PRINTED: 05/20/2019 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		345329	B. WING		C <b>04/11/2019</b>
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645	04/11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
E 000	Initial Comments		E 00	00	
F 578 SS=D	survey was conducted 04/11/19. The facility with the requirement Preparedness. Even Request/Refuse/Dsc CFR(s): 483.10(c)(6)  §483.10(c)(6) The rig discontinue treatment	ntnue Trmnt;FormIte Adv Dir (8)(g)(12)(i)-(v) tht to request, refuse, and/or t, to participate in or refuse rimental research, and to	F 57	78	5/8/19
	construed as the right the provision of medi	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or			
	requirements specific subpart I (Advance D (i) These requirement inform and provide w residents concerning medical or surgical tr resident's option, forr (ii) This includes a wifacility's policies to in and applicable State (iii) Facilities are perrentities to furnish this legally responsible for requirements of this si (iv) If an adult individ time of admission and	ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the mulate an advance directive. The ritten description of the applement advance directives law.  Initiated to contract with other information but are still rensuring that the			
ADODATORY	DIRECTOR'S OR PROVINCE	SLIPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F	(X6) DATE

Electronically Signed 05/06/2019

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 A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345329	B. WING				11/2019	
NAME OF P	ROVIDER OR SUPPLIER	<b>.</b>		S	STREET ADDRESS, CITY, STATE, ZIP CODE			
CATEWAY	REHABILITATION AND	HEAT THOADE		2	030 HARPER AVENUE NW			
GAILWAI	REHABILITATION AND	HEALTHOAKE		L	.ENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 578	Continued From page 1 has executed an advance directive, the facility may give advance directive information to the		F	578				
	individual's resident r with State Law. (v) The facility is not	esident representative in accordance aw. by is not relieved of its obligation to nformation to the individual once he						
	Follow-up procedure the information to the appropriate time.	s must be in place to provide e individual directly at the						
	by: Based on record rev facility failed to have	Γ is not met as evidenced riew and staff interviews the accurate and complete			On 04/09/2019 Resident #192 had ord written for Do Not Resuscitate. On	ler		
		the medical record for 2 of for advance directives Resident # 58).			04/04/2019 the Goldenrod with the Medical Order for Scope of Treatment was placed in the medical record.  Resident #192 discharged on 04/26/20	19.		
	The findings included	<b>d</b> :			On 04/10/2019 resident #58 had a order written for Code status clarification of F			
	04/03/19 with diagno	esident #192 was admitted to the facility 1/19 with diagnoses including osteomyelitis right foot and a diabetic foot ulcer.			Code and was placed in the medical record.			
	revealed a form titled Discussion Documer she wished to withho resuscitation (CPR) i cardiopulmonary arre	nt dated 04/03/19 that stated old cardiopulmonary			On 04/19/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring of all resident code statuses. Any issues identified we addressed.			
	have a Do Not Resus there was no goldeni record, and there wa Scope of Treatment of record.	scitate (DNR) code status, rod DNR form in the medical s no Medical Order for (MOST) form in the medical			On 04/04/2019 through 05/07/2019 all licensed nurses were re-educated by the Director of Nursing and/or Designee or obtaining code status orders, Goldenro and Medical Order for Scope of Treatment of Proceedings of the Nursing Alexandro	n ods,		
		rse #3 on 04/09/19 at 10:49 ance Directives Discussion			complete. Newly hired staff will be educated upon hire			

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NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	1 04	111/2019	
					30 HARPER AVENUE NW			
GATEWAY	REHABILITATION A	ND HEALTHCARE			NOIR, NC 28645			
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 578	Continued From p	age 2	F 5	578				
	Document was co	mpleted upon admission for all						
		not a Physician's order. Nurse						
	#1 stated there sh	ould have been a Physician's			On 05/08/19 the Director of Nursing			
	order for DNR and	d a goldenrod DNR and/or a			and/or designee to perform Quality			
	MOST form in Resident #192's medical record.				Improvement Monitoring on code statu			
		ursing staff should have called			three times a week for four weeks, the			
		gotten a DNR order for			two times a week for four weeks, and t	hen		
	Resident #192's n	nedical record.			one time monthly for three months.			
	On 04/9/19 at 11:	15 AM the Minimum Data Set						
		rided a copy of Resident #192's			The Director of Nursing will report on t	he		
	goldenrod DNR fo			results of the Quality Monitoring (audit	s) to			
	stated DNR. The			the Quality Assurance Performance				
		the medical records office. The			Improvement Committee. Findings will			
	_	rm and MOST forms were			reviewed by QAPI Committee monthly			
	_	by the Nurse Practitioner (NP)			and Quality Monitoring (audit) will be			
	on 04/04/19.				updated if changes are needed based findings. The Quality Assurance	on		
	An interview with t	the medical records staff			findings. The Quality Assurance Performance Improvement Committee			
		/19 at 2:28 PM revealed she			consists of but not limited to the Execu			
		ed DNR and MOST forms and			Director, Director of Nursing, Work For			
	•	nedical record. The medical			Manager, Unit Manager, Social Service			
	records staff mem	ber stated she usually received			Manager, Business Office Manager,			
	the completed DN	R and MOST forms the day			Activities Director, Human Resources,			
		completed them and filed them			Pharmacist, Medical Director, Certified	l		
		ord at that time. The medical			Nursing Assistant, Dietary Manager,			
		er stated she was not sure why			Maintenance Director, Housekeeping			
		NR and MOST forms were not			Supervisor, Admissions, Medical Reco	rds,		
	on her chart.				and MDS Nurse. The Quality	nt		
	An intonvious with t	the Director of Nursing (DON)			Improvement Performance Improvement			
		the Director of Nursing (DON) 0 PM revealed Resident #192's			Committee meets monthly and quarter at a minimum.	ıy		
		ould have contained the DNR			at a minimum.			
		The DON also stated there						
		a Physician's order for DNR in						
		d. The DON stated in the event						
		y arrest he expected staff to						
		records department for						
	advance directive	information and if the medical						

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	ROVIDER OR SUPPLIER			STREET ADDRE		•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION FACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 578	Continued From pag- records department i	e 3 s closed to get the key from	F 5	78				
	the charge nurse and department.	d check the medical records						
		s admitted to the facility on oses included heart failure, abetes.						
		Data Set (MDS) dated with severely impaired						
	advanced directives. Directives were seve a plastic sheet which cardiopulmonary respiration and artific sheet in the same plathe date of 06/05/13. contained a form dathold CPR. Behind the	uscitation (CPR), artificial cial nutrition. Behind this astic sleeve was page 2 with The next plastic sleeve ed 11/20/18 that stated to nat was another plastic all telephone order dated						
	monthly printed orde	ian signed computerized rs revealed Resident #58 cember 2018, January 2019, March 2019.						
		imum Data Set, a quarterly d him with moderately iills.						
	revealed she was ne at the record and flip	ated she would provide full						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345329	B. WING _				C <b>11/2019</b>
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		20	REET ADDRESS, CITY, STATE, ZIP CODE 30 HARPER AVENUE NW ENOIR, NC 28645		
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F 578		e 4 PM, the Regional Nurse nd stated that nurses were to	F!	578			
	go off the signed physical not resuscitate.  On 04/09/19 at 3:02 F (DON) reviewed the computerized physicial notation.	PM the Director of Nursing chart and noted that the an orders for full code was ad not been updated with					
F 600	on 04/09/19. Review advanced directives r with Resident #58 on wanted to be a full co since the care plan al did not need to change	revealed when last reviewed 04/08/19, Resident #58 de. The MDS Nurse stated lready stated full code she ge it. She stated she failed rders but knew Resident #58 e.	Fi	600			5/8/19
SS=D	CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not limic corporal punishment, any physical or chemit treat the resident's me	m Abuse, Neglect, and right to be free from abuse, ation of resident property, efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms.					5/6/13
	§483.12(a) The facility §483.12(a)(1) Not use physical abuse, corpo	e verbal, mental, sexual, or					

