting to go outside with the other residents to smoke. Once outside, he placed his smoking apron on and the staff member lit his cigarette as well as every other resident's cigarette.

On 01/25/16 at 11:23 AM, Nurse Aide #6 who was supervising the smoking area was interviewed. She stated no resident was permitted to smoke alone as they had to be with staff, family or visitors. If a resident smoked with a visitor they were permitted to smoke anytime otherwise they had to find staff to smoke with them if they have missed the scheduled smoking times. In addition, all residents must wear an apron.

On 01/28/16 at 2:11 PM, Resident #10 stated he was permitted to smoke 6 times per day, under supervision and had to wear an apron. He stated he did not mind wearing a smoking apron for protection. Resident #10 further stated that if he was at home, he would smoke whenever he wanted.

On 01/28/16 at 5:00 PM, the SW stated she completed the smoking evaluations initially and quarterly on all residents who smoked. The SW stated she watched residents smoke when she completed the smoking evaluation to ensure they extinguished their cigarettes appropriately. She stated all residents were informed upon admission that they had to smoke at designated

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 20	F 242		

times (unless supervised by family or friends), had to wear an apron and always had to be supervised when smoking. The SW stated she looked at the restrictions as a resident safety issue and not a residents' rights issue. The SW further stated she did not think when she evaluated someone as a safe smoker that meant they could smoke independently.

On 01/29/16 at 4:09 PM the Administrator stated the facility's corporation developed the policy which included no smoking without supervision, without aprons, and at specific times. The Administer stated she tried to get the policy changed but the facility's corporation would not change the policy. She further stated she was not aware there were any residents assessed as safe smokers.

5. The facility's undated smoking policy included:
*"3. Smoking is only allowed under direct supervision of our staff.";
*"4. Each resident is assessed according to our procedures for safety with smoking.";
*"5. Each resident must wear a "smoking apron" when they are smoking to ensure their safety."

Resident #69 was admitted to the facility on 11/19/15.

The admission Minimum Data Set dated 11/26/15 coded her with intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status.

The Safe Smoking Evaluation dated 11/20/15 was completed by the social worker (SW). This form indicated no problems identified and deemed her a safe smoker with the note that she would follow facility guidelines for smoking.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 21	F 242		

On 01/25/16 at 11:23 AM, Nurse Aide #6 who was supervising the smoking area was interviewed. She stated no resident was permitted to smoke alone as they had to be with staff, family or visitors. If a resident smoked with a visitor they were permitted to smoke anytime otherwise they had to find staff to smoke with them if they have missed the scheduled smoking times. All residents must wear aprons.

On 01/28/16 at 5:00 PM, the SW stated she completed the smoking evaluations initially and quarterly on all residents who smoked. The SW stated she watched residents smoke when she completed the smoking evaluation to ensure they extinguished their cigarettes appropriately. She stated all residents were informed upon admission that they had to smoke at designated times (unless supervised by family or friends), had to wear an apron and always had to be supervised when smoking. The SW stated she looked at the restrictions as a resident safety issue and not a residents' rights issue. The SW further stated she did not think when she evaluated someone as a safe smoker that meant they could smoke independently.

On 01/29/16 at 2:11 PM, Resident #69 stated that she has to smoke at specific times and wear an apron when smoking.

On 01/29/16 at 4:09 PM the Administrator stated the facility's corporation developed the policy which included no smoking without supervision, without aprons, and at specific times. The Administer stated she tried to get the policy changed but the facility's corporation would not change the policy. She further stated she was

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 22	F 242		

not aware there were any residents assessed as safe smokers.
6. Resident #54 was admitted to the facility on 10/24/12 with diagnoses including dementia and history of intestinal obstruction.

Review of a quarterly Minimum Data Set (MDS) dated 12/11/15 revealed Resident #54's cognition was intact and she was able to make her needs known.

Review of an undated document titled "Food and Beverage Preference List" revealed Resident #54 did not like sausage, tuna fish, tomato, zucchini, corn, and rice. Listed as a special request was nothing spicy.

Observations of the lunch meal service on 01/27/16 at 12:15 PM revealed Resident #54 was served chicken, mashed potatoes, and corn on a divided plate. Resident #54's tray card was reviewed during the observations and included instructions for "no corn." Resident #54 stated she did not like corn because it bothered her stomach. Resident #54 further explained that a physician had told her not to eat corn, rice, or spicy things.

An interview was conducted with the Dietary Manager (DM) on 01/29/16 at 1:43 PM. The DM stated residents' food dislikes/allergies were entered into the computer and the system pulled all recipes containing the item(s) and delete them for the resident. The DM explained the computer system was set up to pull alternate food items and print them on the residents' tray cards. The DM further stated the cook was expected to review the tray card before she plated the residents' food and then the two dietary aides on

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 23	F 242		

the tray line were also expected to check the tray card against the plate to make sure it was correct. The DM confirmed the instructions for "no corn" was included on Resident #54's tray card at lunch on 01/27/16 and one of the three kitchen staff members should have caught that during the tray line and not served Resident #54 corn.

7. Resident #4 was admitted to the facility on 04/11/14 with diagnoses of heart failure, malnutrition and depression. Review of the quarterly Minimum Data Set (MDS) dated 12/04/15 revealed Resident #4 was cognitively intact.

An observation made of lunch in the main dining room on 01/26/16 at 12:21 PM revealed Resident #4 received baked chicken, buttered noodles and cooked spinach.

Review of Resident #4's tray card on 01/26/16 at 12:23 PM revealed no greens under the dislikes heading.

An interview with Resident #4 conducted on 01/26/16 at 12:24 PM revealed she did not like greens of any kind and she further stated she had told staff over and over not to bring her greens.

An interview was conducted with the Dietary Manager (DM) on 01/29/16 at 1:43 PM. The DM stated residents' food dislikes/allergies were entered into the computer and the system pulled all recipes containing the item(s) and delete them for the resident. The DM explained the computer system was set up to pull alternate food items and print them on the residents' tray cards. The DM further stated the cook was expected to

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 242	Continued From page 24 review the tray card before she plated the residents' food and then the two dietary aides on the tray line were also expected to check the tray card against the plate to make sure it was correct. The DM confirmed the instructions for "no greens" was included on Resident #4's tray card at lunch on 01/26/16 and one of the three kitchen staff members should have caught that during the tray line and not served Resident #4 greens.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and family and staff interviews the facility failed to transport a resident to group activities of interests for 1 of 3 residents sampled for activities. (Resident #96). Findings included: Resident #96 was admitted to the facility on 03/21/15 and review of her admission physician orders revealed diagnoses of osteoarthritis, heart disease, degenerative joint disease, diabetes and Alzheimer's disease. A review of the most recent quarterly Minimum Data Set (MDS) dated 11/11/15 indicated	F 248	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F248- QOL Activities Res. # 96 continues to attend activities as tolerated. Dependent residents who request to attend activities are at risk of the alleged deficient practice.	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 248	Continued From page 25 Resident #96 had long and short term memory impairments and was severely impaired in cognition for daily decision making. The MDS also revealed Resident #96 required extensive assistance with transfers and was totally dependent on staff for locomotion on and off the unit. A review of an Activities evaluation dated 03/26/15 completed by the Activity Director indicated Resident #96's activity preferences were sing alongs and social parties which were indicated as very important. The evaluation revealed Resident #96 was alert with confusion and due to limited communication, staff anticipated and met needs. The evaluation also indicated Resident #96 required passive activities provided by others and family was available to offer activity interest. The evaluation further revealed Resident #96 was dependent on staff for stimulation, socialization and attendance to activities because of physical limits and cognitive deficit and staff assisted in transporting to and from activities. During a family interview on 01/25/16 at 03:18 PM revealed concerns that Resident #96 had participated in activities in the past but they were not sure if she participated in activities when they were not visiting in the facility. They explained they visited Resident #96 on a daily basis and during the visits they took Resident #96 out of her room and transported her throughout the facility in her wheelchair and took her to activities such as bingo in the main dining room and on Wednesday and Sunday they took her to church services because she enjoyed attending religious activities.	F 248	On 02/15/2016 the Administrator reeducated the Activities Director and coordinator regarding assessing and documenting the residents preference to attend facility activities upon admission, annually, and with significant change in residents condition. They were further educated on the expectation of assisting dependent residents to and from activities as indicated. The Activity Director and/or coordinator will ensure that dependent residents who wish to attend activities are assisted to and from activity as appropriate. Additional assistance may be requested by available staff members. Newly hired activity department staff will be educated upon hire. The Administrator and/or designee will monitor 1 activity 3x/week for 3 months, then 1x/week for 3 months there after to ensure attendance of dependent residents as desired. The Activities Director/ Administrator will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 248	Continued From page 26	F 248		

During an observation on 01/26/16 at 10:42 AM Resident #96 was seated in a wheelchair in her room alone with her head bent forward on her chest and her eyes were closed. A group music activity was in progress in the main dining room with residents participating in the activity.

During an observation on 01/27/16 at 2:15 PM Resident #96 was seated in a wheelchair in her room alone with her head bent forward on her chest and her eyes were closed. A group activity was in progress in the main dining room with music and singing provided by a visitor who played the piano.

During an observation on 01/28/16 at 10:30 AM Resident #96 was seated in a wheelchair alone in her room with her head bent forward on her chest and her eyes were closed. A group activity was in progress in the main dining room with 2 musicians playing guitar and banjo and residents clapped to the music while musicians encouraged residents to sing along.

During a follow up interview with family on 01/28/16 at 3:15 PM they confirmed Resident #96 liked music. They explained Resident #96 did not speak but she was able to hear because when they talked to her she smiled and when music played she listened to the music but sometimes she dozed while the music played.

During an interview on 01/28/16 at 4:43 PM with Nurse Aide #10 she explained she routinely provided care for Resident #96 and Resident #96 was totally dependent on staff to do everything for her. She explained Resident #96's family visited every day and when they visited they took Resident #96 out of her room and transported her

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 248	Continued From page 27	F 248		

in her wheelchair throughout the facility and to activities in the dining room.

During an interview on 01/28/16 at 5:42 PM with Nurse #5 she confirmed Resident #96's family visited every day and transported her throughout the facility in her wheelchair. She stated Nurse Aides (NAs) were expected to transport residents to group activities when an activity was announced on the overhead paging system. She further stated sometimes NAs were busy providing care to residents and then they were unable to transport residents to activities.

A review of an activity care plan dated 01/29/16 indicated Resident #96 was dependent on staff for activities, cognitive stimulation and social interaction due to cognitive deficits as evidenced by inability to speak. The goals indicated Resident #96 would engage in activities of interest that were adapted to interests daily. The approaches and interventions were listed for porch sitting outside and people watching; one on one activities; adapt activities to attention span and cognitive level; celebrations and parties; provide food and snacks; music; pet therapy during pet visits and religious services.

