PRINTED: 09/30/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUC  A. BUILDING  A. BUILDING			COMPLETED		
		345329	B. WING		09/07/2021
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	1 000000
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 000	INITIAL COMMENTS	3	F 00	0	
F 551 SS=J	was conducted on 00 information was obta surveyor returned to on 09/07/21 to validate compliance. Therefor changed to 09/07/21 was substantiated at Event ID# 7GVK11.  Immediate Jeopardy 483.10 at tag F 551 at Immediate Jeopardy and was removed on The facility was notif Immediate Jeopardy quality review:  Immediate Jeopardy 483.10 at tag F 835 at Immediate Jeopardy was removed on 09/Rights Exercised by CFR(s): 483.10(b)(3) In the not been adjudged in court, the resident has representative, in accany legal surrogate as the resident's rights at state law. The samemust be afforded treatments.	The 1 complaint allegation and resulted in deficiencies.  (IJ) was identified at CFR at a scope and severity of J.  (IJ) began on 08/14/2021 of 08/21/21.  ded on 09/02/21 of additional identified after management  (IJ) was identified at CFR at a scope and severity of J.  (IJ) began on 08/13/21 and 04/21.  Representative	F 55	.1	9/29/21
ADODATODY		(SLIPPLIER REPRESENTATIVE'S SIGNATUR		TITI F	(X6) DATE

Electronically Signed 09/22/2021

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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	, ,	COMPLETED	
		345329	B. WING			C 09/07/2021
	ROVIDER OR SUPPLIER	) HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	<b>'</b>	00/01/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 551	(i) The resident reprexercise the resident rights are delegated (ii) The resident retarights not delegated including the right to except as limited by §483.10(b)(4) The form of a resident representation to the edlegated by the resident to the edlegated by the resident representation decisions on behalf extent required by the resident, in accordation §483.10(b)(6) If the that a resident representation of a resident, the factories when and State law.  §483.10(b)(7) In the incompetent under the form of competent under the form of the resident's being extent's being extent representative appoon the resident's being extent in the	on in which it was celebrated. esentative has the right to t's rights to the extent those to the representative. ins the right to exercise those to a resident representative, revoke a delegation of rights,	F 55	51		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING			C 9/07/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	9/07/2021
				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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 551	Continued From page	e 2	F 5	51		
	decision-making author court appointment to make those decision representative's auth (ii) The resident's wis be considered in the representative.  (iii) To the extent pracprovided with opported a planning process This REQUIREMENT by:  Based on record revuegal Guardian (LG).  Nurse Practitioner (Ninstructions from the to leave the facility without the make the series of the ser	ority.  thes and preferences must exercise of rights by the exercise to participate in the s.  I is not met as evidenced exercise with the resident, staff, and the P), the facility failed to follow LG and allowed Resident #1 ith an unauthorized person. It diagnosed with aspiration ation affected 1 of 3		Preparation and/or execution of correction does not constitut admission or agreement by the with the statement of deficienci plan of correction is prepared a executed because it is required provision of Federal and State	e provider es. The and/or I by	
	was signed out of the consent from the LG. removed on 8/21/21 and implemented an allegation for remova compliance at a lowe (no actual harm with that is not IJ) to compmonitoring systems pure findings included Resident #1 was adm 6/07/21 with the follows.	I. The facility remains out of r scope and severity of D a potential for minimal harm plete education and ensure out into place were effective.  I:  nitted to the facility on wing diagnoses pneumonia, sorder, schizophrenia,		F551  1. Resident #1continues to recenter. Resident # 1□s electromedical record, hard paper chathe Demographics tab, and the Absence sign out/ sign in book updated by the ED/SS director that Resident #1 has a Legal Gand that resident is not to make financial or leave of absence dwithout the notification to and of from the Legal Guardian. Resident #1 □s plant of the cordered. Resident #1□s plant of the cordered. Resident #1□s plant of the cordered.	entic ent under e Leave of were to indicate Guardian, e medical, ecisions consent dent #1 was urse low up on 8 o and completed as	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  G	· ,	ATE SURVEY DMPLETED
		345329	B. WING			C 09/07/2021
	ROVIDER OR SUPPLIER  Y REHABILITATION ANI	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645	'	
(X4) ID PREFIX TAG	(EACH DEFICIEN	BTATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 551	of North Carolina titl Guardian of the Perbeing an incompete guardianship to the Services (DSS) on Services of Resident revealed the following -A diet order for noth on 6/7/21.  -Enteral feed (intake gastrointestinal trace feeding bolus via sy Review of the Minim 6/17/21 assessed Resident graphics or greater tube.  The care plan revise Resident #1 require dysphagia, infection was for Resident #1 or complications related the review date. Into listen to lung sound document, and reposymptoms of aspirar Review of the facility 8/14/21 at 10:45 AM	document issued by the State led; "Letters of Appointment son" named Resident #1 as nt person and appointed local Department of Social 5/20/21.  #1's physician orders ng: hing by mouth (NPO) written e of nutrition via t) five times a day give tube ringe written on 6/7/21.  hum Data Set (MDS) dated desident #1 cognition as being d for making daily decisions. Every assistance with eating and eater of his calories and 501 of fluids through a feeding ded on 6/23/21 identified d tube feedings related to a, and pneumonia. The goal to remain free of side effects ated to tube feedings through erventions in place included as as needed and monitor, out as needed any signs or tion.  If y sign-out records revealed on the Resident #1 was signed out riend #1 who was not	F 55	been reviewed and updated by the Interdisciplinary Team, according 09/20/21.  2. Executive Director (ED)/Soc Services (SS) Director identified residents with legal guardians or as those residents who are unaked make decisions for themselves of leaves of absence from the cent Current residents have been reverthe ED/SS Director on 8-18-21 to that they have not been out on legal guardians. Also, current rewho have been out on Leave of (LOA) in the past 5 days (since 8 were assessed by the Director of (DON)/Assistant Director of Nurse (ADON) on 8-18-21 to ensure not in condition, as a result. Reside specialized diets were reviewed ED/DON/ADON on 8-18-21 to enconsumption of approved diet, a by the MD while out on LOA in the days (since 8-14-21). There were additional changes in condition of the ridentified current residents gone out on LOA from 8-14-21 to 18-21, requiring immediate notified the MD by the Licensed Nurse for additional orders.  3. On 8-18-21, Regional Vice of Operations (RVPO) educated Executive Director on legal guar residents rights, as pertained to guardians. On 8-20-21 Executive educated the department managed to the department a	gly, as of  cial 9 n 8-18-21, ble to regarding er. riewed by o ensure eave of n their esidents Absence 3-14-21) if Nursing o changes nts on by the nsure s ordered ne past 5 re no noted for is, who had hrough 8- ication to or  President  dians and o legal re Director	

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE						
			A. BOILDI	_	<del></del>	Ι,	C
		345329	B. WING				07/2021
NAME OF P	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 007	0172021
				20	030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	HEALTHCARE			ENOIR, NC 28645		
(X4) ID	SLIMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 551	Continued From pag	ue 4	F:	551			
		on 8/18/21 at 2:31 PM the LG			include the Social Services Director, al	ona	
		o the facility for a visit with			with the nursing and ancillary staff	ig	
	Resident #1 on 8/13	_			members (including the receptionist), t	nat	
		esident #1 and the Social			Residents with Legal Guardians are		
		she made it clear to both			unable to make decisions for themselv	es	
		to leave the facility with			regarding medical and financial to inclu	ıde	
		personnel and could not			leaves of absence from the center. The		
	attend the festival or	n 8/14/21. The LG discussed			resident⊟s legal guardian will be notifi	ed	
	her concerns related	I to Resident #1's history of			for such medical, financial, and Leave	of	
	unsafe decisions tha	t compromised his health.			Absence requests. The approval for a		
On 8/16/21 the LG received information Resident Leave of Absence for a resident w		Leave of Absence for a resident with a					
	#1 left the facility wit	h an unauthorized person			legal guardian will be witnessed by 2 s	staff	
		by a Family Member (FM)			members and noted in the resident□s		
	1	ce unsupervised and eating			medical record. Disapproval by the		
	_	estival on 8/14/21. On			resident⊡s legal guardian for a reques		
		d the facility and spoke with			leave of absence will also be witnesse	•	
	1	ing her Resident #1 left the			2 staff members and documented in th		
		without the LG's knowledge			resident □s medical record. Additional	у,	
		eating and drinking at the			the ED/SS Director has placed a		
		ealed the Administrator was			notification in the electronic medical		
	1	#1 had left the facility on			record, hard paper chart under the		
	8/14/21.				Demographics tab, as well as in the LC	)A	
	An interview was see	nducted on 8/18/21 at 10:59			sign out/sign in book (located at the		
		Resident #1 revealed on			receptionist⊡s desk) to indicate that identified residents with a legal guardia	n	
		icility with Friend #1 to attend					
		h Friend #1 that morning and			are not to make medical, financial or le of absence decisions without the	ave	
		ay after it was dark. Resident			notification to and consent from their le	aal	
	1	appointed LG but denied she			guardians. Residents/Responsible Pa	-	
		8/13/21. Resident #1 also			when going out on LOA, will be educated	-	
		im he couldn't leave the			by the Licensed Nurse regarding their	- u	
		horized person or could not			prescribed diets, to include specialized		
	attend the festival or				and therapeutic diets, along with their		
		1 asked for some water to			dietary restrictions to validate an		
		pefore he shared, he wasn't			understanding of what the resident car	or	
		nk by mouth and had a			cannot consume while out on LOA.		
