STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 000	INITIAL COMMENTS A complaint investigation survey was conducted from 05/18/22 through 05/26/22. There were 15 allegations investigated and 1 allegation was substantiated. The intakes investigated were NC00187528, NC00187619, NC00187579, NC00188345 and NC00188711. See Event ID #KKNG11. Past Non-Compliance was identified at: CFR 483.12 at tag F 600 at a scope and severity G. CFR 483.12 at tag F 607 at a scope and severity G CFR 483.25 at tag F 689 at a scope and severity G. Non-compliance began on 03/13/22 and the facility came back in compliance effective 04/21/22.	F 000	Past noncompliance: no plan of correction required.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or	F 600		6/13/22

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

Electronically Signed 06/13/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 1 involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, resident, hospice nurse and staff interviews, the facility failed to protect a resident's right to be free from mistreatment for 1 of 1 resident investigated for staff to resident abuse (Resident #1) when 2 staff members caught Resident #1 outside smoking and brought him back into the facility and held his arms to remove a cigarette and cigarette lighter from his possession. During the altercation with staff, Resident #1's gown and brief became displaced exposing Resident #1's body at the centrally located nursing station making him feel ashamed. Findings included: Resident #1 was re-admitted to facility on 2/26/2022 and was discharged to another facility on 4/26/2022. His diagnoses included acquired absence of right and left lower leg. Review of Resident #1's most recent Minimum Data Set (MDS), a quarterly assessment, dated 2/6/2022, revealed Resident #1 was cognitively intact and required supervision to limited assist from one staff for Activities of Daily Living (ADL). Review of the Facility Incident Report dated 3/13/2022, revealed resident #1 found smoking outside and telephone report to Director Nursing on 3/13/2022 at 10:15 PM, report was marked as did not feel incident was abuse. Review of Nursing Progress note dated 3/14/2022 at 6:41 PM by Nurse #1 revealed, "Patient was witnessed by staff outside smoking 3/13/2022 around 9:00 PM. Attempted to provide	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 2	F 600		

patient with safety/smoking education with no success. Patient became verbally and physically abusive toward this nurse as well as the NA present. Cigarette and lighter were retrieved from the patient. Resident #1 then stated he would get more from someone, and he would just start smoking in his room. 15-minute checks initiated. Patient made no attempts this shift to smoke in his room."

Telephone interview with Resident #1 was conducted on 05/17/22 at 10:40 AM. Resident #1 stated that on 03/13/22 around 8:30 PM he asked one of the NAs to take him outside for some fresh air. Resident #1 stated that he knew the facility was a nonsmoking facility and he believed "the staff did know" he was going to smoke. After the NA pushed Resident #1 to the gazebo she returned to the facility and Resident #1 stated he began to smoke a cigarette. Resident #1 explained NA #1 was outside smoking saw him smoking and instructed him to put the cigarette out and he replied "no, I have been asking for 4 months to go to a smoking" facility. NA #1 returned to the facility and then came back outside with Nurse #1, they pushed him back into the facility in his wheelchair to the nurse's station. They (Nurse #1 and NA #1) told me to give me my cigarette and lighter and I replied, "no, I am not a child." Then NA #1 held my arms behind my back as Nurse #1 "ripped the pocket off my gown" trying to get the cigarette lighter. Then Nurse #1 hit him with an open hand in the chest. Resident #1 stated he "was embarrassed and ashamed" that the other staff saw the incident and his exposed body. Resident #1 stated he was screaming at them to leave him alone and the staff continued to try and get cigarette and lighter. Resident #1 added he "was scared."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 3	F 600		

A telephone interview was conducted on 5/17/2022 at 12:10 PM with Nurse #1. She stated she and NA #1 had gone outside to retrieve Resident #1 and bring him back inside, because he was outside smoking. She stated when they were at the nurse's station, she asked Resident #1 to give them the cigarettes and lighter. Nurse #1 stated that Resident #1 began to swing at her and hit her several times. She stated NA #1 tried to block those strikes with her arms. Nurse #1 revealed she grabbed the cigarette lighter from a pocket on Resident #1's gown. She stated Resident #1's gown was always in place, and he was never exposed. Nurse #1 stated at no time was Resident #1's arms held behind his back. She stated she did not hit Resident #1 and did not rip the pocket off his hospital gown. She stated no one had instructed her to take the items off Resident #1. Nurse #1 stated she took the items from him because he would not voluntarily give them to her. She stated it was a safety issue, he was on oxygen, but he was not on oxygen during the incident. Nurse #1 stated she had immediately notified the Director of Nursing (DON), by telephone about the incident. She stated she had informed the Director of Nursing that she had physically took the cigarettes and lighter from him.

A telephone interview was conducted with NA #1 on 5/17/2022 at 1:30 PM. She stated on 3/13/2022, on second shift, she had observed Resident #1 outside smoking, he became aggressive when she asked him to put his cigarette out. She revealed she told Nurse #1 and they brought him back inside. She stated he was moving around in his wheelchair, and was starting to get sideways in the wheelchair, when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 4	F 600		

she and Nurse #1 were trying to get the cigarettes and lighter from him. She indicated she was on the side of the wheelchair, and she put her arm underneath his arm, like when you transfer a resident, just for a couple of seconds to keep him from falling out of the wheelchair. She stated Resident #1 was never exposed and no one hit him.

