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 _____	R-C 10/24/2023

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 An onsite revisit was conducted on 10/23/23 through 10/24/23. Tags F578, F584, F641, F656, F657, F695, F725, F727, F755 and F761 were corrected as of 10/24/23. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey that was conducted at the time of the revisit. The facility is still out of compliance.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		

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

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 _____	R-C 10/24/2023

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 561	Continued From page 1	F 561		

interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interview the facility failed to honor resident requests for two showers per week (Resident #2 and Resident #4) for 2 of 4 residents reviewed for choices.

The findings included:

1. Resident #2 was admitted to the facility on 01/21/21.

Review of the quarterly Minimum Data Set (MDS) dated 08/07/23 revealed Resident #2 was cognitively intact and required extensive assistance for bathing.

Review of the facility's shower schedule revealed Resident #2 was scheduled for a shower on Mondays and Thursdays on second shift.

Review of the facility shower documentation from 10/01/23 through 10/23/23 revealed no showers were documented as given to Resident #2. The documentation revealed Resident #2 was provided a bed bath instead of shower on the scheduled shower dates of: 10/02/23, 10/05/23, 10/09/23, 10/12/23, 10/16/23, 10/19/23, and 10/23/23.

An observation and interview were conducted with Resident #2 on 10/24/23 at 11:55 AM. Resident #2 was sitting up in bed, her hair, face, and clothing appeared clean. She stated she was supposed to get two showers a week on Mondays and Thursdays, however staff would not take her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	R-C 10/24/2023

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 561	Continued From page 2	F 561		

to the shower room and would only give her a bed bath. She stated she would rather go to the shower room for a shower, but the staff had told her they did not have time to take her for a shower. Resident #2 stated she had told staff she preferred a shower however they still were giving her a bed bath. The interview revealed during the month of October she had not received a shower on her assigned days, only bed baths. She revealed not receiving a shower made her feel dirty and nasty and she rested better when she was able to have a shower and feel clean.

An interview conducted on 10/24/23 at 12:38 PM with Nurse Aide (NA) #9 revealed to her knowledge Resident #2 had only received bed baths over the past month. She stated typically on second shift the staff that were scheduled had to cover two halls a piece and there was not enough time or staff to complete the assigned showers for residents, so most residents received bed baths unless they refused.

An interview conducted on 10/24/23 at 12:45 PM with NA #10 revealed she was familiar with Resident #2 and her preference for showers on second shift. She stated over the past month when she had been assigned to Resident #2's hall she had been assigned to another hall as well and did not have time to provide Resident #2 with her assigned showers. NA #10 revealed when she was not able to provide residents with their scheduled showers, she did offer and provide them with a bed bath.

An interview conducted on 10/24/23 at 1:14 PM with the Director of Nursing revealed the facility

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 _____	R-C 10/24/2023

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 561	Continued From page 3	F 561		

did not have a shower team but if there were extra staff in the building, she would schedule them to do showers. She stated due to a low census they were sending some of the staff home and there might only be one person completing showers but the Nurse Aides on the hall would also be responsible. She stated she didn't know why Resident #2 had not gotten a shower on her scheduled days. The interview revealed showers should be completed as scheduled and per the resident's preference.

2. Resident #4 was admitted to the facility on 06/13/22 with diagnosis which included Parkinson's, neurogenic bladder, and diabetes mellitus.

Review of the quarterly Minimum Data Set (MDS) dated 10/13/23 revealed Resident #4 was cognitively intact and required maximal assistance for bathing. Resident #4 was documented to weigh 337 pounds during the assessment.

Review of the facility's shower schedule revealed Resident #4 was due a shower on Monday's and Thursdays on first shift.

Review of the facility shower documentation from 10/01/23 through 10/23/23. The documentation revealed no showers were documented as given to Resident #4. The documentation revealed Resident #4 received a bed bath on 10/2, 10/4, 10/5, 10/9, and 10/11.

An observation and interview were conducted with Resident #4 on 10/23/23 at 11:21 AM.