		ent #1 denied he ate or drank			Licensed Nurses were educated on the	,	
		e festival and stated the			above, to include documentation of the		
	, ,	tid were not telling the truth			discussion in the medical record upon		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		,		
		345329	B. WING			1	07/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CATEWAY	REHABILITATION AN	D HEALTHCARE		20	030 HARPER AVENUE NW			
GAILWAI	REHABILITATION AN	DHEALINGARE		L	ENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC 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 551	#1 confirmed he wa and took Resident # Resident # 1 had ca take him to the festi Resident # 1 was de assigned a court ap knowledge he was nout of the facility. Or Resident # 1 and wa member with signin Resident # 1 ready the was not given ar hydrate Resident # 1 together. Friend # 1 alone at any time that the festival did given water which he did revealed he was ab away from Resident # around 10:30 AM an around 9:00 PM. Frifacility staff not to let to eat or drink by malready aware of thi Attempts to identify who assisted signin facility were unsucced. An interview was continued to the property was	on 8/20/21 at 8:15 AM Friend is the person who signed out if 1 to the festival on 8/14/21. Illed and asked if he would val and he was aware remed incompetent and inpointed LG but had no if allowed to take Resident #1 in 8/14/21 Friend #1 picked up is assisted by a male staff go out while a female staff got in leave. Friend #1 revealed in medications or means to if during the time they spent indenied Resident #1 was left in the ey were together but a person we Resident #1 a bottle of take a sip of. Friend #1 ille to get the bottle of water it #1 before he drank anymore in the ey was told by it for the ey was told by it for the ey was told by it Resident #1 have anything outh and indicated he was its.	F	551	Resident s Leave of Absence. ED/DON/ADON educated current licensed nursing staff on 08/18/2021 th residents will be assessed upon return from LOA for an acute change in condition. Resident sphysician will be immediately notified of an acute change condition, as a result of the nursing assessment, for further orders. Staff members not educated by 8/20/2021 whose educated upon the next scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On 8/20/21 the Executive Director provided education the Assistant Director of Nursing that should be responsible for training the staff that are not educated by 8/20/21. The facility social worker will be responsible notifying staff and placing this information in the electronic medical record, hard paper chart under the Demographics to as well as in the LOA sign out/sign in befor new admissions with a legal guardia after 8/18/21. The facility social worker was notified of this responsibility on 08/18/2021. The staff were provided education on 8/20/21 by executive director to look to at the medical record/resider sign out notebook to validate if the residents have a court appointed guard before allowing them to leave the facility as conducted by the ED/DON 5 times	e in  ill  ne to ne aff  for on ab, ook an ctor nt lian y.		
	was walking from a	The FM revealed Resident #1 building that served beer, was holding a cup containing			weekly for 4 weeks, then 3 times weekly for 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3	У		

			TE SURVEY MPLETED			
			A. BOILDIN			,
		345329	B. WING _			07/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	· · · · · · · · · · · · · · · · · · ·	
				2030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	HEALTHCARE		LENOIR, NC 28645		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN	N OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	EACTION SHOULD BE TO THE APPROPRIATE CIENCY)	COMPLETION DATE
F 551	F 551 Continued From page 6		F 5	51		
	a liquid in one hand a	and what appeared to be		months. to ensure the	following: a)	
	bread in the other an	d appeared to be alone. The		Identified residents hav	e notifications in	
	FM did not interact w	rith Resident #1 but did		the electronic medical r	ecord, hard paper	
	observe him for appr	oximately 5 minutes and		chart under the Demog	raphics tab, and	
	stated he did not see	Resident #1 eat or drink.		the Leave of Absence s	sign out/ sign in	
	The FM did notify Re	sident #1's LG but did not		book to indicate that the	ey are unable to	
	contact the facility.			make decisions for ther		
				medical and financial d	ecisions to include	
		nducted on 8/23/21 at 2:31		leaves of absence. b).		
		Police (COP). The COP		Legal Gurardian is notif		
		l information from others that		requests; and, the appr		
		r Friend #1 and was drinking		by the Legal Guardian	- 1	
		1/21. The COP revealed		staff members and note		
		nt #1, he was standing		record. c) The Resider		
		urant and appeared to be		Party is educated by L		
		ve any food or drinks nor did		regarding prescribed di		
		nsume any. The COP		specialized and therape	- 1	
		mes of the persons who		with dietary restrictions		
		nt #1 was drinking at the		understanding of what		
	festival.			and cannot consume w	· ·	
	An intorviou was con	nducted with Director of		and, this discussion is the medical record. d)		
		18/21 at 12:17 PM. The DON		assessed by the nurse		
	,	asked about going to a		LOA for an acute chang		
		eir Department Head (DH)		notification to the physi	-	
		hey discussed concerns		Results of Quality Impre	· ·	
	_	him having a feeding tube		monitoring will be repor		
	1	IPO. A decision was made to		Improvement Committee	- 1	
		d the festival and leave the		months continued comp		
		d the SW was to contact the		revision. The Executive		
		s shift on 8/14/21 she was		responsible for impleme		
	_	as at the facility to pick up		, , , , , , , , , , , , , , , , , , , ,		
		last information she heard it		5)As of 09/29/2021 the	corrective actions	
		proved he could leave the		will be completed.		
