PRINTED: 12/21/2023 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345457	B. WING		C 11/28/2023
	ROVIDER OR SUPPLIER	3	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	3	F 000		
	conducted from 11/2 9S3Q11. The credib was validated on 11/2 date was changed to intakes were investig NC00209806, NC00 Five (5) of the 11 alle deficiency. Intake #N NC00209471 and NC immediate jeopardy. Immediate Jeopardy CFR 483.10 at tag Fa (J) CFR 483.25 at tag Fa (J)	209471 and NC00210488. egations resulted in a IC00209983, NC00209806, C00210488 resulted in			
F 580 SS=J	removed on 11/23/23 was conducted. Notify of Changes (Ir CFR(s): 483.10(g)(14) Notifi (i) A facility must imm consult with the residuents of the consistent with his or representative(s) who (A) An accident involvesults in injury and his physician intervention.	cation of Changes. nediately inform the resident; lent's physician; and notify, r her authority, the resident en there is- ving the resident which nas the potential for requiring	F 580		12/23/23
_ABORATORY I		SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u> =	TITLE	(X6) DATE

Electronically Signed 12/19/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345457	B. WING			·	28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 065 LYON STREET BASTONIA, NC 28052	1102	20/2023
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE	
F 580	status in either life-thr clinical complications (C) A need to alter trea a need to discontinue treatment due to advecommence a new form (D) A decision to transresident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proving physician. (iii) The facility must a resident and the resident	ial status (that is, a an, mental, or psychosocial reatening conditions or an); seatment significantly (that is, an existing form of erse consequences, or to an of treatment); or after or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or as as specified in paragraph ecord and periodically mailing and email) and	F	580			

OLIVIER	O I OIT MEDIO, TILE O	WEDIO/ ND OLIVIOLO					7. 0000 000 I
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				_		(С
		345457	B. WING			11/	28/2023
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BELAIRE	HEALTH CARE CENTER				065 LYON STREET		
				G	GASTONIA, NC 28052		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	by: Based on record revi Practitioner (NP), Phy physician (MD) interv communicate with Re about intermittent loo for polyethylene glyco occasional constipation history of Clostridium in the colon which ha from diarrhea to life-th colon), also known as to notify the medical p stool culture for a res facility failed to notify acute changes in con loose stools, increase and new behavior of a bed on 11/6/23, and b not at her baseline. F emergency room and (a life-threatening cor infection), hypotherm infarction (heart attac 11/10/23. This deficie residents reviewed for The immediate jeopa Resident #1's physici changes in the reside immediate jeopardy w when the facility imple allegation of immedia facility will remain out	ew, family, staff, Nurse vician's Assistant (PA), and iews, the facility failed to sident #1's Medical Provider se stools following an order of (a medication used to treat on and soften stool) with a difficile (a bacterial infection we symptoms that range preatening damage to the se C-difficile. The facility failed provider of an abnormal ident with C-difficile. The the medical provider of dition consisting of multiple and confusion, disorientation, attempting to climb out of low blood pressure that were resident #1 was sent to the low was diagnosed with sepsis inplication of a current if it, and type 2 myocardial k). Resident #1 expired on lent practice affected 1 of 2 in physician notification. In the medical provider of dition consisting of multiple and the was diagnosed with sepsis inplication of a current if it, and type 2 myocardial it, and type 2 myocardia	F	580	The facility sets forth the following plar correction to remain in compliance with federal and state regulations. The facil has taken or will take the actions set for in the plan of correction. The following plan of correction constitutes the facility allegation of compliance. All deficiencic cited have been or will be corrected by date or dates indicated. F580 1. For resident # 1, a stool culture was obtained on 10/30/2023 and resulted a positive C- Difficile. Abnormal laborator result was not reported to provider resulting in positive lab result not being treated for C-Difficile from 10/30-11/06/2023. The facility failed to notify provider regarding abnormal behavior exhibited by the resident on 11/06/2023. The facility failed to notify the provider of a low blood pressure on 11/07/2023. The Director of Nursing/ Staff Development Coordinator and Regional Director of Clinical Services reviewed is 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes behaviors have been reported to the provider. This will be completed by 11/22/2023. 2. Current residents are at risk	n all lity lity with y□s es the as sry lithe	
	monitoring systems p	ut into place are effective.			3. Education will be provided by		

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		345457	B. WING				28/2023
NAME OF P	ROVIDER OR SUPPLIER			S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE] 11/2	20/2023
				20	065 LYON STREET		
BELAIRE	HEALTH CARE CENTER	ł.		G	ASTONIA, NC 28052		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		CIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION S		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 580	Continued From page	e 3	F 580				
	The findings included	l:			11/22/2023, by the Director of Nursing,		
	J				Staff Development Coordinator, or		
		nitted to the facility on			designee to current licensed full time, p		
		es that included status post			time, as needed, and contracted licens		
		turia (bladder inflammation			nursing staff (if applicable). Education	will	
		t in the urine) and surgical			be on proper notification to providers,		
		us of the bile duct with			including abnormal lab results, abnorm		
	chronic cholecystitis without obstruction				vital signs, acute changes in condition abnormal behaviors from baseline.	and	
(gallstones) and abdominal hernia with obstruction or gangrene and a history C-Difficile colitis.					Education will be provided by 11/22/20	23	
		and a filotory of			by the Director of Nursing, Staff		
	o Billiono contio.				Development Coordinator or designee	to	
	A hospital discharge	summary dated 10/5/23			current full time, part time, as needed a		
	indicated Resident #				contracted staff (if applicable) certified		
	Emergency Room (E	R) with abdominal pain and			nursing assistants and therapy staff on		
		ed abdominal surgery for			reporting acute changes in condition to		
	the gallstones.				the charge nurse of the patient		
					immediately and reporting abnormal vit	al	
		ated 10/5/23 indicated			signs The expectation would be to		
		ate 500-125 milligrams (mg) at infection) three times per			receive orders to address the situation reported to the provider. Staff not work	ina	
		stitis. Additionally, Lisinopril			on 11/22/2023 will receive education p		
		treat heart failure and blood			to the start of their shift after 11/22/202		
		by mouth was ordered for			The Staff Development Coordinator wil		
	hypertension.	•			track and ensure education is provided		
					No nursing staff or therapy staff will be		
	A one-day post admis	ssion progress note dated			allowed to work until education is		
	•	e NP indicated Resident #1			received.		
	was admitted to the fa				New nursing staff or therapy staff will		
	•	6/23 through 10/5/23 status			receive education in orientation.	.	
	post endoscopic retro				4. Director of Nursing or designee wi		
		raphy (a procedure using a nd treat problems of the			audit the past 24 hours progress notes behaviors, labs and vital signs for	IUI	
	, ,	system) on 9/28/23 and			abnormal values, and acute episodes t	_	
		ledocholithiasis (gallstones),			ensure provider notification has occurre		
	incarcerated hiatal he	· · · · · · · · · · · · · · · · · · ·			5x weekly x 8 weeks, 3x weekly x 8 we		
		a hernia which can become			and weekly x 8 weeks.		
		reated) on 10/3/23. The note					
		1 was to receive Amoxicillin/			5. The Director of Nursing will provide	э	