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL <sup>*</sup> IDENTIFICATION NUMBER:  A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345329	B. WING		04/11/2019	
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645		
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F 600	by: Based on observation family and staff interned neglected to acknow of 4 sampled resident Resident #45), failed for an hour time from 4 residents, (Resident provide a bed pan upsampled residents do continence care. (Resident #139 was 04/09/19 with diagnor disease, cerebrovascaphasia.  Review of the initial assessment dated 04 #139 was oriented to assistance of one staff.	ons, record reviews, resident, view's the facility staff eledge resident call bells for 2 ats,(Resident #139 and at to provide incontinence care at 4:05 PM to 5:20 PM for 1 of at #139), and failed to be on request for 1 of 4 ependent on staff for esident #45).  d:  s admitted to the facility on the sist that included: Alzheimer's cular accident (CVA) and	F 600		ent stant //or nts ier tor	
	2:00 PM revealed an enema x 1 now".  A continuous observ #139 on 04/10/19 at Resident #139's call PM, a staff member entered the room at by Resident #139 an resident needed inco Records staff member to the resident needed inco Records staff members.	ation was made of Resident 4:05 PM through 5:31 PM. light was turned on at 4:05 from Medical Records 4:56 PM and was informed d her family member the ontinence care. The Medical er stated to Resident #139 the of the Nursing Assistants		and/or designee to perform Quality Improvement Monitoring of call light response time for cognitively intact residents and random observation of cognitively impaired residents incontinueds to be completed two times a wfor four weeks, then one time a week eight weeks, then one time a month for three months. Any discrepancies identified to be reviewed and revised the Interdisciplinary Team as appropri	eek for or by	

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			A. BOILDI	NG _		، ا	С
		345329	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	11/2010
				20	030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	DHEALTHCARE		L	ENOIR, NC 28645		
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F 600	up and turned off the room without provid PM Resident #139's the hallway, NA #1 the she needed to use the member stated to Nalready had a bowel would need her cloth the room stating she incontinent care to the room stating she incontinent care, she incontinent car	dent #139 could be cleaned e call light as she exited the ing incontinence care. At 5:10 if family member stepped into then asked Resident #139 if the restroom. The family A #1 that Resident # 139 had a movement on herself and thing changed, NA #1 exited the would be back to provide the resident. At 5:20 PM NA to the tresident was and provided to exited the room at 5:31 PM.  PM an interview was to provide the interview revealed two on Resident #139's hall and the provident was to on the resident #139's call collowing giving a resident at the breakroom. She was notified by the laft member that call lights the resident hall and residents NA #1 stated the Medical were did not specify which existance. NA #1 stated once and hall no call lights were on. We assisted Resident #139 she living a bowel movement on	F	600	The Director of Nursing will report on the results of the Quality Monitoring (audits the Quality Assurance Performance Improvement Committee. Findings will reviewed by QAPI committee monthly a Quality Monitoring (audit) will be updated if changes are needed based on finding The Quality Assurance Performance Improvement Committee consists of burnot limited to the Executive Director, Director of Nursing, Work Force Manage Business Office Manager, Activities Director, Human Resources, Pharmaci Medical Director, Certified Nursing Assistant, Dietary Manager, Maintenant Director, Housekeeping Supervisor, Admissions, Medical Director, and MDS Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum.  AOC: May 8, 2019	be and ed gs.  ut ger, er, st,	
	member. The intervi	Medical Records staff ew revealed she had					

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	ROVIDER OR SUPPLIER	) HEALTHCARE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW LENOIR, NC 28645	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	light, stating the resichange her due to in went into the break rher residents on the interview revealed the giving a shower in the following notifying Nooffice and did not foll #139 had received at On 04/10/19 at 5:00 conducted with Fam revealed Resident # enema by nursing stomember stated she had an increased undue to effects of the administered. She stomember #139 to her wheelch so long however courestroom alone. The #139 had a bowel mode had now a bowel mode had never had to #139 was visibly ups Family member #1.  On 04/10/19 at 5:47 conducted with the Early member #1 to the DON stated call within a 15-minute to having to wait over 1 from staff. The intervexpected to be on the and two NAs should same time. He stated	dent needed the NAs to continence. She stated she com to find NA #1 and told hall needed assistance. The se other NA on the hall was e shower room. She stated A #1 she returned to her low up to see if Resident ssistance.  PM an interview was sily Member #1. The interview 139 was administered an aff at 2:00 PM. The family had turned Resident #139's PM because Resident #139 gency to use the restroom	F 600			

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		345329	B. WING		04/11/2019	
	ROVIDER OR SUPPLIER  7 REHABILITATION ANI	D HEALTHCARE	20	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW ENOIR, NC 28645	, 02010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 600	members the reside The DON stated it w #139 to have waited incontinence care.	B9's room to notify staff ent still needed assistance. was unacceptable for Resident d over an hour for	F 600			
	09/30/15 and readm diagnoses included (CVA), hypertension pulmonary disease Review of his most Data Set (MDS) dat Resident #45 was of decision making. Til	as admitted to the facility on nitted on 11/12/18. His cerebrovascular accident in, chronic obstructive and diabetes mellitus.  Trecent quarterly Minimum ed 02/08/19 revealed ognitively intact for daily the MDS also revealed he assistance with toileting. The ed he was frequently				
	(CAA) summary dat Resident #45 was p and stated he partic able. The CAA sum preferred to stay in as opposed to show resident with persor	al ADL care area assessment ed 08/31/18 revealed leasant, alert and oriented ipated in ADL care as he was amary further revealed he bed and received bed baths yers and stated staff assisted hal hygiene to maintain clean arance and maintain				
	04/09/19 at 8:37 AM evening before on 0 PM he had put his li bed pan. He stated #6 came in and turn	nducted with Resident #45 on  1. The resident stated the 14/08/19 at approximately 6:15 ght on for assistance with the his assigned nurse aide (NA) led out his light and he had an. According to the resident,				

	F DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER  'REHABILITATION AN	ID HEALTHCARE	•	2	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW LENOIR, NC 28645		
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F 600	pan while trays were him she would be to once the trays were stated he waited ar return to put him or stated it made him to have his bowel in had asked for the bestated if someone to provide a service for keep their word, essomething that he or Resident #45 state around 7:00 PM to stated the nurse cat told him she would turned out the light resident stated the him up but told him and assist him. Resident stated the him up but told him and assist him. Resident stated the him up but told him and assist him. Resident stated the him up but told him and assist him and came in and cleane.  On 04/10/19 at 2:3 conducted with NA she had taken care and had entered his she stated he had a had told him she country was then asked to with feeding reside residents and then ended. NA #6 state	could not offer him the bed re on the floor. The NA told back to put him on the bed pain re off the floor. The resident and waited and she did not an the bed pain. Resident #45 feel "pretty rotten" that he had movement in the bed when he led pan. The resident also old him they would be back to or him he expected them to pecially when it was could not do for himself. d he put his light on again get himself cleaned up and me in around 7:10 PM and find a NA to assist him and before leaving the room. The nurse did not offer to clean she would find a NA to come sident #45 stated finally 7:30 PM a second shift NA	F	600			