		ealed she was not aware		,		
	Resident #1's LG vis					
		could not leave the facility				
	with an unauthorized	person or attend the festival				
		de aware of this information				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G	' '	DATE SURVEY COMPLETED
		345329	B. WING			C <b>09/07/2021</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		09/07/2021
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 551	An interview was company about the phone can always and a many about his request to LG told the SW and leave the facility un. The SW revealed so during their DH merecall who attended Director of Nursing. An interview was company and told face to face not to leave the facunderstood when a cannot leave the fact. The ADON reversely.	the Administrator told her III from the LG.  III	F 58	51		
	PM with the SW. The present during the lasked to notify the attend a festival on before she was able the LG came to fact SW explained she awere standing toge tell Resident #1 set facility and he could 8/14/21. The SW st Resident #1's chart book kept on the missing the same standing toge tell Resident #1 set facility and he could 8/14/21. The SW st Resident #1's chart book kept on the missing the same standard stan	ne SW revealed she was DH meeting on 8/13/21 and LG Resident #1 wanted to 8/14/21. The SW revealed e to contact Resident #1's LG ility for a visit on 8/13/21. The and the LG and Resident #1 ther when she heard the LG veral times not to leave the d not go to the festival on ated she wrote a note in and made a sign to put in a edication cart for nurses to esident information and taped				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	, ,	TE SURVEY MPLETED
		345329	B. WING			C 9/07/2021
	ROVIDER OR SUPPLIER  'REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645	1 0	3/01/2021
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 551	stating Resident #1 c with anyone other that staff.  An interview was con AM with Med Aide (M 8/13/21 from 6:45 AM she did receive a not allowed to go out of the 8/13/21 and stated the 24-hour nurse book a also stated she did the could not recall who the care of Resident #1 cook him out of the fawas not told Residen incompetent to make aware he was appoints the facility with some family member nor different was aware Resident have anything by mowould be at risk for a recall informing Frient #1 explained she she was not to see any type of note the facility with no on During an interview of the stated she was not to see any type of note the facility with no on During an interview of the stated she was not to see any type of note the facility with no on During an interview of the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the facility with no on the stated she was not to see any type of note the see any t	ation for nurses to see ould not leave the facility an DSS personnel or facility ducted on 8/19/21 at 11:18 IA) #1 scheduled to work on 1 to 11:15 PM. MA #1 stated at Resident #1 was only the facility with his LG on the end was kept in the at the nurse station. MA #1 will the oncoming nurse but that was.  In 8/19/21 at 10:47 AM the was responsible for the facility. Nurse #1 revealed she at #1 was deemed with a his own decisions nor sted a LG. Nurse #1 revealed to Resident #1's medical with the was a down the spiration, but she didn't was not allowed to buth and if he ate or drank aspiration, but she didn't did #1 that information. Nurse will we reviewed Resident and notified his LG to be leave the facility. Nurse #1 wild by anyone nor did she Resident #1 was not to leave the other than his LG.  In 8/20/21 at 10:48 AM	F 55	51		
		e was responsible for the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		OMPLETED	
		345329	B. WING _			C <b>09/07/2021</b>	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		1 00/0//2021	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 551	to the facility around speak to Friend #1 n about ingesting food he wasn't told by any allowed to leave the did Nurse #2 see any information. Nurse # time he was notified the facility with anyou asked to sign a pape have 2 facility staff or Guardian with him if  An interview was cor PM with Nurse #5 whis scheduled on 8/13/2 on 8/14/21. Nurse #5 strictly NPO with nut administered via feed Resident #1 was known being NPO and would Nurse #5 stated she Resident #1 being do a LG but was aware information up in Resident #1's could not leave the faperson or attend the not receive any infor he could only leave the personnel.  An interview was cor PM with the DON. The was gigned a LG. The	on 8/14/21 when he returned 9 PM. Nurse #2 did not or question Resident #1 or fluids. Nurse #2 revealed one Resident #1 was not facility except with his LG nor or notes stating that 2 stated 8/19/21 was the first Resident #1 could not leave the other than his LG and or stating Resident #1 had to restating Resident #1 was the left the facility.  Inducted on 8/19/21 at 12:09 the was aware Resident #1 was rition and medications ding tube and revealed own to be non-compliant with desident #1 was resident	F 5	51			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345329	B. WING _			C <b>09/07/2021</b>
	ROVIDER OR SUPPLIER  7 REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZII  2030 HARPER AVENUE NW  LENOIR, NC 28645	PCODE	33/01/2321
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD B O THE APPROPRIA	DATE
F 551	part. The DON reveal Administrator made in suspected of eating at festival which put him DON stated she performs of aspiration are so she did not inform on 8/16/21 and did not assessment.  An interview was comed with the Administrator specially with an unauth called on 8/16/21 state ating and drinking and Administrator told the The Administrator speconfirmed had been of the Administrator did not Resident #1 to the feel Administrator found of the DON to assess Resident #1 to the feel Administrator found of the DON to assess Resident #1 could attend the SW was to contain the SW was to cont	it was an oversight on her led on 8/16/21 the her aware Resident #1 was and drinking when at the hat risk for aspiration. The formed an assessment for ad found nothing abnormal, the Nurse Practitioner (NP) of document her  ducted on 8/18/21 at 4:52 rator. The Administrator aware Resident #1 left horized person when his LG ting a FM saw Resident #1 the festival. The LG she would investigate. Soke with Resident #1 who but of building with a friend. Soke with the SW who exist the SW who exist on 8/13/21. The talk with Friend #1 who took estival. When the but on 8/16/21, she asked hesident #1 but did not inform that are revealed during their on 8/13/21 it was agreed hend the festival and stated exist his LG. The Administrator #1 he could go to the festival as deemed incompetent by a popointed LG. It was the extation the LG would've been ent #1 left the facility with	F 5	551		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		345329	B. WING _			C <b>09/07/2021</b>	
	ROVIDER OR SUPPLIER  REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		33.01.202.	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 551	nurse's station and re Nursing Resident #1 with anyone but his I staff members. He can calls from Friend #1 was signed by the Station with direction no date on the note.  An interview was core 8/18/21 at 1:19 PM. #1 was deemed incoolder. The NP explained to his diagnosis of see he would not be trust decisions about not edid eat or drink it work aspiration pneumonic death. The NP was refacility without the LO aware by facility on 8 eating and drinking, was aware Resident and drinking, she she would expect nurses sounds and obtain a least 2 days and ask #1 on her list of reside for her own assessmant of the state of the sta	vealed it was taped at the ead in part, "Attention cannot leave this building DSS guardian, or one of our annot make or receive any per his Guardian." The note W and posted at the nurse's so not to remove. There was additionable of the NP was aware Resident mpetent and appointed a ead Resident #1 was NPO due evere dysphagia and stated tworthy to make good eating or drinking and if he ald put him at risk for a which could lead to his not aware Resident #1 left the E's knowledge nor made 1/16/21 he was suspected of The NP stated if the facility #1 was suspected of eating ould have been notified and staff to listen to his lung full set of vital signs for at that the nurse put Resident lents to see on her next visit	F 5	51			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED	
		345329	B. WING			C <b>09/07/2021</b>	
	ROVIDER OR SUPPLIER  7 REHABILITATION AND	HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	<u> </u>	03/01/2021	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 551	meaning pneumonia lobes likely due to as physician orders wer and diuretic for the trevealed the following-Levofloxacin (antibid bacterial infections) tablet via peg tube or for day 1 to start on 8-Furosemide (diuretic excess fluid from the via peg tube in the affor 3 days to start on During a follow-up in PM the NP could not on 8/14/21 but stated notification he was stifluids on 8/14/21. If n revealed she would hat that time, and it was notification and treatroutcome and Reside septic from having promote the facility provided immediate jeopardy in correction date of 08. Identify those recipie	the lungs and chest wall) was present in the lower piration. The NP revealed e provided for an antibiotic eatment of pneumonia.  It's physician orders g: bitic medication used to treat r50 milligram (mg) give 1 the time only for pneumonia r6/20/21.  It medication used to remove rebody) 40 mg give 1 tablet remoon for pleural effusions r6/20/21.  Iterview on 8/20/21 at 3:57 resay Resident #1 aspirated if there was a delay in respected of ingesting food or otified on 8/16/21 the NP reave assessed Resident #1 as possible the delay in rement could have a negative int #1 could have become neumonia.  It informed of immediate removal plan with the removal plan with the removal plan with the removal of the removal plan with the removal glan with t	F 55				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345329	B. WING			C 09/07/2021