During an interview on 01/29/16 at 4:13 PM the Activity Director explained Resident #96's family visited every day and took her to activities during their visits. She stated she announced the activity on the overhead paging system before the activity started and she relied on nursing staff to transport residents to the activities. She further stated if a resident did not show up for the activity she tried to go get them but she had to do what she could and could not always go get a resident to take them to activities but she did the best she

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 248	Continued From page 28 could. She stated when NAs were busy providing resident care they couldn't always bring residents to activities and she understood they were busy but she did the best she could because she did not have an assistant to help her. During an interview on 01/29/16 at 6:02 PM with the Director of Nursing he stated it was his expectation for staff to assist residents with transportation to activities. He confirmed Resident #96's family visited every day and acknowledged they had gotten spoiled with family members who took residents to activities while they visited.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to repair resident doors with broken and splintered laminate and wood for 33 of 52 resident rooms (Resident room #101, #102, #103, #104, #106, #107, #108, #109, #110, #111, #112, #113, #114, #116, #117, #118, #119, #121, #122, #123, #132, #133, #135, #136, #138, #141, #142, #143, #147, #148, #150, #151 and #152), failed to repair smoke barrier doors with broken and splintered laminate and wood on the edges of 2 of 4 sets of smoke barrier doors, failed to repair 1 of 2 dining room doors with broken an splintered laminate and wood on the edges of the door, failed to repair 1 of 1 activity room doors	F 253	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F253- Maintenance/Housekeeping 1. On 01/29/2016 room 158 and Room 162, residents personal items were bagged and properly stored/ labeled by the licensed nurse coordinator.	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 29 with broken and splintered laminate on the edges of the door, failed to label resident personal care equipment in 9 resident bathrooms (room #102, #109, #117, #121, #135, #138, #157, #158, #162) and failed to repair armrests for 1 of 1 geri chair. Findings included: 1. a. Observations of Room #101 on 01/25/16 at 3:51 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:22 AM revealed the door of resident room #101 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/27/16 at 9:12 AM revealed the door of resident room #101 had broken and splintered laminate on the edges of the bottom half of the door. b. Observations of Room #102 on 01/25/16 at 3:52 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:23 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/27/16 at 9:13 AM revealed the door of resident room #102 had broken and splintered laminate on the edges of the bottom half of the door. c. Observations of Room #103 on 01/25/16 at 3:53 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:24 AM revealed	F 253	On 01/29/16 Room 118 geri chair arms were repaired to ensure residents safety by the maintenance director. On 02/15/16 the Maintenance Director began repairing/protecting and/ or replacing damaged walls and doors as identified. Supplies were ordered for the repair/replace/ and/or protecting by the Maintenance Director on 02/15/2016 On 02/15/2016 license nurse coordinator physically observed residents personal equipment to ensure proper identify and labeling. On 02/15/2016 the Maintenance Director physically observed resident equipment/doors/doorways/ walls to identify areas requiring repair/replacement to ensure resident safety. Unsafe items were scheduled for repair or replaced by the Maintenance Director upon finding. On 02/15/2016 the Administrator re-educated the Maintenance Director and Housekeeping Supervisor on the expectation of monitoring resident equipment and living environment to ensure residents safety. On 02/24/2016 the Director of Clinical Services re-educated nursing staff on the proper labeling, bagging and storage of residents personal care items. Newly hired maintenance, housekeeping and nursing staff will be educated upon hire.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 30 the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/27/16 at 9:14 AM revealed the door of resident room #103 had broken and splintered laminate on the edges of the bottom half of the door. d. Observations of Room #104 on 01/25/16 at 3:54 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:25 AM revealed the door of resident room #104 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/27/16 at 9:15 AM revealed the door of resident room #104 had broken and splintered laminate on the edges of the bottom half of the door. e. Observations of Room #106 on 01/25/16 at 3:55 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:26 AM revealed the door of resident room #106 had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/27/16 at 9:16 AM revealed the door of resident room #106 had broken and splintered laminate on the edges of the bottom half of the door. f. Observations of Room #107 on 01/25/16 at 3:56 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door. Observations on 01/26/16 at 9:27 AM revealed	F 253	Maintenance Director will monitor residents equipment and environment daily and unsafe items will be removed, repaired or replaced as appropriate.Nursing will ensure residents personal care items are labeled, bagged and stored as appropriate during routine rounding. The DCS and/ or Designee monitor 5 residents personal care items and general facility environment for compliance and safety 3x/week for 3 months, then 1x/week for 3 months. The DCS will report audit results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 31	F 253		

the door of resident room #107 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:17 AM revealed the door of resident room #107 had broken and splintered laminate on the edges of the bottom half of the door.

g. Observations of Room #108 on 01/25/16 at 3:57 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:28 AM revealed the door of resident room #108 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:18 AM revealed the door of resident room #108 had broken and splintered laminate on the edges of the bottom half of the door.

h. Observations of Room #109 on 01/25/16 at 3:58 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:29 AM revealed the door of resident room #109 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:19 AM revealed the door of resident room #109 had broken and splintered laminate on the edges of the bottom half of the door.

i. Observations of Room #110 on 01/25/16 at 3:59 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:30 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 32	F 253		

the door of resident room #110 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:20 AM revealed the door of resident room #110 had broken and splintered laminate on the edges of the bottom half of the door.

j. Observations of Room #111 on 01/25/16 at 4:00 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:31 AM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:21 AM revealed the door of resident room #111 had broken and splintered laminate on the edges of the bottom half of the door.

k. Observations of Room #112 on 01/25/16 at 4:01 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:32 AM revealed the door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:22 AM revealed the door of resident room #112 had broken and splintered laminate on the edges of the bottom half of the door.

l. Observations of Room #113 on 01/25/16 at 4:02 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:33 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 33	F 253		

the door of resident room #113 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:23 AM revealed the door of resident room #113 had broken and splintered laminate on the edges of the bottom half of the door.

m. Observations of Room #114 on 01/25/16 at 4:03 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:34 AM revealed the door of resident room #114 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:24 AM revealed the door of resident room #114 had broken and splintered laminate on the edges of the bottom half of the door.

n. Observations of Room #116 on 01/25/16 at 4:04 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:35 AM revealed the door of resident room #116 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:25 AM revealed the door of resident room #116 had broken and splintered laminate on the edges of the bottom half of the door.

o. Observations of Room #117 on 01/25/16 at 4:05 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:36 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 34	F 253		

the door of resident room #117 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:26 AM revealed the door of resident room #117 had broken and splintered laminate on the edges of the bottom half of the door.

p. Observations of Room #118 on 01/25/16 at 4:06 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:37 AM revealed the door of resident room #118 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:27 AM revealed the door of resident room #118 had broken and splintered laminate on the edges of the bottom half of the door.

q. Observations of Room #119 on 01/25/16 at 4:07 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:38 AM revealed the door of resident room #119 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:28 AM revealed the door of resident room #119 had broken and splintered laminate on the edges of the bottom half of the door.

r. Observations of Room #121 on 01/25/16 at 4:08 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:39 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 35	F 253		

the door of resident room #121 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:29 AM revealed the door of resident room #121 had broken and splintered laminate on the edges of the bottom half of the door.

s. Observations of Room #122 on 01/25/16 at 4:09 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:40 AM revealed the door of resident room #122 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:30 AM revealed the door of resident room #122 had broken and splintered laminate on the edges of the bottom half of the door.

t. Observations of Room #123 on 01/25/16 at 4:10 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:41 AM revealed the door of resident room #123 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:31 AM revealed the door of resident room #123 had broken and splintered laminate on the edges of the bottom half of the door.

u. Observations of Room #132 on 01/25/16 at 4:11 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:42 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 36	F 253		

the door of resident room #132 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:32 AM revealed the door of resident room #132 had broken and splintered laminate on the edges of the bottom half of the door.

v. Observations of Room #133 on 01/25/16 at 4:12 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:43 AM revealed the door of resident room #133 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:33 AM revealed the door of resident room #133 had broken and splintered laminate on the edges of the bottom half of the door.

w. Observations of Room #135 on 01/25/16 at 4:13 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:44 AM revealed the door of resident room #135 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:34 AM revealed the door of resident room #135 had broken and splintered laminate on the edges of the bottom half of the door.

x. Observations of Room #136 on 01/25/16 at 4:14 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:45 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 37	F 253		

the door of resident room #136 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:35 AM revealed the door of resident room #136 had broken and splintered laminate on the edges of the bottom half of the door.

y. Observations of Room #138 on 01/25/16 at 4:15 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:46 AM revealed the door of resident room #138 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:36 AM revealed the door of resident room #138 had broken and splintered laminate on the edges of the bottom half of the door.

z. Observations of Room #141 on 01/25/16 at 4:16 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:47 AM revealed the door of resident room #141 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:37 AM revealed the door of resident room #141 had broken and splintered laminate on the edges of the bottom half of the door.

aa. Observations of Room #142 on 01/25/16 at 4:17 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:48 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 38	F 253		

the door of resident room #142 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:38 AM revealed the door of resident room #142 had broken and splintered laminate on the edges of the bottom half of the door.

bb. Observations of Room #143 on 01/25/16 at 4:18 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:49 AM revealed the door of resident room #143 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:39 AM revealed the door of resident room #143 had broken and splintered laminate on the edges of the bottom half of the door.

cc. Observations of Room #147 on 01/25/16 at 4:19 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:50 AM revealed the door of resident room #147 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:40 AM revealed the door of resident room #147 had broken and splintered laminate on the edges of the bottom half of the door.

dd. Observations of Room #148 on 01/25/16 at 4:20 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:51 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 39	F 253		

the door of resident room #148 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:41 AM revealed the door of resident room #148 had broken and splintered laminate on the edges of the bottom half of the door.

ee. Observations of Room #150 on 01/25/16 at 4:21 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:52 AM revealed the door of resident room #150 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:42 AM revealed the door of resident room #150 had broken and splintered laminate on the edges of the bottom half of the door.

ff. Observations of Room #151 on 01/25/16 at 4:22 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:53 AM revealed the door of resident room #151 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/2716 at 9:43 AM revealed the door of resident room #151 had broken and splintered laminate on the edges of the bottom half of the door.

gg. Observations of Room #152 on 01/25/16 at 4:23 PM revealed the door of the resident's room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:54 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 40	F 253		

the door of resident room #152 had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:44 AM revealed the door of resident room #152 had broken and splintered laminate on the edges of the bottom half of the door.

2. a. Observations of smoke prevention doors on A hall on 01/25/16 at 3:50 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:55 AM revealed the smoke prevention doors on A hall had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:45 AM revealed the smoke prevention doors on A hall had broken and splintered laminate on the edges of the bottom half of the door.

b. Observations of smoke prevention doors on D hall on D hall 01/25/16 at 4:24 PM revealed the doors had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:56 AM revealed the smoke prevention prevention doors on D hall had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:46 AM revealed the smoke prevention doors on D hall had broken and splintered laminate on the edges of the bottom half of the door.

3. a Observations of the dining room door on C hall on 01/25/16 at 4:25 PM revealed the door had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:57 AM revealed

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 41	F 253		

the dining room door on C hall had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:47 AM revealed the dining room door on C hall had broken and splintered laminate on the edges of the bottom half of the door.

4. a. Observations of the activity room door on 01/25/16 at 4:26 PM revealed the door had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/26/16 at 9:58 AM revealed the door of the activity room had broken and splintered laminate on the edges of the bottom half of the door.
Observations on 01/27/16 at 9:48 AM revealed the door of the activity room had broken and splintered laminate on the edges of the bottom half of the door.