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F 600	On 04/10/19 at 4:13 conducted with the The interview reveal facility not to provide care while passing of stated he expected trays and then go be for assistance from the NA provided the expect them to providing assistance stated the call light the resident's needs.  On 04/10/19 at 4:17 conducted with the The interview reveal finish passing trays care to residents or assistance from oth they provided continushe would not expension to providing coalso stated the call lunless the needs of while the NA was in On 04/11/19 at 3:27 conducted with the #45 on 04/08/19. Note of the resident had not asked her for answered his light to be pan. Nurse #8 already had his bow had requested to be she had found his Noresident. Nurse #8	B PM an interview was Director of Nursing (DON).  Iled it was the policy of the e incontinence or continence but meal trays. The DON the staff to finish passing ack and provide care or ask other staff to pass trays while e care. He stated he would ride continence care prior to e with meals. The DON also should not be turned off until es are provided.  I' PM an interview was Work Force Manager (WFM). Iled the WFM expected NAs to and then provide continence stated they could ask for er staff to pass trays while mence care. The WFM stated out them to assist with meals entinence care. The WFM light should not be turned off if the resident were provided	F 600				

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F 658 SS=D	to leaving the room.  On 04/11/19 at 3:46 conducted with the I The interview reveal call lights be answer stated residents hav was unacceptable. was expected to be times. He stated the have been left on ur been met. The DON for Resident #45 to I continence care and that the resident had bed because he was Services Provided M CFR(s): 483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professiona This REQUIREMEN by: Based on observatiresident and staff int provide a tube feeding to the I state of the I s	PM an interview was Director of Nursing (DON). ed it was his expectation that ed within 15 minutes, and ing to wait over 15 minutes The interview revealed a NA on the resident's hall at all e resident's call light should til the resident's needs had I stated it was unacceptable have waited over an hour for stated it was unacceptable I his bowel movement in the s not offered a bed pan. Ileet Professional Standards D(i)  rehensive Care Plans ed or arranged by the facility, omprehensive care plan, I standards of quality. T is not met as evidenced ons, record review, and erviews the facility failed to ng as ordered for 1 of 2 or tube feeding (Resident #	F 6		was er to D 9 or
		mitted to the facility 05/27/16 ding malnutrition and swallowing).		and/or designee performed a Quality Improvement Monitoring for all resid with tube feed nutrition to ensure foll	ents

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NAME OF P	ROVIDER OR SUPPLIER	0.0020		S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	11/2019	
	10115211 011 001 1 2.2.1		2030 HARPER AVENUE NW					
GATEWAY	REHABILITATION AND	HEALTHCARE			ENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 658	Review of Resident # nutrition/hydration lass Resident #8 had a fer intake and had a hister from his tube feeding. The quarterly Minimu 03/26/19 revealed Resident #8 was to refer feeding formula) at 80 12 hours a day through Review of Resident # administration record revealed he was to re 80ml/hour for 12 hours and infusing until 7:00 revealed Jevity 1.5 w at 7:00 PM on 04/10/	8's care plan for t updated 02/25/19 revealed eding tube due to poor ory of disconnecting himself of the model of the mode	F 6	\$58	physicians order. No other issues were identified.  On 4/9/2019 through 5/07/2019 the Director of Nursing and/or designee provided re-education to all Licensed Nurses on following physicians orders and/or to notify physician if unable to follow order. Newly hired staff will be educated upon hire.  On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of tube feed nutrition to be completed two times a week for four weeks, then one time a week for eight weeks and then one tim month for three months.  The Director of Nursing will report on the results of the Quality Monitoring (audits the Quality Assurance Performance Improvement committee. Findings will reviewed by QAPI committee monthly a Quality Monitoring (audits) will be updated.	e a ne s) to be and ated	DAIL	
	5:50 AM revealed he bed with his tube feed feeding tube.			if changes are needed based on finding. The Quality Assurance Performance Improvement committee consists of but not limited to the Executive Director,	t			
	AM revealed he unho himself earlier on 04/Physician's appointm tube feeding was not 04/11/19 and it should PM on 04/10/19. Respect several occasio	oked his tube feeding 11/19 to get ready for a ent. Resident #8 stated his started until 12:30 AM d have been started at 7:00 sident #8 stated there had ns when his feeding was not ordered but he could not			Director of Nursing, Work Force Manage Unit Manager, Social Services Manage Business Office Manager, Activities Director, Human Resources, Pharmaci Medical Director, Certified Nursing Assistant, Dietary Manager, Maintenar Director, Housekeeping Supervisor, Admissions, Medical Records, and MD Nurse. The Quality Assurance	er, ist, nce		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
		345329	B. WING _			1	C /11/2019
	ROVIDER OR SUPPLIER	HEALTHCARE		20	REET ADDRESS, CITY, STATE, ZIP CODE  130 HARPER AVENUE NW  ENOIR, NC 28645	1 04/	11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Continued From page	e 13	F 6	658			
F 658	recall the last time his started on time.  An interview with Nur AM revealed she star 04/11/19 and the nur to 11:00 PM shift had tube feeding when sh #4 stated Resident # infusing as ordered w from midnight to 7:00  An interview with Nur AM revealed she wor PM to 11:00 PM shift thought Resident #8's been started at 8:00 wasn't sure. Nurse # Resident #8's tube feeding hear supervisor, she was she was running beh not notify the on call tube feeding was star pass on to the onconfeeding was started I.  An interview with the 04/11/19 at 11:21 AM feedings to be started provider. The NP staprovider to be notified.	stube feeding was not  see #4 on 04/11/19 at 6:00  ted her shift at midnight on see who worked the 3:00 PM just started Resident #8's see started her shift. Nurse B's tube feeding was usually when she worked her shift of AM.  see #5 on 04/11/19 at 11:10 sked 04/10/19 on the 3:00  Nurse #5 stated she se tube feeding should have PM on 04/10/19 but she se stated she started seding at 10:30 PM on stated she was late starting seuse she was the shift salso assigned to a hall, and sind. Nurse #5 stated she did provider that Resident #8's sted late and she did not hing shift Resident #8's tube	F	658	Performance Improvement committee meets monthly and quarterly at a minimum.  AOC: May 8, 2019		
	on 04/11/19 at 1:55 F	Director of Nursing (DON) PM revealed he expected eding to have been started					

NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE  (X4) ID PREFIX TAG  COMPLETION PREFIX TAG  COMPLETION PREFIX Within the time ordered by the provider and if it was not the provider should have made a notation on the MAR that Resident #8's tube feeding wasn't started until 10:30 PM on 04/10/19 but she was so busy she did not make a notation stating when the tube feeding was started.  STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F 658  F 658  F 658  F 658  F 658  STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645  F 658  F 658  F 658  F 658  F 658  F 658		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE    CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION DATE      F 658   Continued From page 14   within the time ordered by the provider and if it was not the provider should have been notified.    A subsequent interview with Nurse #5 on 04/11/19 at 3:34 PM revealed she should have made a notation on the MAR that Resident #8's tube feeding wasn't started until 10:30 PM on 04/10/19 but she was so busy she did not make a notation stating when the tube feeding was			345329	B. WING		
F 658  Continued From page 14 within the time ordered by the provider and if it was not the provider should have been notified.  A subsequent interview with Nurse #5 on 04/11/19 at 3:34 PM revealed she should have made a notation on the MAR that Resident #8's tube feeding wasn't started until 10:30 PM on 04/10/19 but she was so busy she did not make a notation stating when the tube feeding was			HEALTHCARE	2030 HARPER AVENUE NW		1 04/11/2010
within the time ordered by the provider and if it was not the provider should have been notified.  A subsequent interview with Nurse #5 on 04/11/19 at 3:34 PM revealed she should have made a notation on the MAR that Resident #8's tube feeding wasn't started until 10:30 PM on 04/10/19 but she was so busy she did not make a notation stating when the tube feeding was	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE COMPLETION
F 677 SS=D  ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) 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: Based on observation, record review, resident and staff interview's the facility failed to provide assistance with toileting for 2 of 4 residents reviewed for assistance with activities of daily living (Resident # 139 and Resident # 45).  The findings included:  1. Resident #139 was admitted to the facility on 04/09/19 with diagnosis that included: Alzheimer's disease, cerebrovascular accident (CVA) and aphasia.  Review of the initial admission nursing assessment dated 04/09/19 revealed Resident #139 was oriented to self, requiring limited assistance of one staff member with toileting.  A continuous observation was made of Resident	F 677	within the time ordered was not the provider.  A subsequent intervie 04/11/19 at 3:34 PM made a notation on the tube feeding wasn't southolder of 04/10/19 but she was notation stating when started.  ADL Care Provided for CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily services to maintain opersonal and oral hydris REQUIREMENT by:  Based on observation and staff interview's transistance with toileting reviewed for assistant living (Resident # 139 was 04/09/19 with diagnor disease, cerebrovasor aphasia.  Review of the initial assessment dated 04 #139 was oriented to assistance of one started.	ed by the provider and if it should have been notified.  Ew with Nurse #5 on revealed she should have he MAR that Resident #8's tarted until 10:30 PM on a so busy she did not make a the tube feeding was or Dependent Residents  Eent who is unable to carry iving receives the necessary good nutrition, grooming, and giene;  I is not met as evidenced  In, record review, resident the facility failed to provide ng for 2 of 4 residents ce with activities of daily and Resident # 45).  Estadmitted to the facility on sist that included: Alzheimer's cular accident (CVA) and  I dmission nursing 1/09/19 revealed Resident self, requiring limited ff member with toileting.		Resident #139 had incontinent car provided by Certified Nursing Assis 4/10/2019. Resident #45 had incon care provided by Certified Nursing Assistant on 4/9/2019. A Facility Reportable Incident was initiated or 4/11/2019. The Certified Nursing As was suspended pending an investig On 4/23/2019 the Director of Nursing and/or designee performed a Quali Improvement Monitoring for all resident require assistance with toileting other issues were identified.  On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to Licensed I	e tant on tinent  n ssistant gation.  ng ty dents g. No

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		345329	B. WING		04/11/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE
				2030 HARPER AVENUE NW	
GAIEWAY	REHABILITATION A	ND HEALTHCARE		LENOIR, NC 28645	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE ED TO THE APPROPRIATE CICIENCY)  (X5)  COMPLETION DATE
F 677	Continued From p	age 15	F 6	377	
	#139 on 04/10/19 Resident #139's or PM, a staff membeentered the room by Resident #139 resident needed in Records staff mer that she would let (NAs) know so Re up and turned off room without prov PM Resident #138 the hallway, NA # she needed to use member stated to already had a bow would need her of the room stating s incontinent care to #1 entered Reside	at 4:05 PM through 5:31 PM. all light was turned on at 4:05 er from Medical Records at 4:56 PM and was informed and her family member the accontinence care. The Medical antiber stated to Resident #139 one of the Nursing Assistants asident #139 could be cleaned the call light as she exited the iding incontinence care. At 5:10 by's family member stepped into then asked Resident #139 if the the restroom. The family NA #1 Resident #139 had byel movement on herself and bothing changed, NA #1 exited the would be back to provide to the resident. At 5:20 PM NA ent #139's room and provided		meeting resident toile to include toileting/bed meal time. Newly hire educated upon hire.  On 05/08/19 the Direct and/or designee to perform the Improvement Monitoring require assistance to through observation of impaired residents an with cognitively intact completed two times as weeks, then one time weeks, then one time months. Any discrepal and revised by the Intra as appropriate.  The Director of Nursing results of the Quality I	dpan needs during d staff will be  ctor of Nursing erform Quality ing of residents that toilet/bedpan of cognitively d resident interviews residents to be a week for four a week for eight a month for three incies to be reviewed erdisciplinary Team
	On 04/10/19 at 5:: conducted with N/ NAs were working both NAs were giv during the observatight. NA #1 stated shower she went stated during her in Medical Records signed assistance were going off on needed assistance Records staff mer residents needed revealed once she lights were on. Sh Resident #139 she	she exited the room at 5:31 PM.  32 PM an interview was A #1. The interview revealed two in on Resident #139's hall and wing other residents showers atton of Resident #139's call if following giving a resident a concern break in the breakroom. She break she was notified by the staff member that call lights the resident hall and residents in the Medical inher did not specify which assistance. The interview if got to the resident hall no call if e stated when she assisted in was upset due to having a concern for the resident in the resident hall no call in the re		the Quality Assurance Improvement committ reviewed by the QAPI and Quality Monitoring updated if changes ar findings. The Quality A Performance Improve consists of but not lim Director, Director of N Manager, Unit Manag Manager, Business O Activities Director, Hu Pharmacist, Medical I Nursing Assistant, Die Housekeeping Supern Director, Admissions, and MDS Nurse. The Performance Improve	e Performance tee. Findings will be I committee monthly g (audit) will be re needed based on Assurance ment committee dited to the Executive dursing, Work Force der, Social Services office Manager, man Resources, Director, Certified detary Manager, visor, Maintenance Medical Records, Quality Assurance