Facility ID: 922964

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345457	B. WING _			l	28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE 165 LYON STREET ASTONIA, NC 28052	1	20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 580	per day from 10/6/23 also indicated she was she was pushing a movement last night soft, non-tender, and hepatospleenomegal enlargement). The nor #1 had hospital labs of the following values: cells (WBC) 12.07 and used to monitor kidne assessment listed the behaviors, no gastroid ability to tolerate food hypertension with system and per label to the behaviors of the monitor with system and the per label to the behaviors of the system of the label to the behaviors of the system of the label to the behavior of the system of the label to the behavior of the system of the nurse adiarrhea x 1 day. A review of the nurse 10/07/23 revealed no or contacting the Medic (MAR) dated October administered Resider Loperamide on 10/7/24 Attempts to contact Not A skilled progress not 10/8/23 at 4:23 PM in	mg by mouth three times through 10/9/23. The note is positive for constipation and straining to have a bowel (10/5/23) with her abdomen without by (liver and spleen of the also revealed Resident for 10/4/23 which indicated slightly elevated white blood did a normal creatinine (test by function) level of 0.9. The efollowing: negative for intestinal (GI) upset with als and liquids, and stolic blood pressures to 140's on treatment of conitor blood pressure daily. Interest 10/7/23 indicated edication used to treat loose ch loose stool as needed for thing related to loose stools dical Provider to obtain an exation Administration Record to 2023 revealed Nurse #6 and #1 a single dose of 23. Iturse #6 were unsuccessful.	F	580	Results of the audits will be reviewed a Quarterly Quality Assurance Meeting X for further resolution if needed. 6. Date of Compliance 12/23/2023		

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		345457	B. WING _			11/2	; 28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052			.0,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	A review of the MAR of indicated Nurse #7 ac single dose of Loperal An interview on 11/28 #7 revealed she could she was moved to the admission and Nurse involvement with her notifying the Medical A review of the Medical A review of the Medical (MAR) dated October received Loperamide AM and again on 10/8 A provider progress non 10/9/23 indicated 13-day post admission Resident #1 was not complained to her (the	e #7 notified the Medical #1's loose stools. dated October 2023 dministered Resident #1 a mide on 10/8/23. //23 at 10:00 AM with Nurse d not recall Resident #1 as a South Unit shortly after #7 had no further care. She could not recall Provider of the loose stools. ation Administration Record 2023 indicated Resident #1 2mg on 10/7/23 at 10:29 8/23 at 5:14 PM. ote was written by the NP Resident #1 was seen for a visit. The note indicated	F 5		ENCT)		
	stools that day prior to complained of abdom vomiting. Resident #1 indigestion. The note reported to the NP abon 2/20/23. The note were provided to obtator C-Difficile and discuss administered over	indicated Resident #1 had out her history of C-Difficile further indicated orders in a stool specimen to test continue Loperamide that er the weekend.					

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F 580	Resident #1 was pos A progress note writte a 5-day post admission Resident #1 continue abdominal pain, and culture continued to be visit. Resident #1 is of continued to have a significant with hyperactive bow bladder distention. The #1 had experienced of to the visit. The note were received to star by mouth daily (used diarrhea) and continue condition pending C- The note further indic pressure of 136/66 at as ordered. A nurse progress note Manager dated 10/11 the family member re abnormal lab results C-Difficile colitis and initiated. A physician's order de Cholestyramine Light give one packet by m to diarrhea. A physician's order de Vancomycin (antibiotic	ated 10/10/23 indicated itive for C -difficile colitis. en by the NP on 10/11/23 for on visit. The note indicated d to complain of diarrhea, indigestion. C-Difficile of pending at the time of the currently not able to eat well, soft, non-tender abdomen el sounds and negative for ne note indicated Resident 6 watery stools that day prior further indicated new orders to Cholestyramine 1 packet off label for bile acid the to monitor Resident #1's Difficile laboratory results. Eated Resident #1 had blood and to continue the Lisinopril the written by the Unit 1/23 indicated she spoke with garding Resident #1's and testing positive for antibiotic therapy would be sated 10/11/23 indicated to Oral Packet 4 grams (GM) to outh one time a day related ated 10/11/23 indicated ic 125 milligrams give one y for C-difficile. The order	F	580			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345457	B. WING		C 11/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 580		e 7 um Data Set (MDS) dated lesident #1 was cognitively	F 580			
	by the MD dated 10/was positive for diarrand negative for dys also revealed Reside non-tender, and no gwith normal cognition both recent and remedesident #1 had a lawhich was positive for A laboratory report diarrangement.	boratory test on 10/10/23 or C-Difficile. ated 10/12/23 indicated				
	immune ability to figl elevated to 26.7 (no Creatinine (test for k 1.16 (normal being 0 protein was 28.70 (te	,				
	10/13/23 indicated R on quarantine for C-have watery stools, a nausea was present reviewed with the fol of 26.7, low calcium normal creatinine at a high CRP of 28.7. positive for weaknes strength and mobility or bladder distension	note written by the NP dated desident #1 had been placed Difficile and continued to abdominal pain, and now. Laboratory results were lowing noted: elevated WBC at 8, elevated BUN 21.1, 1.16, low sodium at 132, and At this visit, Resident #1 was a and fatigue, decrease and negative for confusion a. Resident #1's plan of care llowing: Start intravenous				

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		345457	B. WING				28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER	·		2	STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		
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F 580	(cc) per hour for 48 h sodium level. Repeat (10/16/23) to compar previously prescribed secondary to high WI Flagyl 500mg IV ever Discontinue Vancomy At this visit, Resident reviewed to be between and staff were to adm. A physician's order described and Sodium Chloride 0.48 milliliters per hour for acute kidney injury and discontinued on 10/10. A physician's order described for acute kidney injury and discontinued on 10/10. A physician's order described for acute kidney injury and discontinued on 10/10. A physician's order described for acute kidney injury and discontinued on 10/10. A physician's order described for acute kidney injury and discontinued on 10/10. A physician's order described for acute kidney injury and discontinued on 10/10. A provider progress researched for acute for	aline 60 cubic centimeters ours) secondary to a low c CBC and CMP on Monday e trends. Resident was I Vancomycin orally, but BC she was switched to ry 6 hours x 7 days. ycin once Flagyl had started. #1's blood pressures were een 120's and 140's systolic ninister Lisinopril as ordered. ated 10/13/23 indicated 5% intravenous. Give 60 (ml) 3 days for dehydration, and C-Difficile. The order was	F	580			
	14-day post admission during this visit Residuhich completed 10/10/10/10/10/10/10/10/10/10/10/10/10/1	esident #1 was seen for a on visit. The note indicated lent #1 remained on IV fluids 16/23 and Flagyl via midline liarrhea was "uncontrollable".					