	ROVIDER OR SUPPLIER	0.0000		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		09/07/2021
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 551	(SS) Director identifications on 8-18-21 unable to make decisive regarding leaves of a Current residents has ED/SS Director on 8-18-25 Director on 8-18-25 Director on 8-18-25 Director on 8-18-25 Director on 8-18-26 Director on 8-18-26 Director on 8-18-26 Director on 8-18-27 Director on 8-18-27 Director on 8-18-28 Director on the were assessed by the (DON)/Assistant Director of the S-18-21 to ensure not result. Residents on reviewed by the ED/I ensure consumption by the MD while out (since 8-14-21). The changes in condition current residents, who shall be sident shall be sident shall be sident shall be social worker at the final the resident had and was not to not lee other the DSS person accompanied him to Resident #1 out of the m. Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resident #1 return of the Resident #1 return of the Resident #1 out of the m. Resident #1 return of the Resi	or (ED) and Social Services and 9 residents with legal as those residents who are sions for themselves absence from the center. We been reviewed by the control of a leave of absence without a legal guardians. Also, to have been out on Leave of the past 5 days (since 8-14-21) are Director of Nursing (ADON) on a changes in condition, as a specialized diets were DON/ADON on 8-18-21 to of approved diet, as ordered on LOA in the past 5 days are were no additional noted for other identified to had gone out on LOA from 3-21, requiring immediate to by the Licensed Nurse for the allegation:  Initted to the facility on 6/7/21 are pointed guardian met with acility on 8/13/21 to discuss court appointed guardian ave the facility with anyone anel. Family friend who a local festival signed for the festival at mon 8/14/21. Nurse #2 did	F 5	51		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345329	B. WING		۰	C (07/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	08	/07/2021
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 551	resident's stomach for there were none. Nu tube feeding, per phy approximately 9:30 phe court, appointed and informed the adrileft the facility on 8/1 knowledge or conser DSS personnel. The that multiple people at that the resident had drinking and appears 8/18/21, the Nurse President, found resid with minimal chest or chest x ray. The Nurse President, found resid with minimal chest or chest x ray. The Nurse effusions in lungs. Roon antibiotics.  Specify the action the process or system far adverse outcome from and when the action  On 8-18-21, Regional Operations (RVPO) of (ED) on legal guardia pertained to	arn. Nurse #2 checked or residual contents and rese #2 administrated a bolus visician orders at an on 8/14/21. On 8/16/21 guardian called the facility ministrator Resident#1 had 4/21 with a friend without her not with someone other than Legal Guardian revealed at the festival had told her been seen eating and and to be unsupervised. On reactitioner assessed ent to have mild tachycardia ongestion, and ordered a see Practitioner received the rays on 8/20/21 and dent #1 had bilateral pleural esident #1 was then started entity will take to alter the illure to prevent a serious m occurring or reoccurring will be completed.  Al Vice President of educated Executive Director and and residents' rights, as ardians. On 8-20-21 ducated the department of the Social Services the nursing and ancillary staff	F 5	51		

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345329	B. WING		C 09/07/2021	
OVIDER OR SUPPLIER	D HEALTHCARE		2030 HARPER AVENUE NW	1 03/07/2021	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
notified for such me Absence requests. Absence for a resid be witnessed by 2 seresident's medical resident's Legal Gurof absence will also members and documedical record. Ad has placed a notificarecord, hard paper ("Demographics" tabout/sign in book (loodesk) to indicate the Legal Guardian are or leave of absence notification to and condition of the Guardians. Resider going out on LOA, which is the legal Guardians are or leave of absence notification to and condition of the condition of the condition of the condition of the cord, upon Reside ED/DON/ Assistant educated current lice 08/18/2021 that reserturn from LOA for Resident's physician of an acute change	dical, financial, and Leave of The approval for a Leave of ent with a Legal Guardian will staff members and noted in the ecord. Disapproval by the ardian for a requested leave be witnessed by 2 staff mented in the resident's ditionally, the ED/SS Director ation in the electronic medical chart under the o, as well as in the LOA signicated at the receptionist's at identified residents with a not to make medical, financial edecisions without the onsent from their Legal ants/Responsible Party, when will be educated by the arding their prescribed diets, and the rapeutic diets, along strictions to validate an anat the resident can or cannot on LOA. Licensed Nurses he above, to include the discussion in the medical ent's Leave of Absence.  Director of Nursing (ADON) bensed nursing staff on idents will be assessed upon an acute change in condition. In will be immediately notified	F 55	,		
	OVIDER OR SUPPLIER  REHABILITATION AN  SUMMARYS (EACH DEFICIENT REGULATORY OF The Property of	345329	OVIDER OR SUPPLIER  REHABILITATION AND HEALTHCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  notified for such medical, financial, and Leave of Absence requests. The approval for a Leave of Absence for a resident with a Legal Guardian will be witnessed by 2 staff members and noted in the resident's medical record. Disapproval by the resident's Legal Guardian for a requested leave of absence will also be witnessed by 2 staff members and documented in the resident's medical record. Additionally, the ED/SS Director has placed a notification in the electronic medical record, hard paper chart under the "Demographics" tab, as well as in the LOA sign out/sign in book (located at the receptionist's desk) to indicate that identified residents with a Legal Guardian are not to make medical, financial or leave of absence decisions without the notification to and consent from their Legal Guardians. Residents/Responsible Party, when going out on LOA, will be educated by the Licensed Nurse regarding their prescribed diets, to include specialized and therapeutic diets, along with their dietary restrictions to validate an understanding of what the resident can or cannot consume while out on LOA. Licensed Nurses were educated on the above, to include documentation of the discussion in the medical record, upon Resident's Leave of Absence.  ED/DON/ Assistant Director of Nursing (ADON) educated current licensed nursing staff on 08/18/2021 that residents will be assessed upon return from LOA for an acute change in condition. Resident's physician will be immediately notified	OVIDER OR SUPPLIER  REHABILITATION AND HEALTHCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST DE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  F 551  F 551  F 551  Continued From page 15  F 551  Continue	

AND BLAN OF CORRECTION INDESTRUCTION NUMBERS		` '	PLE CONSTRUCTION  IG	COM	(X3) DATE SURVEY COMPLETED	
		345329	B. WING _			C (07/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	09	/07/2021
(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 CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRO  DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 551	she would be responare not educated by Worker will be respoplacing this informati record, hard paper of "Demographics" tab, out/sign in book for reguardian after 8/18/2 was notified of this retailed the resident sign the residents have a before allowing them On 8-20-21, an ad-herormance Improving was held with the Ex Director, DON/ADON	stant Director of Nursing that sible for training the staff that 8/20/21. The facility Social nsible for notifying staff and on in the electronic medical nart under the as well as in the LOA sign ew admissions with a legal 1. The facility Social Worker esponsibility on 08/18/2021. Ided education on 8/20/21 by look to at the medical out notebook to validate if court appointed guardian to leave the facility.  Diec Quality Assurance ement Committee meeting ecutive Director, Medical I, and Social Services diadopt the plan of action to	F 5	51		
	The facility's credible jeopardy removal wit was validated on 8/2 The Administrator rewas provided to her President of Operation ensure LG's were calleave and that training	allegation for immediate h the correction date 8/21/21 7/21. vealed an initial in-service				
	· ·	nist. Review of the education im DON for staff included the : Residents with an				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING _			C <b>09/07/2021</b>
	ROVIDER OR SUPPLIER	D HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2030 HARPER AVENUE NW LENOIR, NC 28645		03/01/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 551	Continued From pa	ge 17	F 5	51		