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345329	B. WING _			1	C 11/2019
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		20	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW ENOIR, NC 28645	1 0-11	11/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From pag	e 16	F 6	677			
		nt#139 with incontinence othing and assisted her back			meets monthly and quarterly at a minimum.		
	light, stating the residence her due to in went into the break reher residents on the interview revealed the giving a shower in the following notifying NA office and did not foll #139 had received as	Medical Records staff ew revealed she had d off Resident #139's call dent needed the NA's to continence. She stated she boom to find NA #1 and told hall needed assistance. The e other NA on the hall was e shower room. She stated A #1 she returned to her ow up to see if Resident essistance.			AOC: May 8, 2019		
	revealed Resident #' enema by nursing sta member stated she h call light on at 4:05 P had an increased urg due to effects of the administered. She st #139 to her wheelch so long however cou restroom alone. The #139 had a bowel m having to wait to use member #1 stated R and had never had to #139 was visibly ups Family member #1.	ly Member #1. The interview 139 was administered an aff at 2:00 PM. The family had turned Resident #139's PM because Resident #139 gency to use the restroom enema previously ated she assisted Resident air because of having to wait ld not assist her to the interview revealed Resident ovement on herself due to the restroom. Family esident #139 was confused to sit in feces before. Resident et during the interview with					
		n Order dated 04/10/19 at order which read, "Fleets					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	· /	TE SURVEY MPLETED
		345329	B. WING _		C 04/11/2019	
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 2030 HARPER AVENUE NW LENOIR, NC 28645		4/11/2019
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACTI  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 677	conducted with the The DON stated of within a 15-minute having to wait over from staff. The intexpected to be on and two NAs shows ame time. He star member should he exiting Resident # members the resident #139 to have wait incontinence care.  2. Resident #45 to 09/30/15 and read diagnoses included (CVA), hypertensi pulmonary diseas.  Review of his most Data Set (MDS) diseased extensive MDS further reveal incontinent of stood Review of his annoted (CAA) summary diseased the part able. The CAA supreferred to stay incontinent of stood preferred to stay inconti	47 PM an interview was e Director of Nursing (DON). call lights should be answered e time frame, stating residents or 15-minutes was unacceptable erview revealed a NA was of the resident's hall at all times ald not be off of the hall at the ated the Medical Records staff ave left the call light on upon e139's room to notify staff dent still needed assistance. It was unacceptable for Resident ed over an hour for  was admitted to the facility on dmitted on 11/12/18. His ed cerebrovascular accident on, chronic obstructive e and diabetes mellitus.  est recent quarterly Minimum ated 02/08/19 revealed e cognitively intact for daily The MDS also revealed he e assistance with toileting. The alled he was frequently	F			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345329	B. WING		C <b>04/11/2019</b>
	ROVIDER OR SUPPLIER	D HEALTHCARE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW ENOIR, NC 28645	1 04/11/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	D BE COMPLETION
F 677	and odor-free apperesident's dignity.  An interview was comply at 8:37 And evening before on the part of the bed pan. He stated the form the bed pan while trays were him she would be bounce the trays were stated he waited an return to put him on stated it made him to have his bowel of the bestated if someone to provide a service for keep their word, especially something that he complete the provide and the prov	anal hygiene to maintain clean arance and maintain  and hygiene to maintain clean and hygiene delta the could not assistance with the could not offer him the bed and hygiene and hygiene and hygiene could not offer him the bed pain are off the floor. The NA told ack to put him on the bed pain are off the floor. The resident did waited and she did not the bed pain. Resident #45 feel "pretty rotten" that he had novement in the bed when he ed pan. The resident also old him they would be back to r him he expected them to	F 677	DELIGITION ()	
	between 7:20 and 7 came in and cleane On 04/10/19 at 2:31 conducted with NA she had taken care	sident #45 stated finally 7:30 PM a second shift NA d him up.  I PM an interview was #6. The interview revealed of Resident #45 on 04/09/19 s room around 6:15 PM and			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG		ATE SURVEY OMPLETED
		345329	B. WING			C 04/11/2019
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 2030 HARPER AVENUE NW LENOIR, NC 28645		J4/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 677	had told him she couwhile trays were on thim she would return up and assist him at was then asked to gwith feeding resident residents and then leeded. NA #6 stated back and assist Residents and assist Residents and then leeded. NA #6 stated back and assist Residents and then leeded. NA #6 stated back and assist Residents revealed the interview revealed facility not to provide care while passing of stated he expected the trays and then go bath for assistance from the NA provided the expect them to providing assistance stated the call light stated the call light stated with the Variable The interview reveals finish passing trays a care to residents or assistance from other they provided continuated with the variable provided continuated with the variable provided continuated with the validation of the providing contains as stated the call light sta	sked for the bed pan and she ld not give him the bed pain he floor. She stated she told a once the trays were picked that time. NA #6 stated she to to another hall and assist is. She stated she fed off because her shift had a she had forgotten to go dent #45 with the bed pan.  PM an interview was birector of Nursing (DON). The staff to finish passing the staff to finish passing to keep the staff to pass trays while care. He stated he would de continence care prior to with meals. The DON also should not be turned off until the provided.  PM an interview was work Force Manager (WFM). The DON also should not be turned off until the provided continence care stated they could ask for the staff to pass trays while the the work of the	F 6	77		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245200	D WING		С
	ROVIDER OR SUPPLIER  7 REHABILITATION AND	345329 HEALTHCARE	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	04/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 690 SS=D	#45 on 04/08/19. Nurcare of the resident of had not asked her for answered his light be bed pan. Nurse #8 stalready had his bowe had requested to be of she had found his NA resident. Nurse #8 stalleanthe resident who light and stated she had leaving the room.  On 04/11/19 at 3:46 Found conducted with the Did The interview reveale call lights be answere stated residents having was unacceptable. To was expected to be of times. He stated the have been left on until been met. The DON for Resident #45 to had continence care and stated the resident had bed because he was Bowel/Bladder Incont CFR(s): 483.25(e)(1) The factorisident who is contined madmission receives somaintain continence until state of the resident who is contined madmission receives somaintain continence until state of the resident who is contined madmission receives somaintain continence until state of the resident who is contined the resid	arse assigned to Resident ree #8 stated she had taken in that evening and stated he the bed pan when she cause it was too late for the rated Resident #45 had I movement in the bed and cleaned up. Nurse #8 stated and asked her to clean the rated she had not offered to en she answered his call ad turned the light out prior.  PM an interview was rector of Nursing (DON). If it was his expectation that it within 15 minutes, and ing to wait over 15 minutes he interview revealed a NA in the resident's hall at all resident's call light should if the resident's needs had stated it was unacceptable have waited over an hour for stated it was unacceptable his bowel movement in the not offered a bed pan. Innence, Catheter, UTI of the country in	F 69		5/8/19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		TE SURVEY MPLETED
		345329	B. WING _			C 4/11/2019
	ROVIDER OR SUPPLIER	ND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CO 2030 HARPER AVENUE NW LENOIR, NC 28645		4/11/2013
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 690	incontinence, bas comprehensive as ensure that- (i) A resident who indwelling catheter resident's clinical catheterization was (ii) A resident who indwelling catheter is assessed for reas possible unless demonstrates that and (iii) A resident who receives appropri prevent urinary tracontinence to the \$483.25(e)(3) For incontinence, bas comprehensive as ensure that a resireceives appropri	a resident with urinary ed on the resident's essessment, the facility must  enters the facility without an er is not catheterized unless the condition demonstrates that as necessary; o enters the facility with an er or subsequently receives one moval of the catheter as soon as the resident's clinical condition t catheterization is necessary; o is incontinent of bladder ate treatment and services to act infections and to restore	F	590		
	by: Based on observed family and staff in maintain a urinary the bladder to fact #186) and failed to off the floor to red	ations, record review, and terviews the facility failed to a catheter bag below the level of ilitate the flow of urine (Resident to keep the urinary catheter bag uce the risk of infection or 2 of 2 residents reviewed for		Resident #36 catheter bag appropriately while lying in t licensed nurse immediately Resident #186 catheter bag appropriately by licensed nu immediately while lying in be 4/09/2019.  On 4/23/2019 the Director of	he bed by the on 4/11/2019. was placed irse ed on	
	The findings inclu	ded:		and/or designee performed		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345329	B. WING _			1	C
NAME OF P	ROVIDER OR SUPPLIER	343323	S:		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	/11/2019
NAME OF T	NOVIDEN ON 3011 LIEN						
GATEWAY	REHABILITATION AND	HEALTHCARE	2030 HARPER AVENUE NW LENOIR NC 28645		ENOIR, NC 28645		
(V4) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		COMPLETION DATE
F 690	Continued From page	e 22	F6	690			
					Improvement Monitoring for all residen	ts	
	1. Resident # 186 wa	as admitted to the facility			with catheters for proper placement. N		
		ses including a stroke and			other issues were identified.		
	,				On 4/9/2019 through 5/7/2019 the		
	Review of the medical record revealed a Minimum Data Set (MDS) was not completed				Director of Nursing and/or designee		
					provided re-education to Licensed Nur		
because Resident #186 was admitted to					and Certified Nursing Assistants, Dieta	ry,	
	facility only 6 days pr	ior.			and Therapy on appropriate catheter		
					placement. Newly hired staff will be		
		#186's baseline care plan			educated upon hire.		
		aled he had an indwelling					
	urinary catheter and was to receive urinary catheter care each shift and as needed.				On 05/08/19 the Director of Nursing		
	Catheter care cach si	int and as needed.			and/or designee to perform Quality		
	Observation of Resid	lent #186 on 04/09/19 at			Improvement Monitoring of proper fole	V	
		was lying in bed with his			catheter bag placement to be complete		
		hanging on the upper quarter			two times a week for four weeks, then		
	side rail of his bed ar	nd the urinary catheter tubing			time a week for eight weeks, and then	one	
	was filled with urine.	The urinary catheter bag			time a month for three months.		
	was above the level of	of the bladder.					
		sident #186's family member			The Director of Nursing will report on the		
		AM revealed Resident #186's			results of the Quality Monitoring (audit	s) to	
		had been hanging on the			the Quality Assurance Performance		
		il of his bed since she came			Improvement committee. Findings will		
	to visit at approximate	ely 8:00 AM on 04/09/19.			reviewed by the QAPI committee mont	hly	
	A :	#0 04/00/40 -+ 40:00			and Quality Monitoring (audit) will be		
		rse #6 on 04/09/19 at 10:00 nt #186's urinary catheter			updated if changes are needed based	On	
		the level of his bladder and			findings. The Quality Assurance Performance Improvement committee		
	_	long the urinary catheter			consists of but not limited to the Execu	itive	
		ig on the upper quarter side			Director, Director of Nursing, Work For		
	rail of the bed.	ag on the apper quarter side			Manager, Unit Manager, Social Service		
					Manager, Business Office Manager,		
	An interview with nur	se aide (NA) #2 and NA #3			Activities Director, Human Resources,		
	on 04/09/19 at 10:02				Pharmacist, Medical Director, CNA,		
		it #186 around 9:00 AM on			Dietary Manager, Maintenance Directo	or,	
		I NA #3 stated they did not			Housekeeping Supervisor, Admissions		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345329	B. WING _			l	C 11/2019
	ROVIDER OR SUPPLIER	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645		1 04/	11/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		(X5) COMPLETION DATE
F 690	upper quarter side raknow how it got there they hung the urinary of the bladder on Research An interview with the on 04/09/19 at 10:12 urinary catheter bags bladder.  2. Resident #36 was 03/23/18 with diagnodiabetes, and hyperton Review of the annua for Resident #36 date moderately impaired indwelling urinary catheter, has infections (UTI), and symptoms of a urinary catheter, has infections of Resident elimination of Resident elimination of Resident elimination of Resident eliminary catheter in the company of the symptoms of a urinary catheter but an interview with Nural Am revealed Resider should not be on the	Is urinary catheter bag on the ill of the bed and did not a. NA #2 and NA #3 stated of catheter bag below the level sident #186's bed frame.  Director of Nursing (DON) AM revealed he expected at the below the level of the state of the below the level of the below the level of the below the level of the below the below the level of the level of the	F	690	Medical Records, and MDS Nurse. The Quality Assurance Performance Improvement committee meets monthly and quarterly at a minimum.  AOC: May 8, 2019		
	revealed she last em	#4 on 04/11/19 at 6:35 AM ptied Resident #36's urinary on 04/11/19 and when she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25			С	
		345329	B. WING			04/	11/2019
	ROVIDER OR SUPPLIER REHABILITATION AND	HEALTHCARE		2	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW ENOIR, NC 28645		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 690 F 812 SS=F	urinary catheter bag of the level of the bladde know how the urinary floor.  An interview with NA revealed she had bee #36's hall for the 11:0 04/10/19 and was not #36's urinary catheter.  An interview with the AM revealed he expe be below the level of floor. Food Procurement, St CFR(s): 483.60(i)(1)(3)(4)(4)(4)(5)(5)(4)(5)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	ne bag she placed the on a hook on the bed below er. NA #4 stated she did not catheter bag got on the #5 on 04/11/19 at 6:37 AM en working on Resident 0 PM to 7:00 AM shift on a sure when or how Resident bag got on the floor.  DON on 04/11/19 at 8:20 cted the urinary catheter to the bladder and not on the core/Prepare/Serve-Sanitary 2)  by requirements.		812			5/8/19
	state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision does facilities from using progradens, subject to consider growing and food (iii) This provision does from consuming foods §483.60(i)(2) - Store,	ses.  cood items obtained directly subject to applicable State ulations.  Is not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices.  Is not preclude residents is not procured by the facility.  In prepare, distribute and lance with professional					

