	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		ONSTRUCTION		TE SURVEY MPLETED
			A. BUILDIN	IG			С
		345457	B. WING			0	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	HEALTH CARE CENTE	P		2065	LYON STREET		
DELAIRE	HEALTH CARE CENTE	ĸ		GAS	STONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE
	1			_	DEFICIENCY)		
F 000	INITIAL COMMENT	S	F 0	00			
	No deficiencies wer	e cited as a result of the					
	complaint investigat	ion. Event ID# 0W3G11.		_			
F 658 SS=D	Services Provided M CFR(s): 483.21(b)(3	/leet Professional Standards ;)(i)	F 6	58			4/11/18
		prehensive Care Plans					
		ed or arranged by the facility,					
	as outlined by the co	omprehensive care plan,					
		l standards of quality.					
	This REQUIREMEN	T is not met as evidenced					
	by:	and record review and staff			The statements included are not an		
		ons, record review and staff ty failed to transcribe a			The statements included are not an admission and do not constitute		
		pain management for 1 of 1			agreement with the alleged deficiencie		
		viewed for Hospice (Resident			herein. The plan of correction is	.0	
	#47).			c	completed in the compliance of state a		
	Finding included:			i	ederal regulations as outlined. To ren n compliance with all federal and state regulations the center has taken or will	9	
	Resident #47 was a	dmitted to the facility on			ake the actions set forth in the followir		
	07/27/17 with diagno	oses that included chronic		l F	plan of correction. The following plan	of	
	kidney disease, chro	• • •			correction constitutes the centers		
	Alzheimer's, and an	xiety disorder.			allegation of compliance. All alleged deficiencies cited have been or will be		
		erly Minimum Data Set (MDS)		c	completed by the dates indicated.		
		ed Resident #47 with					
	-	nt in cognition. The MDS					
		47 reported occasional pain			-658 The science of a surrouting of the surrouting		
	that limited his day-t	o-day activities.			The plan of correcting the specific		
	Review of the booning	tal discharge summary dated			deficiency. The plan should address th processes that lead	IE	
		nt #47 included a signed			to the deficiency cited; For resident #	47	
		e services" with the effective			nursing staff failed to transcribe orders		
		urther review revealed an			he Medication Administration Record		
	order which read, "n				were initiated by a hospice order when		
		edication) 20 milligrams			patient returned to the facility. This is		

Electronically Signed

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.

04/05/2018

TATEMENT (OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:		B	· · · ·	PLETED
						С
		345457	B. WING		03	3/22/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE	
BELAIRE	HEALTH CARE CENTER	1		2065 LYON STREET GASTONIA, NC 28052		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN ((X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	COMPLETIO
F 658	Continued From page	e 1	F 65	58		
		ake 0.25 ml (5 mg) by		direct result of a lack of a	attention to detail	
		ongue every 2 hours as		and education. Patient h		
	needed for pain or sh			outcome from this omissi	ion, however,	
				could have resulted in ca		
	Review of the March			provided that was ordere		
	Administration Record revealed no order for	d (MAR) for Resident #47 morphine sulfate.		the survey, the Morphine the MAR.	was added to	
		are (pharmacy used by the		The procedure for impler		
	-	s) proof of delivery form for		acceptable plan of correct	ction for the	
		nrough 03/12/18 revealed an		specific deficiency		
	-	Ifate 100 mg/5 ml solution		cited; In order to prevent		
	03/08/18 at 11:41 PM	received by the facility on I.		occurring again, all patien hospice patients that wer March 30, 2018 were che	e in-house as of	
	During an interview o	n 03/21/18 at 4:15 PM the		consults/hospice orders t		
		DON) confirmed a written		were no orders that were		
		Ilfate for Resident #47 was		If any missed orders we		
		spital, faxed to the facility's		physician and ordering p		
	pharmacy and the me	edication was received at the		immediately notified and		
		The DON verified the order		transcribed to the MAR/T		
	for morphine sulfate v			order was carried out and		
		onic medical record or		documented. The Staff N		
		. The DON stated she sician orders to be entered		educated starting on Mar the following process by		
	when received.			Development Coordinato resident returns to the fac	r. 1) When a	
	During an interview o	n 03/22/18 at 11:55 AM		consult visit or admission		
	-	ne worked on 03/08/18 when		nursing will review the co	-	
		admitted to the facility after a		and place them on the M		
	brief hospital stay. N			nurse will make a copy o		
	entered medications i			give to the Director of Nu	-	
	electronic medical rec			either check herself or de	-	
		ed on the hospital discharge		Unit Manager or Assistar	÷	
	summary. Nurse #1 s			Staff Development Coord		
	-	order for morphine sulfate lectronic medical record.		the Consult sheet if provi provider for any new orde		
				through Friday. 3) If ord	-	
	During an interview o	n 3/22/18 at 4:31 PM the		then the patients chart w		

