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 ______	02/23/2017

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 170 SS=B	483.10(g)(8)(i)(9)(i)-(iii)(h)(2) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL (g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (g)(9) communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. (h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility failed to promptly deliver mail to 2 of 3 residents sampled (Resident #1 and Resident #80).	F 170	Preperation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan or correction is prepared and/or	3/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/15/2017

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

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 ______	02/23/2017

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 170 Continued From page 1

The Findings included:

1. Resident #1 admitted to the facility on 11/24/04 and her diagnoses include: hypertension, Cerebral Palsy, and osteoporosis.

Review of Resident #1's most recent quarterly minimum data set (MDS) dated 01/25/17 revealed that Resident #1 was cognitively intact for daily decision making. No behaviors were identified. The MDS also revealed that Resident # 1 required limited to extensive assistance with activities of daily living.

During on observation and interview with Resident #1 on 02/20/17 at 12:50 PM the Activity Director was observed delivering mail into Resident #1's room and handing it to her. Resident #1 stated as the Activity Director was exiting the room "this must be Saturday's mail because today was a federal holiday." Resident #1 stated that she was unable to read and write but that she loved receiving mail, she stated "I would take the mail everyday if I could, that is how I keep with my prayer circle." Resident #1's letters that she received in the mail were stamped 02/15/17 and 02/16/17. Resident #1 stated that they used to deliver mail on Saturday's but they did not pass it out anymore until the next week on Monday.

Interview with the receptionist on 02/21/17 at 2:24 PM revealed that she checked the mail daily Monday through Friday after it was delivered and then she sorted it. The resident was mail was immediately placed into the Activity Director Mail box and the activity staff would deliver the mail to the residents. The receptionist was not sure who checked the mail on the weekend when she was

F 170

executed because it is required by provision of Federal and State regulations.

Resident #1 will continue to receive mail on the same day delivered to the facility.

Resident #80 will continue to receive mail on the same day delivered to the facility.

On 2/24/17, the Administrator completed a quality assurance monitor for current residents who receive mail, inclusive of newly admitted residents, to ensure mail was delivered to the resident on the same day of receipt to the facility. No discrepancies were identified.

On 2/28/17, the Administrator provided education to administrative staff including receptionist, Activity Director, Business Office Manager, and weekend RN Supervisor responsible for delivering mail timely. By 3/15/17, the Administrator and Director of Clinical Services provided education to staff regarding mail delivery to resident on same day of receipt to the facility.

The Activity Director or Activity Assistant will sort mail and deliver to residents Monday through Friday. RN Supervisor will sort the mail and deliver to residents on Saturday and Sunday. Business Office Manager and receptionist will serve as alternates for delivery. Mail will be delivered to residents on the date received by the facility.

The Administrator and/or designee will

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 ______	02/23/2017

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 170	Continued From page 2 not there. Interview with the Activity Director on 02/22/17 at 12:30 PM revealed that Monday through Friday the receptionist would get the mail and sort it out. The receptionist would place any resident mail into the activity mail box and her staff would get it and deliver it to the residents. The activity director stated that on the weekends the mail was not delivered at any specific time and there had been times that the mail that was delivered on Saturday was not delivered to the residents until Monday because there was no one specific to check the mail on the weekend. The activity director stated that sometimes her activity assistant would be there on the weekends and she would check the mail and deliver it to the residents. Interview with the Activity Assistant on 02/21/17 at 2:59 PM revealed the she usually worked Monday through Friday and occasionally on the weekends. The activity assistant stated "I feel like I am here all the time." The activity assistant stated that she was at the facility on Saturday 02/18/17 and she had called Bingo for the residents. The activity assistant stated that on the Saturdays that she worked she would check the mail before she left and if the mail had ran she would deliver it to the residents and if the mail had not ran then she would generally come back to the facility later in the afternoon and get the mail and deliver it to the residents at that time. The activity assistant stated she worked Saturday from 9:00 AM to 11:30 AM and the mail had not been delivered yet and she did not come back up to facility to check the mail later that afternoon. Interview with the Administrator on 02/23/17 at	F 170	conduct Quality Assurance Monitoring of 5 random residents for timely mail delivery 2 times per week for 4 weeks, 1 time per week for 8 weeks, then 1 time per month. Schedule for QI monitoring will be modified based on findings. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director and at least three other members.	

