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 04/23/2015

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 Nodeficiencies were cited as a result of the complaint investigation Event ID #4W0G11.	F 000		
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to	F 159		5/21/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/15/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING ______ B. WING ______	C 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 159

Continued From page 1

the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and resident and staff interviews, the facility failed to provide access to resident funds on weekends for 2 of 2 sampled residents who had personal fund accounts managed by the facility. (Residents #25 and #94).

The findings included:

1. On 04/22/15 at approximately 12:15 PM an orange sign regarding personal fund accounts was observed on an office window, located in the facility lobby, posting banking hours from 9:00 AM-10:00 AM and 2:00 PM to 5:00 PM Monday through Friday. No further information was posted on the sign about money being available on weekends.

Resident #35 was admitted to the facility on 03/25/13. A recent Minimum Data Set dated 01/02/15 indicated Resident #35 was cognitively intact for daily decision making and was usually able to understand and usually able to make herself understood.

F 159

This plan of correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal Law.

F 159

1. On 4/27/15 both Resident #35 and Resident #94 were informed verbally and in writing by the Executive Director resident funds are available on weekends from the hours of 2:00 - 5:00 pm. Residents were notified to request any funds needed from their Charge Nurse or Facility Manager On Duty.

2. All residents and responsible parties were notified via letter dated 5/14/15 of the facility daily banking hours; including banking hours on the weekends. A sign

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 159

Continued From page 2

On 04/21/15 at 9:05 AM an interview was conducted with Resident #35. She stated she cannot get money from her personal funds account on the weekends because the posted sign on the front office window noted banking hours only Monday through Friday.

On 04/23/15 at 3:33 PM an interview was conducted with the Assistant Business Office Manager (ABOM). The ABOM stated a resident and/or responsible party
must sign an agreement to open a trust fund account. The resident or responsible party had been told money would be available Monday through Friday from 8:00 AM to 4:30 PM. The ABOM said if a resident required money for the weekend they needed to request the money during the week.

On 04/23/15 at 4:51 PM an interview was conducted with the Administrator. The Administrator stated the facility kept a locked box containing $25 if the residents needed money on weekends. She stated this information was shared with residents that attended a Resident Council Meeting. When the Administrator found the Resident Council Meeting minutes she realized this occurred in 2013 and no further information had been provided to residents.

2. On 04/22/15 at approximately 12:15 PM an orange sign regarding personal fund accounts was observed on an office window, located in the facility lobby, positing banking hours from 9:00 AM -10:00 AM and 2:00 PM to 5:00 PM Monday through Friday. No further information was posted on the sign about money being available on weekends.

F 159

has been placed in the facility lobby noting banking hours for the facility.

3. All new admissions admitted to the facility from 5/15/15 and ongoing will be notified via letter upon admission informing them of facility banking hours. Resident's and/or Responsible Parties will sign an acknowledgment of their understanding of the facility's banking hours. An audit will be completed by the Executive Director and/or BOM of each admission file to assure notification to Resident and/or Responsible Party. This audit will be completed on all new admission (after 5/15/15) for four weeks and then a monthly audit will be completed with a sample size of five new admissions per month for the next three months; then randomly thereafter.

4. The results of these audits will be reported to the Quality Assurance Performance Committee monthly by the Executive Director and/or the Business Office Manager for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Committee will evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make any changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Social Services Director, Activities Director,

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 159	Continued From page 3 Resident #94 was admitted to the facility on 09/25/13. A recent Minimum Data Set dated 03/30/15 indicated Resident #94 was cognitively intact for daily decision making and was usually able to understand and usually able to make himself understood. On 04/21/15 at 10:58 AM an interview was conducted with Resident #94. He stated the business office was closed on the weekends and he could not get any money from his personal funds account. On 04/23/15 at 3:33 PM an interview was conducted with the Assistant Business Office Manager (ABOM). The ABOM stated a resident and/or responsible party must sign an agreement to open a trust fund account. The resident or responsible party had been told money would be available Monday through Friday from 8:00 AM to 4:30 PM. The ABOM said if a resident required money for the weekend they needed to request the money during the week. On 04/23/15 at 4:51 PM an interview was conducted with the Administrator. The Administrator stated the facility kept a locked box containing $25 if the residents needed money on weekends. She stated this information was shared with residents that attended a Resident Council Meeting. When the Administrator found the Resident Council Meeting minutes she realized this occurred in 2013 with no further information provided to residents.	F 159	Maintenance Director and the Minimum Data Set Assessment Nurse.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE	F 274		5/21/15

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 274

Continued From page 4

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set (MDS) assessment for 2 of 4 residents sampled for MDS review related to decline in 5 areas of functional status, bladder and bowel incontinence frequency, significant weight loss, and admission to hospice services. (Residents #139 and #43).

