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

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F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation.	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 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record reviews, the facility failed	F 561	After an internal root cause analysis was completed, it was determined than an	4/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/11/2018

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.

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to honor food preferences for 1 of 7 residents reviewed for choices (Resident #29).

The findings included:

Resident #29 was admitted to the facility on 12/29/17 with diagnoses which included atrial fibrillation, anxiety, depression, and pain.

The most recent Minimum Data Set (MDS) admission assessment dated 1/5/18 revealed Resident #29 was cognitively intact and able to make decisions.

Review of the dietary tray card for Resident #29 noted she was to receive a pimento cheese sandwich and soup on her lunch and dinner trays in addition to the regular meal.

Observations of the lunch meal service were made on 3/12/18, 3/13/18, 3/14/18, and 3/15/18. Resident #29's lunch tray each day contained a pimento cheese sandwich and no soup.

During an interview with Resident #29 on 3/14/18 at 12:00 PM she revealed she requested a pimento cheese sandwich and tomato soup on her lunch and dinner trays in addition to the regular meal because she rarely eats the regular meal. She reported she did not receive soup yesterday or the day before and that it happens often. She also reported she did not tell staff when something was left off her tray.

F 561

effective system was not in place to monitor the dietary tray cards and individual preferences.

On 3-19-18 the Dietary Manager reviewed resident #29's dietary preferences to insure that her dietary preferences continued to include the pimento cheese sandwich and tomato soup in addition to the regular meal tray. The specific dietary preferences were noted on the dietary tray card on 3-19-18 by the Dietary Manager.

On 3-19-18 the Dietary Manager held an inservice with the dietary staff to review the proper process in ensuring food preferences are being followed. The Dietary Manager also completed a 100% review of the dietary preferences for all resident excluding enteral feedings. Any preference changes were noted on the individual tray cards. The Dietary Manager will perform Quality Improvement Monitoring of resident food preferences being honored for 5 trays per meal for 4 weeks, three times a week for 4 weeks, then two times a week for 4 weeks then monthly for one year.

The Dietary Manager will be responsible for implementing this plan.
The Executive Director introduced the plan of correction to the QAPI Committee on 4-12-18.T The results of the Quality Improvement Monitoring are to be reported to the QAPI Committee by the Dietary Manager.

The QAPI committee meeting consists of

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F 561	Continued From page 2 In an interview with the Dietary Manager (DM) on 3/16/18 at 12:50 PM she revealed Resident #29's tray card indicated she was to receive a pimento cheese sandwich and tomato soup for lunch and dinner. The DM reported Resident #29's preferences were noted in the dietary computer software as was indicated on her tray cards. The DM further added, it was the dietary staff's responsibility to review the tray cards during plating the food and loading the trays. Tomato soup was available in the kitchen, therefore, she could not explain why Resident #29's soup was consistently left off her tray. The DM reported it was her expectation that dietary staff would review the tray cards during meal service and serve the meals according to the resident's preferences.	F 561	but is not limited to; the Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services Director, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. The Quality Improvement Monitoring schedule will be modified based on findings.	
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.	F 636		4/13/18

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F 636	Continued From page 3 (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization	F 636		

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or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to complete comprehensive assessments for 3 of 32 sampled residents. The Minimum Data Set and Comprehensive Care Assessment was not completed in 14 days of admission for Resident #86. In addition the Comprehensive Care Area Assessments failed to address the underlying causes and contributing factors for pressure ulcers for Resident #12 and psychotropic medications for Resident #56.

The findings included:

1. Resident #86 was admitted to the facility on 02/28/18 with diagnoses of osteomyelitis of the vertebrae, low back pain, chronic pain syndrome, anxiety disorder, and major depressive disorder.

Review of the Minimum Data Set (MDS), an admission with an assessment reference date of 03/13/18, was noted to be "in progress" and noted to be 1 day overdue on 03/14/18. It remained "in progress" and incomplete as of 03/15/18 at 11:58 AM. There were no Care Area Assessments (CAA) completed at this time.

