STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345406	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gates Health and Rehabilitation Center	38 Carters Road Gatesville, NC 27938

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff and the Wound Care Physician, the facility failed to (1) follow Physician's instructions to apply betadine (an antiseptic) and leave it open to air on a resident's right heel pressure wound, (2) ensure a resident's left buttock pressure ulcer was cleaned before applying a clean dressing, and (3) clean wounds starting from the center of the wound and moving to the outer edges of the wound in a continuous circular motion. This deficient practice affected 1 of 3 residents observed for pressure ulcers (Resident #56).Findings included:Resident #56 was readmitted on [DATE]. Resident #56 had diagnoses of an unstageable pressure ulcer on the right heel and a stage 2 pressure ulcer on the left buttock. The Significant Change Minimum Data Set (MDS) dated [DATE] revealed Resident #56 was severely cognitively impaired with no behaviors. The MDS documented a stage 2 pressure ulcer and deep tissue injury. The MDS also showed Resident #56 was dependent on all activities of daily living. The care plan for Resident #56 dated 08/13/25 showed a focus for a stage 2 pressure ulcer to the left buttock and deep tissue injury (DTI) pressure ulcer to the right heel and potential for pressure ulcer development related to history of ulcers, and immobility. The goals for Resident #56 included the pressure ulcers would show signs of healing and remain free from infection. Interventions included administer treatments as ordered and monitor for effectiveness and follow facility policies/protocols for the prevention/treatment of skin breakdown.A physician order dated 08/13/25 for the right heel wound care revealed: Cleanse the right heel with wound cleanser. Pat dry. Apply betadine and leave open to air every - day shift for DTI.A physician order dated 08/13/25 for the left buttock wound revealed: Cleanse with wound cleanser. Pat dry. Apply collagen particles (a protein that regulates wound healing and forms a protective barrier against bacteria) and medihoney (used for antibacterial and anti-inflammatory effects and removes dead wound tissue). Cover with dry dressing every - day shift for wound care.Review of wound care documentation written by the Wound Nurse Practitioner (NP) dated 08/07/25 revealed a right heel deep tissue injury (DTI). The DTI measured 4 x 3 x 0 centimeters (cm). The wound was described as improving with 100% epithelial tissue (a type of body tissue that covers internal and external surfaces) without drainage.Review of wound care documentation written by the Wound NP dated 08/13/25 revealed an unstageable right heel pressure ulcer and a stage 2 left buttock pressure ulcer. The right heel pressure ulcer measured 4 x 3 x 0 cm. The wound was described as deteriorating with 100% eschar (black, crusty, dead tissue over or around a wound) without drainage. The left buttock pressure ulcer measured 2 x 2 x 0.1 cm with a small amount of serosanguinous drainage (light pink to red colored fluid) affecting the dermis (middle layer of skin).Observation and interview for Resident #56's wound care occurred on 08/14/25 at 10:05 AM with Nurse #2, Wound Care Nurse, and Nurse Aide (NA) #3. Nurse #2 removed the old dressing from Resident #56's right heel that showed a circular eschar (black, crusty, dead tissue over or around a wound) area with a yellow-pink center. Nurse #2 wiped and patted the heel wound with wound cleanser and then obtained a gauze 4x4 that Nurse #2 had previously placed betadine on. Nurse #2 used the betadine 4x4 gauze to pat Resident #56's right heel. She then used a clean 4x4 gauze and wiped over the betadine area of the right heel and replaced Resident #56's sock. Nurse #2 explained she was wiping off any excess betadine from Resident #56's heel. The Wound Care Nurse at this time spoke with Nurse #2 and told her that the heel was to have a generous amount of betadine and left to dry to air. Nurse #2 voiced understanding however Nurse #2 nor the Wound Care Nurse corrected the wound care that was provided. Continued observation of wound care at 10:20 AM revealed after performing hand hygiene, Nurse #2 moved to Resident #56's left buttock wound. NA #3 was observed holding Resident #56 on his right side. Resident #56 was wearing a brief. The brief was observed not to have any visible contamination. Nurse #2 unfastened the brief and removed the old dressing. There was no drainage observed on the old dressing. Nurse #2 obtained a 4x4 gauze that contained wound cleanser and proceeded to wipe Resident #56's wound from the bottom of the wound to the top then left outer edge to the right outer edge. When Nurse #2 turned to perform hand hygiene and obtain the clean dressing, NA #3 was observed to lay Resident #56 back onto his brief allowing the clean wound to touch his brief. Nurse #2 returned with the clean dressing and applied the dressing to Resident #56's left buttock wound without re-cleaning the area. The Wound Care Nurse was interviewed on 08/14/25 at 10:45 AM. All wound care provided for Resident #56 was reviewed. The Wound Care Nurse stated the left buttock wound touching the resident's brief, after it was cleaned, was acceptable due to the brief usually being changed prior to the wound care by the Nurse Aides. She stated a clean barrier