The findings included:

1. Resident #139 was admitted to the facility 11/26/14 with diagnoses which included end stage renal disease.

An admission Minimum Data Set (MDS) dated 12/03/14 indicated Resident #139 presented with memory loss and demonstrated moderate cognitive impairment with decision making. The MDS specified the resident required extensive

F 274

F 274

1. It is the practice of this facility to conduct a comprehensive assessment of a resident within 14 days after the facility determines there has been a significant change in the resident's physical or mental condition. Resident #139 will continue to receive full staff assistance with locomotion, toileting and personal hygiene and extensive staff assistance with eating. Resident #139 continues to be incontinent of bowel and bladder and weight has stabilized. Resident #43 continues to be moderately cognitively impaired and is receiving hospice services at the facility.

2. An audit of all current residents was completed 5/11/15 by the Director of

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 274

Continued From page 5

staff assistance for locomotion on and off the unit, toilet use, and personal hygiene and limited staff assistance with eating. The MDS further specified Resident #139 was frequently incontinent of bladder and bowel and weighed 176 pounds.

Resident #139 was readmitted 01/06/15 following an admission to the hospital and a new diagnosis of a cerebral vascular accident (stroke).

A quarterly MDS dated 03/05/15 indicated Resident #139 presented with memory loss and demonstrated moderate difficulty in making decisions in new situations. The MDS specified the resident was totally dependent upon staff assistance for locomotion on and off the unit, toilet use, and personal hygiene and required extensive staff assistance for eating. The MDS further specified Resident #139 was always incontinent of bladder and bowel and weighed 136 pounds which was a 22.7% weight loss since the December MDS weight assessment.

An interview was conducted with the MDS Coordinator on 04/23/15 at 2:16 PM. The MDS Coordinator stated she observed Resident #139 on a daily basis and had not noticed any major changes in function or cognition. She stated she had not thought of this resident demonstrating a significant change. The MDS Coordinator stated when she saw the December and the March MDS assessments and the decline in function on paper she should have done a significant change assessment.

2. Resident #43 was admitted to the facility on 08/01/14. Diagnoses included adult failure to

F 274

Clinical Services, Minimum Data Set Nurse and Social Worker to identify any residents currently in the facility that are receiving hospice services or have had a significant change is staff assistance requirements for locomotion, toileting, personal hygiene and eating in the past ninety days. Each identified resident's MDS assessments have been updated to reflect the appropriate physical and/or mental condition and staff assistance needs as required.

3. The Minimum Data Set Nurse will maintain an ongoing "MDS Significant Change Log" beginning 5/15/15 to identify residents with significant changes in the resident's physical or mental condition and a comprehensive assessment will be completed within fourteen days after the facility determines that there has been a significant change in the resident's physical or mental condition. An audit of the "MDS Significant Change Log" will be completed weekly for four weeks, monthly for three months and randomly thereafter by the Director of Clinical Services and/or Social Worker to validate a comprehensive assessment was completed within fourteen days for resident's who had a significant change in physical or mental condition. Licensed Nurses received training by the Director of Clinical Services on identifying and communicating changes in resident's physical or mental condition on 5/14/15. The Minimum Data Set Nurse received training by the Director of Clinical Services on completing a comprehensive

