STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345329	A. BUILDING _____ B. WING _____	C 05/02/2018

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
F 000	INITIAL COMMENTS The Statement of Deficiencies was amended on 05/09/18 at tag F-624.	F 000		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and staff, outside agencies, and family interviews, the facility failed to ensure 1 of 3 residents reviewed for discharge had a safe place to go after leaving the facility (Resident #13). The findings included: Resident #13 was admitted to the facility 03/24/17 with diagnoses which included an upper respiratory infection and throat cancer. A review of the resident's medical record revealed the resident was his own responsible party. Additional medical record review revealed Resident #13 was issued a discharge notice from the facility dated 03/15/18. The reason for the discharge notice was due to the resident smoking with cigarettes he kept on his person and not following facility smoking rules. The notice described this as an unsafe practice placing all	F 624	After and internal root cause analysis was completed, it was determined that the Social Services Director did not effectively communicate with the local homeless shelter in securing a bed prior to discharge. Resident #13 no longer resides at the facility. On 5-4-2018 the Director of Clinical Services did quality improvement monitoring of the last 30 days of discharges to verify they were safe. No further issues were identified. On 5-4-18 the Executive Director reeducated the Social Services Director on the process for a safe discharge from the facility. This to include that a bed will be secured prior to the resident leaving, the receiving facility to be called to verify an available bed, and documentation to be included in the medical record with	5/10/18

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

Electronically Signed | 05/10/2018

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F 624	Continued From page 1 residents at risk. An annual Minimum Data Set (MDS) dated 04/01/18 indicated the resident's cognition was moderately impaired and he used tobacco. The MDS specified the resident had no behaviors and required staff supervision for activities of daily living. On 04/11/18, the Social Worker (SW) wrote a note which specified Resident #13 reported he would be willing to discharge to an assisted living facility. An additional SW note dated 04/12/18 specified the resident's family member took Resident #13 (date not provided) to visit an assisted living facility that would accept the resident. When they returned to the facility the resident informed the SW and the family member he refused to go to an assisted living facility and had rather go to the local homeless shelter. The note specified Resident #13 refused to be discharged to the local homeless shelter today, but would go tomorrow. A progress note written by the Nurse Practitioner (NP) dated 04/13/18 specified Resident #13 was discharged to a homeless shelter per his request. An interview was conducted with the Director of Nursing (DON) on 4/30/18 at 4:36 PM. The DON explained in March 2018, Resident #13 was caught smoking and had cigarettes and a lighter which the resident was not supposed to have in his possession. The facility looked for an assisted living facility for the resident but he refused to go. Resident #13 had a family member that would not provide housing for him.	F 624	whom they spoke. On 5-3-18 the Director of Clinical Services educated the Assistant Director of Clinical Services and the Nursing Supervisor on the process for a safe discharge. This will include that a bed be secured prior to the resident leaving, the receiving facility to be called to verify that the bed is still available and documentation to be included in the medical record with whom they spoke to. The Director of Clinical Services and/or Nursing Supervisor are to perform Quality Improvement Monitoring of discharges for being safe two times a week for 8 weeks, 1 time a week for four weeks then monthly thereafter for one year. The Executive Director is to be responsible for implementing this plan. The Director of Clinical Services introduced the plan of correction to the QAPI committee on 5-8-18. The results of the Quality Improvement Monitoring will be reported to the QAPI Committee by the Director of Clinical Services. The QAPI committee consist of but is not limited to : Medical Director, Executive Director, Director of Clinical Services, Activities Director, Social Services, Maintenance Director, Dietary Manager, Housekeeping Manager, Minimum Data Set Nurse and a minimum of one direct caregiver. The Quality Improvement Monitoring will be modified based on findings.	

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F 624	Continued From page 2	F 624		

The DON added Resident #13 wanted to go to the local homeless shelter. The DON further stated the resident's family did not agree with his decision, but Resident #13 did not care. The DON stated the facility provided a cab to take him to the homeless shelter on the day of discharge.

An interview was conducted with Resident #13's family member on 04/30/18 at 7:34 PM. The family member stated the facility called a cab to take Resident #13 to the homeless shelter on the day the resident was discharged. She added when the resident got to the homeless shelter, he found there were no beds available. The family member did not know how Resident #13 got the cab driver to take him to her house, but he did. She explained she and her family determined Resident #13 could not stay there. They found a shelter in a neighboring town that would take the resident and provided transportation to that facility.

An interview was conducted with the Administrator and the SW on 05/01/18 at 7:24 AM. The Administrator stated Resident #13 had been issued a discharge notice on 03/15/18 when he was caught smoking with cigarettes that were not provided by the nurse. The Administrator explained the facility smoking rules prohibited residents keeping their own smoking materials on their person or in their rooms. Cigarettes and lighters were to be kept by the nurses in a locked box and issued to the residents when the asked. The Administrator further explained the facility found 3 assisted living facilities that would take Resident #13 but he refused to go. The resident did say he would go to the local homeless shelter. The SW explained she had made arrangements for the resident to have a bed at the shelter on

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F 624	Continued From page 3	F 624		

04/12/18 but he refused to go that day. The SW stated the resident said he would go to the shelter on 04/13/18. The SW was unable to provide any documentation regarding the person she communicated with at the shelter to assure Resident #13 had a bed there on 04/13/18.

An additional interview with the SW on 05/01/18 at 10:00 AM revealed she did call the homeless shelter 04/12/18 to ensure a bed was available for Resident #13. The SW stated she was told the resident could not bring all of his belongings. She added she called a cab to transport the resident to the homeless shelter. When the cab arrived, the resident refused to go and stated he would go 04/13/18.

An interview was conducted with the cab company dispatcher. He stated a cab was dispatched to the facility on 04/13/18 and instructed to take a passenger (Resident #13) to the local homeless shelter. He added when they arrived, there were no beds available for the passenger. The cab driver waited an hour for this to be determined. The cab driver then transported the passenger free of charge to a neighboring town to a family member's house.

An interview was conducted on 05/01/18 at 4:57 PM with the Assistant Manager (AM) of the homeless shelter. The AM stated he did recall speaking with the SW on 04/09/18 and putting Resident #13 on a waiting list. He stated the SW did not leave a phone number so he was unable to call her when the Resident arrived on 04/13/18 and the shelter did not have a bed that night.

On 05/02/18 at 3:53 PM, SW reported via phone she recalled she did not work on 04/13/18. She

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F 624	Continued From page 4 explained she remembered she was ill that day. The SW added she did not call the homeless shelter on 04/13/18 to ensure Resident #13 had a bed.	F 624		