During an environmental tour and interview with the Maintenance Director and Administrator on 01/29/16 at 4:46 PM the Maintenance Director stated he had a full time assistant and they made rounds on a routine basis to make repairs. He explained staff could complete work order requests and they were placed in a notebook at the nurse's station and he checked them and made repairs as staff reported them. He confirmed the resident doors, smoke prevention doors, dining room door and activity room door had damaged laminate and wood with splinters but he had not received any work orders to repair splintered doors. He stated it was difficult to sand the doors and replacement of the doors was very expensive and he would have to look for options to repair them.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 42	F 253		

During an interview on 01/29/16 at 5:22 PM the Administrator stated it was her expectation that the doors should be repaired or replaced. She stated she had replaced 4 doors in the facility in the last 4 and a half years but the condition of the doors had not been reported to her and she was not aware the doors were as badly damaged with splinters.

5. a. Observations in the bathroom of room #102 on 01/25/16 at 3:52 PM revealed 2 bedpans and an emesis basin were not labeled with resident names.
Observations on 01/26/16 at 9:24 AM in the bathroom of room #102 revealed there were 2 bedpans and an emesis basin not labeled with resident names.
Observations on 01/27/16 at 9:13 AM in the bathroom of room #102 revealed there were 2 bedpans and an emesis basin were not labeled with resident names.

b. Observations in the bathroom of room #109 on 01/25/16 at 3:38 PM revealed 2 bath basins, 2 bed pans and a urinal were not labeled with resident names.
Observations on 01/26/16 at 9:29 AM in the bathroom of room #109 revealed there were 2 bath basins, 2 bedpans and a urinal were not labeled with resident names.
Observations on 01/27/16 at 9:19 AM in the bathroom of room #102 revealed there were 2 bath basins, 2 bedpans and a urinal were not labeled with resident names.

c. Observations in the bathroom of room #117 on 01/25/16 at 4:05 PM revealed 2 bedpans and an emesis basin were not labeled with resident names.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 43	F 253		

Observations on 01/26/16 at 9:36 AM in the bathroom of room #117 revealed there were 2 bedpans and an emesis basin not labeled with resident names.
Observations on 01/27/16 at 9:26 AM in the bathroom of room #117 revealed there were 2 bedpans and an emesis basin not labeled with resident names.

d. Observations in the bathroom of room #121 on 01/25/16 at 4:05 PM revealed a bath basin that was not labeled with a resident name.
Observations on 01/26/16 at 9:39 AM in the bathroom of room #121 revealed there was a bath basin that was not labeled with a resident name.
Observations on 01/27/16 at 9:29 AM in the bathroom of room #121 revealed there was a bath basin that was not labeled with a resident name.

e. Observations in the bathroom of room #135 on 01/25/16 at 4:13 PM revealed a bedpan that was not labeled with a resident name.
Observations on 01/26/16 at 9:44 AM in the bathroom of room #135 revealed there was a bedpan that was not labeled with a resident name.
Observations on 01/27/16 at 9:34 AM in the bathroom of room #135 revealed there was a bedpan that was not labeled with a resident name.

f. Observations in the bathroom of room #138 on 01/25/16 at 4:15 PM revealed 2 toothbrushes on the sink that were not labeled with a resident name.
Observations on 01/26/16 at 9:46 AM in the bathroom of room #138 revealed 2 toothbrushes

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 44	F 253		

on the sink that were not labeled with a resident name.
Observations on 01/27/16 at 9:36 AM in the bathroom of room #138 revealed 2 toothbrushes on the sink that was not labeled with a resident name.

g. Observations in the bathroom of room #157 on 01/25/16 at 4:27 PM revealed a bedpan, bath basin and a clear plastic graduate (used to measure fluids) that were not labeled with a resident name.
Observations on 01/26/16 at 10:00 AM in the bathroom of room #157 revealed a bedpan, bath basin and a clear plastic graduate (used to measure fluids) were not labeled with a resident name.
Observations on 01/27/16 at 9:50 AM in the bathroom of room #157 revealed a bedpan, bath basin and a clear plastic graduate (used to measure fluids) were not labeled with a resident name.

h. Observations in the bathroom of room #158 on 01/25/16 at 4:29 PM revealed a bedpan, hairbrush and toothbrush that were not labeled with a resident name.
Observations on 01/26/16 at 10:05 AM in the bathroom of room #158 revealed a bedpan, hairbrush and toothbrush were not labeled with a resident name.
Observations on 01/27/16 at 9:52 AM in the bathroom of room #158 revealed a bedpan, hairbrush and toothbrush were not labeled with a resident name.

i. Observations in the bathroom of room #162 on 01/25/16 at 4:30 PM revealed an emesis basin that was not labeled with a resident name.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 45	F 253		

Observations on 01/26/16 at 10:07 AM in the bathroom of room #162 revealed an emesis basin that was not labeled with a resident name. Observation on 01/27/16 at 9:55 AM in the bathroom of room #162 revealed an emesis basin that was not labeled with a resident name.

During a tour and interview on 01/29/16 at 3:13 PM with the Unit Manager she explained bedpans, bath basins, emesis basins, urinals, plastic graduates, toothbrushes and resident's personal care items should have the resident's name written with a black marker on each item and each item should be stored in a clear plastic bag. She stated bedpans and graduates were usually stored in a clear plastic bag in the resident's bathroom unless the resident wanted their urinal kept at the bedside and bath basins should be stored in the residents bedside tables and should have the residents name written on them with a black marker. She further stated resident names should be on toothbrushes and they should not be left on sinks in the bathroom. She confirmed during the tour resident care equipment identified did not have resident names on them and they should have had the resident name written on them so staff would know which resident the item belonged to.

During an interview on 01/29/16 at 6:02 PM the Director of Nursing stated it was his expectation for resident care equipment such as bed pans and bath basins to be labeled with the resident's name and placed in a plastic bag for storage. He stated the items were usually stored in the resident's bathroom and the plastic bag was tied to the handrail and should not be stored on the floor of the bathroom.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 253	Continued From page 46 6. During an observation on 01/25/16 at 4:06 PM of a geri chair in room #118 revealed both arms of the chair were ragged and torn with rough edges. During an observation on 01/26/16 at 9:37 AM of a geri chair in room #118 revealed both arms of the chair were ragged and torn with rough edges. During an observation on 01/27/16 at 9:37 AM of a geri chair in room #118 revealed both arms of the chair were ragged and torn with rough edges. During an interview on 01/29/16 at 6:02 PM with the Director of Nursing he stated armrests on chairs that were torn or frayed should be replaced and staff were supposed to put a request in the maintenance book for the arm rests to be changed. He stated it was his expectations for staff to report equipment that needed to be repaired and managers were expected to do rounds daily and to request for worn or torn equipment to be repaired.	F 253		
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication;	F 272		2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 47 Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to comprehensively assess and analyze triggered areas including residents' strengths, weakness and contributing factors when completing the Minimum Data Set for 4 of 20 sampled residents reviewed for quarterly assessments (Residents #8, #15, #25, and #38). The findings included: 1. Resident #25 was admitted to the facility on 07/29/14 with diagnoses including Parkinsonism, Alzheimer's disease, osteopenia, and diabetes.	F 272	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F272- Comprehensive Assessments By 02/26/2016 the Minimum Data Set (MDS) nurse completed a correction for the identified Care Area Assessments	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 48 The annual Minimum Data Set (MDS) dated 08/06/15 coded her as having long and short-term memory impairments, severely impaired decision making skills, being nonambulatory, and having 2 or more falls with no injury since the prior assessment. Review of the Care Area Assessment (CAA) for falls dated 08/12/15 included Resident #25's diagnoses, that she sometimes became combative during care, she required extensive assistance with bed mobility, transfers, dressing, hygiene and bathing, she was incontinent, she had 2 falls with no injuries since the last assessment and she was at risk for falls. The CAA did not describe the location or circumstances of the falls or any analysis related to why the non-ambulatory resident experienced the falls. On 01/28/16 at 3:35 PM, the MDS nurse was interviewed. She stated the nurse who completed the CAA of 08/12/15 was no longer working in the facility. When asked about the contents of the fall CAA, MDS nurse referred to the MDS Corporate Nurse who was present during this interview. MDS Corporate Nurse stated at this time the expectation was that the guidelines listed in the Resident Assessment Instrument (RAI) should be followed including contributing factors, medications, and cognition. The MDS Corporate Nurse further stated that the fall CAA did not meet the RAI guidelines. Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected the CAA to be complete. She further stated there had not been a full time MDS nurse in the facility for about 4	F 272	(CAAs) on Resident #8 for nutrition, #25 for falls,# 15 and #38 for cognition that addresses the underlying causes, contributing factors, and risk factors from the comprehensive Minimum Data Set (MDS) assessment. Current facility residents are at risk of the alleged deficient practice. The MDS nurse completed a review of active resident CAA□s for falls, cognition, and nutrition to ensure that no harm resulted from the alleged deficient practices. No harm was identified. Subsequent MDS Comprehensive Assessments will have accurate and comprehensive triggered CAAs completed by the MDS IDT Team (Inner Disciplinary Team) who consists of the MDS Coordinator, Dietary Manager, Activities Director, and/ or Social Worker as appropriate that address the underlying causes, contributing factors and risk factors admission, annually, and significant change in residents condition The Regional MDS nurse reeducated the MDS IDT Team on 02/24/2016 regarding the overall process completing accurate and comprehensive resident triggered CAA□s on the MDS Comprehensive Assessments per the Resident Assessment Instrument (RAI) regulations. Newly hired MDS IDT Team will be educated upon hire. The MDS Nurse will ensure accurate and	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 49 months. 2. Resident #8 was admitted to the facility on 10/14/14 with diagnoses including atherosclerotic heart disease, bipolar disorder, chronic obstructive pulmonary disease, peripheral vascular disease, and panic disorder. A significant change Minimum Data Set (MDS) dated 05/13/15 coded her as receiving a therapeutic diet and parenteral/IV (intravenous) feedings during the entire 7 day review period which provided 25 % or less calories to Resident #8. Review of the Care Area Assessment (CAA) for nutrition dated 05/22/16 revealed the resident's diet, weight and height were listed. There was no analysis explaining why this area triggered for Resident #8, any contributing factors, functional status, or information regarding the parenteral/IV feedings provided during this period. On 01/29/16 at 10:34 AM, the MDS nurse stated the dietary manager who completed this CAA was no longer employed at this facility. MDS nurse stated that the CAA did not follow the Resident Assessment Instrument guidelines for analyzing the problem area of nutrition for Resident #8. No further explanation was provided. On 01/29/16 at 4:09 PM the Administrator stated during interview it was her expectation that CAAs be complete with all necessary information. 3. Resident #38 was admitted on 12/18/15 with diagnoses including major depression disorder, atherosclerotic heart disease, and chronic obstructive pulmonary disease.	F 272	timely completion and submission of Comprehensive MDS assessments and all triggered CAA□s upon admission, annual and with significant change in residents condition per RAI guidelines. The DCS will monitor the triggered CAA□s for nutrition, cognition, and falls from the admission, annual and significant change in residents condition MDS Assessments for accuracy and completion prior to MDS submission for 3 months, then weekly for 3 months. and monthly for 3 months The DCS will report results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 50	F 272		

The admission Minimum Data Set (MDS) dated 12/25/15 coded Resident #38 with clear speech and being understood and understanding. The section for the Brief Interview for Mental Status (BIMS) was marked as "not assessed". The MDS marked the resident as having "ok" short and long-term memory and having modified independence with daily decision making.