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	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	_	11/20/2023	
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F 580	was normal at 9.0, 0 produced by the live and Creatinine was care included the following completed and addrimprovement in Reswith a normal WBC Creatinine, and sodi indicated Resident # between 120's and on Lisinopril for trea given on this visit. A provider progress 10/20/23 indicated Fimprovement but costaff reports of decreorders included: extra 10 days. A physician's order of Flagyl (antibiotic) 50 Provide 500 mg (IV) for Enterocolitis due 3 days. A physician's order of Flagyl 500 mg by more than 10 mg by more order was discontinuity of the order	alues: white blood cell count c-reactive protein (a protein r) remained elevated at 15.8 normal at 0.90. The plan of lowing: Continue Flagyl until essed a significant ident #1's laboratory results and improving BUN, um levels. The note also the blood pressure remained 140's systolic and continued the three worders were the three with the essence of the blood pressure remained 140's systolic and continued the three with the essence of the blood pressure remained 140's systolic and continued the three with the essence of the blood pressure remained 140's systolic and continued the essence of the blood pressure remained 140's systolic and continued the essence of the blood pressure remained 140's systolic and continued the blood pressure remained 140's systolic and continued to have diarrhea with essence of the blood pressure that the blood pressure is the blood pressure that the blood	F 5				

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F 580	10/25/23 indicated R surgical consult and and give polyethylene Give one scoop by m constipation. The not notified the Medical F ongoing loose stools An interview with Nur AM revealed she couprovided by the surgip previously educated consultation commur not question the ordetreatment for C-Difficialso could not recall in Provider of the new of continued to have loot therapy. A physician's order dipolyethylene glycol 1 scoop by mouth once constipation. A provider note writter indicated Resident # admission visit. The inhad improved with G with on and off diarrh semi-formed stools. #1's had completed halso indicated Resider remained between 12 continued Lisinopril for were given on this visit.	resident #1 was seen for a new orders to advance diet e glycol 17 grams per scoop. Touth once a day related to e did not indicate Nurse #4 Provider of the new order or following antibiotic therapy. The see #4 on 11/28/23 at 9:00 and not recall the order cal consult but entered as from the surgical dication form. Nurse #4 did the because the antibiotic and in the surgical force or that Resident #1 are stools following antibiotic atted 10/25/23 indicated 7 grams per scoop. Give one e a day related to the NP dated 10/27/23 at was seen for a 21-day post anoted reflected Resident #1 asymptoms but continued ea mixed with some the note indicated Resident ther IV antibiotics. The note ent #1's blood pressure 20's and 140's systolic and or treatment. No new orders	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED	
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F 580	every 8 hours for 3 d for a total 8 doses) - Lisinopril 10 mg da except 10/20/23, 10/ BP was outside of th - Cholestyramine Lig one packet by mouth diarrhea (10/12 throu Vancomycin 125 m Four times a day for - Sodium chloride int Used 60 milliliters pe shift for acute kidney difficile times three d - Flagyl 500 milligram milligrams intravenor Enterocolitis due to 0 doses, 10/15/23-10/2 10/24/23 x 1 dose) - Flagyl 500 mg by m (10/24/23 x 2 doses) - Polyethylene glycol one scoop by mouth constipation (10/25/2 A nurse progress not 10/29/23 indicated R have yellow liquid jel indicated Resident # antibiotics for C-diffic been collected. The Medical Provider wa ongoing loose stools obtained from the Me culture.	nate 500-125 mg one tablet lays (10/6/23 through 10/8/23 dily (10/6/23 through 10/31/23 21/23, and 10/22/23 because e parameters) th Oral Packet 4 GM give in one time a day related to ligh 10/31) dilligrams give one tablet. C difficile (10/12 and 10/13) diravenous solution 0.4%. For hour intravenously every injury, dehydration, and C lays (10/13 through 10/16) as per 10ML. Provide 500 disly every six hours for C difficile (10/14/23 x 2 23/23 x 4 doses, and lineath twice daily for C difficile	F 5	80		