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 ______	02/23/2017

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 170	Continued From page 3	F 170		

11:22 AM revealed that she expected the staff to deliver mail to the residents the same day that it was received to the facility including Saturday's.

2. Resident #80 was initially admitted to the facility on 08/09/13 with diagnoses that included: non Alzheimer's dementia, depression, schizophrenia, and chronic obstructive pulmonary disease.

Review of Resident #80's most recent quarterly minimum data set (MDS) dated 12/27/16 revealed that Resident #80 was cognitively intact for daily decision making. No behaviors were identified. The MDS also revealed that Resident #80 required set up assistance with activities of daily living.

During an observation and interview with Resident #80 on 02/22/17 at 3:39 PM revealed that on Monday 02/20/17 the staff had delivered a piece of mail to him that was dated 02/14/17. Resident #80 stated the letter was a financial statement from his bank and he "really needed to have those as soon as possible."

Interview with the receptionist on 02/21/17 at 2:24 PM revealed that she checked the mail daily Monday through Friday after it was delivered and then she sorted it. The resident was mail was immediately placed into the Activity Director Mail box and the activity staff would deliver the mail to the residents. The receptionist was not sure who checked the mail on the weekend when she was not there.

Interview with the Activity Director on 02/22/17 at 12:30 PM revealed that Monday through Friday the receptionist would get the mail and she sort it

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 ______	02/23/2017

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 170	Continued From page 4 out. The receptionist would place any resident mail into the activity mail box and her staff would get it and deliver it to the residents. The activity director stated that on the weekends the mail was not delivered at any specific time and there had been times that the mail that was delivered on Saturday was not delivered to the residents until Monday because there was no one specific to check the mail on the weekend. The activity director stated that sometimes her activity assistant would be there on the weekends and she would check the mail and deliver it to the residents. Interview with the Activity Assistant on 02/21/17 at 2:59 PM revealed the she usually worked Monday through Friday and occasionally on the weekends. The activity assistant stated "I feel like I am here all the time." The activity assistant stated that she was at the facility on Saturday 02/18/17 and she had called Bingo for the residents. The activity assistant stated that on the Saturdays that she worked she would check the mail before she left and if the mail had ran she would deliver it to the residents and if the mail had not ran then she would generally come back to the facility later in the afternoon and get the mail and deliver it to the residents at that time. The activity assistant stated she worked Saturday from 9:00 AM to 11:30 AM and the mail had not been delivered yet and she did not come back up to facility to check the mail later that afternoon. Interview with the Administrator on 02/23/17 at 11:22 AM revealed that she expected the staff to deliver mail to the residents the same day that it was received to the facility including Saturday ' s.	F 170		
F 246	483.10(e)(3) REASONABLE ACCOMMODATION	F 246		3/19/17