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	**2030 HARPER AVENUE NW LENOIR, NC 28645**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	Continued From page 6 thrive. A medical record review revealed a physician order dated 08/20/14 for a hospice consult. Further review of the medical record revealed hospice services began on 09/18/14. A review of submitted MDS assessments-an admission MDS dated 08/11/14 and a quarterly MDS dated 01/22/15-revealed a significant change MDS assessment had not been completed after Resident #43 began receiving hospice services. A quarterly Minimum Data Set (MDS) dated 01/22/15 indicated Resident #43 was moderately cognitively impaired and received hospice services while a resident of the facility. The care plan revised 01/30/15 indicated Resident #43 was receiving hospice services and goals and interventions were in place. An interview was conducted with the MDS Nurse on 04/22/15 at 10:18 AM. She stated no significant change MDS was completed after Resident #43 began receiving hospice services. She explained a significant change MDS was required when a resident began receiving hospice services, and a significant change MDS should have been completed for Resident #43. An interview was conducted with the Administrator on 04/22/15 at 11:07 AM. She stated she expected a significant change MDS assessment to be completed on any resident who began receiving hospice services. She further explained a significant change MDS assessment should have been completed for Resident #43.	F 274	assessment for identified residents within fourteen days on 5/11/15. The Minimum Data Set Nurse also received training by the Regional Minimum Data Set Nurse Coordinator on 5/15/15 regarding completing a comprehensive assessment for identified residents within fourteen days. Newly hired licensed nurses and Minimum Data Set Nurses will receive education upon hire. 4. The results of the audits completed will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services and/or Assistant Director of Clinical Services fore six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the monitoring tools used for maintaining substantial compliance and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director, and the Minimum Data Set Assessment Nurse.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		5/21/15

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 278 Continued From page 7 F 278

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on record reviews and staff interviews, the facility failed to accurately code a significant change Minimum Data Set (MDS) for 1 of 4 residents sampled for MDS review related to hospice. (Resident #10).
Findings included:
Resident #10 was readmitted to the facility on 10/27/14. Diagnoses included congestive heart failure, heart attack, and weight loss.
A review of the medical record revealed a

F 278

1. It is the practice of the facility to accurately code a significant change Minimum Data Set in Box O100K2 for residents receiving hospice services. Resident #10 continues to receive hospice services and it is indicated on the Minimum Data Set in Box O100K2.

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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 physician order dated 03/12/15 for a hospice consult. Further review of the medical record revealed Resident #10 began receiving hospice care on 03/13/15. A significant change MDS dated 03/29/15 indicated Resident #10 was moderately cognitively impaired. Box O100K2 was not checked, indicating Resident #10 did not receive hospice services while a resident of the facility. The care plan revised 03/31/15 indicated Resident #10 was receiving hospice services and goals and interventions were in place. An interview was conducted with the MDS Nurse on 04/22/15 at 12:38 PM. She stated the reason the significant change MDS was completed was because Resident #10 started receiving hospice services. She explained she must have clicked the wrong box in the computer when completing the resident's significant change MDS. She stated Box O100K2 should have been checked, indicating Resident #10 received hospice services while a resident of the facility. An interview was conducted with the Administrator on 04/23/15 at 2:23 PM. She stated her expectation was for each MDS to be completed accurately.	F 278	2. An audit of all current residents receiving hospice services was completed by the Minimum Data Set Nurse on 5/11/15 to validate the Minimum Data Set indicates the resident is receiving hospice services. 3. The Minimum Data Set Nurse will maintain an ongoing "MDS Significant Change Log" to identify residents receiving hospice services and a comprehensive assessment will be completed within 14 days. An audit of the "MDS significant Change Log" will be completed weekly for four weeks, monthly for three months then randomly thereafter by the Director of Clinical Services and/or Social Worker to validate a comprehensive assessment was completed within fourteen days for resident's receiving hospice services. The Minimum Data Set Nurse received training by the Director of Clinical Services on 5/11/15 and the Regional Minimum Data Set Nurse Coordinator on 5/15/15 regarding completing a comprehensive assessment for residents receiving hospice services within fourteen days. Newly hired Minimum Data Set Nurses will receive education upon hire. 4. The results of the audits will be reported to the Quality Assurance Performance Improvement Committee monthly by the Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement Committee will evaluate 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 04/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9	F 278	effectiveneww of the monitoring tools used for maintaining substantial compliance and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director, and the Minimum Data Set Assessment Nurse.	
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement a renal diet as ordered by the physician for 1 of 5 residents reviewed for nutrition. (Resident #97) The findings included: Resident #97 was admitted to the facility 01/06/15 with diagnoses which included diabetes mellitus, end stage renal disease, hypertension, and history of coronary artery disease. An admission Minimum Data Set dated 01/13/15 indicated the resident's cognition was intact and his vision was severely impaired. A care plan dated 01/13/15 noted Resident #97 was on a therapeutic diet. The care plan goal	F 367	F 367 1. It is the practice of the facility to implement therapeutic diets as prescribed by the Physician. Resident #97 is receiving a Regular, NAS, CCD diet as per the Physician order. The therapeutic renal diet was discontinued on 4/22/15 as per the Physician order. 2. An audit of all residents with a therapeutic diet prescribed by the Physician was completed by the Director of Clinical Services and Dietary Manager on 5/15/15 to validate that the diet ordered is accurate on the meal tray ticket and the resident is receiving the appropriate diet.	5/21/15