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		345457	B. WING		C 11/28/2023
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 580	indicated Nurse #5 v #1 on 10/29/23. Nurse #5 was unaval. An interview on 11/2 #1 revealed she had nurse (7:00 AM to 7:10/29/23 where Resindicated she recalled for C difficile and had last month due to redinfection. Nurse #1 sto baseline, alert and outime and event), income and had frequent look while on her unit. Nurse Resident #1 continuate being taken off preca 10/29/23, she placed provider's binder to a loose stools so they the laboratory test for contact a Medical Protect telephone. Nurse #1 stool sample at that laboratory to test for Attempts were made worked 10/29/23 (7:1 success. Nurse Aide documer reflected Resident # stools. A nurse's progress in dated 10/30/23 indicorientation (ability to	ilable for interview. 0/23 at 11:30 AM with Nurse been the primary day shift 00 PM) on the South Unit on ident #1 resided. Nurse #1 d Resident #1 was positive d been transferred to her unit quirements of isolation for the tated Resident #1 was, at riented x 4 (person, place, ontinent of bowel and bladder use stools containing a mucus rse #1 said that she recalled ed to have loose stools after autions and therefore on a note in the medical alert them of the ongoing would provide an order for r C-Difficile but did not ovider in person or via explained she obtained a time and sent it to the C-Difficile. It to interview Nurse #8 who 00 PM- 7:00 AM) without ontation dated 10/29/23 1 had four loose/diarrhea	F 58		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMP	SURVEY
		345457	B. WING				C 28/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 117.	20/2023
BELAIRE	HEALTH CARE CENTER				065 LYON STREET SASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	reflect the Medical Prongoing loose stools changes. An interview with Nur AM revealed worked she could not recall the was charted regarding recalled throughout Rexperienced diarrhea while she no longer gone of the worked Resident #1 stools. An interview on 11/20 Aide (NA) #1 revealed where Resident #1 remonths on day shift a following days in Octo 10/14/23, 10/15/23, 1 and 10/29/23. NA#1 in any specific day, but alert and oriented, ab known, incontinent of multiple loose stools mucous the entire time South Unit. NA #1 state aware of the ongoing An interview with Nur 11/20/23 at 11:55 AM on the South unit on 10 non 10/17/23, 10/18/23, 10/26/23, 10/27/23, a indicated Resident #1	n day shift. The note did not ovider was notified of the or Resident #1's orientation se #4 on 11/28/23 at 9:00 day shift on 10/30/23 and he resident other than what gorientation changes. She tesident #1's stay, she so frequently that after a ot out of bed. tation dated 10/30/23 had six loose/diarrhea 1/23 at 11:25 AM with Nurse dishe had worked the unit sided for approximately 4 and documented on the ober 2023: 10/13/23, 0/19/23, 10/24/23, 10/28/23, ndicated she could not recall Resident #1 was normally le to make her needs bowel and bladder with which frequently contained he she had been on the other steels are she had been on the other steels are she had been on the other she had been she had been on the other she had been she had been on the other she had been she had been she had	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345457	B. WING		C 11/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 580	NA #2 stated she mastools but could not nurse daily. An interview with Nu 11/20/23 at 1:45 PM South unit where Redocumented on nighin October 2023: 10/10/24/23, 10/25/23, NA #3 stated Reside like stools on each salerted the nurse on recall the names of a A laboratory report of Resident #1 was poreflected the laborate abnormal lab and sp 10/30/23 at 9:34 PM reviewed by the Phyat 1:18 PM. It howeved was notified of the at the laboratory notified results. A review of Resident revealed she was not Provider after the about the success. A review of Resident revealed she was not provider after the about the success. A review of Resident reflect Nurse #2 asserview of the nurses Nurse #2 had not not stool to the sto	estools as "slimy and thick. ade the nurse aware of loose recall the names of each arse Aide #3 (NA #3) on revealed she worked on the esident #1 resided and at shift on the following dates (16/23, 10/19/23, 10/20/23, 10/28/23, 10/29/23, 10/30/23. ant #1 diarrhea and mucous hift she worked and had duty each shift but could not all nurses she alerted. Lated 10/30/23 indicated esitive for C difficile. The report fory notified the facility of the looke with Nurse #2 on The report indicated it was resician's Assistant on 10/31/23 arer did not indicate a provider bnormality on 10/30/23 when and Nurse #2 of the critical at #1's medical record by seen by a facility Medical anormal C. difficile result. at #1's medical record did not lessed Resident #1. The by progress notes indicated full the MD or NP of the level any orders for medical	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345457	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		11/28/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 580	revealed she was mand had not provided. The PA stated becampositive for C-Difficinot have treated he experiencing ongoin. A review of Resider revealed the last timprovider was on 10 physician orders for colitis after the position. An interview with the 11/21/23 at 3:24 PM was familiar with Rebe alert and oriented person, place, time shortly after her additional loose stools and shoch colitis after the treatment was orded indicated the treatment was orded indicated the treatment following culture and therefore treatment. The NP than thinking another process.	e PA on 11/21/23 at 11:20 AM of familiar with Resident #1 ed her with any direct care. Juse a resident can test le for up to 90 days she would rewith Resident #1 and intermittent loose stools. In #1's medical record are she was seen by a medical /27/23 and there were no are the treatment of C-Difficile tive test results were received. In Wasse Practitioner (NP) on and 4:02 PM revealed she esident #1 and recalled her to do x 4 (accurately aware of and event). The NP stated mission she began having the ordered a laboratory test for sulted as positive, and ared at the time. The NP then was for Vancomycin oral and oral. The NP recalled using to have loose stools but ovider had placed her on the second positive stool are did not order any further could not recall anything other the period aware of orientation.	F 58			
	at 4:08 PM revealed	e Physician (MD) on 11/21/23 d he was aware Resident #1 or C-Difficile shortly after her				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345457	B. WING		C 11/28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11/26/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 580	admission; howeve aware of the abnorm 10/30/23 and did not ongoing loose stool loose stools could have the Polyethylene gly at Resident #1's foll 10/25/23. He acknowith Resident #1 was recall any further up condition. The MD is lab to be reviewed his monitoring or intervant A nurse's progress Resident #1 had see The note did not incontified of the stools. A review of the MAI indicated Resident #1 stools. A review of the MAI indicated Resident #1 stools. A review of the MAI indicated Resident #1 choperamide 2 mg as needed for diarring as needed for diarring to the progress not 11/1/23 the Polyethylene glycolone scoop by mout Constipation (11/1/23 indicated Resident Resident #1) and progress not 11/1/23 indicated Resident Resident #1 cone packet by mout diarring (11/1/23 indicated Resident Re	r, he had not been made mal laboratory results on of prescribe treatment for the s. The MD stated the ongoing have been exacerbated from eycol prescribed by the surgeon ow-up appointment on whedged the only visit he had as on 10/12/23. He did not evaluate to Resident #1's andicated he would expect the ey the PA and proper pentions to be placed. Indicated 10/31/23 indicated mi formed stools on day shift. His dicate a Medical Provider was section of the eye o	F 58		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345457	B. WING		C 11/28/2023
	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11120/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTIO
F 580	Continued From page	e 17	F 58	0	
	Resident #1 had inco note indicated MD wa continue to monitor.	omen were normal and ontinence with diarrhea. The as aware and staff should			
	Nurse Aide documen reflected Resident #1 stools.	tation dated 11/1/23 I had six loose/diarrhea			
	dated 11/2/23 indicat and oriented and her gastrointestinal obse quadrants of the abd Resident #1 had loos Polyethylene glycol v The note did not indic				
	Nurse Aide documen reflected Resident #1 stools.	tation dated 11/2/23 had eight loose/diarrhea			
	Nurse #4 dated 11/3/ was alert and oriente status and her blood gastrointestinal obse quadrants of the abd Resident #1 had inco diarrhea stools and s day shift. The note di Provider was notified	omen were normal and ontinence with a mixture of emi formed stools during d not indicate a Medical of the loose stools.			