The Care Area Assessment (CAA) dated 12/30/15 for cognition referred the reader to the social work notes and care plan for analysis. The only social work notes in the medical record was a safe smoking evaluation.

An interview with the MDS nurse on 01/28/16 at 3:22 PM revealed she completed the MDS and CAA. She further stated that the social worker normally completed the cognition section. At this time the Corporate MDS Nurse who was in the room at the time of this interveiw stated the social worker had been trained to follow the Resident Assessment Instrument guidelines when completing CAAs and MDS.

An interview with the Social Worker (SW) on 01/28/16 at 4:56 PM revealed she did not complete the MDS section regarding cognition or the CAA. She further stated she would have written a CAA if she had completed this section.

Follow up interview with MDS Nurse on 01/28/16 at 5:20 PM revealed she coded the BIMS as not assessed because this section had not been completed. The Corporate MDS nurse, included in this interview, stated that if the section was not completed then her expectation was that someone go back and complete this section by

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 51	F 272		

asking the resident questions.

Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected the MDS and CAA to be complete.

4. Resident #15 was admitted on 11/18/15 with diagnoses including aftercare following joint replacement and Alzheimer's disease.

Review of the admission Minimum Data Set (MDS) dated 11/25/15 revealed Resident #15 was able to make herself understood and understand others. Review of Section C- Cognitive Patterns indicated a Brief Interview for Mental Status (BIMS) should be conducted. All of the responses were coded with a dash (-) instead of a numerical value. The next area in Section C noted the Staff Assessment for Mental Status was conducted because the resident was unable to complete the interview and noted short term memory problems and modified independence with daily decision making. Review of Section D- Mood revealed all of the responses were coded with a dash (-) instead of a numerical value.

Review of Resident #15's Care Area Assessment (CAA) for Cognitive Loss/Dementia dated 12/01/15 revealed the reader was referred to the Social Worker's documentation for the analysis of findings.

An interview with the Social Worker (SW) on 01/28/16 at 3:20 PM revealed she completed Sections B, C, D, E, and Q for residents' MDS assessments. The SW stated she was also responsible for the cognition, psychosocial, and behavioral Care Area Assessment (CAA)

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 52	F 272		

Summaries and the corresponding care plans. The SW stated the MDS Nurse (a traveler) completed this assessment because she was out sick.

During an interview on 01/28/16 at 5:26 PM the MDS Nurse reviewed Resident #15's admission MDS dated 11/25/15 and stated she had completed Section B for the SW entered dashes in Sections C and D because the SW had not entered her data by 12/01/15 and the MDS had to be transmitted no later than 12/01/15. The MDS Nurse stated she was not the permanent MDS Nurse for the facility and was in another facility the week of 11/23/15. The MDS Nurse further stated she was back at the facility on 11/30/15 and notified the SW by Email on 12/01/15 that she needed to complete her sections for Resident #15's admission MDS assessment as this MDS had to be completed and closed on 12/01/15. The Administrator was copied on this Email that was sent to the SW. The MDS Nurse explained she could not interview Resident #15 on 11/30/15 because the assessment reference date (ARD) for the admission MDS was 11/25/15 and the interviews and assessment needed to be completed the 7 days prior to 11/25/15. The interview further revealed the MDS Nurse had talked with the Administrator prior to 12/01/15 regarding the SW not completing her assessments timely.

A follow up interview was conducted with the SW on 01/28/16 at 6:14 PM. The SW stated she would have completed the worksheets for Resident #15's admission MDS prior to 11/25/15 but did not produce the worksheets during the interview. The SW further stated she must have been back logged and had not entered Resident

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 272	Continued From page 53 #15's assessment data for the admission MDS. The SW did not recall the Email from the MDS Nurse on 12/30/15 and thought she may have been out sick that day. An interview with the Administrator on 01/28/16 at 6:22 PM revealed she expected the SW to enter residents' MDS data on the ARD or soon after so the MDS assessments were completed before they were reviewed and closed by the MDS Nurse.	F 272		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.	F 278		2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 54 Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident interview, and staff interviews, the facility failed to accurately code information for 10 of 20 sampled residents on their Minimum Data Set (MDS) assessments which were reviewed for accuracy (Residents #4, #8, #10, #15, #21, #25, #38, #69, #78, and #91). The findings included: 1. Resident #8 was admitted to the facility on 10/14/14 with diagnoses including atherosclerotic heart disease, chronic obstructive pulmonary disease and peripheral vascular disease. The significant change MDS dated 05/13/15 coded her with no broken or loose dentures coded that she was not edentulous (no natural teeth). This resulted in the dental care area not triggering for a comprehensive assessment. Resident #8 was observed on 01/26/16 at 11:44 AM, up, dressed and having no natural teeth and no dentures in place. She was observed without dentures or natural teeth on 01/27/16 at 11:49 AM and at 1:54 PM. Resident #8 was interviewed on 01/28/16 at 3:44 PM. She stated at this time she had no natural teeth and has had no natural teeth since being admitted to this facility.	F 278	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F278- Assessment accuracy/coordination/certified- Dental. PASSAR, Flu/Pneumonia By 02/26/2016 the Minimum Data Set (MDS) nurse completed a correction to Resident #4, 8, and 91 on the MDS assessment to modify section L to reflect the residents current, accurate dental condition. By 02/26/2016 the MDS nurse completed a correction to Resident #10 MDS assessment to modify section A1500 to reflect the residents current, accurate PASSAR level II status. By 02/26/2016 the MDS nurse completed correction to Residents #4, 10, 15, 21, 25, 38, and 69 MDS assessment to modify section C to reflect the residents current, accurate Flu and Pneumonia vaccine history.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 55 Interview with the MDS nurse on 01/28/16 at 3:00 PM revealed she did not complete this MDS and the staff member who did the MDS on 05/13/15 was no longer employed. She stated Resident #8 should have been coded as being edentulous since she had no natural teeth. Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected the MDS to be accurately completed. 2. Resident #10 was admitted to the facility on 05/09/15. His diagnoses included major depressive disorder, bipolar disorder, and schizophrenia. a. The admission MDS dated 05/16/15 did not code that Resident #10 had been reviewed by a Preadmission Screening and Annual Resident Review (PASRR), coded as a level 2, and appropriate for nursing home placement. Upon request of evidence of PASRR screening information, not found in the medical record, the facility provided evidence of Resident #10's PASRR tracking information. which noted he was a PASRR level 2 due to having a mental illness. Interview with the MDS nurse on 01/28/16 at 3:14 PM revealed the MDS staff who completed the admission MDS dated 05/16/15 was no longer employed at this facility. She further stated that MDS staff would look in the medical record for the PASRR information when coding the MDS and that the PASRR information may not have been in the medical record. The Corporate MDS nurse, involved in this same interview, stated that given Resident #10's mental health diagnoses, the MDS staff should have researched other	F 278	By 02/26/2016 the MDS nurse completed a correction to Resident # 78 MDS Assessment to modify section J to reflect the residents current, accurate pain assessment. By 02/26/2016 the MDS nurse completed a correction to Residents # 21 MDS assessment to modify residents current, accurate hospice status. Current facility residents are at risk of the alleged deficient practice. The MDS IDT Team (Inner Disciplinary Team, who consist of the Social Worker, MDS Nurse, Dietary manager, Activities Director, and Licensed Nurse completed a review by 02/26/2016 of the most recent comprehensive MDS assessment for flu/pneumonia vaccinations, hospice status, dental, pain, and PASARR to validate that no harm resulted due to MDS coding inaccuracies if identified. The Regional MDS nurse reeducated the MDS IDT Team on 02/24/2016 regarding the appropriate process for completing accurate and comprehensive resident MDS assessments for pain, PASARR, dental, hospice status, and flu/pneumonia vaccinations upon admission, annually and with significant change in residents condition per the Resident Assessment Instrument (RAI) regulations. Newly hired MDS IDT Team will be educated upon hire. The MDS IDT Team will complete	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 56 resources for PASRR information. b. Review of the quarterly MDS dated 10/28/15 revealed Resident #10 was not given the flu vaccine because it was not offered. During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine. An interview conducted on 01/28/16 at 6:17 PM with the Director of Nursing (DON) revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident. He then provided documentation which showed Resident #10 was offered the flu vaccine and he refused it. 3. Resident #25 was admitted to the facility on 07/29/14 with Parkinsonism, diabetes, Alzheimers Disease and osteopenia. The quarterly MDS dated 10/30/15 coded	F 278	accurate and comprehensive resident MDS assessments upon admission, annually, and with significant change in residents condition per the Resident Assessment Instrument (RAI) regulations. The MDS IDT Team will complete accurate 1.) dental assessments by physically inspecting the residents oral cavity; 2.) PASRR levels by inspecting the residents PASRR screening tool in the medical record; 3.) hospice status by validating physicians order for hospice services; 4.) pain level by interviewing resident for 5 day pain history and 5.) Influenza and Pneumococcal offering by review of the residents signed consent or declination form in the medical record. Other areas of the MDS assessment will be completed as appropriate per the RAI regulations. The DCS will audit monitor the admission, annually, and significant change in resident condition comprehensive MDS assessments to validate accurate completion of the residents dental status, hospice, PASSAR, Flu/Pneumonia, and pain section prior to MDS submission for 6 months. The DCS will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 57 Resident #25 as not having received the flu vaccine and not having been offered the flu vaccine. During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine. An interview conducted on 01/28/16 at 6:17 PM with the Director of Nursing (DON) revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident. He then provided documentation which showed Resident #25 was offered and received the flu vaccine. 4. Resident #69 was admitted to the facility on 11/19/15 with diagnoses including cerebral infarct, dysphagia, chronic obstructive pulmonary disease and diabetes. The admission MDS dated 11/26/15 coded her as not being given the flu vaccine and not being	F 278	monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 58	F 278		

offered the flu vaccine.

During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine.

An interview conducted on 01/28/16 at 6:17 PM with the Director of Nursing (DON) revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident.

The DON obtained Resident #69's hospital records printed 01/29/16 at 4:00 PM which included documentation that Resident #69 received the flu vaccine on 10/01/15 which showed Resident #69's MDS was inaccurately coded for the flu vaccine.

5. Resident #38 was admitted to the facility on 12/18/15 with diagnoses including metabolic encephalopathy, clostridium difficile (c-diff), and chronic obstructive pulmonary disease.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 59	F 278		

The admission MDS dated 12/25/15 coded that the flu vaccine was not given and not offered to her. The section related to medically contraindicated was not checked.

During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine.

An interview conducted on 01/28/16 at 6:17 PM with the Director of Nursing (DON) revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident.

A follow up interview with the DON on 01/29/16 at 3:59 PM revealed DON found evidence that Resident #38 received the flu vaccine in March 2015. He stated when she was admitted to this facility in December, she was on contact precautions due to c-diff and was still on antibiotics on Prednisone for pneumonia and she

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 60	F 278		

could not take the flu vaccine due to her health being compromised.