Event ID:0W3G11

Facility ID: 922964

If continuation sheet Page 2 of 14

		ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 04/09/2018 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>i</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345457	B. WING				C / 22/2018
NAME OF P	ROVIDER OR SUPPLIER	1		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
BELAIRE	HEALTH CARE CENTER	2			065 LYON STREET		
				G	ASTONIA, NC 28052		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658		e 2 it was his expectation ere entered when received.	F	658	ensure that the order was transcribed the patients MAR/TAR if order was obtained during provider visit. 4) If or was present on the consult sheet and transcribed then documentation of re-education for the first infraction by nurse and disciplinary action for any further infractions. Nurses not educa on the above process on April 9, 2018 be removed from schedule until educa is received. This process will be inclu as part of the Orientation program for hires. The monitoring procedure to ensure the the plan of correction is effective and specific deficiency cited remains correct and/or in compliance with the regulator requirements; When a resident return to the facility from a consult visit or admission, nursing will review the com for orders and place them on the MAR/TAR. The nurse will make a cop the consult and give to the Director of Nursing who will either check herself delegate to the Unit Manager or Assis Unit Manager, Staff Development Coordinator, will check the Consult sl if provided by the provider for any new orders Monday through Friday. If order are present then the patients chart will checked to ensure that the order was transcribed to the patients MAR/TAR applicable. If order was present and ne transcribed then documentation of re-education for the first time and disciplinary action for further infractior This audit will continue daily Monday through Friday X 4 weeks, weekly X 4	rder not a ted a tion ded new nat that ected ory ns sult oy of or tant neet v ers I be if not	

Event ID:0W3G11

Facility ID: 922964

If continuation sheet Page 3 of 14

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION BUILDING	(X3) DATE SURVEY COMPLETED
345457 В.	WING	C
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, S	STATE, ZIP CODE
BELAIRE HEALTH CARE CENTER	2065 LYON STREET GASTONIA, NC 28052	2
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORR	R'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE COMPLETION ENCED TO THE APPROPRIATE DATE DEFICIENCY) DATE
F 658 Continued From page 3 F 761 Label/Store Drugs and Biologicals SS=E CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h) (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	How facility will m action(s) to ensur not re-occur: Th responsible to en correction is imple findings will be re	bi-weekly X 10 months. nonitor corrective re deficient practice will ne administrator will be sure that the plan of emented. Audits of viewed at the Quality mance Improvement ng, monthly for 4

If continuation sheet Page 4 of 14

		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345457	B. WING		C 03/22/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
				2065 LYON STREET	
BELAIRE	HEALTH CARE CENTER			GASTONIA, NC 28052	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
F 761	Continued From page	e 4	F 761		
	quantity stored is min be readily detected.	imal and a missing dose can is not met as evidenced			
	by: Based on observations, record review, and staff interviews the facility failed to remove 1 vial of			F761	
	opened and expired I			The plan of correcting the specif	
		ooms in the facility and failed		deficiency. The plan should addr	
		bened and expired Advair		processes that lead to the deficie	ency
		le of opened and expired blution, 1 opened Novolog		cited: Facility failed to discard a vial of	expired
		ning date, and 1 bottle of		Novolog Insulin, 1 box of opened	
	-	0.9% Sodium Chloride		expired Advair Diskus inhaler, 1	
		el in 3 of 5 medication carts		opened and expired glucometer	
	in the facility.			3 bottles of opened bacteriostation	
				Sodium Chloride solution, 1 oper	ned
	Findings included:			Novolog FlexPen without an ope	ning date.
				This is a direct result of the lack	-
	-	policy section 5.3 regarding		attention to detail when preparin	g med
		on of Medications, Biological,		charts for med pass.	
		s dated 11/14/17 indicated		The Dreadure for implementing	the
	-	d ensure that medications n expiration date on the		The Procedure for implementing acceptable plan of correction for	
	label, had not been re	-		specific deficiency cited:	
		manufacturer or supplier		Drugs and biologicals in each me	edication
	-	ot been contaminated or		cart were audited, and any expire	
	deteriorated.			unlabeled or not dated items, or	
				items were removed and dispose	ed of per
		once any medication or		facility policy.	
		as opened, the facility should		Nurses were in-serviced on Pha	-
		supplier guidelines with		Policy 5.3 Storage and Expiratio	
	respect to expiration	-		of Medications, Biologicals, Syrir	•
		facility staff should record he medication container		Needles, 5.0 Once any medica biological package is opened, Fa	
		had a shortened expiration		should follow manufacturer/supp	-
	date once opened.			guidelines with respect to expira-	
				for opened medications. Facility	
	A review of the facility	y protocol titled Insulin		should record the date opened of	
		lation with revision dated		medication container when the n	