An interview was conducted with NA #2 on 5/17/2022 at 10:15 AM. She stated she and NA #3, got Resident #1 up out of bed on 3/13/2022 around 9:30 PM. She stated they told Resident #1 that they didn't know if they would let him go outside that time of night. She stated she was at the nursing station not long after he had gone outside, and they (Nurse #1 and NA #1) were bringing him back inside. They were holding him back; they were holding his arms so that he couldn't punch. They were trying to get his lighter and cigarettes. This occurred at the nurse's station. She stated she observed his gown coming up starting to go up towards his head, where they were trying to get his cigarettes, and his brief was coming down, it was loose, and she walked away. She stated she did not want to be a witness to all of that. She stated she had been told that she should not put her hands on anyone unless they are going to get hurt or she was providing care. She stated she was not real sure what was going to happen, the nurse was standing right there. She stated the only thing she observed was Nurse #1 and NA #1 touching was his arms. Resident #1 was saying "xxxx xxxx, quit it, let me go," in a very loud voice. He threw the lighter on the floor, they were digging for the lighter.

An interview was conducted by telephone with NA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 5	F 600		

#3 on 5/17/2022 at 11:00 AM. She stated she had let Resident #1 go outside on 3/13/2022. She stated she did not know he wanted to go outside to smoke. She stated that while he was outside, NA #1 had been outside and saw him smoking. NA #3 stated NA #1 came back inside and got Nurse #1 and they brought Resident #1 back inside. She stated she and NA #2 had been at the Nurse's station when Resident #1 was brought to the station by NA #1 and Nurse #1, and they were trying to get the cigarettes and lighter from him. She stated NA #2 stated to her, "this is wrong, and I won't be involved in it, they should have called the Administrator or the Law." She stated she observed NA #1 standing behind Resident #1's wheelchair, she was holding his arms and Nurse #1 was trying to get the cigarettes and lighter out of his pocket. She stated she observed Resident #1's butt-crack showing, and his gown was coming off and his brief was coming down. She stated she did not see anyone hit Resident #1. She stated she and NA #2 left the nurse's station together. She stated that Resident #1 was shaking all over after the incident and his blood pressure was up.

An interview was conducted with NA #4 on 5/17/2022 at 11:30 AM. She stated she had been standing at the nurse's station on 3/13/2022 around 9:00 PM when Nurse #1 and NA #1 brought Resident #1 back inside from smoking. She stated he was brought to the nurse's station and Nurse #1 noticed he had cigarettes in the pocket of his hospital gown, he was moving around and swinging his hands to prevent them from getting his cigarettes. She stated Nurse #1 was verbally arguing with Resident #1 and struggling with him, and he was sliding in his wheelchair, NA #1 was holding him up with her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 6	F 600		

arm around his chest, so he would not slide onto the floor. She stated Resident #1's arms were not behind his back, and she did not see anyone hit him. NA #4 stated normally staff would not take a resident's property from them physically, but he said he was going to smoke in his room. NA #4 stated she felt like Resident #1 was safe during the incident.

An interview was conducted with DON on 5/17/2022 at 2:15 PM. DON stated she was notified, by telephone, on 3/13/2022 around 10:00PM, by Nurse #1 that Resident #1 had been outside smoking. She stated she was told by Nurse #1 that she and NA #1 had brought Resident #1 back inside the building and got his cigarettes and lighter from him. DON stated she did not know how they got the cigarette and lighter from Resident #1 nor was she aware that a scuffle had occurred between Resident #1, Nurse #1, and NA #1 until Wednesday, 3/16/2022, when NA #2 had reported to her. DON indicated she called the Administrator immediately and had the ADON perform a skin assessment on Resident #1. DON stated she did not know how the cigarette and lighter were retrieved from Resident #1, she did not ask, she assumed he had given them to Nurse #1 when asked. DON stated Resident #1 was documented as being a smoker on admission. She stated she was not aware he had been requesting to go to another facility so he could smoke.

An interview was conducted with the Assistant Director of Nursing (ADON) on 5/17/2022 at 1:45 PM. She stated on her arrival to work on the morning of 3/14/2022, she had been met at the door by Nurse #1, who was leaving for the day. She was handed an incident report and a baggie

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 7	F 600		

with a partially smoked cigarette and a lighter. She stated Nurse #1 told her that Resident #1 had been outside smoking last night (3/13/2022). She stated Nurse #1 told her that Resident #1 had become verbally abusive to them when they asked him for the cigarettes and lighter. ADON stated she did not recall Nurse #1 telling her there had been a struggle to get the cigarettes and lighter from Resident #1. ADON stated she became aware there had been a struggle with Resident #1 on Wednesday, 3/16/2022, when she was asked by the Director of Nursing (DON) if she was aware of a struggle occurring between Resident #1 and staff. ADON stated she was asked to assess Resident #1 for injuries and conduct an interview with him. She stated she did not find any concerns, except for soreness in his arms. ADON stated she would have preferred staff remove the cigarette and lighter if they could see them, for example laying on his lap or beside him in the wheelchair, but she was not 100% sure about them searching him. ADON stated when she had interviewed staff, she was told they held his arms down beside of him. She stated Resident #1 had started to swing at Nurse #1 and NA #1 had put her arms up around Resident #1 to block him from hitting Nurse #1 and to keep him from sliding out of the wheelchair. ADON demonstrated how she was shown NA #1 had put her arms around Resident #1, she positioned herself behind the resident with one arm around his upper chest and held one arm with one hand, and with the other hand, she demonstrated holding the other arm, to keep him from sliding out of the chair.