6. a. Resident #21 was admitted to the facility on 02/24/15 with diagnoses of dementia, depression and a wound infection. The significant change Minimum Data Set (MDS) dated 01/04/16 revealed Resident #21 was severely cognitively impaired and was rarely/never understood.

Review of Resident #21's medical record revealed she was admitted to hospice services on 01/04/16.

Review of the MDS dated 01/04/16 revealed Resident #21 was not coded for receiving hospice services.

An interview conducted on 01/28/16 at 4:41 PM with the MDS Nurse revealed she created the significant change MDS on 01/04/16 for Resident #21. She stated the significant change was for Resident #21 being admitted to hospice services. The MDS Nurse stated when she coded the MDS she did not code Resident #21 as receiving hospice services and that was the reason the significant change MDS was done.

During an interview conducted on 01/29/16 at 6:13 PM the Director of Nursing (DON) stated his expectation was for resident's receiving hospice services to be coded on the MDS.

b. Resident #21 was admitted to the facility on 02/24/15 with diagnoses of dementia, depression and a wound infection. The significant change Minimum Data Set (MDS) dated 01/04/16 revealed Resident #21 was severely cognitively impaired and was rarely/never understood.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 61	F 278		

Review of the MDS dated 01/04/16 revealed Resident #21 was coded as not receiving an influenza vaccine and was not offered the influenza vaccine.

During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine.

An interview conducted on 01/28/16 at 6:17 PM with the DON revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident.

7. a. Resident #4 was admitted to the facility on 04/11/14 with diagnoses of heart failure, malnutrition and depression.

Review of the annual Minimum Data Set (MDS) dated 04/05/15 and the quarterly MDS dated 12/04/15 revealed Resident #4 was cognitively

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 62	F 278		

intact. Under the section for Oral and Dental Status Resident #4 was coded as having no dental problems for the annual and quarterly MDS. The option for "Obvious or likely cavity or broken natural teeth" was not checked on the MDS.

During an interview on 01/29/16 at 9:30 AM Resident #4 stated her bottom teeth had been broken off and causing her pain since she was admitted to the facility. She stated she had seen the dentist several times at the facility but wanted to go to the hospital for extractions. Observations made at the time of the interview revealed Resident #4 to have multiple lower teeth missing down to the gum line.

An interview with the MDS Nurse on 01/28/16 at 4:41 PM revealed she completed the MDS assessments by using information gathered from observations, record review and resident interviews. The MDS Nurse stated she typically looked in the resident's mouth when completing the Oral and Dental Status section of the MDS. She stated she did not complete the Oral and Dental Status section for Resident #4 and the nurse that did no longer worked at the facility. The MDS Nurse stated Resident #4 should have coded as having broken natural teeth on the annual and quarterly MDS dated 04/05/15 and 12/04/15.

During an interview on 01/29/16 at 4:56 PM the Director of Nursing (DON) stated he was aware of Resident #4's missing and broken lower teeth and expected the MDS Nurse to attempt an oral exam when completing the Oral and Dental Status section of the MDS. He stated the MDS should have been coded as having missing

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 63	F 278		

broken natural teeth.

b. a. Resident #4 was admitted to the facility on 04/11/14 with diagnoses of heart failure, malnutrition and depression.

Review of the quarterly Minimum Data Set (MDS) dated 12/04/15 revealed Resident #4 was cognitively intact. The MDS further revealed Resident #4 was coded as not receiving and not offered the influenza vaccine.

During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded influenza vaccines by reviewing the resident's immunization record and consent forms in their medical record. She stated if the influenza was not documented as being, received elsewhere or refused she coded the MDS as not given and if the resident's consent form indicated they did not refuse to receive the flu vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that received the influenza vaccine.

An interview conducted on 01/28/16 at 6:17 PM with the DON revealed he was in charge of the influenza vaccines for the facility. He stated a letter was sent to every resident or their responsible party for consent to receive the influenza vaccine. He stated all residents that signed the consent received the influenza vaccine. The DON stated he was not aware that the MDS Nurse had coded residents that didn't receive the influenza vaccine as not being offered. He stated the influenza vaccine was offered to every resident.

8. Resident #91 was admitted to the facility on

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 64	F 278		

06/05/15 with diagnoses of cerebrovascular accident, dementia and depression.

Review of the quarterly Minimum Data Set (MDS) dated 12/13/15 revealed Resident #91 was severely cognitively impaired. Under the section for Oral and Dental Status Resident #4 was coded as having no dental problems for the annual and quarterly MDS. The option for "Obvious or likely cavity or broken natural teeth" was not checked on the MDS.

An observation made of Resident #91 on 01/26/16 at 9:10 AM revealed he had numerous missing upper and lower teeth.

An interview with the MDS Nurse on 01/28/16 at 4:41 PM revealed she completed the MDS assessments by using information gathered from observations, record review and resident interviews. The MDS Nurse stated she typically looked in the resident's mouth when completing the Oral and Dental Status section of the MDS. She stated she did not complete the Oral and Dental Status section for Resident #91 and the nurse that did no longer worked at the facility. The MDS Nurse stated Resident #91 should have coded as having broken natural teeth on the quarterly MDS dated 12/13/15.

During an interview on 01/29/16 at 4:56 PM the Director of Nursing (DON) stated he was aware of Resident #91's missing upper and lower teeth and expected the MDS Nurse to attempt an oral exam when completing the Oral and Dental Status section of the MDS. He stated the MDS should have been coded as having missing or broken natural teeth.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 65	F 278		

9. Resident #78 was admitted on 04/20/12 with diagnoses including chronic pain syndrome, degenerative disc disease, and degenerative joint disease.

Review of the annual Minimum Data Set (MDS) dated 07/22/15 revealed Resident #78's cognition was intact and he was able to make his needs known. Review of Section J: Health Conditions under the section for Pain Management revealed the MDS Nurse noted a Pain Assessment Interview should be conducted. The MDS Nurse coded the interview to indicate Resident #78 verbalized occasional pain the last 5 days that did not limit his activities or make it hard to sleep. For the Pain Intensity question which asked Resident #78 to rate his worst pain over the last 5 days on a scale of 1 to 10 the MDS Nurse entered "99" in the response block which indicated Resident #78 was unable to answer.

An interview with the MDS Nurse on 01/28/16 at 5:56 PM revealed she did not complete Resident #78's annual MDS dated 07/22/15. The MDS Nurse explained it had been completed by a staff member no longer employed by the facility. The MDS Nurse reviewed the coding for Resident #78's Pain Assessment Interview for the annual MDS during the interview and stated she could not explain how the Pain Intensity response block had populated with "99" but thought it was a data entry error.

During an interview on 01/29/16 at 6:48 PM the Administrator stated she expected MDS assessments to be accurate.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 66	F 278		

10. Resident #15 was admitted on 11/18/15 with diagnoses including aftercare following joint replacement and Alzheimer's disease.

Review Resident #15's admission Minimum Data Set (MDS) dated 11/25/15 revealed the coding of Section O indicated she had not received the Influenza vaccine in the facility and was not offered the the Influenza vaccine by the facility. In addition, Section O indicated Resident #15's Pneumococcal vaccination was not up to date and had not been offered.

Review of the medical record revealed documents that confirmed Resident #15 had received the Influenza vaccine on 11/16/15 during a hospital stay and had received the Pneumococcal vaccination on 09/17/14.

During an interview conducted on 01/28/16 at 4:41 PM the MDS Nurse stated she coded Influenza and Pneumococcal vaccines on the MDS by reviewing the resident's immunization record and consent forms in their medical record. She stated if either vaccine was not documented as being received, given elsewhere, or refused she coded the MDS as not given. In addition the MDS Nurse noted if the resident's consent forms indicated they did not refuse to receive either vaccine she coded the MDS as not offered. The MDS Nurse stated she did not ask staff for a list of residents that had received the Influenza and Pneumococcal vaccine.

An interview conducted on 01/28/16 at 6:17 PM with the Director of Nursing (DON) revealed he was in charge of the vaccinations for the facility. He stated staff determined the status of residents' Influenza and Pneumococcal vaccines on