Facility ID: 922964

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345457 B. WING 03/22/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET **BELAIRE HEALTH CARE CENTER** GASTONIA, NC 28052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 761 Continued From page 5 F 761 03/31/2015 indicated that Novolog vials and has a shortened expiration date once Novolog Flex Pens should be labeled with date opened. 5.1 Facility Staff may record the opened and were to be discarded after 28 days. calculated expiration date based on date opened on the medication container, 5.2 A review of the facility protocol titled Medications with a manufacturers Recommended Minimum Medication Storage expiration date expressed in month and Parameters (based on manufacturer guidance) year (e.g. May, 2019) will expire the last Inhaled Medications with revision dated 03/31/15 day of the month.. Nurses during indicated that Advair Diskus should be dated in-service were given a copy of the when removed from the foil pouch and discarded **Omnicare Insulin Storage** 1 month after removal from the foil pouch or after Recommendations. The Facility will all blisters had been used, whichever came first. require that nursing personnel will inspect nursing station storage areas for proper 1. a. Resident #37 was admitted to the facility on storage compliance on a regularly on a 05/10/13 with diagnoses included diabetes weekly basis. mellitus (DM). The monitoring procedure to ensure that A physician's order dated 01/27/17 indicated that the plan of correction is effective and that Resident #37 was to receive Novolog per sliding specific deficiency cited remains scale before meals and at bedtime corrected/and or in compliance with the subcutaneously four times daily related to type II regulatory requirements: DM. Director of Nursing, RN Unit manager, or House Supervisor will conduct audit of On 03/21/18 at 09:53 AM an expired vial of drugs and biologicals on each medication Novolog for Resident #37's was found in the cart Monday - Friday X 4 weeks, Weekly refrigerator of Main medication storage room on X 4 weeks and bi-weekly X 10 months. North unit. There was a yellow sticker located on Results of audits will be reviewed at the opened Novolog vial indicated it was opened Weekly Quality Assurance Risk meeting on 02/13/18 and the space for expiration was for further problem resolution if needed. All new hire licensed nurses will be blank. The sticker stated the Novolog vial should be refrigerated until opened and discarded educated in general orientation on storage unused insulin after 28 days. and expiration of drugs and biologicals. On 03/21/18 at 09:59 AM an interview was conducted with Nurse #2. She acknowledged that The Title of the person responsible for the vial of Novolog was expired and had to be implementing the acceptable plan of discarded. She stated each nurses were correction: instructed to check the expiration of the Director of Nursing will be responsible to medication before administration and to check ensure that the plan of correction is