An interview was conducted with Administrator on 5/18/2022 at 11:00 AM. She stated she and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 8	F 600		

DON were responsible for abuse investigations. She stated she was not in the facility with the alleged allegation of abuse was noted on 3/13/2022. She stated she first heard there was an allegation of abuse on 3/16/2022, late in the afternoon, when she was contacted by telephone by the DON. She stated she was informed Resident #1 was stating he had been hit by staff. She stated ADON went immediately and conducted an interview with Resident #1 and assessed him for injuries. Administrator stated she and DON interviewed NA #2 by telephone together and the alleged employees involved, Nurse #1 and NA #1 were suspended pending outcome of the investigation. She stated Resident #1 was furious when he was brought back inside the building on 3/13/2022, after he had been found smoking, but the staff did not put their hands on him. She stated she had specifically asked staff if Resident #1 had been abused and was told no. She stated Resident #1 had wanted to go to another facility so he could smoke, and the facility worked very hard on that for him. She stated she did not ask Nurse #1 what she had reported to DON on 3/13/2022.

The facility provided the following corrective action plan with at completion date of 3/31/2022.

1. On 3/16/2022 at approximately 4:00PM Resident #1 was immediately assessed by the Assistant Director of Nursing (ADON) for any injuries related to the allegation of being punched in the chest. No redness or bruising of any kind was found on the resident. At that time the resident was interviewed by the ADON, stating a nurse (Nurse #1) had punched him in the chest when he was caught smoking on 3/13/2022. On

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 9	F 600		

3/16/2022 at approximately 4:00, Nurse #1 and Nurse Aide #1 were interviewed and provided written statements. Nurse Aide #2 and Nurse Aide #3 were verbally interviewed by the Director of Nursing on 3/16/2022 with no changes noted from statement they gave on 3/13/2022. On 3/16/2022 at approximately 5:00pm staff members (Nurse #1 and Nurse Aide #1) accused of hitting the resident were suspended pending the investigation. On 3/17/2022 at approximately 3:00pm the police were notified. An initial report was turned in to the state on 3/16/2022 4:18pm and the investigation was completed and submitted to DHSR on 3/22/2022 at 4:36pm. APS was contacted by the administrator on 3/17/2022 at approximately 10:00am. The Medical Director interviewed the resident regarding general conditions of his health on 3/22/2022 in order to obtain resident's state of mind to include how things have been going and has anything new happened. The resident stated "no" and made a request for brand name Ambien. At no time did he report abuse of any kind to the physician.

2. On 3/17/2022 current residents with a BIMS of 8 or greater were interviewed by Social Services Director regarding abuse and if any staff member had hit them, no new concerns were voiced. Additionally, on 3/16/2022 and 3/17/2022 current resident with a BIMs of 7 and below were given a full body skin assessment by the Director of Nursing and the Assistant Director of Nursing to determine if there were any injuries of unknown origin or injuries that could be related to abuse, no new areas of concern.

3. On 3/17/2022 current staff, to include Nurses and Nurse Aides, housekeeping/laundry, dietary, therapy and all department heads were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 10	F 600		

re-educated on the abuse policy to include any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately to the Administrator and to other officials in accordance with State law. The facility is expected to report to DHSR no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. In the absence of the Administrator, the Director of Nursing is the designated abuse coordinator. Education also included if a resident is combative make sure that the resident is safe and walk away. Do not initiate physical contact if the resident's behavior is escalating. Touching can trigger violence in some. Provide time for the resident to calm down and re-approach. Employees are trained to protect residents from abuse at all times, including intervening with said abuse if they witness it. Notify police if additional assistance is needed. All new staff will be educated upon hire during orientation. All staff were educated on 3/17/2022 or prior to their next shift. The education was provided by the Director of Nursing.

4. Residents will be asked at least three times weekly for 12 weeks during daily rounds of the department heads; has any staff member mistreated/abuse/neglect you since you have been a resident here? Has any staff member taken or misused your property since you have been a resident here? Are you fearful of any staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 11	F 600		

member while residing here? Do you know who to report abuse to? Are you fearful of retaliation for reporting abuse/neglect? The department head will report findings to the Administrator and/or designee in stand down meeting, daily times five per week.

5. The Administrator is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nurse Aide, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. Results of audits will be reported to Quality Assurance Performance Improvement Committee monthly for three months.