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
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ł.		STREET ADDRESS, CITY, STATE, ZIP C	ODE		
AND UEALTHOADE		2030 HARPER AVENUE NW			
AND HEALTHCARE		<b>LENOIR, NC 28645</b>			
IENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE CO	(X5) DMPLETION DATE	
· <del>-</del>	F 81	2			
vations, record review, and staff bility failed to remove a black all 4 walls of the walk-in cooler, of 4 walls from rust damage in r., failed to keep the floor in the e from debris, failed to repair a of the walk-in cooler, failed to e wall of the walk-in cooler for 1 ars. The facility also failed to bstance from the hot shield in for 1 of 1 ice machines, and ents for 1 of 1 ice machines.  Ided:  of the kitchen on 04/08/19 at end a black substance that was removed with a paper towel on walk-in cooler. The wall to the end the walk in cooler near the end to have an approximately 12 of drink lid, 1 packet of artificial ce of aluminum foil, and 1 strip of the did in the corner of the walk in middle of the ceiling in the walk served with water droplets ripped onto the floor. In the kin cooler an irregular gap was the cooler walls.  The Food Service Director (FSD) 1:17 AM revealed there should bstance on all 4 walls of the		4/9/2019. Ice in the ice mad discarded and new ice pure 4/9/2019, the ice machine with 4/9/2019. Replacement of the cooler has been initiated. Of walk-in cooler and the ice in been placed on a two times cleaning schedule.  On 4/23/2019 the Director of and/or designee performed Improvement Monitoring for walk-cooler and ice machin substance on walls, repairs debris on the floor, a pink is clean vents. No other issue identified.  On 4/9/2019 through 5/7/20 Director of Nursing and/or of provided re-education to dimaintenance staff on approtimely repairs, cleaning of it and walk-in cooler. Newly he educated upon hire.  On 05/08/19 the Director of and/or designee to perform Improvement Monitoring of and ice machines for clean completed two times a weeks, then one time a weeks.	chine was chased on was cleaned on the walk-in on 04/15/19 the machine have is a week  of Nursing I a Quality I al other lies for a black is needed, libstance and is were  of the walk-in of Nursing I a Quality I al other lies for a black is needed, libstance and is were  of the walk-in cooler liness to be lik for four lines to reight		
	IDENTIFICATION NUMBER:	A BUILDING  345329  B. WING  PREFIX TAG  AND HEALTHCARE  RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)  Page 25  ENT is not met as evidenced  rations, record review, and staff cility failed to remove a black all 4 walls of the walk-in cooler, of 4 walls from rust damage in r, failed to keep the floor in the e from debris, failed to repair a p of the walk-in cooler, failed to e wall of the walk-in cooler for 1 res. The facility also failed to bestance from the hot shield in or 1 of 1 ice machines, and ents for 1 of 1 ice machines.  Ided:  Of the kitchen on 04/08/19 at ed a black substance that was removed with a paper towel on walk-in cooler. The wall to the ed to have an approximately 12 1 drink lid, 1 packet of artificial ce of aluminum foil, and 1 strip of red in the corner of the walk in middle of the ceiling in the walk erved with water droplets ripped onto the floor. In the k in cooler an irregular gap was re cooler walls.  The Food Service Director (FSD) 17 AM revealed there should bstance on all 4 walls of the the FSD stated the wall of the d been rusted since he began	AND HEALTHCARE  AND HEALTHCARE	A BUILDING  345329  B. WINKS  STREET ADDRESS. CITY, STATE, ZIP CODE 2030 HARPER AVENUE W  LENOIR, NC 28645  PRETIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)  F 812  F 812  The walk-in cooler was cleaned on 4/9/2019, Ice in the ice machine was discarded and new ice purchased on 4/9/2019, Ice in the ice machine was discarded and new ice purchased on 4/9/2019, Ice in the ice machine was discarded and new ice purchased on 4/9/2019, Ice in the ice machine was discarded and new ice purchased on 4/9/2019, Ice in the ice machine was discarded and new ice purchased on 4/9/2019, Ite ice machine was cleaned on 4/9/2019, Ite ice machine was cleaned on 4/9/2019, Ite ice machine was cleaned on 4/9/2019, the ice machine was cleaned on a two times a week cleaning schedule.  On 4/23/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for al other walk-cooler and ice machines for a black substance on walls, repairs needed, debris on the floor, a pink substance and clean vents. No other issues were identified.  On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to dietary staff and maintenance staff on appropriate and timely repairs, cleaning of ice machines and walk-in cooler. Newly hired staff will be educated upon hire.  On 05/08/19 the Director of Nursing and/or designee to perform Quality Improvement Monitoring of walk-in cooler an exchines or object to for four walk-in cooler an irregular gap was the cooler and irregular gap was the cooler and interest of the walk-in cooler and itemely repairs, cleaning of ice machines and walk-in cooler in the corner of the walk in cooler for for for for designee provided re-education to dietary staff and maintenance staff on appropriate and timely repairs, cleaning of ice machines and walk-in cooler in the corner of the walk in cooler for for for designee provided re-education to dietary staff and maintenance staff on appropriate and timely repair	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING _		_	04/	) 11/2019	
NAME OF P	ROVIDER OR SUPPLIER	<b>L</b>		STREET ADDRESS, CITY, ST	TATE, ZIP CODE	1 0-1/	11/2013	
				2030 HARPER AVENUE NV	N			
GATEWAY	REHABILITATION AN	ND HEALTHCARE		LENOIR, NC 28645				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTED CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 812	Continued From payalk-in cooler floor aware of the leak in cooler.  An interview with the od/08/19 at 11:27 walk-in cooler had 2019 and he had contacted for the rust on the walk maintenance Direct of the walk-in coole a vehicle since the been repaired on the been repaired on the company for a quotinside of the walk-in coole a vehicle since the company for a quotinside of the walk-in received a quote. Stated he did not retain the repair company.  A subsequent inter Director on 04/08/2 possible the black cooler walls could ceiling of the walk-director also stated.		F	The Director of Nurresults of the Quality Assural Improvement commerciewed by the Quality Monitor updated if changes findings. The Quality Performance Improconsists of but not Director, Director of Manager, Unit Mar Manager, Business Activities Director, Pharmacist, Medico Dietary Manager, Nousekeeping Sup Medical Records, a Quality Assurance	rsing will report on the ity Monitoring (audits note Performance mittee. Findings will be a reneeded based ity Assurance overment committee limited to the Executof Nursing, Work Formager, Social Services Office Manager, Human Resources, and Director, CNA, Maintenance Directo pervisor, Admissions and MDS Nurse. The Performance mittee meets monthly minimum.	ne s) to be hly on tive ce es		
	An observation of the at 9:00 AM reveals walk-in cooler walk of the walk-in cooler.	the walk-in cooler wall should e of the walk-in cooler. the walk-in cooler on 04/09/19 ed a black substance on all 4 s. An observation of the corner er floor revealed there was 1 of artificial sweetener, 1 piece						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  B	(X3) DATE SURVEY COMPLETED			
		345329	B. WING		C <b>04/11/2019</b>		
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	04/11/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION		
F 812	of aluminum foil, and of the ceiling in the with water droplets be cart filled with cups of the Administrator on Administrator stated black substance on the cooler.  An interview with a decontract company the tothe facility on 04/0 all the cups of juice to walk-in cooler were of the tothe facility on 04/0 all the cups of juice to walk-in cooler walls to with a paper towel.  An observation of the at 8:39 AM revealed walk-in cooler walls to with a paper towel.  An observation of the at 7:50 AM revealed walk-in cooler walls to with a paper towel.  A subsequent interview birector on 04/11/19 in the walk-in cooler walls to with a paper towel.  A subsequent interview birector on 04/11/19 in the walk-in cooler walls to walk-in cooler walls to walk-in cooler walls to walk-in cooler walk-in cooler. The Maintennew walk-in cooler walk-in cooler maintenance birector walner walk-in cooler walk-in cooler maintenance birector walk-in cooler maintenance birector	1 strip of tape. The middle valk-in cooler was observed eaded up that dripped onto a of juice.  cooler was conducted with 04/09/19 at 9:37 AM. The he would not expect to find a he 4 walls of the walk-in istrict manager from the at provided dietary services 9/19 at 10:30 AM revealed under the ceiling leak in the	F 81	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345329		(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345329	B. WING		C <b>04/11/2019</b>	
	ROVIDER OR SUPPLIER	HEALTHCARE	2	TREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW LENOIR, NC 28645	1 04/11/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 812	The Maintenance Director cooler roof had been and a repair compant the roof and it was the that was leaking instemation and a repair compant the roof and it was the that was leaking instemation of the torget a quote from the called a different the roof on 04/10/19 a quote for repairs in Maintenance Director notify him if there were a companied with a part the ice machine. The were observed to be an interview with the AM revealed the main cleaned the inside of filters every 3 month down the outside of filters every 4 month every	rector stated the walk-in leaking since January 2019 by came 04/10/19 to check he roof of the walk-in cooler ead of the ceiling. The part stated he had been trying the vendor approved by the recompany and they would never diaintenance Director stated company and they checked and were going to have him at to 2 days. The part stated he expected staff to be retained and were going to have him at the company and they checked and were going to have him at the company and they checked and were going to have him at the company and they checked and were going to have him at the company and they checked and were going to have him at the company and they checked and were going to have him at the company and the stated the covered with dust.  FSD on 04/08/19 at 11:17 intenance department and the covered with dust.  Maintenance department the ince machine daily.  Maintenance Director on the Maintenance Director on the Maintenance Director on the including the filters were ance monthly and were he could not remember the nece Director stated there substance on the hot shield he and the filters should not the could not not the	F 812			
		nachine cleaning schedule cleaned by the maintenance				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	<b>345329</b> B. WING			C <b>04/11/2019</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	04/11/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETION
F 812	department on 03/21.  An observation of the 9:08 AM revealed a pshield. The 2 filters cobserved to be cover.  The ice machine was Administrator on 04/0. Administrator stated lipink substance on the machine and he would the ice machine filters.  An interview with a dicontract company that to the facility on 04/0. The ice in the ice machine maintenance was cle.  A subsequent intervied Director on 04/11/19 the pink substance of month when he clear.	rice machine on 04/08/19 at bink substance on the hot on the ice machine were ed with dust.  observed with the 19/19 at 10:37 AM. The ne would not expect to see a se hot shield of the ice do not expect dust to be on s.  strict manager from the at provided dietary services 19/19 at 10:30 AM revealed thine was discarded and aning the ice machine.  ew with the Maintenance at 7:57 AM revealed he saw in the ice machine every leed the machine and it might	F 8	,	
F 814 SS=D	CFR(s): 483.60(i)(4)  §483.60(i)(4)- Dispos properly. This REQUIREMENT by: Based on observatio	e of garbage and refuse is not met as evidenced n and staff interviews the the dumpster area free of osters.	F 8	On 4/11/2019 the area around all the dumpsters was cleaned and made fr from debris.  On 5/6/2019 the Executive Director a designee performed a Quality	ee