The MDS coordinator #1 stated during interview on 03/15/18 at 4:00 PM that Resident #86 was scheduled for discharge prior to the due date of the admission MDS. When Resident #86 did not discharge as planned, the due date for the admission 14 day MDS and CAAs were missed by MDS staff. She confirmed that the sections for Hearing, Speech and Vision; Cognitive patterns; Mood; Behaviors; Nutrition; and Participation in

After an internal root cause analysis was completed, it was determined that an effective system was not in place to monitor that comprehensive assessments were completed timely.

On 3-16-18, the Minimum Data Set (MDS Coordinator completed the assessments for resident #86. The comprehensive Care Area Assessments were completed and modified for Resident #12,#56 and Resident#69 on 3-16-18. Resident #86 is no longer residing in the facility.

On 3-20-18 and 4-2-18 the Regional MDS Coordinator completed a quality assurance monitor for residents with pressure ulcers and psychotropic medications. Quality Improvement Monitoring of the last 30 days was completed on 4-11-2018.

On 3-21-18, The Regional MDS Coordinator, reeducated the MDS nurses regarding The Resident Assessment Instrument (RAI) Guidelines for completing comprehensive care assessments within 14 days of admission and addressing the underlying causes and contributing factors for pressure ulcers for resident #12 and resident#69 and the psychotropic medications for resident #56.

The DCS/Designee will review the validation reports for submitted MDS's to

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F 636	Continued From page 5 Assessment and Goal Setting had not been completed and nor were the CAAs. Interview with the Director of Nursing on 03/16/18 at 1:01 PM revealed she expected the MDS and CAAs to be completed timely. 2. Resident #12 was admitted to the facility on 02/24/15. The most recent comprehensive Minimum Data Set (MDS) was an annual dated 12/20/17. This MDS coded Resident #12 with being severely cognitively impaired, requiring total to extensive assistance with all activities of daily living skills (ADLs) and having one stage 4 pressure ulcer which was present on admission. Measurements of the stage 4 pressure area were documented as 1.6 centimeters (cm) by 0.5 cm by 0.3 cm. The Care Area Assessment (CAA) dated 12/30/17 which addressed pressure ulcers stated that this area triggered secondary to potential for pressure ulcers. She had contributing factors of ADL functional and mobility impairment and incontinence. She will receive skin checks weekly by a licensed nurse and daily skin checks by non-licensed staff during routine care. Staff will assist with repositioning and provide incontinence care. Risk factors included pain, development of pressure ulcer and skin condition and fluid deficit risk. The CAA did not include the actual presence of the pressure ulcer, the location of the pressure ulcer, or that the resident was receiving care by a wound specialist weekly. On 03/16/18 at 12:07 PM the MDS coordinator (#1) was interviewed. The actual MDS	F 636	ensure that the assessments are completed per RAI Guidelines. The DCS or Designee will review CAAS for Pressure Ulcers to ensure that they address underlying causes and any contributing factors. The DCS/Designee will review the psychotropic CAA to insure that they address how the medications affect residents, day to day activities, if the resident is receiving psychiatric services, or if gradual dose reductions have been attempted. The DCS and/or designee will conduct Quality Assurance Monitoring of MDS Comprehensive Assessments. The Quality Assurance Monitoring will be conducted on 5 random residents 2 x a week for 8 weeks and then 1 x per month for 1 year. QI monitoring schedule will be modified based on findings. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee will evaluate effectiveness of the monitoring/observation tool for making changes to the corrective actions necessary to maintain substantial compliance. The QA Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director and at least 3 other members.	

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coordinator (#2) who completed this CAA was no longer working at the time of this interview. The MDS coordinator #1 stated during this interview that she would have expected the CAA include the presence of the pressure ulcer and pertinent information regarding this pressure ulcer.

The Director of Nursing stated during an interview on 03/16/18 at 1:01 PM that she expected the pressure ulcer CAA to include the actual presence of the pressure ulcer for Resident #12.

3. Resident #69 was admitted to the facility on 02/09/18 with diagnoses of pressure ulcer, quadriplegia and dementia.

Review of the admission Minimum Data Set (MDS) dated 02/16/18 revealed Resident #69 was cognitively intact and needed extensive to total assist with most activities of daily living. The MDS further revealed Resident #69 had one stage 1 pressure ulcer, six stage 3 pressure ulcers and one stage 4 pressure ulcer.