	make decisions for of absence and the and/or disapproval wand documented in diet education will be completed on 8/20/2 confirmed her, and staff that was comply was related to the faleave for a resident appointed LG. An in she was aware it wand maintain reside a permanent note in sign in/out logbook contact the LG beforthe facility. Interview revealed they were residents medical reprovide notification could leave and to president's diet and unchange of condition concerns were note above. Interviews were note above. Interview in the facility's process appointed LG wants sign in/out logbook work other resident with a out during 08/2021. Performance Improvidentified a resident facility without approvidentified a resident facility without approvidenti	ardian (LG) are unable to themselves regarding leaves LG will be notified; approval will be witnessed by 2 staff their medical record; special e provided upon leave 21. The interim DON the DON provided training to eted on 8/20/21. The training acility's process for approval of deemed incompetent with an terview with the SW revealed as her responsibility to notify into with an appointed LG with a their hard chart and in the triggering facility staff to be the resident could leave as conducted with nurses responsible for checking the ecord for guardianship and to the LG before a resident provided education related to a supon return assess for a sund notify the physician if do and to document all the sith Nursing staff, Department anagement Office staff, and the edith were able to define sident to be deemed as to be deemed and found no an appointed LG were signed as Quality Assurance and wement (QAPI) dated 8/20/21 with court appointed LG left boval. The goal was to review the siding with LG. The QAPI				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				_		С	
		345329	B. WING			09/	07/2021
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE		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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	DON, and the Medica records of the 9 residivere reviewed and re-Physician orders we Medication Administrathe resident was not the anyone without permittriggered administering Diet orders were in place to the sign in/out logical desk identified the 9 resident with directions to leaving the building was LG's contact information. The hard chart for the appointed LG contain directions to check with the building with anyocontact information. Notify of Changes (Ing. CFR(s): 483.10(g)(14) Notifical (i) A facility must immonsult with the residuconsistent with his or representative(s) where (A) An accident involves with the residuconsistent in injury and health status in injury and health status in either life-throllinical complications.	ne Administrator, the interim all Director. The medical ents with an appointed LG evealed the following: are transcribed to their ation Record with directions to leave the facility with assion from the guardian and ag staff to initial each shift. acce with instructions for cy of fluids. book kept at the reception residents using a permanent to check with their LG before with anyone and provided the ion. The 9 residents with an ed a permanent note with their LG before leaving one and provided the LG's gury/Decline/Room, etc.)  (i)(i)-(iv)(15)  Cation of Changes. Rediately inform the resident; the entire isponsible to the potential for requiring the resident which as the potential for requiring the resident's physical, ial status (that is, a an, mental, or psychosocial reatening conditions or		551			9/29/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345329	B. WING_		C 09/07/2021
	PROVIDER OR SUPPLIER  Y REHABILITATION AND			STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	1 09/07/2021
(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 SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	a need to discontinue treatment due to adv commence a new for (D) A decision to transesident from the face §483.15(c)(1)(ii).  (ii) When making not (14)(i) of this section all pertinent informatic is available and proviphysician.  (iii) The facility must resident and the reside	e an existing form of erse consequences, or to m of treatment); or usfer or discharge the elity as specified in elity as specified in elity as specified in second in specified in second in paragraph in second and periodically mailing and email) and	F 58	F580  1. Resident #1continues to reside center. Resident #1 was assessed a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING _			l	0 <b>7/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
0.47514/4	/ DELLA DIL ITATIONI AND	UEAL TUOA DE		20	030 HARPER AVENUE NW			
GAIEWAY	REHABILITATION AND	HEALTHCARE		LI	ENOIR, NC 28645			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	e 20	F t	580				
F 580	suspected to consume resulted in delay in the treatment for pneumoreviewed for accident. The findings included Resident #1 was admitted with the following dia dysphagia, bipolar dischizoaffective disord. Review of Resident #1 revealed the following -A diet order for nothing on 6/7/21.  -Enteral feed (intake gastrointestinal tract) feeding bolus via syring Review of the Minimus 6/17/21 assessed Remoderately impaired He required extensive received 51% or great milliliters or greater of tube.  The care plan revised Resident #1 required dysphagia, infection,	ne food and fluids which ne identification and onia for 1 of 3 residents ts.  d:  nitted to the facility on 6/7/21 gnoses: pneumonia, sorder, schizophrenia, der, and dementia.  der, and dementia.  der, and dementia.  five physician orders g: ing by mouth (NPO) written of nutrition via five times a day give tube inge written on 6/7/21.  Jum Data Set (MDS) dated esident #1 cognition as being for making daily decisions. The assistance with eating and five times and 501 and on 6/23/21 identified tube feeding related to and pneumonia. The goal	F	580	treated by the Nurse Practitioner on 8-21 with follow up on 8-20-21 to include chest x- ray and antibiotics, which have been completed as ordered. Resident #1□s plan of care has been reviewed a updated by the Interdisciplinary Team, accordingly, as of 09/20/21.  2. Current residents who have been on Leave of Absence (LOA) in the past days (since 8-14-21) were assessed by the Director of Nursing (DON)/Assistan Director of Nursing (ADON) on 8-18-21 ensure no changes in condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON 8-18-21 to ensure consumption of approved diet, as ordered by the MD wout on LOA in the past 5 days (since 8-21). There were no additional changes condition noted for other identified currersidents, who had gone out on LOA from 8-14-21 through 8-18-21, requiring immediate notification to the MD by the Licensed Nurse for additional orders.  3. ED/DON/ADON educated current licensed nursing staff on 08/18/2021 the residents will be assessed upon return from LOA for an acute change in condition. Resident so physician will be immediately notified of an acute change condition as a result of the pursing condition.	a e and out 55 / t to on while -14- s in ent om		
	or complications related the review date. Interlisten to lung sounds	to remain free of side effects ted to tube feeding through ventions in place included as needed and monitor, t as needed any signs or on.			condition, as a result of the nursing assessment, for further orders. License Nursing Staff members not educated b 8/20/2021 will be educated upon the ne scheduled shift. The Executive Director will be responsible for tracking staff that have completed the education. On	y ext r		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345329	B. WING _	B. WING			C 09/07/2021
NAME OF PR	ROVIDER OR SUPPLIER	L	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	0172021
					030 HARPER AVENUE NW		
GATEWAY	REHABILITATION AND	HEALTHCARE			ENOIR, NC 28645		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 21	F 5	580			
	Review of the facility Resident #1 showed signed out.	sign in/out record for on 8/14/21 at 10:45 he was			8/20/21, the Executive Director provide education to the Assistant Director of Nursing that she would be responsible training the staff that are not educated	for	
	Review of Resident # revealed the following				8/20/21. This education will also be provided to all new employees as part new hire orientation, contract staff and		
	8/19/21.	one time only written on otic medication used to treat			agency staff, this education will be provided prior to starting work.		
	tablet via peg tube or for day 1 to start on 8	750 milligram (mg) give 1 ne time only for pneumonia 8/20/21. c medication used to remove			<ol> <li>Quality Improvement monitoring o notification of residents acute chang of condition will be conducted by the ED/DON 5 times weekly for 4 weeks,</li> </ol>		
	excess fluid from the via peg tube in the at	body) 40 mg give 1 tablet fernoon for pleural effusions a space between the lungs			then 3 times weekly for 4 weeks, then time weekly for 4 weeks, and then 1 time monthly for 3 months. to ensure the		
	and chest wall) for 3	days to start on 8/20/21.			following: a) Resident is assessed by licensed nurse upon return from LOA for an acute change in condition b)		
	PM with the Director explained the Admini	of Nursing (DON). The DON strator was notified by			Resident⊡s physician is immediately notified of an acute change in condition		
	suspected of consum a festival. After being				as a result of the nursing assessment, further orders. Results of Quality Improvement monitoring will be reported	ed	
	#1. The DON stated for signs and sympto wheezing, difficulty in	the DON to assess Resident she assessed Resident #1 ms of aspiration such as n breathing, and congestion 8/19/21. The DON revealed			to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan.		
		nd nothing abnormal notify the Nurse Practitioner number the facility became aware.			5) As of 09/29/2021 the corrective actions will be completed.		