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 0W3G11

Facility ID: 922964

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	OF DEFICIENCIES	MEDICAID SERVICES		E CONSTRUCTION		D. 0938-039 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION	` '		
					С		
		345457	B. WING		03/22/2018		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BELAIRE	HEALTH CARE CENTER			2065 LYON STREET			
				GASTONIA, NC 28052		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 761	Continued From page	e 6	F 761				
		cation cart each shift to		implemented. The Administrator	will		
		expired medication. She did		ensure that the audits are reviewe	ed and		
		his vial of Novolog was tor of the Main medication		discussed at the Quality Assurance Performance Improvement Comm			
	storage room.			Meeting, monthly for 4 months an			
				minimum quarterly thereafter for a			
		Administration Record		of 8 months.			
		dent #37 had been receiving usly per sliding scale as					
		d glucose (BG) levels in the					
		remained at the baseline.					
	 b. Resident #18 was admitted to the facility on 04/04/16 with diagnoses included type II DM. 						
	Resident #18 was to	ated 09/26/16 indicated that receive Novolog per sliding v one times daily at noon					
	On 03/21/18 at 10: 26 AM an opened Novolog FlexPen was found in the medication cart #3 on North Unit and it was undated. There was a yellow sticker located on the opened Novolog FlexPen with a space for date opened and it was blank.						
	conducted with Nurse had used the Novolog Medication Cart #3 fo noon. She stated that have indicated the da opening date, she wo expiration date. Nurse received training and	or Resident #18 yesterday at the yellow sticker should the opened and without an ould unable to determine the e #3 added she had					

Facility ID: 922964

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345457	B. WING				C 22/2018
NAME OF PI	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
BELAIRE	HEALTH CARE CENTER				2065 LYON STREET GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	27	F	761			
	receiving Novolog sul	aled Resident #18 had been ocutaneously per sliding her BG levels in the past ned at the baseline.					
		dmitted to the facility on ses included dyspnea and					
	Resident #8 was to re	ated 06/0917 indicated that eceive Adviair Diskus 250/50 pump by mouth every 12 d respiratory failure.					
	Advair Diskus 250/50 medication cart #3 on sticker on the inhaler	AM an expired box of mcg was found in the North Unit. There was a box indicated it was opened ed it would be expired 1					
	had used the Advair E on Medication Cart #3 morning. She thought it was opened for 48 of had been instructed to of each medication be was no sure who was	# #3. She confirmed that she Diskus 250/50 mcg located B for Resident #18 this Advair could be used after days instead of 30 days. She b check the expiration dates efore administration but she					
	30 millimeter (ML) mu 0.9% sodium chloride	59 AM an opened bottle of Itiple dose bacteriostatic solution for injection nd in medication cart #1 on					

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	••••••	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/09/2018 // APPROVED). 0938-0391
STATEMENT OF DEFI	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345457	B. WING					C 22/2018
NAME OF PROVIDE	R OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, Z	IP CODE		
BELAIRE HEALT	TH CARE CENTER				2065 LYON STREET GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD B		(X5) COMPLETION DATE
F 761 Cont	inued From page	8	F	761				
cond wher sodiu state each there medi e. O Assu solut North glucc open manu expir sticke 90 da On 0 cond work had b medi abou main medi abou main medi sticke 90 da	lucted with Nurse in the multiple dos um chloride soluti ed he would check in medication before was no set time ication on regular on 03/21/18 at 11: ure high dose level ican was found in th Unit. There was cometer control so need on 08/10/17. Julfacturer's specifi red on 10/31/17. I er on the bottle in ays of first openin 03/21/18 at 01:32 lucted with Nurse ing part-time for 2 been instructed to ication cart thorou at the frequency. So that her medicati ications and she onsibility. She con cometer control so agreed that the g expired and shou buted the incident	27 AM an expired bottle of el 2 glucometer control the medication cart #2 on a sticker on the opened lution indicated it was According to the ication on the bottle, it was In addition, there was a addicated it should be used ag. PM an interview was • #4. She stated she was 2-3 shifts per week. She o check the entire ughly but was not sure She had been trained to on cart free of expired was aware of her uld not recall when the lution was used recently. lucometer control solution ld be discarded. She • as an oversight. AM an interview was rector of Nursing (DON). ses had been instructed to						