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 278	Continued From page 67 admission and a letter was sent yearly to every resident or their responsible party for consent to receive the vaccinations. The DON confirmed Resident #15's vaccination information had not been tranferred to the immunization record but noted the information was available on other documents in her medical record.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a care plan for a resident receiving Hospice services and for a resident with self-injurious behaviors for 2 of 20 residents	F 279	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 279	Continued From page 68 reviewed care plans (Resident #21 and Resident #38). The findings included: 1. Resident #21 was admitted to the facility on 02/24/15 with diagnoses of dementia, depression and a wound infection. The significant change Minimum Data Set (MDS) dated 01/04/16 revealed Resident #21 was severely cognitively impaired and was rarely/never understood. Review of Resident #21's medical record revealed she was admitted to hospice services on 01/04/16. Review of the care plan dated 01/06/16 revealed no hospice or end of life care plan for Resident #21. An interview conducted on 01/28/16 at 4:41 PM with the MDS Nurse revealed she created the significant change MDS on 01/04/16 for Resident #21. She stated the significant change was for Resident #21 being admitted to hospice services. The MDS Nurse stated when she coded the MDS she did not code Resident #21 as receiving hospice services and that was why a care plan for hospice was not created. She stated Resident #21 should have had a hospice/end of life care plan. During an interview conducted on 01/29/16 at 6:13 PM the Director of Nursing (DON) stated his expectation was for resident's receiving hospice services to have a hospice/end of life care plan. 2. Resident #38 was admitted to the facility from the hospital on 12/18/15 with diagnoses including	F 279	correction is prepared and/or executed because it is required by provision of Federal State regulations. F279- Comprehensive Care Plans Res. #38 care plan was updated on 01/29/2016 by Social Services to reflect residents risk for specific to risk for self injuries. Res. # 21 care plan was updated on 01/29/2016 by the MDS nurse to reflect the residents hospice care services. Residents at risk for self injuries and residents receiving hospice services are at risk of the alleged deficient practice. On 02/24/2016 the Social Worker reviewed residents at risk for self injuries and residents receiving hospice care to ensure comprehensive care plans are in place to meet the residents care needs. On 02/24/2016 the Regional MDS Nurse reeducated MDS IDT Team (inner disciplinary team) on the completion and updating of a comprehensive care plan for residents at risk for self injury and for residents receiving hospice care to meet the residents care needs. Newly hired MDS IDT Team will be educated upon hire. The MDS IDT Team will identify residents at risk for self injury through psycho-social assessment and review of the resident's history and physical; residents receiving hospice services by verifying physicians	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 279	Continued From page 69 major depression disorder, metabolic encephalopathy and intentional self harm. Review of the hospital psychiatric discharge summary dated 12/18/15, Resident #38 was admitted to a hospital on 12/06/15 with diagnoses of metabolic encephalopathy and a self inflicted arm laceration. She was transferred to the psychiatric department of another hospital on 12/10/15 once stabilized medically. The admission Minimum Data Set (MDS) dated 12/25/15 coded Resident #38 with intact long and short term memory and modified independence with daily decision making. She was coded as receiving antidepressants during the last 7 days. According to the Psychotropic Drug Use Care Area Assessment CAA) dated 12/30/16, Resident #38 had a history of depression, Opioid dependence and benzodiazepine dependence. She was recently hospitalized with a self inflicted arm laceration and was noted to have attempted suicide in the past. Review of the care plans developed for Resident #38 revealed there was no care plan specific to her history of self harmful behaviors or suicide attempts. The care plan dated 12/25/15 developed for anti-depressant medications had a goal for Resident #38 to have no side effects for 92 days. Interventions were to report residual signs and symptoms of depression or symptomatic relief as needed, monitor effectiveness and side effects, and if side effects present report to practitioner and provide symptomatic relief as needed. Interview with the MDS nurse on 01/29/16 at	F 279	order for hospice care to ensure that a comprehensive care plan is completed and updated upon admission, quarterly, annually and with significant change in conditions as appropriate to meet the residents care needs. The Director of Clinical Services and/or licensed nurse designee will monitor 5 random residents 2x/week for 3 months, then 1x/week for 3 months to ensure residents at risk for self injury and residents receiving hospice services have comprehensive care plans completed as appropriate. The Director of Clinical Services will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 279	Continued From page 70 10:39 AM revealed the care plans were usually initiated by the MDS nurse. MDS nurse had signed as completing the CAAs. She stated she would have expected a care plan specific to self injurious behaviors if the nurse developing the care plan felt a care plan was pertinent. She stated she was not sure who was responsible for the development of the care plans for Resident #38. Interview with the Director of Nursing on 1/29/16 at 11:10 AM revealed staff continually observe all residents for behaviors. He further stated Resident #38 had been a resident in the facility once before and she acted no differently than before, showing no signs of injurious behaviors since being admitted on 12/18/15. He further stated a care plan to address self injurious behaviors should have been developed given her recent psychiatric hospitalization. The Administrator stated during interview on 01/29/16 at 4:09 PM that she would have expected a care plan be developed for Resident #38 related to her recent history of self injurious behaviors.	F 279		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by:	F 312		2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 71 Based on observations, record reviews, and resident and staff interviews the facility failed to provide oral care and nail care for 3 of 6 dependent residents reviewed for activities of daily living (Residents #21, #96, and #106). The findings included: 1. Resident #106 was admitted on 09/30/15 with diagnoses including generalized muscle weakness and arthritis. Review of a significant change Minimum Data Set (MDS) dated 12/15/15 revealed Resident #106's cognition was intact and he was able to make his needs known. The significant change MDS noted Resident #106 required extensive assistance with personal hygiene and rejection of care was not exhibited. Review of a care plan dated 12/30/15 revealed Resident #106 had an activities of daily living (ADL) self-care deficit due to fatigue, limited mobility, arthritis, and impaired balance. The goal was for Resident #106 to receive appropriate staff support with personal hygiene. During an initial interview on 01/26/16 at 12:23 PM Resident #106 stated he had his own natural teeth and staff did not assist him with brushing his teeth. An interview with Resident #106 on 01/27/16 at 11:49 AM revealed he could brush his teeth if staff set him up with the supplies because he currently did not get out of bed due to a healing wound on his buttocks. Resident #106 stated he had not brushed his teeth for approximately a week and a half.	F 312	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F312-ADL Care for dependent residents Res. #96 and Res.# 21 had their nails cleaned and appropriately trimmed by a Certified Nursing Assistant (CNA) on 01/29/2016 and will continue to receive nail care routinely as needed. Res. #106 received set-up assistance for oral hygiene care by a CNA on 01/29/2016 and will continue to receive oral hygiene assistance routinely as needed. Residents who are dependent with Activities of Daily Living (ADLs) are at risk for the alleged deficient practice. Dependent residents fingernails and toenails were assessed by nursing staff by 02/24/2016 for cleanliness, length and smooth edges and nail care was provided as appropriate. Dependent or residents requiring staff assistance with oral care were assessed by nursing staff by 02/24/2016 and total or assisted set-up oral care was provided as appropriate.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 72 On 01/28/16 at 9:30 AM Resident #106 stated staff had not assisted him with oral care the previous evening or so far this morning. During an interview on 01/29/16 at 11:20 AM Resident #106 stated he had asked for a tooth brush recently but did not think he had one amongst his care supplies. Resident #106 further stated staff had not assisted him with oral care yesterday or so far this morning. An interview with Nurse Aide (NA) #1 on 01/29/16 at 11:28 AM revealed she had provided oral care for Resident #106 this morning using oral care swabs because he told her one time that the bristles were too hard on the tooth brush. An interview was conducted with NA #7 by phone on 01/29/16 at 3:01 PM. NA #7 confirmed she had cared for Resident #106 during the 3:00 PM to 11:00 PM shift on 01/25/16, 01/27/16, and 01/28/16. NA #7 stated Resident #106 could brush his own teeth if staff set him up with the supplies. NA #7 stated 01/27/16 was the last time she had assisted Resident #106 with oral care because he was asleep when she checked on him after assisting another resident with a shower on 01/28/16. On 01/29/16 at 3:06 PM NA #1 was accompanied to Resident #106's room and looked through his drawers and closet and could not locate a toothbrush. NA #1 stated Resident #106 used to have a plastic storage bag with a toothbrush, toothpaste, and dental floss. An interview was conducted with NA #8 on 01/29/16 at 4:38 PM. NA #8 confirmed she had	F 312	On 02/24/2016 the Director of Clinical Services reeducated nursing staff regarding providing oral hygiene and nail care for dependent residents requiring assistance with ADLs. Newly hired nursing staff licensed nurses and social workers will be educated upon hire. Nursing will provide nail care per residents bathing schedule and will also inspect nails with routine ADL care. CNA□s will provide oral hygiene care or set-up assistance at a minimum of daily and as needed. The DCS and/or licensed nurse will monitor 5 random residents nails and oral hygiene 3x/week for 3 months, then 1x/week for 3 months and will report results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 73	F 312		

cared for Resident #106 during the 7:00 AM to 3:00 PM shift on 01/25/16 through 01/28/16. NA #8 stated Resident #106 could brush his own teeth if staff set him up with the supplies. NA #8 further stated she typically asked Resident #106 if he wanted to brush his teeth after breakfast and sometimes he would not be interested. NA #8 did not recall what days she had set up Resident #106 with his supplies so he could brush his teeth this week.

An interview with the Director of Nursing on 01/29/16 at 4:00 PM revealed he expected residents to have their teeth brushed at least once a day and when requested.

2. Resident #96 was admitted to the facility on 03/21/15 and review of a facility document titled Admission record revealed diagnoses of osteoarthritis, heart disease, degenerative joint disease, diabetes and Alzheimer's disease.

A review of the most recent quarterly Minimum Data Set (MDS) dated 11/11/15 indicated Resident #96 had long and short term memory impairments and was severely impaired in cognition for daily decision making. The MDS also revealed Resident #96 required extensive assistance with personal hygiene and total dependence on staff for bathing.

A review of a care plan titled Activities of Daily Living dated 03/31/15 indicated Resident #96 had a self-care deficit and interventions were listed in part that Resident #96 required extensive assistance with grooming.

During a family interview on 01/25/16 at 3:48 PM concerns were expressed that Resident #96's

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 74	F 312		

finger nails were too long on both hands but especially on her right hand because she kept her fingers clutched in a tight fist and they felt her nails were pressing into the skin in the palm of her right hand. They stated they had to routinely ask and remind staff to clip Resident #96's nails because they weren't routinely clipped.

During an observation on 01/25/16 at 3:50 PM Resident #96 was seated in a wheelchair in her room with her hands in her lap and her right hand was closed tightly in a fist. All of the nails on her left hand were approximately ¼ - ½ inch long and uneven.

During an observation on 01/26/16 at 10:17 AM Resident #96 was seated in a wheelchair in her room with both hands in her lap. All of the nails on her left hand were approximately ¼ - ½ inch long and uneven and her right hand was clutched in a tight fist and the nails were not visible.

During an observation on 01/28/16 at 3:15 PM Resident #96 was seated in her room in a wheelchair with her hands in her lap. Both hands were relaxed and the nails were visible on both hands. All of the fingernails on both hands were approximately ¼ - ½ inch long and uneven.

During an observation and interview on 01/29/16 at 11:08 AM with the Unit Manager in Resident #96's room Resident #96 was seated in a wheelchair and had her right hand closed tightly in a fist. The Unit Manager gently opened Resident #96's fingers and verified the nails were long and pressed into the skin in the palm of her right hand but she confirmed there was no broken skin. She also confirmed the nails on Resident #96's left hand here long and the nails on both

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 75	F 312		

hands needed to be cut and filed. She explained Resident #96's shower days were on Monday and Thursday on second shift and her nails should have been trimmed and filed when she had a shower last night. She explained if the resident refused to have their nails clipped the Nurse Aide (NA) was expected to tell the nurse and the nurse was expected to make 2 attempts to clip the resident's nails and the attempts made were supposed to be documented on the shower sheet. The Nurse Manager confirmed there was no documentation on Resident #96's shower sheet that she had refused to have her nails clipped or that any attempts had been made to clip her nails. She also confirmed NA #10 gave Resident #96 a shower last night and was working the day shift today.

During an interview on 01/29/16 at 11:19 AM with NA #10 she confirmed she gave Resident #96 a shower on second shift last night. She stated she did not do nail care for Resident #96 because she forgot it. She explained on the resident's shower day she was supposed to check the resident's nails and if they needed to be cut she was supposed to cut them. She further explained if the resident refused nail care she was supposed to tell the nurse. She confirmed Resident #96 had not refused care and she had not had to report to the nurse that Resident #96 refused nail care. She explained Resident #96 kept her right hand tightly clutched in a fist and several months ago had a red spot in palm of right hand because her fingernails were too long.

During an interview on 01/29/16 at 6:02 PM with the Director of Nursing he stated it was his expectation when a resident received a bath or shower staff should check the resident's nails and

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 76	F 312		

do nail care. He stated he expected for resident's nails to be cleaned and trimmed and at any time if staff observed a resident's nails needed to be cleaned or trimmed they should do it.
3. Resident #21 was admitted to the facility on 02/24/15 with diagnoses of dementia, depression and a wound infection.

Review of the significant change Minimum Data Set (MDS) dated 01/04/16 revealed Resident #21 was severely cognitively impaired and was rarely/never understood. The MDS further revealed Resident #21 required extensive assistance with personal hygiene and was dependent for bathing.

Review of the care plan for activities of daily living (ADL) dated 01/06/16 revealed Resident #21 had a self-care deficit. The interventions included Resident #21 would receive appropriate staff support with bed mobility, transfers, eating, dressing, toileting and personal hygiene.

Observations of Resident #21's toenails revealed the following:
· On 01/27/16 at 11:53 AM all toenails on both feet were noted to be approximately ¼ inch long and jagged.
· On 01/28/16 at 10:20 AM all toenails on both feet were noted to be approximately ¼ inch long and jagged.
· On 01/29/16 at 11:42 AM all toenails on both feet were noted to be approximately ¼ inch long and jagged.