	NP revealed she bed suspected of consum surveyor told her on	on 8/20/21 at 10:00 AM the ame aware Resident #1 was ning food or fluids when the 8/18/21. The NP completed gns and symptoms of					

		IDENTIFICATION NUMBER		PLE CONSTRUCTION  G	COMI	COMPLETED	
		345329	B. WING			C / <b>07/2021</b>	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645	1 03	10112021	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 580 F 684 SS=D	aspiration and found tachycardic (abnormal minimal chest conges x-ray. On 8/20/21 the chest x-ray results are bilateral pleural effusion the lower lobes likely revealed she ordered medications for treatrestated she would expon 8/16/21 when they was suspected of eath A second interview w 8/20/21 at 3:57 PM. Indetermine Resident # stated there was a define was suspected of and if notified on 8/16 made aware the NP stated aware the NP stated aware the NP stated aware the Albandard awa	Resident #1 to be slightly ally high heart rate) with stion and ordered a chest. NP received Resident #1's and explained there was ions meaning pneumonia in due to aspiration and antibiotic and diuretic ment of pneumonia. The NP leet the facility to notify here to became aware Resident #1 ling and drinking.  The NP stated she could not the spirated on 8/14/21 but leave in the notification when consuming food or fluids 6/21 when the facility was stated she would have 1 for signs and symptoms of the NP also stated it was notification and treatment the outcome and Resident #1 tic from having pneumonia.  The NP also stated it was notification and treatment the outcome and Resident #1 tic from having pneumonia.	F 58			9/29/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345329	B. WING			C 09/07/2021	
NAME OF P	ROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP COD		9/01/2021	
	10115211 011 001 1 2.2.1			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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	e 23	F 68	34			
	Based on record rev	iew, interviews with the staff,		F684			
		e Legal Guardian, and the					
		e facility failed to provide		Resident #1continues to			
		s for a resident (Resident		center. Resident #1 was asse			
		to receive nothing by mouth		treated by the Nurse Practition			
		d he consumed food and		21 with follow up on 8-20-21 t			
		val for 1 of 3 residents		chest x- ray and antibiotics, w			
	reviewed for accident	ts.		been completed as ordered.			
	The first and the state of	1.		#1 □s plan of care has been re			
	The findings included			updated by the Interdisciplinal accordingly, as of 09/20/21.	ry leam,		
		nitted to the facility on					
		wing diagnoses: pneumonia,		Current residents who ha			
		sorder, schizophrenia,		on Leave of Absence (LOA) ir	-		
	schizoaffective disord	der, and dementia.		days (since 8-14-21) were ass the Director of Nursing (DON)			
	Review of Resident #	<sup>£</sup> 1's physician orders		Director of Nursing (ADON) or			
	revealed the following			ensure no changes in condition			
		ng by mouth (NPO) written		result. Residents on specializ			
	on 6/7/21.			were reviewed by the ED/DOI			
	-Enteral feed (intake			8-18-21 to ensure consumption			
		five times a day give tube		approved diet, as ordered by			
	feeding bolus via syri	nge written on 6/7/21.		out on LOA in the past 5 days	•		
				21). There were no additiona	-		
		um Data Set (MDS) dated		condition noted for other ident			
		esident #1 cognition as being		residents, who had gone out of			
		for making daily decisions.		8-14-21 through 8-18-21, requ			
		e assistance with eating and		immediate notification to the M	•		
	_	ater of his calories and 501		Licensed Nurse for additional	orders.		
	_	f fluids through a feeding		2 FD/DON/ADON advantas	-l		
	tube.			3. ED/DON/ADON educated			
	The care plan revises	d on 6/23/21 identified		licensed nursing staff on 08/1 residents will be assessed up			
		d on 6/23/21 identified tube feeding related to		from LOA for an acute change			
		and pneumonia. The goal		condition. Resident □s physici			
		to remain free of side effects		immediately notified of an acu			
		ted to tube feeding through		condition, as a result of the n	-		
		ventions in place included		assessment, for further orders			
		III piaco illoladoa			u	I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	345329		B. WING			C 09/07/2021		
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0172021	
					030 HARPER AVENUE NW			
GATEWAY	REHABILITATION AND	HEALTHCARE			ENOIR, NC 28645			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 684	Continued From page	e 24	F 6	684				
	listen to lung sounds as needed and monitor, document, and report as needed any signs or symptoms of aspiration.				Nursing Staff members not educated b 8/20/2021 will be educated upon the no scheduled shift. The Executive Directo will be responsible for tracking staff tha	ext r		
		sign out and sign in records ed he was signed out on			have completed the education. On 8/20 the Executive Director provided educat to the Assistant Director of Nursing tha she would be responsible for training the	0/2, tion t		
	made as a late entry Director of Nursing (E read in part: "Temper Respirations 18; and	note dated 8/16/21 was created on 8/19/21 by the OON). The progress note			staff that are not educated by 8/20/21. This education will also be provided to new employees as part of new hire orientation, contract staff and agency staff, this education will be provided pri to starting work.			
	not noted and is NPC GI complaints are not bowel sounds are wit Respiratory status is breath noted, lung so cough noted, and oxy were no other assess set of vital signs or lu status after the late e	n, place, and time. Swallowing problems are ted and is NPO with feeding tube in place. Inplaints are none and abdomen is soft and sounds are within normal limits. In atory status is clear with no shortness of noted, lung sounds are clear with no noted, and oxygen is not in use." There are other assessments that included a full wital signs or lungs sounds or respiratory after the late entry note created on 8/16/21 coate nurses assessed Resident #1 for			4. Quality Improvement monitoring or notification of residents □ acute change of condition will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times weekly for 4 weeks, then time weekly for 4 weeks, and then 1 times weekly for 3 months. to ensure the following: a) Resident is assessed by a licensed nurse upon return from LOA for an acute change in condition b) Resident □s physician is immediately notified of an acute change in condition	es 1 ne a or		
	PM with the Family M The FM revealed he a 8/14/21 and saw Res revealed Resident #1 that served beer, sod a cup containing a liq appeared to be bread interact with Resident	ident #1 there. The FM was walking from a building a, and food and was holding uid in one hand and what I in the other. The FM didn't t #1 but did observe him for tes and revealed he did not			as a result of the nursing assessment, further orders. Results of Quality Improvement monitoring will be reported to the Quality Improvement Committee monthly for 6 months continued compliance and/or revision. The Executive Director is responsible for implementing this plan.  5) As of 09/29/2021 the corrective actions will be completed.	for		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:			PLE CONSTRUCTION  IG	СОМІ	(X3) DATE SURVEY COMPLETED		
		345329	B. WING			C /07/2024	
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP CODE  2030 HARPER AVENUE NW  LENOIR, NC 28645		/07/2021	
(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 CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 25	F 6	84			
	PM with the Legal G The LG revealed Re incompetent with a h failed 3 swallow stud tube. The LG revealed informed by a FM it w had been eating and on 8/14/21. The LG facility on 8/16/21 ar of the suspicions.  During an interview of Administrator revealed Resident #1 was sus on 8/16/21 when his Administrator revealed to complete an assess  During an interview of DON revealed she as signs of aspiration of Administrator was in he was suspected of a festival on 8/14/21 assessment included she checked for abn stated his lung sound no changes of condi- readings.  A second interview of 5:04 PM with the DO on eye on Resident is symptoms of aspirat difficulty of breathing was unable to provide	ed she then asked the DON ssment of Resident #1. on 8/18/21 at 4:38 PM the ssessed Resident #1 for					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345329	B. WING	B WING		C 09/07/2021	