AND PLAN OF CORRECTION IDENTIFI	CATION NUMBER:	A. BUILDIN	NG		COMPLETED
	345457	B. WING _			C 11/28/2023
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER		'	STREET ADDRESS, CITY, STATE, ZIP COD 2065 LYON STREET GASTONIA, NC 28052	DE	11/20/2020
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PR TAG REGULATORY OR LSC IDENTIFYII	ECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	
An interview on 11/20/23 at 11:29 Aide (NA) #1 revealed she had where Resident #1 resided for appropriate months on day shift and was one following days in November 2023 11/2/23. NA #1 indicated she had nurse on duty aware of the ongoin each shift although she could now names of each nurse daily. A nurse's progress note written be dated 11/4/23 indicated Resident and oriented with inconsistent contained and oriented with inconsistent contained and pressure was 110/20 gastrointestinal observation reverous quadrants of the abdomen were Resident #1 had incontinence with diarrhea stools and semi formed day shift. The note did not indicate Provider was notified of the loose Nurse Aide documentation dated reflected Resident #1 had one lost stools. A nurse's progress note written be dated 11/5/23 did not indicate Recognitive status Her blood pressing 90/50. A gastrointestinal observation of the abdomen were Resident #1 had incontinence with diarrhea stools and semi formed day shift. The note did not indicate Provider was notified of the loose Resident #1 had experienced a lepressure. An interview with Nurse #4 on 11 AM revealed she could not recall	worked the unit opproximately 4 duty on the 3: 11/1/23 and d made the hall ing loose stools to recall the by Nurse #4 to #1 was alert ognitive status /54. A aled all 4 normal and the amixture of stools during the a Medical estools. In 11/4/23 ose/diarrhea by Nurse #4 to was listed as ation revealed all the normal and the amixture of stools during the amixture of stools or that ow blood	F5	580		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		345457	B. WING			C 11/28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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)	OULD BE	(X5) COMPLETION DATE
F 580	changes or low blood throughout Resident diarrhea so frequent longer got out of bed Nurse Aide docume reflected Resident # stools. A nurse's progress redated 11/6/23 indicated 11/6/23 indicated through 11/6 at alert and oriented at known. Resident#1 110/56. A gastrointed 4 quadrants of the ashe had multiple lood The note indicated Livithout any favorable indicate a Medical Ploose stools or that I administered. Attempts to interview unsuccessful. A nurse's Progress of dated 11/6/23 indicated Polyethylene glycol stools on day shift. Medical Provider was or that Polyethylene A nurse progress not 11/6/23 indicated Resident #1's blood Resident #1's blood	charted regarding orientation d pressure. She recalled at #1's stay, she experienced by that after a while she not d. Intation dated 11/5/23 I had six loose/diarrhea Interest written by Nurse #2 Ited on night shift (11/5 at 7:00 7:00 AM) Resident #1 was and able to make needs had a blood pressure of stinal observation revealed all bdomen were normal and se stools during night shift. Interest and the stoody of the coperamide was administered at effects. The note did not rovider was notified of the coperamide had to be In Nurse #2 were In the written by Nurse #1 Ited Resident #1's was held secondary to loose of the note did not indicate a is notified of the loose stools	F 58			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345457	B. WING _			C 11/28/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2065 LYON STREET GASTONIA, NC 28052	IP CODE	11/20/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BI FO THE APPROPRIA			
F 580	had multiple loose sto Polyethylene Glycol w stools. The note did n Provider was notified Polyethylene glycol w A review of Resident revealed no progress on 11/6/23. A telephone interview at 9:38 AM revealed s worked the South unit but could not recall Restools or behaviors or all the units and her w basis only. She could Medical Provider of R change in cognition, of Nurse Aide document reflected Resident #1 stools. An interview with Nurse 11/20/23 at 11:55 AM on the South unit on r on the following dates 11/1/23, 11/4/23, 11/5 indicated Resident #1 rang the call light freq NA #2 described the s NA #2 stated she was C-Difficile and thereforesident having loose	omen were normal and she cols during day shift and was held secondary to loose of indicate a Medical of the loose stools or that has held. #1's medical record notes written by Nurse #3 with Nurse #3 on 11/21/23 she acknowledged she on 11/6/23 on night shift esident #1 to include any in 11/6/23 due to her working working on an as needed not recall notifying the desident #1's loose stools, or behaviors. #ation dated 11/6/23 had six loose/diarrhea see Aide #2 (NA #2) on revealed that she worked night shift and documented	F	580				
	aware of them.	,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			DATE SURVEY COMPLETED			
		345457	B. WING			C
	ROVIDER OR SUPPLIER HEALTH CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	l	11/28/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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	(X5) COMPLETION DATE
F 580	11/20/23 at 1:45 PM South unit where Reshift on 11/6/23. NA 11/6/23, Resident #1 normal. She indicate #1 continued to have ring her light to be chould, was disorient bed. NA #3 said she Attempts were made success. A review of Resident reflect Nurse #2 asson review indicated Nurse review indicated Nurse review indicated Nurse Attempts to interview unsuccessful. Nurse Aide document reflected Resident # stools. A nurse's Progress of dated 11/7/23 at 2:3 was alert and oriented needs known. Resident 107/48. A gastrointed 4 quadrants of the aleast had multiple lood Polyethylene Glycol stools. The note did Provider was notified Polyethylene glycol stools.	arse Aide #3 (NA #3) on revealed she worked on the resident #1 resided on night #3 stated on the night of a was more confused than ad during her shift, Resident a mucous stools but did not hanged as she normally red and trying to climb out of told Nurse #2. The to contact Nurse #2 without the sessed Resident #1. The rese #2 had not notified the MD real lab or received any orders rions. We Nurse #2 were Intation dated 11/7/23 I eight had loose/diarrhea The told written by Nurse #1 O PM indicated Resident #1 Ded and able to make her reent #1's blood pressure was stinal observation revealed all bdomen were normal and se stools during day shift and was held secondary to loose not indicate a Medical did of the loose stools or that	F 5	30		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345457	B. WING _			C 11/28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2065 LYON STREET GASTONIA, NC 28052	CODE	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA	
F 580	approximately 3:30 F that Resident #1 had appeared confused. assessed Resident # and found the value of patient at 106/51. Co baseline. The note di Provider was notified pressure, lethargy, co inability to take her mongoing loose stools. An interview on 11/20 Therapy Assistant #1 to Resident #1's then therapy on 11/7/23. Fentered the room bet noticed Resident #1 previously had a very when he had worked prior. PTA #1 indicate appeared more lethal stated he made attenthe edge of the bed ther normal self with salerted Certified Occi (COTA #1) who was look at obvious concern the previous time. He indicated that CO agreed that Resident as he routinely provide this discussion between Nurse #1 entered the her medications. He #1 that Resident #1 in nurse did not response.	9 PM indicated on 11/7/23 at PM, Nurse #1 was informed a low blood pressure and The note indicated Nurse #1 11's blood pressure manually to be at baseline for the infusion noted also to be at d not indicate a Medical of Resident #1's low blood profusion, behaviors, her norning medications, or	F	580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
			A. BOILD	_		Ι ,	С
		345457	B. WING				-
NAME OF D	ROVIDER OR SUPPLIER	0.0.0		-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 117.	28/2023
NAME OF T	NOVIDEN ON SOIT LIEN				2065 LYON STREET		
BELAIRE	HEALTH CARE CENTE	ER .					
				,	GASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From pa	ge 23	F	580			
	-	#1 spit the medications out,	•				
		the pills, and the nurse left the					
		ated Resident #1 continued to					
	**	nd uncooperative with therapy					
		he room. He explained he and					
	COTA #1 obtained v						
		ted it took them approximately					
		obtain two blood pressures					
		was fidgety and restless.					
		I pressure was obtained and					
		oressure reflected between the					
		(millimeters of mercury)					
		ng greater than 90/60). PTA					
	#1 stated he and Co	OTA #1 placed Resident #1					
	back in a supine po	sition in bed and left the room					
	to locate Nurse #1.	PTA #1 stated Resident #1					
	was fidgety and agi	tated during the therapy					
	treatment but did no	ot recall any behaviors such as					
	hollering out while h	ne was in her room. PTA#1					
		ed Nurse #1 who was at her					
		ne hallway and alerted her that					
		l pressure readings had been					
		ey were, and she had increase					
		g like herself, and was unable					
	l ' '	rapy. PTA #1 stated Nurse #1					
	· ·	Resident #1's blood pressure					
		t baseline and did not appear					
	•	orts by him. PTA #1 stated					
		I him that she would assess					
	**	aluate his concerns of the					
		. PTA #1 stated he left the					
		ation cart and proceeded					
		room. When he passed the nator's office, he entered the					
		d the nurse to review Resident					
		pressures and alerted her of					
		ure readings that he and					
		ned. PTA #1 stated the MDS					
		ood pressures obtained by the					
	Transcripted the DIO	ou prossures obtained by the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С		
		345457	B. WING			11/	28/2023	
NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
BELAIRE	HEALTH CARE CENTER	!			065 LYON STREET			
				G	ASTONIA, NC 28052			
(X4) ID PREFIX TAG			1		×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	2 4	F :	580				
	PTA #1 and COTA #1 #1's baseline. PTA #1 contacted the Staff D (SDC) Nurse via phot for the day but would #1's blood pressure.	were lower than Resident I stated the MDS Nurse evelopment Coordinator ne who said she was leaving go and recheck Resident						
	PM revealed he was afternoon (he could in #1 that he was concernot her "normal self." Resident #1's room was room the hall nurse (I with the resident's madminister them, but on her clothes. COTA was in the room, PTA that Resident #1 did in baseline, but Nurse # statement, but instead medications Resident room. COTA #1 indications continued to attempt participate without su vital signs on Resider and PTA #1 obtained secondary to the first being abnormally low pressure readings we systolic and the readiful.	1 did not acknowledge the d quickly retrieved the t #1 spit out and left the ated he and PTA #1						
	Resident #1 and that been low. COTA #1 in	ng was abnormal about her blood pressure had ndicated Nurse #1 was at her imply stated Resident #1's						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		0.45457	D. MING				С
		345457	B. WING _			11/	28/2023
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BFI AIRF	HEALTH CARE CENTER			2	065 LYON STREET		
BLLAIRL	TIERETTI OAKE GERTEK	•		C	GASTONIA, NC 28052		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
TAG	REGULATORT OR I	LOC IDENTIFTING INFORMATION)	TAG		DEFICIENCY)	116	
-							
F 580	Continued From page		F :	580			
		seline was low, but she did					
	_	ent #1 at the time. COTA #1					
		were returning to the					
		ey stopped at the MDS					
		d her about Resident #1's					
		low. COTA #1 stated the					
		Resident #1's vital history					
		vith the blood pressure as					
		she called the SDC Nurse					
		1, then he and PTA #1 left					
	the office and continu	led to the therapy gym.					
	An interview on 11/20	0/23 at 11:30 AM with Nurse					
	#1 revealed she expla	ained she had not observed					
	any abnormal behavio	ors by Resident #1 prior to					
	11/7/23 (the date of h	er discharge), but had					
	received report from t	the night shift nurse (Nurse					
	#3) that she had exhi	bited behaviors and					
	increase confusion th	e night before but Nurse #1					
		behaviors Nurse #1 stated					
		made any previous attempts					
	to get up as she requ						
		tated she entered Resident					
		ter her morning medications.					
		attempted to administer the					
		nd Resident #1 spit them out.					
		had forgotten that Resident					
		ons crushed so she collected					
	•	oom. Nurse #1 stated on					
		PM and 4:00 PM, two					
		nd COTA) approached her at				ĺ	
	her medication cart a						
		pressure had been obtained					
		eadings around 70-80s				ĺ	
		nally had low blood pressure				ĺ	
		rectly to re-check the blood				ĺ	
	· .	Nurse #1 stated she later				ĺ	
	went back into Reside					ĺ	
	auministered the med	dications crushed which					

· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED		
		345457	B. WING		C 11/28/2023		
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11720/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION		
F 580	Resident #1 had protherapy was in the allow what medications is afternoon, she state medications because administer them ealethargic. Nurse #1 provider about the minability to take her to lethargy, nor that had been reported a clarification orders and Lisinopril at that time. An interview with the 2:00 PM revealed interactions with Resident #1's low is seem like herself. To looked in Resident interactions with Resident #1's low is seem like herself. To looked in Resident interactions with reapy staff were left. MDS Nurse stated in Director of Nursing left the building, so assess her. The MI Nurse agreed to as involvement with Resident wi	eviously spit out earlier when room. When asked Nurse #1 he administered that ed Resident #1's morning se she had been unable to rlier due to Resident #1 being stated she did not contact the new behaviors, Resident #1's medication that morning due Resident #1's blood pressure as low in order to obtain whether to administer the e. e MDS Nurse on 11/20/23 at the had not had many esident #1; however, on DPM, PTA #1 and COTA #1 ce and notified her of clood pressure and did not the MDS Nurse stated she #1's medical record and ressures obtained by the ower than her normal. The she attempted to notify the (DON), but she had already she notified SDC Nurse to DS Nurse stated after the SDC sess her, she had no further	F 580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345457	B. WING		C 11/28/2023	
	NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	1 11/20/2023	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
F 580	#1 in about 5 minutes she was concerned #1. The SDC Nurse the hall and saw Nurse admitting a new resi of the door and the She had been in to a SDC Nurse stated Nobeen in yet but woul indicated she then eand obtained Reside was near her baseling recall what Resident 11/7/23. The SDC Nobeen Resident #1 was concerned blood pressure, apparent distress. To and alerted Nurse #1 then left the unit. An interview with Resident weekly and had been week before dischard good memory without behaviors during her stated she had contained evening (she could recalled it was prior delivered) and spoken Member stated told because she was or in the last 5 minutes out and it sounded lishe dropped the phony nurse #1 walked to told by Nurse #1 that	s. The SDC Nurse explained and went to assess Resident explained she approached rese #1 in a nearby room dent but poked her head out SDC Nurse asked Nurse #1 if it issess Resident #1 yet. The urse #1 told her she had not d shortly. The SDC Nurse intered Resident #1's room ent #1's blood pressure and it is ealthough she could not if it is blood pressure was on urse could not recall if infused when she obtained but stated she was not in any in e SDC Nurse left the room if to continue to monitor her is ident #1's Family Member of AM was conducted. The end she visited Resident #1 in to see her approximately a ge and Resident #1 had a sut obvious confusion or invisit. The Family Member acted the facility earlier in the mot recall the exact time but to supper trays being the with Nurse #1. The Family Nurse #1 she was concerned in the phone with Resident #1 and Resident #1 was yelling the she may have fallen when one. The Family Member said Resident #1's room and was at Resident #1 was in the bed as yelling out, she had not fell	F 580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345457	B. WING			C 11/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			STREET ADDRESS, CITY 2065 LYON STREET GASTONIA, NC 280		1 11/2	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580			F t	580			
	she was called short that Resident #1 had room for evaluation. indicated that when shortly after being not extremely confused a her lower extremities. A nurse's note written at 9:57 PM indicated the floor adjacent to as follows: BP 106 / 91 bpm, and oxygen #1 had skin tears to linterventions were purounding, keep persoplace Resident #1 at The confusion noted message was left for return a call to the faindicate a Medical Propersion of the resident #1's change. An interview on 11/2/41 revealed on 11/7/41 revealed and states fallen, but Nurse #1 room Resident #1 was but unable to articula #1 stated she though hollering and therefor daughter that she han Nurse #1 indicated Fallen out and cursed and she was trying to assistance. Nurse #1	she arrived at the hospital offied, Resident #1 was and complaining of pain to a second paining of paining and complaining of paining and complaining of paining and complaining of paining at the paining at t					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
			A. BOILD			С	
		345457	B. WING			11/	28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER	₹		206	REET ADDRESS, CITY, STATE, ZIP CODE 65 LYON STREET ASTONIA, NC 28052	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	9:00 PM) Resident # between her bed and explained Resident # floor, she was assessibilateral lower extreme both legs. Nurse #1 sto say, "Help me, hel which was abnormal stated at the time of resident needed to goleaned the wounds, her back to bed. Nurnotify the on-call MD Resident #1's change stated she did notice increased confusion #1 and thought she rinfection and was gowhen she had time. It recognized Resident condition because sharticulate her needs a provided orders to see mergency room for A Situation Backgroun Recommendation (S 10:49 PM written by #1 had increase confusions place, and the weakness post fall, a which was a change signs listed Resident 106/51. A late entry progress	id later in the shift (around 1 was found on the floor of the wall. Nurse #1 if 1 was found to be on the sed to have bleeding to her nities with hematomas to stated Resident #1 continued p me" and "G** D******" for Resident #1. Nurse #1 the fall, she did not feel the to to the hospital, so she bandaged them, and placed se #1 indicated she did not at the time of the fall or of the of condition. Nurse #1 that Resident #1 had which was new for Resident may have a urinary tracting to request a urinalysis At 10:30 to 11PM, Nurse #1 #1 was having a change of the was yelling, unable to and contacted the DON who and Resident #1 to the evaluation.	F	580			

