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	345329	A. BUILDING _____ B. WING _____	C 11/03/2020

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
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted in conjunction with a complaint investigation from 10/28/20 through 10/29/20 with exit from the facility on 10/29/20. Additional information was reviewed through 11/03/20. Therefore, the exit date was changed to 11/03/20. The facility was found in compliance with 42 CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# IBG011.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted in conjunction with a complaint investigation from 10/28/20 through 10/29/20 with exit from the facility on 10/29/20. Additional information was reviewed through 11/03/20. Therefore, the exit date was changed to 11/03/20. The facility was found to be out of compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were twenty-two allegations invesitgated and they were all unsubstantiated. Event ID# IBG011.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff	F 658	1. On 10/25/20 Resident #2 did not	12/9/20

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

Electronically Signed | 11/25/2020

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F 658	Continued From page 1 interviews, and Nurse Practitioner (NP) interviews the facility failed to order an out of stock medication from the back-up pharmacy which caused the medication to be omitted for one dose of a blood thinner medication for 1 of 7 sampled residents (Resident #2) reviewed for providing care in accordance with professional standards. The findings included: Resident #2 was admitted to the facility with diagnoses including chronic embolism (the blockage of a blood vessel by a foreign substance or blood clot that travels through the bloodstream) and thrombosis (the formation of a blood clot in a blood vessel) of unspecified deep veins of the lower extremity. Review of the admission Minimum Data Set (MDS) dated 07/16/20 revealed Resident #2 was cognitively intact. A review of a Physician's order dated 09/30/20 revealed Resident #2 was to receive apixaban (blood thinner medication) 5 milligrams (mg) two times a day. Review of the Medication Administration Record (MAR) for October 2020 revealed Resident #2 did not receive the 08:00 AM dose of apixaban on 10/25/20. An interview with resident #2 on 10/28/20 at 1:25 PM revealed he missed a dose of apixaban on the weekend of October 24 and 25, 2020 but could not remember which day he missed the dose. Resident #2 stated he was concerned about not receiving the medication because he had a history of having blood clots.	F 658	receive morning dose of blood thinner medication (apixaban). Medication Error completed by nurse management. Resident 32 assessed by Nurse Practitioner and there was no harm or negative outcomes to Resident #2. 2.On 11/4/2020 through 11/24/2020 the Director of Nursing and/or designee performed a Quality Improvement monitoring for the current residents for medication availability, refusals of medications/treatments and/or omissions to ensure medications are administered per physician's order. Medication carts were audited to ensure medications are available for residents. All issues identified were corrected and/or medication error completed. 3. The Director of Nursing and/or designee will re-educate Licensed Nursing staff about medication availability, refusals of medications/treatments and/or omissions to ensure medications are administered per physician's order. The nurse must continue to call/follow up with pharmacy to ensure timely delivery of medications. if medications are not available check the Omnicell for back up medications, notify the pharmacy of missing medications and order from back up pharmacy, also notify the physician if medications cannot be given, notify the Director of Nursing/Executive Director of missing medications and document actions taken in the medical record and on the 24 hour report. The Medical Director and/or the Nurse Practitioner will	