Facility ID: 922964

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/09/2018 / APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION			LETED
		345457	B. WING			_		C 22/2018
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
BELAIRE	HEALTH CARE CENTER				2065 LYON STREET GASTONIA, NC 28052			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID			S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 761	medications that were	9 in or inhaler, to ensure each e readied for use in the e labeled, and to discard	F	761	1			
	expired medications a specifications in a tim staff had been educated	according to manufacturer's ely manner. All the nursing ted to check the expiration tion before dispensing and						
	they were supposed t medication cart at lea addition, unit manage	o check their respective st once every shift. In rs would perform follow-up						
	and storage rooms in would send staff to th	k for all the medication carts the facility. The pharmacy e facility to check for expired quest. The DON attributed						
	staff were conducting It was her expectation and storage rooms to medication and to ens	f attentiveness when nursing expired medication checks. n for all the medication carts be free of expired sure all medications in the e labeled according to facility						
	On 03/22/18 at 03:59 conducted with the Ac facility had a system f place. However, due position that resulted	dministrator. He stated the for medication storage in to turnovers in leadership in lack of clinical leadership						
	his expectation for all	y found in the facility. It was the medication carts and ree of expired medication eadied for use in						
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(g)(2)(ent Activities	F	867	7			4/11/18
	§483.75(g) Quality as	sessment and assurance.						

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/0 FORM APPI OMB NO. 0930	ROVE
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
		345457	B. WING		C 03/22/20	18
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				2065 LYON STREET		
DELAIRE	HEALTH CARE CENTER	e e e e e e e e e e e e e e e e e e e		GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMP	X5) PLETION ATE
F 867	Continued From page	e 10	F 86	7		
1 007			F 00			
		ality assessment and				
	assurance committee	e must: ement appropriate plans of				
		tified quality deficiencies;				
		Γ is not met as evidenced				
	by:					
	Based on observation	ons, record reviews, and		F867		
	resident and staff inte	erviews the facility's Quality		The plan of correcting the speci	fic	
		urance (QAA) committee		deficiency. For resident #47, n	-	
		plemented procedures and		staff failed to transcribe orders t		
		that the committee had		Medication Administration Reco		
		ace. This failure related to		were initiated by a hospice orde		
		es that were originally cited 7 recertification survey,		patient returned to the facility. direct result of a lack of attentio		
	recited following the			and education. Patient had no		
	-	ited again on the current		outcome from this omission, ho	-	
		mplaint investigation survey.		could have resulted in care not		
		ies were in the areas of		provided that was ordered. At t		
	providing care accord	ding to professional		the survey the Morphine was ad	ded to the	
	standards and label/s	store drugs and biologicals.		MAR.		
		of the facility during three				
		cord show a pattern of the		Nursing staff failed to discard a		
		ustain an effective Quality		expired Novolog Insulin, 1 box		
	Assurance Program.			and expired Advair Diskus inhal		
	Findings included:			of opened and expired glucome solution, 3 bottles of opened ba		
	r munys muudeu.			0.9% Sodium Chloride solution,		
	This tag is cross refe	renced to:		Novolog FlexPen without an op	-	
				This is a direct result of the lack	•	
	1. a. 483.21 Providin	g Care According to		attention to detail when preparin		
		ds: Based on observations,		charts for med pass.		
	record review and sta	aff interviews, the facility				
		medication order for pain		The procedure for implementing		
	management for 1 of	-		acceptable plan of correction fo	r the	
	reviewed for Hospice	e (Resident #47).		specific deficiency		
				cited; In order to prevent this fr		
	÷ .	investigation of 01/05/18 the		occurring again, all patient char		
	-	ailure to transcribe orders for		hospice patients that were in-ho		
	wound care.			March 30, 2018 were checked f	UI	