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING	B. WING		C 04/11/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		1 04/	11/2019
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 814	During the tour of the at 11:21 AM with the observations reveale plastic wrap on the g partially eaten food a ground around dump were visible under dubox was lying on the The FSD stated he w supposed to keep the would not expect the debris on the ground An interview with the Services (RDCS) on revealed cleaning the was a collective effor and dietary departments.	e dumpster area on 04/11/19 Food Service Director (FSD) d cigarette butts and clear round around dumpster #1, and a medicine cup on the ester #2, 2 cardboard boxes ampster #3, and a cardboard ground next to dumpster #3. vas not sure who was e dumpster area clean but he dumpster area to have .  Regional Director of Clinical	F	314	Improvement Monitoring of all dumpster Any issues identified were addressed.  On 5/1/2019 through 5/7/2019 the Maintenance Department and the Dieta Departments were re-educated by the Executive Director and/or designee on maintaining the area around the dumpsters clean and free from debris. Newly hired staff will be educated upor hire.  On 05/08/19 the Executive Director and designee will perform Quality Improvement Monitoring on dumpster area five times a week for four weeks, then three times a week for four weeks, then two times weekly for three months.  The Executive Director and/or designer will report on the results of the Quality Monitoring (audits) to the Quality Assurance Performance Improvement committee. Findings will be reviewed be the QAPI committee monthly and Quali Monitoring (audit) will be updated if changes are needed based on findings. The Quality Assurance Performance Improvement committee consists of bu not limited to the Executive Director, Director of Nursing, Work Force Manage Business Office Manager, Activities Director, Human Resources, Pharmaci Medical Director, CNA, Dietary Manage Maintenance Director, Housekeeping Supervisor, Admissions, Medical Record and MDS Nurse. The Quality Assurance and MDS Nurse. The Quality Assurance	ary  d/or  d/or  t ger, er, er, er,	