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F 658	Continued From page 2 An interview with the Nurse Practitioner (NP) on 10/28/20 at 2:39 PM revealed it was concerning that Resident #2 missed a dose of apixaban but missing one dose of apixaban did not cause the resident harm. The NP further stated there was no risk of resident harm unless 3 days worth of apixaban had not been administered. An interview with Nurse #2 on 10/28/20 at 3:33 PM revealed she administered Resident #2's 5:00 PM dose of apixaban on 10/24/20 from the facility's back-up medication supply because the facility had run out of Resident #2's supply of apixaban. She stated she used the last two 2.5mg tablets of apixaban from the facility's back-up supply of medication for Resident #2's 5:00 PM dose on 10/24/20. Nurse #2 stated she omitted the 8:00 AM dose of apixaban on 10/25/20 because Resident #2's supply of apixaban had not arrived from the pharmacy and she thought the pharmacy would deliver the medication in time for Resident #2 to receive his 5:00 PM dose on 10/25/20. Nurse #2 stated she did not call the pharmacy to request a stat dose or notify the provider that Resident #2 had missed a dose of apixaban. An interview with the Director of Nursing (DON) on 10/29/20 at 8:35 AM revealed she expected nursing staff to call the pharmacy to request a stat dose of a blood thinner if there was no more medication in the facility's back-up supply or to notify the provider that the medication was not available if pharmacy was unable to send a stat dose of medication. An interview with the Regional Administrator on 10/29/20 at 3:31 PM revealed he expected	F 658	give you orders to address medications not available. The Director of Nursing and/or Designee to be notified of findings immediately. The education will be completed by 12/9/20. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All current staff will be educated prior to their next scheduled shift. 4. The Director of Nursing and/or Nursing designee to perform Quality Improvement monitoring of 10 resident orders to include medication availability, refusals of medications/treatments and/or omissions to ensure medications are administered per physician's order to be completed 2 times a week for 4 weeks, then weekly x 2 months, and then 1 x monthly for 3 months. Th Director of Nursing introduced a plan of correction to the Quality Assurance performance Improvement Committee on 11/24/20. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee Members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct Care giver. Quality Improvement Quality Monitoring schedule modified based on findings.	

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F 658	Continued From page 3 nursing staff to look for medication in the facility's back-up supply of medication and if the medication was not there to call the pharmacy and request a stat dose of the medication. The Regional Administrator stated if pharmacy was unable to deliver a stat dose of medication the provider should have been notified the ordered medication was unavailable and ask if a substitute medication that was available needed to be ordered.	F 658	AOC Date: 12/9/2020	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		12/9/20

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F 880	Continued From page 4 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the facility's Handwashing/Hand Hygiene policy the facility failed to implement their policy on hand hygiene when a nurse changed a dressing for 1 of 3 residents reviewed for wound care (Resident #1) and when a housekeeper failed to perform hand hygiene before and after glove use and between cleaning the rooms of residents (Residents #2, #3, #4, #5, #6, #7, #8, and #9). This failure occurred during a COVID-19 pandemic. The findings included: A review was completed of the facility's policy titled Handwashing/Hand Hygiene revised August 2019. The policy stated, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors." A. The policy also stated in part, "Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-anti-microbial) and water for the following situations: 1. Before and after direct contact with residents; 2. Before handling clean or soiled dressings, gauze pads, etc.: 3. After contact with blood or bodily fluids; 4. After handling used dressings, contaminated equipment, etc.; 5. Before moving from a contaminated body site to a clean body site during resident care: 6. After contact with objects (e.g. medical equipment) in the immediate vicinity of the	F 880	1. Nurse #1 failed to perform hand hygiene after providing incontinence care, after removing soiled gloves, and after applying cream to Resident #1's buttocks. Housekeeper #1 failed to perform hand hygiene before and after glove use between cleaning the rooms of residents'#2, #3, #4, #5, #6, #7, #8, and #9. Nurse #1 and Housekeeper #1 were immediately re-educated by the Director of Nursing on 10/28/2020 2. On 11/24/20 through 12/9/20 the Director of Nursing and/or designee performed a Quality Improvement Monitoring for staff to include: Nursing, Housekeeping, Dietary, Therapy, and Administrative staff to ensure proper Handwashing/Hand Hygiene performed by completion of Hand Hygiene Competency. On 10/28/2020 the Maintenance Director completed a Quality Review to ensure sinks in the facility are functioning properly. Issues identified were corrected immediately. The Root Cause Analysis was completed by the Regional Director of Clinical Services, Executive Director, and the Director of Nursing on 11/25/2020. 3. The Director of Nursing and/or designee will re-educate staff to include: Nursing, Housekeeping, Dietary, Therapy, and Administrative staff on Proper Handwashing/Hygiene. Housekeeping received education specific to performing hand hygiene before and after glove use	