	ROVIDER OR SUPPLIER  'REHABILITATION AND	l		S 2	STREET ADDRESS, CITY, STATE, ZIP CODE 030 HARPER AVENUE NW LENOIR, NC 28645	1 09/	07/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	she personally did the when she encountered check on him. The Dodocument her assess.  An interview was con PM with Nurse #4. Note on first shift and was Resident #1. Nurse # Resident #1's lung soft temperature. Nurse # was suspected Resident gluids when at a festive for signs of aspiration report anything relate Resident #1's oncome.  An interview was con PM with Nurse #5. Nower was a suspected Resident #1's oncome.  An interview was con PM with Nurse #5. Nower was a suspected Resident #1's oncome.  An interview was con PM with Nurse #5. Nower was a suspected Resident #1's oncome.  An interview was con PM with Nurse #5. Nower was a suspected Resident #1 was deed to check his I aspiration or it was soft ood or drank fluids we have a suspiration or it was soft of the worked from 8 AM to unsuccessful.  During an interview on Nurse Practitioner (Nower was a suspiration or it was deed to the worked from 8 AM to unsuccessful.  During an interview of Nurse Practitioner (Nower was a suspiration or it was deed to check his I aspiration or it was suspiration or it was sus	and vital signs and stated assessments every day and Resident #1 and would DN revealed she did not aments.  ducted on 8/20/21 at 5:38 ares #4 worked on 8/17/21 responsible for the care of 4 did not recall checking bunds but did check his 4 stated no one told her it ent #1 consumed food or ral nor asked her to monitor in Nurse #4 stated she didn't do assess for aspiration to ing nurse.  ducted on 8/20/21 at 6:50 ares #5 explained she om 11 PM to 7 AM. Nurse #5 or Resident #1 went out of and no one told her she ungs sounds for possible aspected he had consumed when at the festival.  erview the Nurses who 11 PM on 8/16/21 were  n 8/18/21 at 1:19 PM the P) revealed she was aware med incompetent with a LG. esident #1 received nothing agnosis of severe dysphagia wing) and stated he would make good decisions about	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345329	B. WING			07/2021	
NAME OF PROVIDER OR SUPPLIER		1 7	STREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	01/2021	
GATEWAY REHABILITATION AND	UEALTUCADE		2030 HARPER AVENUE NW			
GATEWAY REHABILITATION AND	HEALINGARE		LENOIR, NC 28645			
PREFIX (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	(X5) COMPLETION DATE	
risk for aspiration pneh is death. The NP was suspected of conwhen at a festival untithe surveyor. The NP was suspected of eat be notified, and she was listen to his lung soun signs for at least 2 dat to her list of residents her to assess.  F 835 SS=J  CFR(s): 483.70  §483.70 Administration CFR(s): 483.70  §483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, well-being of each restrict This REQUIREMENT by:  Based on record revitlegal Guardian (LG), Nurse Practitioner (NI to provide oversight and Department Heads (Deffectively communicate assigned legal guardian guardian's directive to authorized persons was resident (Resident#1)  Immediate Jeopardy of the facility's administric communicate to DH and the surveyor communicate to DH and the surveyor.	or drink it would put him at eumonia which could lead to as not aware Resident #1 assuming food and drinks il 8/18/21 after being told by a stated if the facility knew he ing and drinking, she should would've had the nurses ands and obtain full set of vital ays and request he be added to see on her next visit for a maintain the highest mental, and psychosocial sident.  To is not met as evidenced itew and interviews with the resident, staff, and the P), the administration failed and leadership to onto the property of the		F835  1. Resident #1continues to reside a center. Resident # 1 selectronic medical record, hard paper chart und the Demographics tab, and the Leav. Absence sign out/ sign in book were updated by the ED/SS director to ind that Resident #1 has a Legal Guardia and that resident is not to make med financial or leave of absence decision without the notification to and conser from the Legal Guardian. Resident #	er e of icate an, cal, ns	9/29/21	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
	345329		B. WING _				C / <b>07/2021</b>	
NAME OF PI	ROVIDER OR SUPPLIER			S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0172021	
					030 HARPER AVENUE NW			
GATEWAY	REHABILITATION AND	HEALTHCARE			ENOIR, NC 28645			
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFI) TAG	Х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 835	Continued From pag	e 28	F 8	835				
F 835	communicate the LG could not leave the fa person. The failure of communicate LG dire and other residents a injury. Immediate Jee 9/4/21 when the facility a lower scope and se with a potential for modern complete education a systems put into place. The findings included The citation was cross. Based on record revit Legal Guardian (LG) Nurse Practitioner (Ninstructions from the to leave the facility was lated pneumonia. This situresidents reviewed for the Administrator was jeopardy on 9/2/21 a	's directives that a resident acility with an unauthorized f administration to effectively ectives placed Resident #1 at risk for harm or serious opardy was removed on ity provided and eptable credible allegation for remains out of compliance at everity of D (no actual harm inimal harm that is not IJ) to and ensure monitoring se were effective.  It:  It:  It:  It:  It:  It:  It:  It	F &	835	assessed and treated by the Nurse Practitioner on 8-18-21 with follow up of -20-21 to include a chest x- ray and antibiotics, which have been completed ordered. Resident #1 □s plan of care have been reviewed and updated by the Interdisciplinary Team, accordingly, as 09/20/21.  2. Executive Director (ED)/Social Services (SS) Director identified 9 residents with legal guardians on 8-18-as those residents who are unable to make decisions for themselves regardileaves of absence from the center.  Current residents have been reviewed the ED/SS Director on 8-18-21 to ensut that they have not been out on leave of absence without permission from their legal guardians. Also, current resident who have been out on Leave of Absence (LOA) in the past 5 days (since 8-14-2) were assessed by the Director of Nursing (ADON) on 8-18-21 to ensure no changin condition, as a result. Residents on specialized diets were reviewed by the ED/DON/ADON on 8-18-21 to ensure consumption of approved diet, as order by the MD while out on LOA in the past days (since 8-14-21). There were no	d as as as of 21 ng by re f sce 1) ng ges		
	removal plan with the A brief summary of th	e correction date of 9/4/21.  ne allegation:			additional changes in condition noted for other identified current residents, who ligone out on LOA from 8-14-21 through	nad 8-		
	guardian of Resident he was not allowed to	e Social Services Director spoke with the ardian of Resident #1 and was informed that was not allowed to leave the facility on 4/2021 to attend a festival. However, the			18-21, requiring immediate notification the MD by the Licensed Nurse for additional orders. The 9 residents with guardian have been validated that the current plan of care is accurate.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
	<b>345329</b> B. WING			09/0	07/2021			
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				20	030 HARPER AVENUE NW			
GATEWAY	REHABILITATION AND	HEALTHCARE		L	ENOIR, NC 28645			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 835	Continued From page	<del>2</del> 9	F	335				
	Social Service Director	or did communicate to some						
	but not all of the depart	artment heads during stand			3. The Regional Vice President of			
	· ·	f Nursing was unaware of			Operations (RVPO) educated the ED o	n		
		guardian and allowed the			09/02/2021 in regards to effective			
		f the facility and go to the			communication pertaining to the			
	-	Other direct care staff were			administrative staff being informed duri	na		
		dian's directives because it			the facility⊡s daily stand up and stand	9		
		nicated to them by any			down meetings on residents with			
	department head.	,			guardians and the directives given by t	hat		
	'				guardian concerning their resident. If a			
	Identify those recipier	nts who have suffered, or			department head is not in attendance,			
		ous adverse outcome as a			email and phone call will be made to th			
	result of the non-com				department head by the ED or designe			
		F			to inform them of the most recent	-		
	Executive Director (E	D)/Social Services (SS)			changes to the resident□s plan of care			
	•	esidents with legal guardians			during morning meeting. The departme			
		residents who are unable to			head will notify their staff of residents w			
	make decisions for th	emselves regarding leaves			guardians and inform them of the			
		center. Current residents			guardian⊡s directive concerning the			
	have been reviewed I	by the ED/SS Director on			resident. The DON or designee will use	<u>ڊ</u>		
	8-18-21 to ensure that	it they have not been out on			on-shift (internal staffing communicatio	n		
	leave of absence with	out permission from their			platform) to send a notification to direct			
	legal guardians. Also	o, current residents who			care staff, which includes agency staff			
	have been out on Lea	ave of Absence (LOA) in the			upon knowledge of the change in plan	of		
	past 5 days (since 8-	14-21) were assessed by the			care. On the weekend, the Customer			
	Director of Nursing (D	OON)/Assistant Director of			Service Liaison (CSL) who is a current			
	Nursing (ADON) on 8	-18-21 to ensure no			department head will ensure that staff a	are		
	changes in condition,	as a result. Residents on			aware of the residents with guardians a	and		
	specialized diets were	e reviewed by the			directives given by the guardians			
	ED/DON/ADON on 8-	-18-21 to ensure			concerning their residents .When			
		oved diet, as ordered by the			concerns are identified, the			
		in the past 5 days (since			CSL/Department Head will notify the E	D		
	•	e no additional changes in			immediately.			