1 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION  JILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		30 HARPER AVENUE NW	04/11/2019		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETION DATE	
F 814	Continued From pag	e 31	F 8	314	Performance Improvement committee meets monthly and quarterly at a minimum.  AOC: May 8, 2019			
F 842 SS=D	CFR(s): 483.20(f)(5), §483.20(f)(5) Reside (i) A facility may not resident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or	nt-identifiable information. release information that is to the public. elease information that is	F 8	342			5/8/19	
	§483.70(i) Medical re §483.70(i)(1) In according professional standard must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The fact all information contain regardless of the formation records, except where (i) To the individual, of representative where (ii) Required by Law; (iii) For treatment, pa	ridance with accepted ds and practices, the facility all records on each resident nented; le; and reganized cility must keep confidential and in the resident's records, m or storage method of the n release istrates or their resident expermitted by applicable law; anyment, or health care tted by and in compliance						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY MPLETED
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	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	'	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	neglect, or domestic activities, judicial and law enforcement pur purposes, research predical examiners, to a serious threat to he by and in compliance §483.70(i)(3) The fact record information again authorized use.	activities, reporting of abuse, violence, health oversight diadministrative proceedings, poses, organ donation ourposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512.	F8	42		
	for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 years legal age under State §483.70(i)(5) The med (i) Sufficient informat (ii) A record of the re (iii) The comprehens provided; (iv) The results of an and resident review of determinations cond (v) Physician's, nurse professional's progret (vi) Laboratory, radio services reports as retained to the services reports as retained to the services record revision of the services reports as retained to document the services record revision of the services reports as record record revision of the services reports as record	e required by State law; or the date of discharge when the law; or the date are sident reaches the law.  Redical record must containation to identify the resident; sident's assessments; ive plan of care and services by preadmission screening evaluations and sucted by the State; the law of the licensed the ses notes; and other licensed the logy and other diagnostic equired under §483.50.  This not met as evidenced when and staff interviews, the ment complete and accurate		On 4/10/2019 at 4pm resident # order placed for enema on the N	/ledication	
	· ·	edical record for 1 of 3		Administration Record and 24 h On 4/11/2019 resident # 139 Me	our report.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING _	B. WING		C 04/11/2019	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-7/	11/2013
					030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	HEALTHCARE		LENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 842	Continued From page	e 33	F8	342			
	The findings included	:			Administration Record was signed for administration of enema that was order on 4/10/2019.	red	
	1. Resident #139 was admitted to the facility on 04/09/19 with diagnosis that included: Alzheimer's disease, cerebrovascular accident (CVA) and aphasia.  Review of the initial admission nursing assessment dated 04/09/19 revealed Resident #139 was oriented to self, requiring limited assistance of one staff member with toileting.  A review of Physician orders revealed an order dated 04/10/19 at 2:00 PM which read, "Fleets enema x 1 now".  Review of Resident #139's Medication Administration Record (MAR) for April 2019 revealed no order or documented administration of a fleet enema at 2:00 PM.				On 5/1/2019 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for the past 30 days for all residents to ensure orders were transcribed to the Medication Administration Record and 24 hour rep No other issues were identified.		
					On 4/9/2019 through 5/7/2019 the Director of Nursing and/or designee provided re-education to Licensed Nursabout transcribing new orders to the Medication Administration Record and hour report. Newly hired staff will be educated upon hire.		
	conducted with Nurse #3 had received the padministered the ene PM. The interview rev Nurse #3 by telephon administered to the rewas the responsibility physician order to pla residents MAR and daccordingly which was	10/19 at 5:46 PM an interview was ted with Nurse #1. Nurse #1 stated Nurse received the physician order and stered the enema to Resident #139 at 2:00 to interview revealed Nurse #1 had called the enema to verify if the enema was stered to the resident. Nurse #1 stated it responsibility of the nurse receiving the ten order to place the order on the ten MAR and document administration angly which was Nurse #3. Nurse #1 stated and #139 should have been included on the least on 04/09/19			On 05/08/19 the Director of Nursing and/or designee will perform Quality Improvement Monitoring of all residents orders to include transcription to the Medication Administration Record and placed on the 24 hour report to be completed two times a week for four weeks, then one time a week for eight weeks, then one time a month for three months.		
	On 04/11/19 at 2:00 F conducted with Nurse received the physicia				The Director of Nursing will report on the results of the Quality Monitoring (audits the Quality Assurance Performance Improvement committee. Findings will reviewed by the QAPI committee mont	s) to be	

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345329	B. WING			C	
NAME OF PE	ROVIDER OR SUPPLIER	343323		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/11/2019	
				2030 HARPER AVENUE NW			
GATEWAY	REHABILITATION AND	HEALTHCARE		LENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	PM. She stated she of physician order onto to document the administration of the order of the physician order. Nurse #Resident #139 onto the Nurse #2. The intensional have transcribed Resident #139's MAR administration of the order of the DON stated nurs receiving physician or orders onto the MAR administration of the order of the ord	id not transcribe the the residents MAR or stration of the enema in a stated she did not include the hall handoff report given review revealed Nurse #3 and documented the enema accordingly.  PM an interview was rector of Nursing (DON), ing staff was responsible for orders and transcribing the	F 8		based on emittee Executive fork Force Services ager, ources, CNA, Director, nissions, rse. The		