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F 880	Continued From page 6 resident; 7. After removing gloves; B. Hand hygiene is the final step after removing and disposing of personal protective equipment C. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." 1. A continuous observation on 10/28/20 from 10:04 AM to 10:29 AM of Nurse #1 providing incontinence and wound care to Resident #1 revealed the following: Nurse #1 provided incontinence care for Resident #1. After providing incontinence care Nurse #1 removed her soiled gloves, placed them in the trash can, and put on a clean pair of gloves. Nurse #1 did not perform hand hygiene after performing incontinence care and before applying clean gloves. Nurse #1 removed the soiled dressing from Resident #1's sacral wound, removed her soiled gloves, placed them in the trash can, and put on a pair of clean gloves. Nurse #1 did not perform hand hygiene after removing the soiled dressing from Resident #1's wound. Nurse #1 cleaned Resident #1's wound with normal saline (a cleansing solution for wounds), placed calcium alginate (a dressing used to manage wound drainage) in the wound, and covered the wound with a foam dressing. Nurse #1 applied cream to Resident #1's buttocks, applied a clean brief, assisted nurse aide (NA) #1 with repositioning Resident #1 in bed, pulled the bed cover up to Resident #1's shoulders, rolled the overbed table beside Resident #1's bed, removed soiled gloves, and exited the room. Nurse #1 did not perform	F 880	and between cleaning rooms of residents. Nurses received education specific to performing hand hygiene after removing soiled gloves before applying clean gloves. The education will be completed by 12/9/20. This education will be provided to all new employees as part of new hire orientation, contract staff and agency staff, this education will be provided prior to starting work. All current staff will be educated prior to their next scheduled shift. 4. The Director of Nursing and/or Nursing designee to perform Quality Improvement monitoring of 5 random staff members to include housekeeping and wound nurse to ensure proper handwashing/hand hygiene is being performed during resident care and when cleaning resident rooms 2 times a week for 4 weeks, then weekly x 2 months, and then 1 x monthly for 3 months. On 11/25/2020 the Executive Director and the Director of Nursing introduced the direct plan of correction for Infection Prevention and Control to the Quality Assurance Performance Improvement Committee. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee Members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of direct	

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F 880	Continued From page 7 hand hygiene after removing her soiled gloves. An interview with Nurse #1 on 10/28/20 at 10:29 AM revealed she should have performed hand hygiene after providing incontinence care for Resident #1 and before applying clean gloves. Nurse #1 stated she should have performed hand hygiene after removing the soiled wound dressing and before applying clean gloves. Nurse #1 further stated she should have removed her soiled gloves and performed hand hygiene after applying cream to Resident #1's buttocks and before applying clean gloves. Nurse #1 stated she did not perform hand hygiene because the sink in Resident #1's bathroom was not working and hand sanitizer was out in the hall. Nurse #1 stated she just became aware of the sink in Resident #1's bathroom not working the morning of 10/28/20 and she left a bottle of hand sanitizer on her treatment cart that was out in the hall. An interview with the Infection Preventionist Nurse on 10/28/20 at 10:32 AM revealed staff had been provided with multiple in-services on hand hygiene. The Infection Preventionist Nurse stated hand hygiene was to be performed each time gloves were removed and soiled gloves should be removed and hand hygiene performed before touching other items. The Infection Preventionist stated she was unaware of the sink not working in Resident #1's bathroom. She also stated pocket sized hand sanitizer bottles were available and all staff needed to do was ask for a bottle. An interview with the Director of Nursing (DON) on 10/29/20 at 08:35 AM revealed hand hygiene should be performed every time gloves were removed. She also stated after cream was	F 880	care giver. Quality Improvement Quality Monitoring schedule modified based on findings.	

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F 880	Continued From page 8	F 880		

applied to Resident #1's buttocks the soiled gloves should have been removed and hand hygiene performed. The DON stated she was not aware of the sink not working in Resident #1's bathroom.