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 04/23/2015

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 367	Continued From page 10 was for the resident to comply with the diet through the assessment period ending 04/13/15. Interventions included provide and serve the ordered diet and for Registered Dietician (RD) to evaluate and make diet change recommendations as needed. A review of Resident #97's medical record revealed the resident was readmitted to the facility 04/16/15 following placement of a stent related to a coronary arterial blockage. Included with physician admission orders on that date was an order for a regular, no added salt (NAS), consistent carbohydrate (CCD), renal diet. Continued medical record review revealed a nutrition evaluation written by the RD and dated 04/21/15. The note specified Resident #97 was readmitted to the facility 04/16/15 following stent placement and provided other diagnoses which included end stage renal disease, diabetes mellitus, and coronary syndrome. The RD further specified the resident was on a therapeutic renal, NAS, CCD diet that was appropriate related to diagnoses of end stage renal disease, hypertension, and diabetes mellitus. An observation on 04/22/13 at 11:57 AM revealed Resident #97 received parmesan chicken with tomato sauce, roll, tossed salad, banana pudding, and milk. A review of the tray card that came with the lunch revealed regular, NAS and CCD were listed as diet requirements. The tray card did not indicate a renal diet was part of the order. An interview was conducted with the Dietary Manager (DM) on 04/22/15 at 3:18 PM. The DM was not aware a renal diet had been ordered for Resident #97. The DM found a yellow diet slip in	F 367	3. The Dietary Manager will maintain an updated "Daily Diet Census" to ensure that residents are receiving therapeutic diets as prescribed by the Physician. Licensed Nurses will notify the Dietary Department of Physician prescribed diet orders utilizing the "Dietary Communication" form which will then be updated on the "Daily Diet Census" by the Dietary Manager. An audit will be completed by the Director of Clinical Services for five random residents to validate that the appropriate Physician prescribed diet order is documented on the "Daily Diet Census" and "Dietary Communication" and will physically observe the resident is receiving meal tray as indicated. This audit will be completed weekly for four weeks, monthly for three months and then randomly thereafter. The Dietary Manager and Licensed Nurses received training by the Regional Director of Clinical Services and the Director of Clinical Services on 4/22/15 on appropriate communication and implementation of therapeutic diets as prescribed by the Physician, Newly hired Dietary Managers and Licensed Nurses will receive training upon hire. 4. The results of the audits will be reported to the Quality Assurance Performance Committee monthly by the Director of Clinical Services and/or the Assistant Director of Clinical Services for six months and/or until substantial compliance is obtained. The Quality Assurance Performance Improvement	

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 04/23/2015

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 367	Continued From page 11 Resident #97's medical record that noted the resident's diet order as of 04/16/15 was regular, NAS, CCD, renal diet. The DM stated Resident #97 would have not gotten tomato sauce for lunch and milk was limited to ½ cup per day on a renal diet. During a continued interview at 3:30 PM on 04/22/15 the DM stated she found the diet slip noting the NAS, CCD, renal diet for Resident #97. She stated the new order was misplaced when sent to dietary and the required diet would be corrected. An interview was conducted with the Administrator on 04/22/15 at 5:00 PM. The Administrator stated she expected physician orders for diets were carried out as ordered. The Administrator confirmed the facility acknowledged renal diets when ordered by the physician.	F 367	Committee will evaluate the effectiveness of the monitoring tools for maintaining substantial compliance and make changes to the corrective action if necessary to obtain substantial compliance. The Quality Assurance Performance Improvement Committee members consist of, but not limited to, the Executive Director, Director of Clinical Services, Medical Director, Social Services Director, Activities Director, Maintenance Director, and the Minimum Data Set Assessment Nurse.	