	condition noted for ot							
	residents, who had go				The ED will educate the administrative			
		-21, requiring immediate			staff on 09/03/2021 in regards to effect	ive		
	notification to the MD	by the Licensed Nurse for			communication pertaining to the			
	additional orders. All	9 residents with a guardian			administrative staff being informed duri	ng		
	have been validated t	that the current plan of care			the facility⊡s daily stand up and stand			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345329	B. WING		C 09/07/2021		
NAME OF PE	ROVIDER OR SUPPLIER	0.0020	<del> </del>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 09/	0772021
TVAINE OF T	TO VIDER OR OUT FIER						
GATEWAY	REHABILITATION AND	HEALTHCARE			HARPER AVENUE NW		
				LENC	DIR, 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 835	Continued From page	30	F 8	35			
F 835	is accurate.  Specify the action the process or system fair adverse outcome from and when the action of the Regional Vice Process (RVPO) educated the regards to effective of the administrative state facility's daily stand upon residents with guardient given by that guardiant if a department head email and phone call department head by the most recent changes care during morning repeated will notify their substitutes guardians and inform directive concerning the designee will use one communication platfor direct care staff which knowledge of the challenge of the	entity will take to alter the lure to prevent a serious in occurring or reoccurring will be completed.  esident of Operations ED on 09/02/2021 in communication pertaining to ff being informed during the property and stand down meetings radians and the directives in concerning their resident, its not in attendance an will be made to that the ED to inform them of the to the resident's plan of the eto the residents with them of the guardian's the resident. The DON or shift (internal staffing rm) to send a notification to includes agency staff uponinge in plan of care. On the er Service Liaison (CSL)	F8	gradu el de	own meetings on residents with uardians and the directives given by tour diance concerning their resident. If a separtment head is not in attendance, mail and phone call will be made to the partment head by the ED or designed inform them of the most recent thanges to the resident splan of care turing morning meeting. The department head will notify their staff of residents would uardian and inform them of the uardian staffing communication atternance to the concerning the esident. The DON or designee will use the sident. The DON or designee will use the sident of the communication atternance to the change in plan are. On the weekend, the Customer ervice Liaison (CSL), who is a current epartment head, will ensure that staff ware of the residents with guardians a frectives given by the guardians concerning their residents. When concerns are identified, the instruction of the concerns are identified, the concerns are identified at the concerns are identified.	an an ant ant ant ant ant ant ant ant an	
	staff are aware of the			re w w fo	Quality Improvement monitoring of esidents with regard to communication will be conducted by the ED/DON 5 times weekly for 4 weeks, then 3 times week or 4 weeks, then 1 time weekly for 4 weeks, and then 1 time monthly for 3 months. to ensure the following: a) The	n nes ly	
	09/03/2021 in regards pertaining to the admi informed during the fa	he administrative staff on s to effective communication inistrative staff being acility's daily stand up and on residents with guardians		ao fa m th	dministrative staff is informed during t acility⊡s daily stand up and stand dow neetings on residents with guardians a ne directives given by the guardian oncerning their resident. b) When a	he ⁄n	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X:	(X3) DATE SURVEY COMPLETED	
	345329		B. WING _			C 09/07/2021	
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE				STREET ADDRESS, CITY, STATE, ZIP COD 2030 HARPER AVENUE NW LENOIR, NC 28645	)E	00/01/2021	
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 835	and the directives gi concerning their resinot in attendance armade to that departrinform them of the mesident's plan of ca The department hear residents with guard guardian's directive DON or designee wistaffing communicat notification to direct agency staff upon krylan of care. On the Service Liaison (CSI department head will of the residents with given by the guardia Any concerns identification by the guardia Any concerns identification to direct was validated on 9/7 completed revealed system put into place LG and their directive role was to ensure E residents with a LG directives were delived uring stand up and a follow up email and staff received the mediant of the resident with DH sto explain how they directives and their residents with the residents with the sto explain how they directives and their residents and their residents with the sto explain how they directives and their residents and their residents with the sto explain how they directives and their residents and their residents with the sto explain how they directives and their residents with the storest and the storest an	ven by the guardian dent. If a department head is a email and phone call will be ment head by the ED to nost recent changes to the re during morning meeting. d will notify their staff of ians and inform them of the concerning the resident. The II use on-shift (internal ion platform) to send a care staff which includes nowledge of the change in weekend the Customer L) who is a current I ensure that staff are aware guardians and directives ins concerning their residents. Fied the CSL/Department ED immediately.  J removal effective date  a allegation for IJ removal (7/21. Review of the education the ED received training on a set to identify residents with a less. The ED explained her of the staff were aware of and information pertaining to the ered upon receipt to DH staff stand down meetings and/or diphone call to ensure all DH opting to date information. Staff revealed they were able were kept up to date with	F 8	department head is not in atte email and phone call is made department head by the ED to them of the most recent chan resident splan of care during meeting. c) The department notifies their staff of residents guardians to inform them of the guardian staffing complatform) to send a notification care staff, which includes age upon knowledge of the chang care. e) On the weekend, the Service Liaison (CSL), who is department head, will ensure aware of the residents with guardianet their residents. f) concerns are identified, the CSL/Department Head notified immediately. Results of Quali Improvement monitoring will to the Quality Improvement Comonthly for 6 months continuation compliance and/or revision. Executive Director is responsimplementing this plan.  5) As of 09/29/2021 the cactions will be completed.	e to that o inform iges to the g morning head s with he ining the nee uses munication in to direct ency staff ge in plan of Customer is a current that staff are uardians and ians When es the ED ity be reported committee ued The sible for	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345329		B. WING			C 09/07/2021		
NAME OF PROVIDER OR SUPPLIER  GATEWAY REHABILITATION AND HEALTHCARE				STREET ADDRESS, C 2030 HARPER AVEN LENOIR, NC 2864		1 09/	0772021
(X4) ID PREFIX TAG			ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 835	staff received the mosi information pertaining directives put in place were conducted with staff to confirm they were conducted with staff to confirm they were conducted legal guardia residents residing at the During an interview of revealed she received Regional Vice Preside to the process for confirm and to discuss resided directive during stand meetings. If a DH was ED's responsibility to phone call to ensure information was received was the responsibility staff and the Director responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send a text requesting then the DH's responsible for the nuincluding agency staff send at text requesting the nuincluding agency staff send	st current up to date g to a resident 's specific g by their LG. Interviews newly hired and direct care were aware where and how anship information for the facility.  In 9/7/21 at 2:53 PM the ED d education from the ent of Operations pertaining municating with DH staff ints with changes to their if up and stand down is not present it was also the notify them via email and the most current directive wed. The ED explained it of each DH to notify their of Nursing would be ursing and/or direct care staff of using an on-shift system to g staff see their DH. It was sibility to inform their staff of citives put in place by a D also revealed their ad-hoc e root cause of LG	F	35			