An interview with the Regional Administrator on 10/29/20 at 3:31 PM revealed hand hygiene should be performed each time gloves were removed and soiled gloves should be removed and hand hygiene performed before touching other items in a resident's room.

2. A review of the facility's hand hygiene policy and procedure revised August 2019 stated, "This facility considers hand hygiene the primary means to prevent the spread of infections." Under the section titled, "Interpretation and Implementation" #2 read in part, "all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The hand hygiene policy and procedure under #7 read in part, "Use an Alcohol Based Hand Rub or alternatively soap and water for the following situations; subsection L "after contact with objects in the immediate vicinity of the resident" and subsection M. "after removing gloves."

A continuous observation of Hallway 100, a non-COVID unit, was made from 11:16 AM through 11:47 AM on 10/28/20 of Housekeeper #1 cleaning resident rooms. At 11:16 AM House Keeper (HK) #1 had finished mopping the floor of the shared room of Resident #2 and Resident #3. HK #1 was not wearing gloves and did not perform hand hygiene when he exited the room. At 11:19 AM HK #1 then pushed the cleaning cart

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to the entrance door of the shared room of Resident #4 and #5 and without hand hygiene entered the room and with ungloved hands touched the entry door and bathroom door handles. HK #1 went to his cart and without performing hand hygiene donned a pair of gloves and returned to the room to wipe down surface areas, he cleaned Resident #5's tray table and touched a cup and book. HK #1 removed his gloves and without performing hand hygiene began to sweep and mop the floors of the room. Two Alcohol Based Hand Rub (ABHR) dispensers were located nearby and available for use. At 11:27 AM HK #1 exited the room without performing hand hygiene and pushed his cart to the janitor closet and used the coded key pad to open the door. HK #1 emptied the bucket of dirty mop water and with one hand touched the spray hose and with the other hand turned the dispenser dial to soap and began to fill the mop bucket. At 11:33 AM when finished changing the mop water and without performing hand hygiene HK #1 touched the handle of the door to close the janitor closet and pushed his cart to the laundry room where he touched the handle of the door to open. HK #1 then removed the dirty mop head and without performing hand hygiene, touched the handle of the storage closet to retrieve a clean one which he replaced on the mop. HK #1 then touched the handle of the door to close the laundry room then proceeded to push the cleaning cart back to the same area and without hand hygiene entered the shared room of Resident #6 and #7. HK #1 touched the handle of the door to enter the room and removed plastic trash bags from both sides. Without performing hand hygiene HK #1 exited the room. At 11:47 AM HK #1 touched the handle of the door to enter the shared room of Resident #8 and #9 then

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touched the handle to the bathroom door to remove a plastic bag of trash then disposed of the bag at the cart outside the room entry door.

During an interview on 10/28/20 at 11:47 AM HK #1 acknowledged he had not performed hand hygiene before entering and exiting resident rooms and before and after glove use. HK #1 revealed his training included not to wear gloves when on the hallway, but he was unsure about when he should perform hand hygiene. He was aware of the COVID-19 pandemic and explained he received training related to precautions to prevent the transmission which included to wear a face mask and goggles and stay 6 feet apart. HK #1 acknowledge ABHR dispensers were available and revealed he had a small bottle in his pocket. HK #1 had assumed he could not use the bathroom sink in a resident's room to wash his hands but gave no reason of why he did not perform hand hygiene during the observation.

An interview was conducted with the Training Manager of Housekeeping on 10/29/20 at 9:08 AM. The Training Manager indicated she had spoken with HK #1 who confirmed he had not performed hand hygiene during the observation. The Training Manager explained all employees were trained hand hygiene and COVID-19 precautions. She indicated HK #1 was trained how to clean resident rooms and about the precautions to prevent the transmission of COVID-19 which included hand hygiene. The Training Manager revealed HK #1 had not worked in Long Term Care or housekeeping prior to his current position and felt he was nervous. The Training Manager revealed the expectation was to perform hand hygiene before entering resident rooms and/or before crossing the threshold of the

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F 880	Continued From page 11 entrance door and before and after gloves use.	F 880		