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		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURV COMPLETE	
			A. BUILDING	3		
		345457	B. WING		C	
	ROVIDER OR SUPPLIER	545457		STREET ADDRESS, CITY, STATE, ZIP CO	03/22/20	J18
	ROVIDER OR SUPPLIER			2065 LYON STREET	JDE	
BELAIRE	HEALTH CARE CENTER	1		GASTONIA, NC 28052		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COM TE APPROPRIATE	MPLETIC DATE
F 867	Continued From page	e 11	F 86	57		
				consults/hospice orders to e	ensure there	
		e Drugs and Biologicals:		were no orders that were no		
		ns, record review and staff		If any missed orders were for		
		failed to remove one vial of		physician and ordering phys		
	opened and expired I	booms in the facility and failed		immediately notified and the transcribed to the MAR/TAR		
		opened and expired Advair		order was carried out and ca		
		ottle of opened and expired		documented. The Staff Nur		
		olution, one opened Novolog		educated starting on March		
	FlexPen withoug ope	ning date, and one bottle of		the following process by the		
		0.9% sodium chloride		Development Coordinator.		
	solution without a label in 3 of 5 medication carts			resident returns to the facilit	-	
	in the facility.			consult visit or admission to		
	During the recertificat	tion survey of 04/06/17 the		nursing will review the const and place them on the MAR		
	-	ailure to remove opened and		nurse will make a copy of th	-	
	-	and an expired oral inhaler		give to the Director of Nursi		
	from medication carts	-		either check herself or deleg		
	opened and undated	vial of Influenza vaccine and		Unit Manager or Assistant U		
	an expired injectable	-		or Staff Development Coord		
		and failure to discard		check the Consult sheet if p	-	
		uid supplement stored at		provider for any new orders		
	room temperature.			through Friday. 3) If orders then the patients chart will b	-	
	During an interview o	n 03/22/18 at 4:21 PM the		ensure that the order was tr		
		after the recertification		the patients MAR/TAR if ord		
		t investigation the QAA met		obtained during provider vis		
	to review the areas of	f concern and systems were		was present on the consult	,	
		ect the deficiencies cited. He		transcribed then documenta		
		past year the facility had		re-education for the first infr	-	
		leadership and have noticed		nurse and disciplinary action	-	
		e Director of Nursing started added he was confident		further infractions. Nurses r on the above process on Ap		
		the right direction now that		be removed from schedule		
	the facility had strong			is received. This process w		
	Administrator indicate	-		as part of the Orientation pro		
		ored to address issues		hires.	-	
	identified.					
				Drugs and biologicals in eac	ch medication	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/09/2018 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345457	B. WING				C 22/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
				20	065 LYON STREET		
DELAIRE	HEALTH CARE CENTER			G	ASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	Continued From page	≥ 12	F	867	cart were audited, and any expired ite unlabeled or not dated items, or loose items were removed and disposed of facility policy. Nurses were in-serviced on Pharmacc Policy 5.3 Storage and Expiration Dat of Medications, Biologicals, Syringes Needles, 5.0 Once any medication of biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration of for opened medications. Facility staff should record the date opened on the medication container when the medic has a shortened expiration date once opened. 5.1 Facility Staff may record calculated expiration date based on d opened on the medication container, Medications with a manufacturers expiration date expressed in month a year (e.g. May, 2019) will expire the la day of the month Nurses during in-service were given a copy of the Omnicare Insulin Storage Recommendations. The Facility will require that nursing personnel will ins nursing station storage areas for prop storage compliance on a regularly on weekly basis. The monitoring procedure to ensure to the plan of correction is effective and specific deficiency cited remains corre and/or in compliance with the regulator requirements; When a resident retur to the facility from a consult visit or admission, nursing will review the corr for orders and place them on the MAR/TAR. The nurse will make a cop the consult and give to the Director of	e pills per y ing and or lates ation the ate 5.2 nd ast spect er a hat that ected ory ns sult oy of	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 04/09/2018 FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULT		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345457	15457 B. WING			C 03/22/2018		
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
BELAIRE HEALTH CARE CENTER				2065 LYON STREET				
BELAIRE HEALTH GARE GENTER				GASTONIA, NC 28052				
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		SHOULD BE COMPLETION		
F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	867	Nursing who will either check herself delegate to the Unit Manager or Assis Unit Manager, Staff Development Coordinator, will check the Consult s if provided by the provider for any new orders Monday through Friday. If ord are present then the patients chart wi checked to ensure that the order was transcribed to the patients MAR/TAR applicable. If order was present and transcribed then documentation of re-education for the first time and disciplinary action for further infraction This audit will continue daily Monday through Friday X 4 weeks, weekly X 4 weeks and then bi-weekly X 10 month Director of Nursing, RN Unit manage House Supervisor will conduct audit of drugs and biologicals on each medica cart Monday - Friday X 4 weeks, Week X 4 weeks and bi-weekly X 10 month Results of audits will be reviewed at Weekly Quality Assurance Risk meetif for further problem resolution if needed All new hire licensed nurses will be educated in general orientation on sto and expiration of drugs and biological How facility will monitor corrective action(s) to ensure deficient practice of not re-occur: The administrator will responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Qualit Assurance Performance Improvement Committee meeting, monthly for 4 months, for review and revision as needed.	CTION SHOULD BE D THE APPROPRIATE NCY)		

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