Allegation of Compliance 3/31/2022

The Corrective Action plan was validated on 5/26/2022 and concluded the facility had implemented an acceptable corrective action plan on 4/21/2022. Interviews with current nursing staff including agency staff revealed the facility had provided education and training on abuse, notify supervisor immediately, ensure resident is safe and the Administrator is Abuse Coordinator. The audits conducted starting on 3/30/2022 revealed residents were asked about abuse and if they had been abused. Skin checks were completed for all non-alert and oriented Residents by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 600	Continued From page 12 3/17/2022.The audits continued weekly through the validation date. On 5/26/2022 there was sufficient evidence to support the Facility's Corrective Action Plan was implemented and carried out by 3/31/2022.	F 600		
F 607 SS=G	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to implement their abuse policy in the area of reporting; 2 staff members (Nurse Aide #2 and Nurse Aide #3) failed to immediately report an allegation of abuse when they witnessed Nurse #1 and Nurse Aide #1 in a struggle with a resident over a cigarette and cigarette lighter for 1 of 1 residents (Resident #1). Findings included: Review of the facility abuse, neglect, and misappropriation of resident property policy dated 11/30/2014 revealed a section titled: Reporting/Response, this section states any employee or contracted service provider who	F 607	Past noncompliance: no plan of correction required.	6/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 13	F 607		

witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately, but no later than 2 hours after the allegation is made to the Administrator.

Resident #1 was re-admitted to facility on 2/26/2022 and was discharged to another facility on 4/26/2022. His diagnoses included acquired absence of right and left lower leg.

Review of Resident #1's most recent Minimum Data Set (MDS), a quarterly assessment, dated 2/6/2022, revealed Resident #1 was cognitively intact and was required supervision to limited assist from one staff for Activities of Daily Living (ADL).

Review of Nursing Progress note dated 3/14/2022 at 6:41 PM by Nurse #1 revealed patient was witnessed by staff outside smoking 3/13/2022 around 9 PM. Attempted to provide patient with safety/smoking education with no success. Patient became verbally and physically abusive toward this nurse as well as the NA present. Cigarette and lighter were retrieved from the patient. Resident #1 then stated he would get more from someone, and he would just start smoking in his room. 15-minute checks initiated. Patient made no attempts this shift to smoke in his room.

An interview was conducted with NA #2 on 5/17/2022 at 10:45 AM and a 2nd interview by telephone on 5/18/2022 at 8:41 AM. She stated she and NA #3, got Resident #1 up out of bed on 3/13/2022 around 9:30 PM. She stated they told

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 14	F 607		

Resident #1 that we didn't know if they would let him go outside that time of night. She stated she was at the nursing station not long after he had gone outside, and they (Nurse #1 and NA #1) were bringing him back inside. They were holding him back; they were holding his arms so that he couldn't punch. They were trying to get his lighter and cigarettes. This occurred at the nurse's station. She stated she observed his gown coming up starting to go up towards his head, where they were trying to get his cigarettes, and his brief was coming down, it was loose, and she walked away. She stated she did not want to be a witness to all of that. She stated the reason she did not report the incident on 3/13/2022 was because she thought Nurse #1 would report it, since she was involved and was in charge. She stated she did not work again from the end of her shift on 3/13/2022 until she reported for second shift on 3/16/2022. She then realized that the incident had not been reported, so she went to the Director of Nursing on 3/16/2022 around 4:00 PM and reported to her that Resident #1 was stating he had been hit by staff.

An interview was conducted by telephone with NA #3 on 5/17/2022 at 11:00 AM and a 2nd telephone interview on 5/18/2022 at 9:18 AM. She stated she had let Resident #1 go outside on 3/13/2022. She stated she did not know he wanted to go outside to smoke. She stated that while he was outside, NA #1 had been outside and saw him smoking. NA #3 stated NA #1 came back inside and got Nurse #1 and they brought Resident #1 back inside. She stated she and NA #2 had been at the Nurse's station when Resident #1 was brought to the station by NA #1 and Nurse #1, and they were trying to get the cigarettes and lighter from him. She stated NA #2 stated to her,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 15	F 607		

"this is wrong, and I won't be involved in it, they should have called the Administrator or the Law." She stated she observed NA #1 standing behind Resident #1's wheelchair, she was holding his arms and Nurse #1 was trying to get the cigarettes and lighter out of his pocket. She stated she observed Resident #1's butt-crack showing, and his gown was coming off and his brief was coming down. She stated she and NA #2 left the nurse's station together. NA #3 stated the reason she had not reported the incident on 3/13/2022 was because she had already given a written statement for the Administrator and Director of Nursing, and no one did anything for 3 days. She stated she did not know who else to report the incident too, since Nurse #1 was there, Nurse #1 should have reported it, and she didn't know why Nurse #1 had not reported the incident to the Director of Nursing. She stated she felt uncomfortable during the incident about how Resident #1 was being treated.