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 ______	02/23/2017

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 246 SS=D	Continued From page 5 OF NEEDS/PREFERENCES (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to accommodate resident's needs by placing furniture in room where resident could not reach the light cord to turn his light on and off for 1 of 4 residents reviewed for accommodation of resident's needs (Resident #160). Resident #160 was admitted to the faciltiy on 01/27/2017 with diagnoses which included diabetes mellitus, hypertension, amyotrophic lateral sclerosis (ALS), history of falling, traumatic brain injury and fatigue. Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/03/2017 revealed that the resident was cognitively intact, had adequate vision and hearing, clear speech, was understood and understands and was able to make his needs known. The resident required minimal assistance of 1 with activities of daily living (ADL) and used a walker and wheelchair for mobility. He was always continent of bladder and occasionally incontinent of bowel. Observation of the room on 02/21/2017 @ 8:42 AM revealed the resident was currently out of his room in therapy and the bed was positioned horizontally against the wall. The light was positioned towards the foot of the bed and light	F 246	On 2/22/17, Resident #160 gave permission for Maintenance Assistant to reposition bed for easy accessibility to the over bed light cord. On 2/24/17, the Administrator and Maintenance Assistant completed a quality assurance monitor of resident rooms to ensure accessibility to the over bed light cord to accommodate the residents lighting needs, unless care planned otherwise. On 2/28/17, the Administrator reeducated IDT team including Social Services Director, Activity Director, Business Development Coordinator, receptionist, Human Resource Coordinator, Medical Records Coordinator, Director of Clinical Services and Assistant Director of Clinical Services regarding accommodation of needs and over bed light cords being within reach of resident in bed, unless care planned otherwise. By 3/15/17, the Administrator and Director of Clinical Services reeducated direct care staff regarding accommodation of needs and over bed light cords being within reach of resident in bed, unless care planned otherwise.	

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 ______	02/23/2017

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 246

Continued From page 6
switch was positioned at the foot of the bed.

An interview on 02/21/2017 at 9:02 AM, Resident #160 stated that he could not reach his light cord without sitting up in the bed and reaching to turn the light out. He stated that he had a history of falls and was afraid to reach that far for fear that he would fall out of the bed. Resident #160 confirmed that he could not reach the light cord.

Observation of the room on 02/22/2017 at 8:56 AM revealed the resident was out of the room in therapy and the bed remained in the same position with the light cord at the end of the bed.

Observation of the room on 02/22/2017 at 3:06 PM revealed the resident was up in his wheelchair and his bed had been moved and positioned so the head of the bed was centered under the light. The resident stated that his bed was moved while he was in therapy. He stated that he did not know that his bed was going to be moved until he came back from therapy. Resident #160 stated that he liked his bed up against the wall better because it decreased his chances of falling out of the bed by 50%.

An interview on 2/22/2017 with the maintenance assistant on 02/22/2017 at 3:49 PM revealed that he moved the resident's bed earlier as instructed to do so by the Administrator. He stated that he did not know why the Administrator wanted the bed moved but if the resident did not like it he would move it back now.

An interview on 02/23/2017 at 9:40 AM with two nurse aides who typically work on the hall revealed that the resident had not complained to them about not being able to reach his light cord

F 246

Resident rooms will be inspected by IDT team prior to admission to ensure over bed light cords are accessible to resident in bed. IDT team will continue to monitor rooms during morning rounds to ensure over bed light cords are accessible to resident in bed.

The Director of Clinical Services and/or designee will conduct Quality Assurance Monitoring of 5 random residents to ensure over bed light cords are within reach of resident in bed, unless care planned otherwise. Quality assurance monitoring will be completed 3 times per week, 1 time per week for 8 weeks, then 1 time per month. Schedule for QI monitoring will be modified based on findings.

The results of QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director, and at least three other members.

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 ______	02/23/2017

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 246	Continued From page 7	F 246		

but they both stated that he had only been on this hall for a couple of weeks. They both stated that beds are typically positioned according to resident preference or for prevention of falls. They stated that sometimes beds are placed against the wall because the resident tends to fall out of the bed on that side.

An interview on 02/23/2017 at 9:57 AM with the Administrator revealed that she asked Resident #160 if he would prefer to have his bed turned so that he could see the TV better. So she stated she had maintenance move his bed with his permission.

An interview on 02/23/2017 @ 10:40 AM with the Director of Nursing revealed that the resident beds are positioned according to resident and family preference or for intervention purposes such as a resident fall. The DON stated that the family sometimes requests that the bed be positioned against the wall to open up the area and allow room for chairs for visiting purposes. He stated that typically the resident and family are told that management and maintenance will have to evaluate the positoning of the bed to ensure that the resident's things are accessible to them. He stated that management personnel are assigned to halls to evaluate each morning whether resident's things are accessible to them and to ensure that there are no broken light cords that need repairing, etc. The DON stated that the Social Services Director was responsible for evaluating Resident #160's room each day.