An interview conducted with Nurse #2 on 01/28/16 at 2:22 PM revealed hospice provided bed baths for Resident #21 two to three times per week and the facility staff gave her a shower two

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 312	Continued From page 77 times a week. Nurse #2 stated nail care should be performed during showers and as needed. An interview with nurse aide (NA) #6 on 01/28/16 at 2:30 PM revealed nail care was provided during showers and as needed. An interview conducted with the Unit Manager on 01/29/16 at 11:42 AM revealed she expected nail care to be provided during showers and as needed. The Unit Manager was accompanied to Resident #21's room on 01/29/16 at 11:45 AM to observe resident toenails and confirmed toenails should have been trimmed. During an interview conducted on 01/29/16 at 6:13 PM the Director of Nursing stated it was his expectation for nail care to be performed with showers and as needed.	F 312		
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 interview, the facility failed to implement care plan interventions for 1 of 4 residents reviewed for accidents (Resident #25).	F 323	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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	Continued From page 78 The findings included: Medical record review revealed Resident #25 was admitted to the facility on 07/29/14 and most recently on 01/09/16 following a hip fracture. Her diagnoses included a fractured hip, Parkinsonism, anxiety, diabetes, Alzheimer's disease, osteopenia and osteoarthritis, diabetes, and peripheral vascular disease. The annual Minimum Data Set (MDS) dated 08/06/15 coded her as rarely or never being understood, having long and short term memory impairments and severely impaired decision making skills. The MDS noted she required extensive assistance with most activities of daily living skills including bed mobility and transfers, being non-ambulatory, having no skin integrity issues and she had 2 or more falls with no injury since the previous assessment. Review of the Fall Care Area Assessment (CAA) dated 08/12/16 revealed Resident #25 sometimes became combative during care and required extensive assistance of two staff for bed mobility, transfers, dressing, personal hygiene and bathing. The CAA stated her bed was kept in low position with fall mats at the bedside. She was reminded not to get up without calling for assistance. A care plan developed on 08/12/15 for potential for impaired skin integrity due to fragile skin had the goal for the resident to be free from impaired skin integrity through the next review of 02/10/16. Interventions included to assist with turning and repositioning approximately every 2 hours, geri-sleeves as tolerated, and pad side rails on bed.	F 323	because it is required by provision of Federal State regulations. F323- Accidents and Incidents On 01/29/2016 the Director of Clinical services re-assessed Resident #25 safety needs and implemented padded grab bars and bilateral fall matts and updated safety care plan as needed. All Residents are at risk of the alleged deficient practice. On 02/18/2016 the Director of Clinical Service and licensed nurses re-assessed resident safety needs and updated the corresponding care plans as appropriate. On 02/24/2016 the Director of Clinical Services re-educated licensed nurses regarding comprehensive assessment of resident safety needs in completion of safety care plan upon admission, quarterly, and with significant change in resident condition or fall. Newly hired licensed nurses will be educated upon hire. The licensed nurses will assess the residents safety need upon admission, quarterly, and significant change of resident condition or fall and document findings in medical record utilizing the data collection tool and fall risk assessment period. The licensed nurse will initiate and update	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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	Continued From page 79 A care plan developed on 08/12/15 for the potential for injury due to history of falls, gait/balance problems, and poor safety awareness included the goal that she would not sustain serious injury through next review 02/10/16 such as skin tears, bleeding, bruises. Interventions included geri-sleeves as needed, bilateral mats on floor for safety, bed against the wall with mat at bedside. Review of incident and accident reports and Situation, Background, Assessment and Recommendation communication forms for Resident #25 revealed the following: *08/20/15 at 2:00 PM scratch to right hand - staff clipped nails; *08/23/15 at 2:20 PM round bruise left side of neck, cluster of small round bruises on top of left forearm, discoloration to left cheek - resident on Xarelto (a blood thinner) and has combative behaviors and known behaviors of picking and scratching self; *10/27/15 at 2:00 PM discoloration to left forearm - due to combative during shower hitting staff and shower chair; *11/11/15 at 1:15 AM two lacerations on forehead, the center of forehead 1 centimeter (cm) long and one below it 0.5 cm between eyebrows. Right lower arm pea size open area and discoloration on face. Moved bed against wall. The nightstand had rough and sharp edges and blood on it too; *11/11/15 at 11:00 AM skin tear left hand due to being combative during care; *11/19/15 at 2:00 PM scratches noted on upper left arm - resident picks at skin; *12/19/15 11:00 PM skin tear to left inner buttocks;	F 323	an appropriate safety care plan and intervention to aide in the residents safety as appropriate. The Director of Clinical Services and/or licensed nurse designee will review residents incidents/accidents during morning clinical meeting and weekly risk meetings to validate that appropriate safety care plan interventions are in place to aide in the residents safety. The Director of Clinical Services and/or licensed nurse designee will monitor 5 random residents to ensure safety care plans and appropriate interventions are in place 3xweek for 3 months, then 1x time a week for three months and will report results monthly to the Quality Assurance Performance Monthly Committee (QAPI) for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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	Continued From page 80	F 323		

The Nurse Tech Information Kardex which was available to nurse aides and identified individual needed care information was last updated on 01/10/16. The kardex revealed Resident #25 should have geri-sleeves as tolerated, low bed, mat on floor, pad side rails on the bed, and on 01/10/16 the bed against the wall was discontinued.

A Situation, Background, Assessment and Recommendation communication form and Incident report revealed Resident #25 sustained a skin tear on the left hand on 01/14/16 at 7:00 PM when she became combative during care and hit her hand on the side rail.

During initial tour on 01/25/16 at 1:10 PM, Resident #25 was observed in bed with a floor mat on the right/door side of the bed and no mat on the left/window side of the bed, two unpadded turn rails upright, wearing short sleeves, no geri-sleeves and she had two scabbed skin tears on the top of her left hand. She remained in bed with no padded turn rails, a floor mat on the right/door side only, and wearing short sleeves and no geri-sleeves when observed on 01/26/16 at 10:56 AM; and on 01/27/15 at 11:46 AM and at 1:50 PM; and on 01/28/16 at 9:06 AM. On 01/28/16 at 10:05 AM, Resident #25 was on her right side, her head was against the unpadded turn rail, one mat on the floor on the right/door side of the bed, no geri-sleeves were in place, and she was wearing a short sleeve hospital gown. She remained in this position when observed on 01/28/16 at 11:22 PM. Resident #25 was in bed, with no padded turn rails, wearing a short sleeved hospital gown, no geri-sleeves and with only one floor mat in place when observed on 01/28/16 at 1:57 PM and 01/29/16 at 8:31 AM.

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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	Continued From page 81 Interview on 01/29/16 at 10:10 AM with Nurse Aides (NA) #4 and #5 caring for her on 01/29/16 revealed they had worked with her when she was on another hall before her last admission on 01/09/16. They stated previously her bed was against the wall with one floor mat, her side rails were not padded and they could not recall geri-sleeves in use. They stated she leaned to the right side and she was now being positioned with pillows. At this time they repositioned her in bed as she was lying in bed with her head against the right turn rail. When they removed the covers, Resident #25's left leg was hanging off the left side of the bed, on the side where there was no floor mat. When staff looked in the closet, they could not find any geri-sleeves to put on Resident #25. On 01/29/16 at 10:21 PM Nurse #1 stated that Resident #25 should be wearing geri-sleeves and that they may be in the boxes in her room that were not unpacked from her most recent hospitalization. Nurse #1 stated she had not seen Resident #25 wear geri-sleeves all week. Interview with the Director of Nursing (DON) on 01/29/16 at 11:12 AM revealed Resident #25 should still have the geri-sleeves in place. He further stated he would expect mats on both sides of the bed now that her bed was not against the wall. He also stated she does not fling her limbs around as much as she used to but the care plan did include padded rails. Interview with the Administrator on 01/29/16 at 4:09 PM revealed she expected Resident #25 to have the same interventions in place as she did before going to the hospital.	F 323		

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to clean dust from the hood over the stove, failed to clean 3 of 3 ice scoop holders and 1 ice machine, failed to discard expired milk stored on a tray to be served at the evening meal and other unlabeled, undated food items stored in the freezer and failed to date opened nutritional supplements and individual puddings stored ready for use in 1 of 1 nourishment room refrigerator. The findings included: 1. a. An initial tour of the kitchen was made on 01/25/16 at 1:50 PM with Cook #1 due to the Dietary Manager (DM) being home sick. Observations made during the initial tour included the following: · Hood over the stove had approximately ½ inch dust and grim build up. · Blue plastic ice scoop holder sitting on top of the ice machine with the ice scoop immersed in approximately ¾ inches of water, two blue ice	F 371	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F371- Food Storage/Sanitation 1. On 01/29/2016 the Dietary Manager disposed of expired, improperly sealed/stored, and unlabeled items found in the kitchen and nourishment rooms and cleaned the ice machine/scoops. The hood was cleaned by a licensed contractor on 02/16/2016. All resident have the potential to be affected by the alleged deficient practice. On 02/15/2016 the Dietary Manager re-inspected the kitchen and nourishment	2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 371	Continued From page 83 scoop holders attached to a portable stand, used to pass ice to residents on the halls, with the ice scoops immersed in approximately 1/2 inch of water with brown matter. When held up to light, there was a brown, gelatinous appearing substance in the water. The water was discarded and the bottom of the ice scoop holders and had a slimy looking appearance that was easily removed with light pressure. · There was a blackish/purple colored substance covering the inside top of the ice maker located in the kitchen. · The walk in refrigerator had 2 trays of milk sitting on top of the milk crates with 4 having an expiration date of 01/23/16. · There was an unlabeled and undated blue bag of broccoli, 1 box of soft dinner roll dough opened to air with no covering and 1 box of biscuits opened to air with no covering and one partially used box of pork chops with ¼ to ½ inch of ice on top of the box stored in the walk in freezer. An interview conducted with Cook #1 on 01/25/16 at 2:15 PM revealed she was not aware of the last time the hood over the stove was cleaned or of a schedule for the hood to be cleaned. She stated the ice scoops were sent through the dishwasher daily but did not know how often the ice scoop holders were cleaned. Cook #1 stated the blue bag of broccoli in the freezer should have been labeled and dated, the box of pork chops with ice on top should have been discarded and the dinner roll dough and biscuits should have been covered. She further stated the 4 expired milks had been pulled and placed on the tray to serve with supper to residents and should have been discarded due to being out of date.	F 371	rooms on the proper disposal of expired, improperly sealed/stored and unlabeled food items and proper sanitation of ice machine/scoops and hood. The Dietary Manager reeducated staff on 02/24/2016 on the proper disposal of expired, improperly sealed/stored and unlabeled food items and proper sanitation of ice machine/scoops and hood. Newly hired staff will be educated upon hire. The Dietary Manager and/or kitchen supervisor will inspect the kitchen and nourishment rooms daily for expired, improperly sealed/stored or mislabeled food items. Food items identified will be disposed of per company policy. The Ice Machines will be deep cleaned and sanitized monthly by maintenance. The Administrator and /or designee will monitor kitchen, hood, nourishment rooms and ice machines/scoops 3x/week for 3 months, then 1x/week for 3 months, to ensure compliance with food storage and sanitation. The Administrator will report monitoring results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 371	Continued From page 84	F 371		

During an interview conducted on 01/26/16 at 9:30 AM the DM stated all dietary staff were responsible for discarding out of date items and items with ice buildup from the freezer. She stated all opened items stored in the refrigerator and freezer should be dated and labeled when opened. The DM stated the ice scoops and the ice scoop holders should be sent through the dishwasher daily and was not aware that wasn't being done. The DM stated the hood over the stove was professionally cleaned on 06/15/15 but was not aware if it had been cleaned by staff since. She further stated she had only worked at the facility for three weeks and was still working on cleaning schedules.

b. An initial tour of the facility nourishment room was conducted on 01/25/16 at 3:45 PM with the Director of Nursing (DON). The observations included the following:

· Two chocolate puddings and three vanilla puddings in kitchen bowls ready for use not dated.
· Thickened water opened and not dated.
· Five opened and partially used butter pecan Med plus 2.0 (nutritional supplement) not dated.