An interview was conducted with Nurse #1 on 5/17/2022 at 12:10 PM and again on 5/18/2022 at 4:48 PM. Nurse #1 stated she called the Director of Nursing on the evening of 3/13/2022, around 10 PM, after the incident with Resident #1. She stated she told the Director of Nursing that Resident #1 had been caught outside of the building smoking by NA #1, and she and NA #1 had brought him back inside the building. She stated she told the Director of Nursing she had asked Resident #1 to give her his cigarettes and lighter and he had refused. She stated she told the DON that she had physically retrieved the cigarettes and lighter from him. She stated the DON did not ask her how she had retrieved the cigarettes and lighter. Nurse #1 stated the reason she did not inform the Director of Nursing on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 16	F 607		

3/13/2022, while she had her on the telephone, that there had been a struggle getting the cigarettes and lighter from Resident #1 was because she did not feel there had been a struggle at the time, she stated she felt like it was a safety issue to retrieve the cigarettes and lighter from him. Nurse #1 stated that Resident #1 was the one swinging at her and trying to hit her when she tried to get the cigarettes and lighter. She stated she never hit Resident #1.

A telephone interview was conducted with NA #1 on 5/17/2022 at 12:30 PM. NA #1 stated the reason why she did not report the incident with Resident #1 to anyone was because Nurse #1 had called the Director of Nursing after the incident to tell her what happened. She stated Nurse #1 had notified the Director of Nursing that Resident #1 had been caught outside smoking and she and Nurse #1 had to bring him back inside the facility. She stated she did not feel that she needed to do anything else or report to anyone else about the incident. She stated she was only trying to keep Resident #1 from sliding out of his wheelchair onto the floor and keep him from hitting Nurse #1, since he was swinging his arms at Nurse #1.

An interview was conducted with DON on 5/17/2022 at 2:15 PM. DON stated she was notified, by telephone, on 3/13/2022 around 10:00 PM, by Nurse #1. She stated she was told by Nurse #1 that Resident #1 had been outside smoking and that she and NA #1 had brought Resident #1 back inside the building and got his cigarettes and lighter from him. DON stated she did not know how they got the cigarette and lighter from Resident #1 nor was she aware that a scuffle had occurred between Resident #1, Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 17	F 607		

#1, and NA #1 until Wednesday, 3/16/2022, when NA #2 had reported to her. DON stated she did not know how the cigarette and lighter were retrieved from Resident #1, she did not ask, she assumed he had given them to Nurse #1 when asked. DON stated Resident #1 was documented as being a smoker on admission. She stated she was not aware he had been requesting to go to another facility so he could smoke. DON stated as soon as she was made aware an allegation of abuse had been made by Resident #1, she immediately notified the Administrator, had the ADON assess Resident #1 for injuries, and the investigation was started.

An interview was conducted with Administrator on 5/18/2022 at 11:00 AM. She stated she and the DON were responsible for abuse investigations. She stated she was not in the facility with the alleged allegation of abuse was noted on 3/13/2022. She stated she first heard there was an allegation of abuse on 3/16/2022, late in the afternoon, when she was contacted by telephone by the DON. She stated she was informed Resident #1 was stating he had been hit by staff. She stated ADON went immediately and conducted an interview with Resident #1 and assessed him for injuries. Administrator stated she and DON interviewed NA #2 by telephone together and the alleged employees involved, Nurse #1 and NA #1 were suspended pending outcome of the investigation. She stated Resident #1 was furious when he was brought back inside the building on 3/13/2022, after he had been found smoking, but the staff did not put their hands on him. She stated she did not ask Nurse #1 what she had reported to DON on 3/13/2022.

The facility provided the following corrective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 18	F 607		

action plan with at completion date of 3/31/2022.

1. On 3/16/2022 at approximately 4:00 PM Resident #1 was immediately assessed by the Assistant Director of Nursing (ADON) for any injuries related to the allegation of being punched in the chest. No redness or bruising of any kind was found on the resident. At that time the resident was interviewed by the ADON, stating a nurse (Nurse #1) had punched him in the chest when he was caught smoking on 3/13/2022. On 3/16/2022 at approximately 4:00, Nurse #1 and Nurse Aide #1 were interviewed and provided written statements. Nurse Aide #2 and Nurse Aide #3 were verbally interviewed by the Director of Nursing on 3/16/2022 with no changes noted from statement they gave on 3/13/2022. On 3/16/2022 at approximately 5:00 PM staff members (Nurse #1 and Nurse Aide #1) accused of hitting the resident were suspended pending the investigation. On 3/17/2022 at approximately 3:00 PM the police were notified. An initial report was turned in to the state on 3/16/2022 4:18pm and the investigation was completed and submitted to DHSR on 3/22/2022 at 4:36 PM. APS was contacted by the administrator on 3/17/2022 at approximately 10:00 AM. The Medical Director interviewed the resident regarding general conditions of his health on 3/22/2022 in order to obtain resident's state of mind to include how things have been going and has anything new happened. The resident stated "no" and made a request for brand name Ambien. At no time did he report abuse of any kind to the physician.

2. On 3/17/2022 current residents with a BIMS of 8 or greater were interviewed by Social Services Director regarding abuse and if any staff member

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 19	F 607		

had hit them, no new concerns were voiced. Additionally, on 3/16/2022 and 3/17/2022 current resident with a BIMs of 7 and below were given a full body skin assessment by the Director of Nursing and the Assistant Director of Nursing to determine if there were any injuries of unknown origin or injuries that could be related to abuse, no new areas of concern.