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to keep a urinary catheter drainage bag from touching the floor to reduce the risk of infection for 1 of 1 resident reviewed for urinary catheter (Resident #56).Findings included:Resident #56 was readmitted on [DATE]. Related diagnoses included urinary tract infection, chronic kidney disease, bacteremia (bloodstream infection), pyonephrosis (kidney infection).Physician order dated 08/06/25 for an indwelling urinary catheter to straight drainage related to acute kidney injury and secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction every shift for acute kidney injury.The significant change Minimum Data Set (MDS) dated [DATE] revealed Resident #56 was severely cognitively impaired without behaviors. The MDS documented an indwelling urinary catheter. The MDS showed Resident #56 was dependent on rolling left to right and lying to sitting on the side of the bed was not attempted.Care plan for Resident #56 dated 08/13/25 showed a focus for an indwelling catheter. The goals were for the resident to be/remain free from catheter-related trauma; and the resident will show no signs and symptoms of urinary infection. Interventions included position catheter bag and tubing below the level of the bladder and away from entrance room door and check tubing for kinks.On 08/15/25 at 8:08 AM an observation of Resident #56 showed the resident lying in bed. The indwelling urinary catheter bag was observed positioned below the level of the bladder on the floor and partially under the bed, covered with a privacy bag.Another observation on 08/15/25 at 8:53 AM showed the indwelling urinary catheter bag was positioned below the level of the bladder on the floor and partially under the bed, covered with a privacy bag.Follow-up observation on 08/15/25 at 10:10 AM revealed the catheter bag remained positioned below the level of the bladder on the floor covered with the privacy bag. A subsequent observation on 08/15/25 at 11:39 AM revealed the catheter bag remained on the floor covered with the privacy bag.Interview with Nursing Aide (NA) #2 on 08/15/25 at 1:32 PM confirmed that she was assigned to Resident #56. The NA observed the resident's catheter on the floor with the surveyor. NA #2 stated the catheter should not be touching the floor. She stated she did not know how the catheter ended up on the floor because she had hung it up on the side of the bed after providing Resident #56 with morning care. NA #2 stated the resident could not reach the catheter bag to knock it on the floor.Interview with Nurse #3 on 08/15/25 at 2:51 PM confirmed she was assigned to Resident #56. Nurse #3 stated she was unaware of the catheter bag lying on the floor. She confirmed that she had been in the resident's room throughout the day (08/15/25) and had not assessed the catheter and/or catheter bag. She stated she assessed catheters once per shift.Interview with the Director of Nursing (DON) on 08/15/25 at 4:07 PM revealed NA #2 made her aware Resident #56's catheter bag was lying on the floor. She acknowledged the bag should not be lying on the floor. Stated there were areas on the bedframe that were thinner and could be used to clip the bag to those areas. The DON stated the bag clip may be broken and the bag may need to be replaced.Interview with the Administrator on 08/15/25 at 4:27 PM revealed she was made aware of the catheter on the floor by NA #2 and that it should not be on the floor. She stated that it was difficult to keep catheter bags off the floor when the bed was in the lowest position. The Administrator stated that the resident could be responsible for the catheter drainage bag being on the floor by knocking it off.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to keep 1 of 1 walk-in refrigerator walls free of a dark black/green substance. The Findings Included: An initial tour of the kitchen was conducted on 8/12/2025 at 10:20 am. A dark black /green substance was observed on all four walls of the walk-in refrigerator. An area located under the refrigerator rack and adjacent to the walk-in freezer door was observed to have a large area of a dark black/green substance in the corner that extended to the floor. An interview and observation were conducted on 8/12/2025 at 10:25 am of the walk-in- refrigerator with the Dietary Manager. Upon observation of the walk-in refrigerator, the Dietary Manager stated she did not know what the substance was on the walk-in refrigerator walls. She further stated the dietary staff cleaned the walk-in- refrigerator every Wednesday. Although the walk-in refrigerator was cleaned, the substance continued to come back. The Dietary Manager indicated she had not notified the Maintenance Director or the Administrator that the substance continued to return. Interview and observation with the Maintenance Director on 8/12/2025 at 10:36 am revealed the dark black/green substance in the walk-in refrigerator appeared to be mold. He further revealed that what appeared to be mold could have been due to condensation. If the walk-in refrigerator door was not closed properly, the door seal would not ensure the walk-in refrigerator stayed cooled. The Maintenance Director stated he had not been notified of the substance in the walk-in refrigerator or that when it was cleaned it would return. An interview with the Administrator on 8/15/2025 at 4:51 pm revealed she had observed the walk-in refrigerator on 8/12/2025. She revealed she did not know what the substance was, but it was dark in color. She thought the substance was from when the walk-in refrigerator doors were not being closed properly. An outside agency had cleaned the walk-in refrigerator months ago, but she was not informed that the black substance had come back. She was unaware the Maintenance Director had no knowledge of the dark black/green substance.