AND PLAN OF CORRECTION IDENTIFICATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345457	B. WING			C 11/28/2023	
	ROVIDER OR SUPPLIER	ER	•	STREET ADDRESS, CITY, STATE, ZIP C 2065 LYON STREET GASTONIA, NC 28052	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	Resident #1 was not Resident #1 had a stime of the fall she was trying to do. We continued to curse bed and the MD gas to the emergency realtered mental statushe notified the Mecondition for Resident The hospital emergency for the emergency of the emergency of the emergency of the hospital with altered (low blood pressure over 60s, a blood gwBC 53.8, positive urinary tract infection with a left low sodium of 122, temperature of 94.4 between 97-99 deg (s/p) a fall resulting extremities (legs) wand left lower extremities (legs) wand left lower extrement sepsis with acute on sepsis) with possible cystitis with hematupseudomembranous colon related to base of C difficile colitis, failure secondary to acute encephalopas secondary to infection the plaque rupture).	which was unusual for her. formally alert and oriented. fall around 9 PM but at the could not tell staff what she hen she fell, Resident #1 the staff and tried to get out of ove orders to send Resident #1 com for evaluation related to us. The note did not indicate dical Provider of a change in	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345457	B. WING			C 1/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIF 2065 LYON STREET GASTONIA, NC 28052		1723/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	note indicated Resid the hospital with alter difficile. Resident #1 including oral vancor resuscitated (fluids of depleted). Resident vasopressors (medicial blood vessels in patifor hypotension despresuscitation. She reworsening clinical strucell count, and poor Conversations occur and family regarding family agreed to transmeasures only. Residual with the change of costaff on 11/7/23 becaused greater than 23 or 4 days then she An interview with the revealed she was not however, the PA shochange of condition she was not aware Fidischarged. An interview with the at 4:08 PM revealed Resident #1's condition the condition of the condition was not aware Fidischarged.	et expired at the hospital. The lent #1 had been admitted to be red mental status and C was started on antibiotics, mycin and volume given to replace the volume #1 ultimately required cations used to constrict the lents with low blood pressure) bite adequate volume emained on vasopressors with latus, increasing white blood response to treatment. The between the care team in goals of treatment and the lastition care to comfort ident #1 subsequently expired the record. The PA on 11/21/23 at 11:20 AM anot have been concerned condition noted by multiple lause "the change had not expendent would have addressed it." The NP on 11/21/23 at 4:02 PM and the lastition care to comfort in the lause would have been notified of the by Nurse #1. The NP stated Resident #1 had been the Physician (MD) on 11/21/23 he was not made aware of	F	580			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED	
		345457	345457 B. WING		C 11/28/2023		
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CO 2065 LYON STREET GASTONIA, NC 28052		11/20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 580	made aware of the The DON stated shintermittent ongoing aware of the abnormatated she was notion the evening of 1 stated Nurse #1 tole and was confused stransfer to the emeritarist of the immediate of	M revealed they had been concerns with Resident #1. e was aware Resident #1 had gloose stools and she was mal laboratory values. She fied of Resident #1's condition 1/7/23 after she fell. The DON d her Resident #1 had fallen so the DON told Nurse #1 to regency room. Ind Director of Nursing were ediate jeopardy on 11/21/23 at differ the following credible liate jeopardy removal. In the following credible liate	F	580			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C 11/28/2023	
		345457	B. WING_				
	ROVIDER OR SUPPLIER HEALTH CARE CENTER	L		STREET ADDRESS, CITY, STATE, ZIP COD 2065 LYON STREET GASTONIA, NC 28052		•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	process or system fair adverse outcome from when the action will be provided by 11/22/20. Nursing, Staff Develor designee to current funds and contracted staff (nursing assistants an acute changes in contracted staff). The experience of the patient immediate vital signs. The experience of the patient immediate vital signs.	e entity will take to alter the lure to prevent a serious in occurring or recurring, and e complete; vided by 11/22/2023, by the staff Development ince to current licensed full eded, and contracted (if applicable). Education fication to providers, b results, abnormal vital in condition and abnormal ne. Education will be	F 5				
	after 11/22/2023. The Coordinator will track provided. Alleged date of IJ ren	and ensure education is noval is November 23, 2023.					
	Administrator The validation of the notification of change facility on 11/28/23. S	or implementation is the credible allegation for was conducted in the taff interviewed and record nsed staff and unlicensed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345457	B. WING		C 11/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
F 684 SS=J	regarding the require Physician following a seek clarification for a discharge summaries also included educati identifying a change is reporting to the Licent Education was given when a change of coresident presents diff lethargic, restless, or pressure, behaviors, abnormal bodily elimit physician, even if dur serious or life-threate. The immediate jeopa was validated. Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a furth applies to all treatment facility residents. Bas assessment of a resident residents receives accordance with profipractice, the compresident plan, and the residents REQUIREMENT by: Based on record rev Practitioner (NP), Phyphysician (MD) intervicemplete comprehent	ted on the facility policy ments for notification of the change of condition and to all new orders from hospital and consulting providers. It ing Nursing Assistants on in resident condition and sed Nurse immediately. to licensed nurses regarding indition is noted or when a erent than known baseline, short of breath, low blood falls, new orders, and ination concerns to call the ring the night when there is a uning change of condition. In red are moved and that of the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered	F 68		as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
	345457	B. WING			C		
NAME OF PROVIDED OR CURRUED	343437	B: Willo		EDEET ADDRESS CITY STATE ZID CODE	11/2	28/2023	
NAME OF PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE			
BELAIRE HEALTH CARE CENTER				065 LYON STREET			
			G	ASTONIA, NC 28052			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
stools post antibiotic to Difficile (C-Difficile) who (C-difficile is a bacterior of the colon. Symptom to life-threatening dama afternoon of 11/07/23 significant change in concreased lethargy and pressure, spitting out. There was no compressure, spitting out. There was no compressed medical attention the significant change evening on 11/07/23 at the hospital for an evadated 11/7/23 indicated diagnosed with sepsis dysfunction, acute endinfectious process, hy myocardial infarction (expired on 11/10/23. occurred for 1 of 2 resof care/providing care standards (Resident # The immediate jeopart the facility failed to eff seek medical attention significant change in conjection of compliants severity of "D" no actual completion of education put into place are effered.	reatment for Clostridium hich ended on 10/24/23. um that causes an infection as can range from diarrhea mage to the colon.). The the resident had a condition including d confusion, low blood her pills and hollering out. Thensive assessment are if there was the need to an endition until late in the and the resident was sent to aluation. Hospital records the tresident was sent to aluation. Hospital records the with acute organ cephalopathy secondary to pothermia, and type 2 (heart attack). The resident This deficient practice sidents reviewed for quality according to professsional full. The dy began on 11/7/23 when fectively respond to and a condition. The immediate d on 11/23/23 when the	F	684	getting clarification from the in-house provider. Miralax was held at times due loose stools. The in-house provider wan not notified of holding the Miralax. On 10/30/2023, resident #1 received a positive stool culture for C-Difficile, the patient was not adequately assessed a did not receive adequate intervention to treat the C-Difficile. Resident #1 was noted to have increased confusion by tweekend supervisor. The increased confusion was not assessed by facility staff. The resident noted to have intermittent confusion on 11/06 and 11/ and was not assessed appropriately to adequate intervention. Resident #1 was noted to have a low blood pressure by therapy staff. The charge nurse gave resident #1 a blood pressure medication with a low blood pressure. The charge nurse failed to assess the patient prior giving the blood pressure medication. Resident #1 had an acute change in condition on 11/07/2023 that was not assessed at the time of the change in condition. This resulted in a hospital transfer. The Director of Nursing/ Staff Development Coordinator and Regional Director of Clinical Services reviewed is 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes behaviors have been reviewed to ensure proper assessments and interventions have been completed and provider notification. Outside provider consults	nd o he 07 get s on to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345457	B. WING		C	8/2023	
NAME OF P	ROVIDER OR SUPPLIER	0.0.0.		STREET ADDRESS, CITY, STATE, ZIP CODE	11/2	0/2023	
TVAIVIL OF T	TOVIDER OR OUT FIELD						
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 PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRICENCY)	ULD BE	(X5) COMPLETION DATE	
F 684	Continued From page	÷ 36	F 68	34			
	The findings included			attending providers by the Directo Nursing to ensure proper medical intervention was provided This v completed by 11/22/2023.			
indicated Resident #1 presented to the Emergency Room (ER) with abdominal pain and vomiting which required abdominal surgery for		presented to the R) with abdominal pain and		Current Residents are at Risk	(
	vomiting which requir the gallstones. The di Resident #1 received for chronic leukocytos count) (WBC 11.41) a (inflammation of the gcorrected with the choremoval of the gallbla without hematuria as Amoxicillin-Clavulana milligrams (mg) 1 tabl for 3 days. Resident #1 was adm 10/5/23 with diagnose cystitis without hemat	ed abdominal surgery for scharge summary reflected intravenous (IV) antibiotics sis (high white blood cell and cholecystitis pall bladder) which was blecystectomy (surgical dder). It also listed cystitis resolved and orders for te (antibiotic) 500-125 let by mouth every 8 hours sitted to the facility on es that included status post uria (bladder inflammation in the urine) and surgical is of the bile duct with		3. Education will be provided by 11/22/2023, by the Director of Nur Staff Development Coordinator, or designee to current licensed full till time, as needed, and contracted linursing staff (if applicable). Educate be on assessing acute medical chand acute changes in condition in abnormal vital signs, abnormal lab abnormal behaviors from baseline Licensed nurses will be educated use of the Interact clinical pathway assessment and intervention of conditions. The Interact pathways located at each nursing station. The pathways contain suggestions on treatment option after assessment Nurses will follow the suggested to	ssing, r me, part censed tion will anges cluding os, and define are are		
	per day for 3 days for Lisinopril 10mg daily hypertension. A one-day post admis 10/6/23 written by the was admitted to the fa	ated 10/5/23 indicated ailligrams (mg) three times cystitis. Additionally, by mouth was ordered for assion progress note dated NP indicated Resident #1 acility after being 6/23 through 10/5/23 status		pathways and notify the providers further instruction. Education will provided to current licensed nurse notification of provider when receivanters from outside consults before transcribing the order into the electhealth record. Education to license nursing staff will include abnormal pressure parameters and when to administer blood pressure medicated Education will be provided by 11/2 by the Director of Nursing, Staff Development Coordinator or designation of the provided by 11/2 current full time, part time, as need	also be sis on ving re stronic ed blood not tion. 22/2023		