3. On 3/17/2022 current staff, to include Nurses and Nurse Aides, housekeeping/laundry, dietary, therapy and all department heads were re-educated on the abuse policy to include any employee or contracted service provider who witnesses or has knowledge of an act of abuse or an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, to a resident, is obligated to report such information immediately to the Administrator and to other officials in accordance with State law. The facility is expected to report to DHSR no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. In the absence of the Administrator, the Director of Nursing is the designated abuse coordinator. Education also included if a resident is combative make sure that the resident is safe and walk away. Do not initiate physical contact if the resident's behavior is escalating. Touching can trigger violence in some. Provide time for the resident to calm down and re-approach. Employees are trained to protect residents from abuse at all times, including intervening with said abuse if they witness it. Notify police if additional assistance is needed. All new staff will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 20	F 607		

educated upon hire during orientation. All staff were educated on 3/17/2022 or prior to their next shift. The education was provided by the Director of Nursing.

4. Residents will be asked at least three times weekly for 12 weeks during daily rounds of the department heads; has any staff member mistreated/abuse/neglect you since you have been a resident here? Has any staff member taken or misused your property since you have been a resident here? Are you fearful of any staff member while residing here? Do you know who to report abuse to? Are you fearful of retaliation for reporting abuse/neglect? The department head will report findings to the Administrator and/or designee in stand down meeting, daily times five per week.

5. The Administrator is responsible for implementing this plan. Findings will be reviewed by QAPI committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nurse Aide, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and MDS Nurse. Results of audits will be reported to Quality Assurance Performance Improvement Committee monthly for three months.

Allegation of Compliance 3/31/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 607	Continued From page 21 The Corrective Action plan was validated on 5/26/2022 and concluded the facility had implemented an acceptable corrective action plan on 4/21/2022. Interviews with current nursing staff including agency staff revealed the facility had provided education and training on abuse, notify supervisor immediately, ensure resident is safe and the Administrator is Abuse Coordinator. The audits conducted starting on 3/30/2022 revealed residents were asked about abuse and if they had been abused. Skin checks were completed for all non-alert and oriented Residents by 3/17/2022.The audits continued weekly through the validation date. On 5/26/2022 there was sufficient evidence to support the Facility's Corrective Action Plan was implemented and carried out by 3/31/2022.	F 607		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Nurse Practitioner interview the facility failed to safely transfer a resident from a wheelchair to bed when one staff member performed a stand pivot transfer when the resident required a two-person assistance with stand pivot transfers (Resident #55) for 1 of 3 residents reviewed. Resident #55 was assisted	F 689	Past noncompliance: no plan of correction required.	6/13/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 22	F 689		

with a stand pivot transfer by a Nurse Aide and heard and felt a "pop" in her right leg and sustained a closed fracture of the patella (small bone in front of knee joint).

The findings included:

Resident #55 was readmitted to the facility on 01/26/22. Her current diagnoses included fracture of patella (small in front of knee join).

Review of a Transfer mobility status dated 01/26/22 indicated that Resident #55 required a sit to stand lift.

Review of an Activities of Daily Living care plan revised on 01/27/22 included the following intervention: the resident required two-person assistance to pivot between transfers.

Review of the quarterly Minimum Data Set (MDS) dated 04/07/22 indicated that Resident #55 was cognitively intact and required one person assistance with transfers.

Review of a document titled "Report of Resident Other Event" dated 04/19/22 read in part, resident reports that when she was being transferred from wheelchair to bed, she felt her knee move. The severity level of the injury read; minor injury (abrasion, bruise, laceration, pain, skin tear, sprains). The Nurse Practitioner (NP) was notified by the Assistant Director of Nursing (ADON).

Review of a nurses note by the ADON dated 04/19/22 at 12:28 PM read in part, notified by a visitor that Resident #55 was in bed crying. Resident #55 is in bed, crying. Reports that her right knee "hurts like I died and went to hell."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 23	F 689		

Resident #55 stated that during a transfer her knee popped or something. Resident #55 tense and crying out in pain as her pants were adjusted to visualize the knee. Denies pain or tenderness when right knee area was touched. Called placed to the NP and new orders obtained for Xray.

Review of a Radiology Report dated 04/19/22 from the facility read in part; Right knee conclusion: acute appearing periprosthetic (fracture that occurred around the joint that has been replaced). Recommend orthopedic consult.

An Emergency Room (ER) evaluation dated 04/19/22 read in part; patient presented to ER after injuring her right knee. She was being placed in her bed when she heard a pop and had sudden pain in the right knee. Her foot was planted when she twisted. At rest the pain is negligible but with any type of motion it becomes significant. She is unable to bear weight on right lower extremity. She does have a history of foot drop (difficulty lifting the foot) on the right side. The physical examination revealed moderate swelling noted to the right knee, moderate tenderness to gentle palpation. Patient unable to straighten out the knee due to pain. Knee Xray report; large lipohemarthrosis (presence of intra-capsular floating fat in a joint cavity most common cause is traumatic knee injury), possible avulsion (pulling or tearing) injury of part of the patella. Otherwise, no distinct fracture or dislocation. Disposition: will give patient pain medication, knee immobilizer and referral to orthopedics.