Review of the Care Area Assessment (CAA) dated 02/20/18 revealed pressure ulcers triggered secondary to actual pressure ulcer. The CAA did not address Resident #69 had 8 pressure ulcers and a wound vacuum, a type of therapy that helps wounds heal, in use for one of the pressure ulcers.

An interview conducted with MDS Nurse #1 revealed she did not write the CAA and MDS Nurse #2 that wrote the CAA no longer worked at the facility. She stated the CAA should have addressed all of the wounds and the use of the wound vacuum and how the wounds and wound

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F 636	Continued From page 7 vacuum affected Resident #69's day to day life. 4. Resident #56 was admitted to the facility on 11/11/17 with diagnoses of Alzheimer's disease, renal failure, anxiety, and depression. Review of the significant change Minimum Data Set dated 02/11/18 revealed Resident #56 was moderately cognitively impaired and received antipsychotics and antidepressants during the assessment period. Review of the Care Area Assessment (CAA) dated 02/20/18 revealed psychotropic drug use triggered secondary to use of psychotropic medication to manage psychiatric illness/condition. The CAA did not address how the medications affected Resident #56's day to day activities, if she had behaviors, if she was receiving psychiatric services, or if gradual dose reductions had been attempted. An interview conducted with MDS Nurse #1 revealed she did not write the psychotropic drug CAA and MDS #2 that wrote the CAA no longer worked at the facility. She stated the CAA should have included any psychiatric services Resident #56 was receiving, behaviors, and if any GDR's had been attempted. She further stated the CAA should have revealed how the medications affected Resident #56's day to day activities.	F 636		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	F 641		4/13/18

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F 641	Continued From page 8 by: Based on record review and staff interviews the facility failed to accurately code 2 of 32 sampled residents utilizing the Minimum Data Set (MDS) for dental (Resident #84) and pressure ulcer status (Resident #9). Findings included: 1. Resident #54 was admitted to the facility 2/12/18 with diagnoses including cancer, asthma, and respiratory failure. In an interview with Resident #84 on 3/12/18 at 3:33 pm he stated, "I don't have a tooth in my head". An admission MDS dated 2/19/18 indicated Resident #84 was not coded under Section L Oral/Dental Status as being edentulous. The most recent care plan dated 2/18/18 revealed that Resident #84 was edentulous. The MDS Coordinator was interviewed on 3/16/18 at 10:00 am regarding the accuracy of Resident #84's admission MDS. The MDS did not code Resident #84 as edentulous. The MDS Coordinator stated the MDS should have been coded to reflect Resident #84 was edentulous and was inaccurately coded. The MDS Coordinator stated the admission MDS would require a correction to reflect that Resident #84 was edentulous. On 3/16/18 at 10:30 am an interview was conducted with the Director of Nursing (DON). The DON stated it was his expectation that the admission MDS would have been coded correctly	F 641	After an internal root cause analysis was completed, it was determined that an effective system was not in place to monitor the accuracy of assessments for residents #84 and #9. On 3-20-18 and 4-2-18 the Regional MDS Coordinator completed a Quality Assurance monitor for residents with Pressure Ulcers and resident oral status. On 3-21-18, the Regional MDS Coordinator, reeducated the MDS Nurses regarding accuracy of all MDS assessments according to The Resident Assessment Instrument (RAI)Guidelines. An audit was completed on the proper coding of all MDS assessments related to the risk for Pressure Ulcers and for residents oral status. Any modifications necessary were completed by the MDS Coordinators. The Director of Clinical Services/Designee will audit the assessments for accurate coding of pressure ulcer status/risk and the oral status prior to transmitting as follows: 3 per week x 4 weeks; then 2 per week x 4 weeks; then 1 per week x 4 weeks then 1 per month x 1 year. The Executive Director is to be responsible for implementing this plan. The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee will evaluate the effectiveness of the	