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 _____	R-C 10/24/2023

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 561	Continued From page 4	F 561		

Resident #4 was sitting up in bed dressed in a hospital gown. She stated she was supposed to get two showers a week on Mondays and Thursdays, however staff would not take her to the shower room and would only give her a bed bath. She stated she would rather go to the shower room for a shower, but the staff had told her they could not get her on the shower stretcher. She stated she was unable to use the shower chair because of mobility. Resident #4 stated she had told staff she preferred a shower however they still were giving her a bed bath. The interview revealed during the week of 10/16 through 10/19 she had not received a shower on her assigned days but finally was given one on 10/20. Resident #4 stated the Nurse Aide was able to place her on the shower stretcher and give a shower without difficulty, so she did not understand why other staff continued to tell her they could not take her to the shower room.

A facility invoice dated 10/26/22 revealed an order for a bariatric shower bed with a 900-pound weight capacity.
On 10/23/23 at 10:45 AM an observation was conducted of the facility shower room. A bariatric shower bed was observed in the shower room.

An interview conducted on 10/23/23 at 11:32 AM with Nurse Aide (NA) #7 revealed Resident #4 only received bed baths. She stated the facility had a shower team and they had told her that the shower stretcher was not large enough to accommodate Resident #4.

An interview conducted on 10/23/23 at 11:40 AM with NA #3 revealed Resident #4 had told her during the week of 10/16 through 10/19 that she would prefer to have a shower. NA #3 stated she

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 _____	R-C 10/24/2023

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 561	Continued From page 5	F 561		

had taken care of Resident #4 during that week and had not given her a shower or bed bath. She stated she thought the facility had a shower team during that week. The interview revealed no staff members from the shower team had told her they were unable to give Resident #4 a shower or bed bath.

An interview conducted on 10/23/23 at 2:07 PM with NA #8 revealed she was assigned to complete showers for the facility on Resident #4's assigned shower days of 10/16 and 10/19. She stated she was by herself on both days and had up to 20 residents to give a shower to. NA #8 stated she was not able to give Resident #4 a bed bath on her assigned days due to being alone and not having the time during her shift. The interview revealed she thought she told NA #3 that she hadn't given Resident #4 a bed bath but wasn't sure. NA #8 stated she didn't think Resident #4 took showers because she did not fit on the shower stretcher.

An observation and interview were conducted on 10/24/23 at 8:30 AM with Resident #4. She was observed sitting up in the bed dressed in a hospital gown. She stated she felt so good because NA #3 had put her on the shower stretcher on 10/23/23 and gave her a shower. She stated, "that was what I wanted all along".

An interview conducted on 10/23/23 at 9:26 AM with NA #3 revealed she had given Resident #4 a shower on 10/23/23. She stated the shower team had thought Resident #4 was over the weight limit for the shower stretcher and were scared to take her to shower room. The interview revealed she had no issues while giving the resident a shower.

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 _____	R-C 10/24/2023

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 561	Continued From page 6 An interview conducted on 10/24/23 at 1:14 PM with the Director of Nursing revealed the facility did not have a shower team but if there were extra staff in the building, she would schedule them to do showers. She stated due to a low census they were sending some of the staff home and there might only be one person completing showers but the Nurse Aides on the hall would also be responsible. She stated she didn't know why Resident #4 had not gotten a shower on her scheduled days and was not aware the resident had told NA #3 that she wanted a shower last week. The interview revealed showers should be completed as scheduled and per the resident's preference.	F 561		
F 677 SS=G	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide hair care to a dependent resident for 1 of 3 residents reviewed for activities of daily living (Resident #1). Resident #1 was observed with matted hair while waiting to go for an outside Physician appointment. Resident #1 stated the matted hair was painful and she felt like the staff did not care. The findings included: Resident #1 was admitted to the facility on 09/08/22 with diagnoses that included cancer.	F 677		

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 _____	R-C 10/24/2023

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 677	Continued From page 7	F 677		

An annual Minimum Data Set (MDS) assessment dated 08/08/23 indicated Resident #1 was cognitively intact and required extensive assistance of two staff members for personal hygiene and was dependent for bathing. It further indicated no rejection of care or behaviors.

Review of the nurse's progress notes from 09/08/23 through 10/24/23 revealed no notes regarding Resident #1 refusing showers or personal hygiene care. Review of the Nurse Aide (NA's) documentation of the same period revealed no indication Resident #1 refused hair care.