Review of a Physician Progress Note dated 04/21/22 read in part; Chief complaint: nondisplaced fracture of the bone in the lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 24	F 689		

leg. History of present illness: the patient was being transferred and unfortunately suffered the above fracture. She was sent to the ER, no surgery required but she does have a brace and will follow up with orthopedic surgeon. She stated that by and larger her pain is controlled except with she must be transferred.

An orthopedic consult dated 04/27/22 read in part, Resident #55 had a recent injury while being moved and felt a painful pop in her knee. Xray suggest avulsion (pulling or tearing) injury of the patella. Today she presents with pain that is a 12 on a scale from 0 to 10. The assessment and plan read in part, superior patella (small bone in front of knee joint) fracture right knee.

An observation and interview were conducted with Resident #55 on 05/18/22 at 1:25 PM. Resident #55 was resting in bed with her right leg elevated on pillows. There was a knee immobilizer on her right knee that extended down to her mid-calf. She reported that approximately 3-4 weeks ago she had just gotten back from a doctor's appointment and wanted to go back to bed. She stated she asked Nurse Aide (NA) #7 to lay her down. Resident #55 stated that she put her knees between NA #7 ' s knees and wrapped my arms around her neck and NA #7 had her arms around my waist and stood me up and pivoted me to the bed, "but my legs did not pivot." She stated that she and NA #7 both heard and felt a pop in her right knee and it "was so painful" "on a scale of 0-10 it was a 12." Resident #55 stated that they ordered some Xray ' s and once those were done, they sent me over to the ER for evaluation and confirmed a fracture in my knee. Resident #55 stated several days later she saw her orthopedic doctor and he again took several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 25	F 689		

Xray ' s and confirmed the fracture and drew some fluid off the knee which helped ease the pain.

NA #7 was interviewed on 05/18/22 at 2:19 PM. NA #7 stated that she was working in activities on 04/19/22 and had accompanied Resident #55 to her doctor's appointment when they returned to the facility Resident #55 wanted to lay back down. NA #7 stated that she "done it like she had seen therapy do it" by pivoting Resident #55. She stated that Resident #55 was in a high back wheelchair, and she placed her knees between Resident #55's knees and she wrapped her arms around my neck, and I grabbed the back of her pants and stood her up. As Resident #55 stood up NA #7 stated that they both heard and felt a pop and Resident #55 stated "ouch that hurts", NA #7 stated she finished pivoting Resident #55 to the side of the bed and sat her on the edge of the bed and then lifted both of her legs into the bed. Once Resident #55 was in the bed, NA #7 stated she reported the incident to the nurse on the hallway, but she could not recall who that was but also reported the incident to the ADON. NA #7 stated that she did not know if Resident #55 required a mechanical lift or what her transfer status was. She stated she had reviewed her Kardex (care plan) previously and could not find the information. NA #7 did say she did look in the wheelchair to see if there was mechanical lift pad under Resident #55 but there was not, so she assumed that meant Resident #55 did not require a lift for transfers.

The ADON was interviewed on 05/18/22 at 2:45 PM. The ADON stated that on 04/19/22 someone but she could not recall who reported that Resident #55 was in her room crying. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 26	F 689		

she went down to Resident #55's room to see what was going on. Resident #55 told the ADON that when she had gotten back from her doctor's appointment and the NA was transferring her from her wheelchair to her bed, she felt a pop in her knee. The ADON stated that there were no obvious signs of bruising, swelling or redness, and stated that she could not recall if Resident #55 was in pain or not, "nothing stands out in my mind." The ADON stated she contacted the NP and an Xray was ordered and then the DON and Administrator were made aware of the incident. She added that the Xray report came back, and she could not recall exactly what it said but it suggested a possible fracture, so the NP was made aware and gave an order to send Resident #55 to the ER for evaluation and treatment. When Resident #55 returned she stated that she had an appointment with the orthopedic provider and a knee immobilizer in place. The ADON stated that prior to the incident Resident #55 was a lift transfer but did not know if it was a sit to stand lift or a total mechanical lift transfer. After the incident Resident #55 was reassessed and determined to be a total mechanical lift for transfers. The ADON stated that the day after she returned for the ER, she went down to check on Resident #55 and she was in a lot of pain and when asked to rate her pain she replied, "on a scale of 1-10 it is a 12."

The DON was interviewed on 05/18/22 at 3:05 PM. The DON stated that from what she could recall on 04/19/22 Resident #55 returned from a doctor's appointment and NA #7 transferred her by herself and during the transfer heard and felt a pop in Resident #55's knee. NA #7 notified the ADON, and the NP was contacted and an Xray ordered then Resident #55 was sent to the ER for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 27	F 689		

evaluation and returned shortly thereafter. Prior to the incident the DON stated Resident #55 was a two person assist with transfer, but she was not sure if the transfer required a lift or not but stated "she definitely required 2 person assist" with transfers. The DON stated that NA #7 was suspended for not following the plan of care for Resident #55 and transferring her alone. After the incident all the resident transfer/statuses were updated, and all the staff were reeducated on the Kardex (care plan) and where to locate the transfer status and the proper way to transfer a resident.