Review of a sign on the wall in the nourishment room stated Med Plus must have an opened date written on it and must be used within 4 days of opened date. Resident food needs resident name and date it was stored.

An interview conducted with the Director of Nursing (DON) on 01/25/16 at 3:45 PM revealed it was his expectation for snacks for residents being stored in the nourishment room refrigerator

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 371	Continued From page 85 be dated before leaving the kitchen. He stated Med Plus should be dated when opened and discarded 4 days from open date. He stated thickened water and any other item for resident use should be dated when opened. The DON further stated all staff should check the dates on items in the nourishment room refrigerator and discard anything that was out of date. An interview conducted with the DM on 01/26/16 at 9:30 AM revealed dietary should date all resident snacks that come from the kitchen to be stored in the nourishment room. She stated dietary staff should check dates of all snacks in the nourishment room refrigerator daily and discard the out of date snacks.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 441	Continued From page 86 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to wash or sanitize their hands in between providing resident care during 1 of 2 meals observed (Resident #59). The Findings included: During meal observations on 01/26/16 at 12:39 PM, Nurse Aide (NA) #2 served and proceeded to feed Resident #85 while she remained in bed. When NA #2 was finished feeding Resident #85, NA #2 proceeded to lower her bed with the remote control, place a blanket over her, and take her tray back to the tray cart. Then without any hand sanitation, NA #2 proceeded to enter Resident #59's room. The tray had already been delivered to the room and was sitting on the overbed table. NA #2 proceeded to reposition	F 441	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F441- Infection Control Employee # 2 was immediately reeducated on 01/29/2016 for failing to wash hands between feeding resident # 85 and # 59. All residents are at risk for the alleged deficient practice. On 01/29/2016 the Director of Clinical Services and/or licensed nurse designee monitored hand	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 441	Continued From page 87 Resident #59, sat and fed Resident #59 without washing or sanitizing her hands. On 01/26/16 at 1:08 PM, NA #2 was interviewed about hand washing. NA #2 stated she should have washed her hands between feeding Resident #85 and proceeding to feed Resident #59. She gave no reason for the lack of handwashing saying she just didn't wash her hands. The Administrator stated during interview on 01/29/16 at 4:09 PM she expected NAs to wash their hands in between resident care including between Resident #59 and #85. Interview with the Director of Nursing (DON) on 01/29/16 at 4:52 PM revealed he expected handwashing to be completed if there was personal contact with a resident and going to another resident to provide care. The DON stated NA #2 should have washed or sanitized her hands between leaving Resident #59 and feeding Resident #85.	F 441	sanitizer equipment/supplies and replenished as appropriate. On 02/24/2016 the Director of Clinical Services reeducated facility nursing staff on the infection control practice of sanitizing hands between patient care to aid in the prevention of infectious disease. Newly hired nursing staff will be educated upon hire. Nursing staff will effectively sanitize hands prior, between and after providing patient care and adhere to the facilities infection control practices for hand washing. The Director of Clinical Services and/or licensed nurse designee will monitor 5 random nursing staff for proper hand sanitizing prior, between and after patient care 3x/week for 3 months, then 1x/week for 3 months a month and report audit monitoring results monthly in QAPI for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary.	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and	F 520		2/26/16

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 520	Continued From page 88 assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in May of 2015. This was for two recited deficiencies which occurred in April of 2015 and on the current recertification survey. The deficiencies were in the areas of management of personal funds and accuracy of resident Minimum Data Set (MDS) assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance	F 520	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. F520 QA The facility maintains a quality assessment and assurance committee consisting of the director of nursing services, a physician designated by the	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 520	Continued From page 89 Program. The findings included: These tags were cross referenced to: 1. a. F 159: Management of Personal Funds. Based on resident interview, staff interview and record review, the facility failed to make resident funds available to 1 of 2 residents reviewed for personal funds. (Resident #66). The facility was recited for F 159 for failure to have funds available on request for a resident with a personal fund account managed by the facility. F 159 was originally cited during the April 2015 recertification survey for failure to provide access to resident funds on weekends. b. F 278: Accuracy of Resident Assessment. Based on observations, record reviews, resident interview, and staff interviews, the facility failed to accurately code information for 10 of 20 sampled residents on their Minimum Data Set (MDS) assessments which were reviewed for accuracy (Residents #4, #8, #10, #15, #21, # 25, #38, #69, #78, and #91). The facility was recited for F 278 for failure to accurately code resident information on their MDS assessments in the following areas: Preadmission Screening and Resident Review, Oral/Dental Status, Pain Management, Hospice Care, and Vaccinations. F 278 was originally cited during the April 2015 recertification survey for failure to accurately code a significant change MDS assessment for hospice care. During an interview on 01/29/16 at 6:48 PM the Administrator stated the facility had focused on	F 520	facility, and at least three other members of the facility staff. Resident # 66 will continue to have resident funds available for personal use. On 02/25/2016 the Minimum Data Set (MDS) nurse completed a correction to Resident #4, 8, and 91 on the MDS assessment to modify section L to reflect the residents current, accurate dental condition. By 02/26/2016 the MDS nurse completed a correction to Resident #10 MDS assessment to modify section A1500 to reflect the residents current, accurate PASSAR level II status. By 02/26/2016 the MDS nurse completed a correction to Residents #4, 10, 15, 21, 25, 38, and 69 MDS assessment to modify section C to reflect the residents current, accurate Flu and Pneumonia vaccine history. By 02/26/2016 the MDS nurse completed a correction to Resident # 78 MDS Assessment to modify section J to reflect the residents current, accurate pain assessment. By 02/26/2016 the MDS nurse completed a correction to Residents # 21 MDS assessment to modify hospice status to reflect the residents current, accurate hospice coding.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 520	Continued From page 90 residents' having access to their funds on the weekends after the April 2015 recertification survey. The Administrator further stated she was not aware of any residents who complained the facility did not have funds available when they requested and she would ask need to request an increase in petty cash from the corporate office. The interview further revealed the facility had reviewed MDS assessments for accuracy for 6 months after the April 2015 recertification survey. The Administrator noted the facility had not had a permanent MDS nurse since the middle of August 2015 and had hired a permanent MDS nurse to start on 02/08/16.	F 520	All residents are at risk of the alleged deficient practice for F159 and F278. There will be sufficient resident funds available at all times. By 02/26/2016 the MDS IDT Team (Inner Disciplinary team) completed a review the most recent comprehensive MDS assessment to validate that no harm resulted due to MDS coding inaccuracies if identified. The QAPI team received an reeducation on 02/15/2016 by the Regional Director of Clinical Services regarding the policy and procedure of a effective on going QAPI committee. On 02/26/2016 the Administrator reeducated alert and oriented residents who have personal funds that they may request monies from the business office Monday through Friday from 8:00am-5:00pm and after hours and on weekends from the charge nurse. Newly admitted residents will receive written notice of the Resident Funds policy upon admission. On 02/15/2016 the Administrator reeducated the charge nurse and the receptionist on the policy of ensuring resident funds are available in the medication room lock box after hours and initialing every shift to validate balance and availability.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 520	Continued From page 91	F 520	Newly hired charge nurses will be educated upon hire. The charge nurse will be responsible for notifying the ABOM Assistant Business Office Manager if available resident funds are low and the HR Director will replenish funds weekly and notify the Administrator of additional funds needed as appropriate. The Regional MDS nurse reeducated the MDS IDT Team (Inner Disciplinary team) on 02/24/2016 regarding the appropriate process for completing accurate and comprehensive resident MDS assessments upon admission, quarterly and with significant change in residents condition per the Resident Assessment Instrument (RAI) regulations. Newly hired MDS IDT Team will be educated upon hire. The MDS IDT Team will complete accurate 1.) dental assessments by physically inspecting the residents□ oral cavity; 2.) PASRR levels by inspecting the residents PASRR screening tool in the medical record; 3.) hospice status by validating physicians order for hospice services; 4.) pain level by interviewing resident for 5 day pain history and 5.) Influenza and Pneumococcal offering by review of the residents signed consent or declination form in the medical record. Other areas of the MDS assessment will be completed as appropriate per the RAI regulations.	

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 01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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 520	Continued From page 92	F 520	The ABOM and/or the Administrator will monitor the medication lock box weekly for 6 months to validate the charge nurse is initialing availability and usage every shift and that ample fund are available to meet residents needs for 6 months and will report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI Committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action if necessary. The DCS will audit monitor the admission, annual, and significant change in resident condition comprehensive MDS assessments to validate accurate completion of the residents dental status, hospice status, PASSAR level, Flu/Pneumonia, and pain section prior to MDS submission for 6 months and report monitoring results monthly to the Quality Assurance Performance Improvement (QAPI) committee for 6 months or until substantial compliance is obtained. The QAPI committee will evaluate the effectiveness of the monitoring/observation tools for maintaining substantial compliance, and make changes to the corrective action as necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0485	A. BUILDING: _____ B. WING _____	01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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) COMPLETE DATE
L 040	.2209(A) INFECTION CONTROL 10A-13D.2209 (a) (a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection. This Rule is not met as evidenced by: Based on record reviews and staff interviews the facility failed to have designated staff who was responsible for infection control complete a course in an approved program for infection control. Findings included: During an interview on 01/29/16 at 6:00 PM with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) the DON confirmed he was designated in charge of infection control in the facility and the ADON assisted with data collection. He confirmed no staff in the building had attended a course in an approved program for infection control and was not aware of the requirement. He also confirmed no staff were registered for an approved program for infection control and was not aware of programs available that were approved courses for infection control. During an interview on 01/29/16 at 6:30 PM the Administrator explained there had been transitions in management positions since the last recertification survey. She confirmed there were no staff currently in the facility that had attended a course in an approved program for infection control and she could not remember when the last person who was responsible for infection control had attended an approved course. She stated no staff had been scheduled	L 040	Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal State regulations. State Licensure L040Spice training The DCS will enroll in the next available spice training. All residents are at risk for the alleged deficient practice. The Administrator will ensure that there is at minimum one active employee that has received Spice Training to aide in the prevention of infectious disease per NC state licensure.. Nursing staff will effectively sanitize hands prior, between and after providing patient care. The Administrator and/or DCS will monitor Spice training certificates to ensure there is a current Spice trained employee on staff in the facility at all	2/26/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/22/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0485	A. BUILDING: _____ B. WING _____	01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE 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) COMPLETE DATE
L 040	Continued From page 1 to attend an approved course during this year at this time.	L 040	times. The QAPI Committee will evaluate the effectiveness of the monitoring tool for maintaining substantial compliance, and make changes to the corrective action if necessary.	