An interview on 02/23/17 at 10:52 AM with the Social Services Director revealed that Resident #160 had not complained to her about not being able to reach his light cord to turn his light on 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 ______	02/23/2017

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 246	Continued From page 8 off. She stated that she had made daily rounds on his room and stated "I did not think about his cord being at his feet and him not being able to reach it." An interview on 02/23/2017 at 10:58 with the Administrator and the DON revealed that their process for the administrative staff that are assigned to hallways was to great residents in the morning and find out if they have any concerns. They stated they utilize a mock survey quality assurance sheet to mark concerns and then these concerns are transferred onto a form for the Administrator to work to resolve the concerns. A review of the concern forms from 01/27/2017 to present revealed that there was no indication on the conern forms regarding Resident #160 not being able to reach his light cord. An interview on 02/23/17 @ 11:42 AM with the nurse who typically works on the hall revealed that the resident had not complained to her about not being able to reach his light cord. An interview on 02/23/2017 at 12:16 PM with the Administrator revealed that if the resident had told them he could not reach the light cord they would have fixed it immediately. She stated that her expectation was for all residents to have what they need within their reach. The Administrator stated that she was not aware if a staff member had asked Resident #160 how he needed his room set up.	F 246		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that	F 274		3/19/17

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 ______	02/23/2017

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 274	Continued From page 9 there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Significant Change in Status Assessment (SCSA) following hospice enrollment for 1 of 2 residents sampled for hospice (Resident #71). The Findings include: Resident #71 was most recently readmitted to the facility on 01/11/17 with diagnoses that included: hypertension, peripheral vascular diseases, urinary tract infection, diabetes mellitus, anxiety, depression, schizophrenia, and respiratory failure. Review of Resident #71's most recent comprehensive minimum data set (MDS) dated 01/18/17 revealed that Resident #71 had was cognitively impaired and required extensive assistance with activities of daily living. The MDS indicated that Resident #71 was not receiving hospices services during the assessment period. Review of a document titled "Hospice Initial Certification" dated and signed by Resident #71's attending physician on 02/07/17 revealed that Resident #71 started hospice care on 02/01/17.	F 274	On 2/22/17, the Minimum Data Set (MDS) Coordinator completed a significant change Minimum Data Set Comprehensive Assessment for Resident #71 to accurately reflect the residents current hospice services. On 2/24/17, the Regional MDS Coordinator and Administrator completed a quality assurance monitor for residents with hospice elections to confirm a significant change assessment was completed appropriately. On 2/24/17, the Regional MDS Coordinator reeducated MDS licensed nurses regarding the Resident Assessment Instrument (RAI) guidelines for completing a significant change MDS Comprehensive Assessment within 14 days of a resident's significant change, including election of hospice services. Newly hired MDS licensed nurses will be educated upon hire. MDS Coordinator will review orders as	

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 ______	02/23/2017

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 274	Continued From page 10 Review of Resident #71's MDS assessment revealed the resident had no SCSA after the effective date of the election of hospice. Interview with the MDS nurse on 02/22/17 at 4:25 PM revealed that she completed SCSA on residents after they go hospice of if they had a change in condition that was not likely to resolve itself after 14 days. The MDS nurse stated that she attended the morning clinical meeting and listened for residents that had started on hospice care or had a hospice referral and that was how she kept up with residents that had went to hospice service and would require a SCSA. The MDS nurse stated that they had some "discrepancy in the date" that Resident #71 actually went to hospice service and that was why there was not SCSA completed yet. The MDS nurse stated that 14 days after the resident started on hospice she would complete a SCSA. The MDS further stated that it was just a "miscommunication on the date" and she would correct it accordingly. Interview with the Director of Nursing and the Administrator on 02/23/17 at 11:22 AM revealed that they both expected the MDS nurse to complete a SCSA 14 days after hospice election like required.	F 274	received from hospice referral. Order of hospice election will be reviewed in morning meeting by IDT team and Administrator will verify completion of significant change MDS Comprehensive Assessment within 14 days of election of hospice services by the MDS Coordinator. The Administrator and/or designee will conduct Quality Assurance Monitoring of Comprehensive MDS Assessments to ensure a significant change indicating hospice services is completed within 14 days as appropriate. Quality Assurance Monitoring will be conducted on 5 random residents 2 times per week for 4 weeks, 1 time per week for 8 weeks, and then 1 time per month. QI monitoring schedule will be modified based on findings. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will evaluate effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director and at least 3 other members.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		3/19/17