The Administrator was interviewed on 05/18/22 at 4:50 PM. The Administrator stated that when they found out about the fracture, they interviewed NA #7 and learned that she had pivoted Resident #55 from the wheelchair to the bed. When NA #7 was asked why she had done that she replied that she was confident in her ability to perform the transfer that way. The Administrator stated that prior to the incident Resident #55 required a lift for her transfers along with 2-person assistance and that was what NA #7 should have done. Following the incident all the residents had an updated transfer/mobility status assessment completed and their care plan/Kardex update. The staff were reeducated on where to locate the information and the importance of how and why to follow the care plan.

The NP was interviewed on 05/18/22 at 2:00 PM. The NP stated that on 04/19/22 Resident #55 had been out to an appointment and when she returned asked to go to bed. The staff member transferred her from the wheelchair to the bed and during the transfer they heard and felt a pop in her leg. The NP stated she was not in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 28	F 689		

facility that day but was contacted by the ADON and gave an order for an Xray that came back suspicious for a fracture. Resident #55 was sent to ER for evaluation and after an orthopedic consult the fracture was confirmed of the right patella. She added she evaluated Resident #55 on 04/20/22 and she was still in a lot of pain and her pain medications were adjusted to help keep her as comfortable as possible. The NP indicated that Resident #55 had taken oral steroids for years along with her immobility would cause her bones to be brittle and more prone to fractures.

The facility provided the following Corrective Action Plan with a completion date of 04/21/22:

1. On 04/19/22 resident was being transferred from wheelchair to bed by Nurse Aide (NA) #7 when NA #7 heard resident ' s right knee pop. NA #7 made sure resident was in bed and immediately informed the nurse. Nurse #5 completed a visual assessment of resident right knee. Assessment revealed no swelling, redness, or bruising to right knee. At that time vital signs obtained by nurse. Nurse #5 then reported the incident to the Assistant Director of Nursing (ADON). The ADON also assessed resident's right knee; ADON ' s assessment revealed no swelling/edema, no redness, no bruising. Right knee palpated, no facial grimacing or tendering noted. The ADON contacted the Nurse Practitioner (NP) and an order was obtained for an X-ray to the right knee. Nurse #5 reported the X-ray results to the ADON. The X-ray report stated periprosthetic fracture and recommended an orthopedic consult. ADON contact the NP and an order was given to send resident to the Emergency Room (ER) for evaluation. Emergency Medical Services (EMS) arrived

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 29	F 689		

around 4:10 PM, stabilized residents ' right leg and transferred resident to stretcher via 4 persons. Resident out of facility around 4:25 PM.

On 04/19/22 resident evaluated in the local emergency department for right knee pain and x-ray performed. The x-ray report stated: Right Total knee arthroplasty is in normal alignment without evident of hardware failure or loosening. Large lipohemarthrosis present with heterotopic calcification superior to the patella. No possible distinct fracture or dislocation. Bony mineralization is normal. Vascular calcifications present. Resident was discharged back to the facility on third shift with order for knee immobilizer with referral to orthopedics.

2. On 04/19/2 NA #7 was immediately suspended pending investigation. No other residents were affected. As a result of the investigation, it was determined that NA #7 did not follow the resident Kardex/care plan regarding transfer. Resident required 2 person assist with transfers and NA#7 transferred resident alone. On 04/21/22 NA #7 was terminated.

3. Starting on 04/19/22 nursing staff including Nurse Aides will be reeducated by the Director of Nursing/Nursing management regarding transfers and where to find the appropriate information for individual resident transfers. New staff will be educated upon hire during orientation:
a. Transfer assessments will be completed for residents residing in the facility by nursing management.
b. Resident Kardex will be reviewed and updated with the results of the transfer assessments.
c. Resident care plans will be reviewed and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 30	F 689		

updated to correspond with transfers assessment and Kardex by nursing management.
d. Therapist and Director of Nursing educated nursing staff on mechanical lift, sit to stand lift, and assist to ambulate using transfer belt.
e. The DCS/Nurse Manager/Designee will observe a transfer for nursing employee to ensure that appropriate transfer technique is being demonstrated during resident transfers.
f. Starting on 04/21/22 random weekly observations of transfers will be conducted by Director of Nursing/Nurse Manager/Designee for three (3) employees to ensure that appropriate transfer technique is being sustained by nursing staff during resident transfer.
g. An impromptu QA/PI meeting was held on 04/20/22 to discuss the plan of correction and corrective measures.

4. Results of the random weekly observations will be discussed at the monthly QA/PI meeting for three (3) months to sustain substantial compliance.

5. Allegation of compliance date: 04/21/22.

The Corrective Action plan was validated on 05/26/22 and concluded the facility had implemented an acceptable corrective action plan on 04/21/22. Interviews with current nursing staff including agency staff revealed the facility had provided education and training on transfer status assessments, where to find the results of the transfer assessment, and how to safely transfer a resident using stand pivot technique and/or mechanical lift. Each nursing staff member conducted competency sheets to verify knowledge of how to operate the mechanical lift. The audits conducted starting on 04/19/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/26/2022

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 689	Continued From page 31 revealed the facility management observed transfers to ensure that proper transfer technique was being utilized by staff. The audits continued weekly through the validation date. The corrective action plan was reviewed with the Quality Assurance committee on 04/20/21.	F 689		