An observation and interview with Resident #1 on 10/24/23 at 10:40 AM revealed Resident #1 sitting in her wheelchair at the nurse's station. Resident #1 stated she was ready and waiting to go to her cancer treatment appointment. The back of Resident #1's hair was observed to matted protruding over the back of the resident's wheelchair. She was observed to have long, thick hair. Resident #1 stated the last time her hair had been washed was 3-4 weeks prior. She stated she knew her hair was matted because she could not brush it herself due to not being able to lift her arms above her head. Resident #1 stated her matted hair caused her scalp and head to hurt all the time on a pain level of 4 on a 0-10 scale. She stated staff had tried to brush it today, but it hurt too bad. The interview revealed she had told staff her hair was matted, and they were aware of it. She stated her husband had even offered to pay to have her hair cut but the facility did not have a hairdresser. Resident #1 stated, "I feel like the staff don't care". Resident #1 then went on to say that it really wasn't the staff's fault because she

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 _____	R-C 10/24/2023

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 677	Continued From page 8	F 677		

had thick hair that needed to be cut and the facility did not have a hairdresser.

An interview conducted with Resident #1's Family Member #1 on 10/24/23 at 10:48 AM revealed he had wanted Resident #1's hair cut for several months. He stated he had talked with the former Administrator of the facility. The interview revealed the former Administrator had told him they did not have anyone to cut her hair but if he wanted to, they would make an area in the beauty shop for him to wash and cut her hair. The family member stated he had medical conditions himself and he was not able to wash Resident #1's hair or cut it.

A review of the undated shower schedule revealed Resident #1 was to receive bathing and personal hygiene twice weekly on Monday and Thursdays during day shift (7AM- 3PM).

An interview with Nurse Aide (NA) #1 on 10/24/23 at 10:22 AM revealed he had been assigned to Resident #1 on 10/23/23 on day shift (7A-3P) and had not provided hair care. He stated the hall Resident #1 is on had 12 dependent residents requiring a mechanical lift for transfers including Resident #1. He stated he often had to give the residents bed baths because he could not get them up for a shower due to staffing and bed baths did not always include washing the resident's hair. NA #1 stated Resident #1's hair was matted because nobody was brushing it and with the number of residents on the hall the staff didn't have time. He stated Resident #1 had told him for several months she wanted her hair cut, so he stated he told the nurses, but nothing had

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 _____	R-C 10/24/2023

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 677	Continued From page 9	F 677		

been done. The interview revealed Resident #1's hair was matted to the point the staff could not brush it out.

An interview with Nurse Aide (NA) #2 on 10/24/23 at 11:05 AM revealed she had been assigned to Resident #1 on the week prior to 10/24/23. She stated she had to get Resident #1 ready for a cancer treatment appointment and had noticed her hair was matted. NA #2 stated Resident #1 was screaming and stated it hurt when she tried to brush the hair because it was matted. She stated, "her hair is matted because staff aren't brushing it". The interview revealed she had seen Resident #1's hair matted for the last several months. NA #2 stated she had not told the Nurse on duty about the resident's hair condition.

An interview with Nurse #1 on 10/24/23 at 11:38 AM revealed she had been assigned to Resident #1 in the past. She stated she knew Resident #1's hair was matted in the back, but it was to the point the Nurse Aides could not brush it out without hurting the resident. Nurse #1 stated Resident #1 was getting up daily to go out for cancer treatments and staff were brushing the hair over the matted hair to make it less obvious. Nurse #1 stated she had not told the Director of Nursing about Resident #1's hair because she thought everyone knew.

An interview with Nurse #2 on 10/24/23 at 12:09 AM revealed she had been assigned to Resident #1 on 10/24/23. Nurse #2 stated Resident #1 had matted hair for several months. She stated she got Resident #1 up on the morning of 10/24/23 for her appointment and tried to brush her hair but it was hurting the resident so she just put what she could in a ponytail. Nurse #2 stated, "I did 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 _____	R-C 10/24/2023

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 677	Continued From page 10 best I could". The interview revealed Resident #1 had asked Nurse #2 to cut her hair the week prior. She stated she told the Director of Nursing on 10/24/23 after she got her up for the appointment that the resident had matted hair. Nurse #2 stated she did not cut the resident's hair because she did not feel comfortable doing so. An interview with the Director of Nursing on 10/24/23 at 1:24 PM revealed she expected all residents to receive hair care on bath days and when needed by nurse aides. She stated Nurse #2 told her about the matted hair on 10/24/23. The DON stated no staff members had come to her and told her about the matted hair prior to 10/24/23. An interview with the Administrator on 10/24/23 at 2:01 PM revealed that he had only been in the facility 3 weeks. He stated each resident should receive hair care on their shower day and no resident's hair should be in a matted condition. The interview revealed the facility would have someone come in to cut Resident #1's hair and staff would wash the resident's hair.	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		

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 _____	R-C 10/24/2023

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 812	Continued From page 11	F 812		

facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations and staff interviews, the facility failed to date opened items stored in the dry storage area located in the main kitchen. These practices had the potential to affect food served to residents.