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 ______	02/23/2017

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 11 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the minimum data set to reflect a residents palliative care election	F 278	On 2/22/17, the Minimum Data Set (MDS) Coordinator modified the Comprehensive MDS Assessment	

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 ______	02/23/2017

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 12
for 1 of 2 residents sampled for hospice (Resident #71).

The findings included:

Resident #71 was most recently readmitted to the facility on 01/11/17 with diagnoses that included: hypertension, peripheral vascular diseases, urinary tract infection, diabetes mellitus, anxiety, depression, schizophrenia, and respiratory failure.

Review of Resident #71's most recent quarterly minimum data set (MDS) dated 01/25/17 indicated that Resident #71 was moderately impaired for daily decision making. No behaviors were identified on the assessment. The MDS also revealed that Resident #71 required extensive assistance of 2 staff members with activities of daily living. The MDS further revealed that Resident #71 received hospice care and that she had a life expectancy of 6 months or less to live (J1400).

Review of a document titled "Hospice Initial Certification" dated and signed by Resident #71's attending physician on 02/07/17 revealed that Resident #71 started hospice care on 02/01/17. The document further indicated that Resident #71 was to receive palliative care from 01/25/17 until her hospice start date of 02/01/17.

Interview with the MDS nurse on 02/22/17 at 5:24 PM revealed that if a resident was hospice then she had been instructed by her corporate office to code the resident as hospice in section O of the MDS and to also code that the resident had a life expectancy of less than 6 months or less to live (J1400). The MDS nurse further stated that if the resident was palliative care then there were

F 278

Section O and J1400 for Resident #71 to accurately reflect the resident's hospice services.

On 2/24/17, the Regional MDS Coordinator and Administrator completed a quality assurance monitor on residents with hospice elections to confirm Section O and J1400 were coded accurately to reflect the resident's hospice and palliative status.

On 2/24/17, the Regional MDS Coordinator reeducated MDS licensed nurses regarding RAI guidelines to complete a MDS Comprehensive assessment that accurately reflects the resident's status, including resident's palliative and/or hospice election. Newly hired MDS licenses nurses will be educated upon hire.

The Administrator will conduct Quality Assurance Monitoring for accuracy of assessments for residents with elected hospice and/or palliative services. Quality Assurance Monitoring will be conducted on 5 random residents 2 times per week for 4 weeks, 1 time per week for 8 weeks, and then 1 time per month. QI monitoring schedule will be modified based on findings.

The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee monthly by the Administrator and/or designee. The Quality Assurance Performance Improvement Committee will

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 ______	02/23/2017

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 13 instructed to code section O of the MDS as hospice and not to check the life expectancy of less than 6 months to live (J1400). The MDS nurse stated that on 01/25/17 Resident #71 was palliative care and she should have coded the MDS dated 01/25/17 as hospice but the life expectancy question should have been coded as no (J1400) since Resident #71 was not hospice until 02/01/17. Interview with the Director of Nursing and the Administrator on 02/23/17 at 11:22 AM revealed that they fully expected all MDS's to be coded as accurately as possible to reflect the residents current status.	F 278	evaluate the effectiveness of the monitoring/observation tool for making changes to the corrective action if necessary to maintain substantial compliance. The Quality Assurance Improvement Committee consists of but not limited to the Administrator, Director of Clinical Services, Medical Director and at least 3 other members.	