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F 641	Continued From page 9 to reflect that Resident #84 was edentulous. 2. Resident #9 was admitted to the facility 12/8/17 with diagnoses including depression, disorientation, and hypertension (high blood pressure). An admission MDS dated 12/15/17 indicated Resident #9 was not assessed or there was no information for pressure ulcer risk under Section M Skin Conditions. The most recent care plan dated 12/8/17 revealed that Resident #9 was at risk for impaired skin integrity. The MDS Coordinator was interviewed on 3/16/18 at 10:00 am regarding the accuracy of Resident #9's admission MDS. The MDS was coded that Resident #9 was not assessed or there was no information for pressure ulcer risk. The MDS Coordinator stated the MDS should have been coed to reflect Resident #9 was assessed for pressure ulcer risk and was inaccurately coded. The MDS Coordinator stated the admission MDS would require a correction to reflect that Resident #9 was assessed for pressure ulcer risk. On 3/16/18 at 10:30 am an interview was conducted with the DON. The DON stated it was his expectation that the admission MDS would have been coded correctly to reflect that Resident #9 was assessed for pressure ulcer risk.	F 641	monitoring for making changes to the corrective actions as necessary to maintain substantial compliance. The QA Improvement Committee members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director and at least 3 other members.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		4/13/18

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F 656	Continued From page 10 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656		

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F 656 Continued From page 11

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interview, the facility failed to develop plans of care for 2 of 33 sampled residents reviewed for care plans. Resident #12 had no interventions for meeting the goal for her behavior care plan and Resident #69's care plan did not address the wound vacuum used for pressure ulcer treatment.

The findings included:

1. Resident #12 was admitted to the facility on 02/24/15. The most recent comprehensive Minimum Data Set (MDS) was an annual dated 12/20/17. This MDS coded Resident #12 with being severely cognitively impaired, having physically abusive behaviors daily, and requiring total to extensive assistance with all activities of daily living skills (ADLs).

The behavior Care Area Assessment dated 12/30/17 stated she had dementia, behavioral disturbance, schizophrenia and bipolar disorder. She screamed out at times, would bite at staff and attempt to pinch them if they got close to her. She was also noted to be followed by in house psychiatric services. The CAA noted a care plan would be developed.

Review of the care plan revealed a predeveloped computerized care plan in which checks by the appropriate focus, etiologies, goals and interventions were to be marked. The focus was the potential for impaired or inappropriate behaviors due to schizophrenia and ineffective impulse control. The goal was for the resident to have less episodes of screaming, biting and pitching. The implementation dated was

F 656

After an internal root cause analysis was completed, it was determined that an effective system was not in place to monitor that comprehensive plans of care were completed for resident #12 and #69.

On 3-16-18 the MDS Coordinator completed the care plan updates for both resident #12 and #69.

On 3-20-18 and 4-2-18 the Regional MDS Coordinator completed a quality assurance monitor for residents with pressure ulcers and behavioral care plan needs.

On 3-21-18, the Regional MS Coordinator reeducated the MDS nurses and the Social Worker regarding the care plan requirements for insuring comprehensive content and appropriate individualized approaches for each resident with a risk of pressure ulcers and for behavioral care interventions.

The MDS Coordinator will review orders as received during the 24 hour daily report. Orders pertaining to treatments for pressure ulcers and behavioral management will be reviewed and care plans developed and updated as needed during the morning IDT meetings.

The MDS Coordinator will review care plans weekly to ensure all newly created comprehensive care plans are complete according to the care plan decision in

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	345329	A. BUILDING ______ B. WING ______	C 03/16/2018

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

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handwritten in as 12/30/17 with a target date handwritten in for 03/31/18. Review of the interventions noted no preprinted interventions were checked and no additional interventions were handwritten in.

Interview with the MDS Coordinator on 03/16/18 at 12:07 PM verified no interventions had been checked. She stated that after each comprehensive assessment, a care plan would be printed off and the responsible staff member should check the appropriate interventions. This would have been the social worker's responsibility (who at this time was no longer employed by the facility). The MDS Coordinator also stated that Resident #12 would have had a more distinct preprinted behavior care plan which should have also been completed.

The Director of Nursing on 03/16/18 at 1:01 PM stated during interview that she expected the behavior care plan to be completed with checks for the appropriate interventions for Resident #12's behavior goals.

2. Resident #69 was admitted to the facility on 02/09/18 with diagnoses of pressure ulcer, quadriplegia, and dementia.

Review of the admission Minimum Data Set dated 02/26/18 revealed Resident #69 was cognitively intact and required extensive to total assistance with most activities of daily living.