Findings included:

A tour of the facility's dietary department on 10/23/23 beginning at 9:30 AM revealed the following items:

Dry storage area:

- A 35 ounce (oz) opened and undated bag of cereal
- A large bag of opened and undated cake mix

An interview with Cook #1 on 10/23/23 at 9:45 AM revealed they had been educated all items should be labeled and dated with an open/discard date. He stated the opened bag of cereal should have been sealed and labeled with the date it was opened.

An interview with the Regional Dietary Manager on 10/24/23 at 1:38 PM revealed she was made

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 _____	R-C 10/24/2023

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 812	Continued From page 12 aware of items that were unlabeled and dated in the dry storage area stated all items should be labeled and dated with an open and discard date.	F 812		
{F 867} SS=G	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will	{F 867}		

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	345329	A. BUILDING _____ B. WING _____	R-C 10/24/2023

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GATEWAY REHABILITATION AND HEALTHCARE	2030 HARPER AVENUE NW LENOIR, NC 28645

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{F 867}	Continued From page 13	{F 867}		

systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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{F 867}	Continued From page 14 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by:	{F 867}		

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{F 867}	Continued From page 15	{F 867}		

Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following a recertification and complaint survey dated 9/08/23. This was for two repeat deficiencies that were cited in the areas of self-determination, activities of daily living care provided for dependent residents that were originally cited during a recertification and complaint survey dated 03/21/23, 09/08/23 and subsequently recited during the onsite revisit and complaint survey dated 10/24/23. The area of food procurement was originally cited during a recertification and complaint survey dated 09/08/23 and subsequently recited during the onsite revisit and complaint survey dated 10/24/23. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program.

The findings included:

The tag is cross referenced to:

F561- Based on observations, record review, resident and staff interview the facility failed to honor resident requests for two showers per week (Resident #2 and Resident #4) for 2 of 4 residents reviewed for choices.

During the recertification and complaint survey dated 9/08/22, the facility failed to honor resident request for two showers per week and the facility also failed to honor a resident's request to get out of bed this affected 4 of 6 residents reviewed for choices.

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{F 867}	Continued From page 16	{F 867}		

During the recertification and complaint survey dated 3/21/22 the facility failed to honor a resident's bathing preferences for 3 of 7 residents reviewed for choices.

F677- Based on observations, record reviews, resident, family and staff interviews, the facility failed to provide hair care to a dependent resident for 1 of 3 residents reviewed for activities of daily living (Resident #1). Resident #1 was observed with matted hair while waiting to go for an outside Physician appointment. Resident #1 stated the matted hair was painful and she felt like the staff did not care.

During the recertification and complaint survey dated 9/08/23, the facility failed to provide nail care to a dependent resident for 1 of 2 residents reviewed for providing activities of daily living.

During the recertification and complaint survey dated 3/21/22 the facility failed to provide facial grooming for 1 of 4 dependent residents reviewed for activities of daily living.

F812- Based on observations and staff interviews, the facility failed to date opened items stored in the dry storage area located in the main kitchen. These practices had the potential to affect food served to residents.

During the recertification and complaint survey dated 9/08/22 the facility failed to label and date leftover food items available for resident consumption stored in 1 of 1 reach in refrigerator and failed to date pre-filled bowls of cereal stored in the dry storage area located in the main kitchen. These practices had the potential to

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{F 867}	Continued From page 17 affect food served to residents. An interview with the Director of Nursing (DON) and Administrator on 10/24/23 at 4:00 PM revealed monthly Quality Assurance (QA) meetings were held to review measures put in place and discussed with the Medical Director and other departments for their response and feedback to issues identified. When issues were identified a review and corrective action plan was implemented and if there was no improvement, the QA committee revisited it. The DON and Administrator felt interventions put into place were beginning to aid in preventing repeat deficiencies but need to be revisited by the QA committee to ensure ongoing compliance in all areas.	{F 867}		