Review of the care plan dated 02/16/18 revealed Resident #69 had impaired skin integrity as evidenced by pressure ulcer. The goal was for Resident #69's wound to show signs of healing

F 656

Section V as follows: 3 per week x 4 seeks; then 2 per week x 4 weeks; then 1 per week x 4 weeks ; then 1 per month x 1 year. The Social Work Director will review behavioral care plans for auditing following the above mentioned schedule.

The ED will be responsible for implementing this plan.
The results of the QI monitoring will be reported to the Quality Assurance Performance Improvement Committee to evaluate the effectiveness of the monitoring for making changes to the corrective actions as necessary to maintain substantial compliance. The QA Improvement Committee Members consist of, but not limited to, the Administrator, Director of Clinical Services, Medical Director and 3 other Team members.

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F 656	Continued From page 13 and remain free from infection, not to develop additional skin integrity problems or wounds, and continue to have interventions in place to prevent impaired skin integrity through the next review date. The interventions did not include the use of a wound vacuum, a device used in wound healing, for Resident #69's stage 4 pressure ulcer to her sacrum. An interview conducted with MDS Nurse #1 revealed she writes and updates the care plan. She stated she was aware Resident #69 had a wound vacuum for her stage 4 pressure ulcer to her sacrum and she thought she had made a care plan for the wound vacuum. She stated the wound vacuum should have had a care plan with goals and interventions. An interview conducted on 03/16/18 at 1:01 PM with the Director of Nursing revealed it was his expectation for wound vacuum treatment to be care planned for residents.	F 656		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		4/13/18

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F 865	Continued From page 14 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions placed to ensure the facility maintained accuracy of assessments. The deficiency was cited on 2/23/17 following a recertification survey and subsequently recited on March 16, 2018 on the current recertification survey. The repeat deficiency was in the area of accuracy of assessments (F641). This deficiency was recited during the facility's current recertification survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross-referenced to: 483.10 Accuracy of Assessments: Based on observations, staff and resident interviews, and record reviews, the facility failed to accurately code 3 of 32 Minimum Data Sets (MDS's).	F 865	After an internal root cause analysis was completed it was determined that an effective system was not in place to monitor the accuracy of assessments for the Minimum data Sets (MDS's). The Director of Nursing and the Administrator , on3-19-18, completed a root cause analysis and determined that the previous Quality Assurance Monitoring should have been conducted for a longer period of time. this action would have insured compliance of the plan of correction written and initiated for the accuracy of the MDS assessments. The current process and procedure for correcting the QA plan for the MDS accuracy will include the following: current monitoring put into place to audit the accuracy of the MDS plans will be reviewed by the Administrator/ Designee during the morning clinical meetings occurring daily with the IDT staff. A report ill be completed from the findings of the information and presented to the monthly Quality Assurance and performance Improvement Meetings. The Executive Director will be responsible for implementing this plan.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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F 865	Continued From page 15 During the previous recertification survey of 2/23/17 this regulation was cited for failure to accurately code an MDS to capture elected palliative care services. An interview was conducted with the Administrator and the MDS Coordinator on 3/16/18 at 1:12 PM. The Administrator stated that the Quality Assurance (QA) Committee met monthly and included herself, the Director of Nursing (DON), the Medical Director (MD), Registered Dietician (RD), MDS Coordinator, all department managers, and a nurse assistant (NA). Concerns brought from customer service audits, morning meetings, QA meetings, resident council, and any concerns voiced by residents, families, or staff are brought to the QA meetings and then incorporated into the Quality Assurance Performance Improvement (QAPI) program. The MDS Coordinator reported inaccuracy issues had been identified with assessments performed by another MDS nurse who was no longer working at the facility. The MDS Coordinator revealed she was responsible for monitoring accuracy of assessments through a system put into place, as indicated in the QAPI plan, for auditing assessments in order to assure compliance.	F 865	The Quality Assurance Performance Improvement Committee will evaluate effectiveness of the monitoring / observation information and make recommendations for changes if necessary to ensure compliance. Accuracy of the Mds assessments will be monitored 2 times a week for 8 weeks and then 1 x per month for one year.	