PRINTED: 12/21/2023 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR NC	0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION		LETED
		345457	B. WING				28/2023
NAME OF PR	ROVIDER OR SUPPLIER			S	FREET ADDRESS, CITY, STATE, ZIP CODE	1	
					065 LYON STREET		
BELAIRE	HEALTH CARE CENTER				ASTONIA, NC 28052		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 004	0 11 15	0.7					
F 684	Continued From page		F (684			
		raphy (a procedure using a			contracted staff (if applicable) certified		
		d treat problems of the			nursing assistants and therapy staff or		
		ystem) on 9/28/23 and			reporting acute changes in condition to)	
	_	ledocholithiasis (gallstones),			the charge nurse of the patient		
	incarcerated hiatal he	**			immediately including what abnormal		
		a hernia which can become			behaviors consist of and reporting		
	_	eated) on 10/3/23. The note			abnormal vital signs. Education will	ina	
	indicated Resident #1 was to receive Amoxicillin 500/125 by mouth three times per day from				contain signs and symptoms of identify an acute change in condition. Staff not	-	
	•	23. The note also indicated			working on 11/22/2023 will receive		
	_				education prior to the start of their shift		
	she was positive for constipation as she was pushing and straining to have a bowel movement				after 11/22/2023. The Staff Developm		
	last night (10/5/23) wi				Coordinator will track and ensure	5110	
	, ,	out hepatospleenomegaly.			education is provided.		
		ed Resident #1 had hospital			No nursing staff or therapy staff will be	;	
		indicated the following			allowed to work until education is		
		ed white blood cells (WBC)			received.		
		reatinine level of 0.9. The			New nursing staff or therapy staff will		
	assessment listed the	following: negative for			receive education in orientation.		
	behaviors, no gastroi	ntestinal (GI) upset with			4. Director of Nursing or designee w	II	
	ability to tolerate food	s and liquids, and			audit the past 24 hours of progress no	es	
	hypertension with sys				for behaviors, labs and vital signs for		
	0 0	s to 140's on treatment of			abnormal values, and acute episodes		
	Lisinopril daily and m	onitor blood pressure daily.			ensure that abnormal findings have be		
					assessed and interventions provided v		
		ated 10/7/23 indicated			provider notification 5x weekly x 8 wee	ks,	
		let after each loose stool as			3x weekly x 8 weeks and weekly x 8		
	needed for diarrhea x	1 day.			weeks.		
	A review of the nurse	s' progress notes for			5. The Director of Nursing will provid	е	
		thing related to loose stools.			Results of the audits will be reviewed a		
		-			Quarterly Quality Assurance Meeting >		
	A skilled progress not	e written by Nurse #7 dated			for further resolution if needed.		
	10/8/23 at 4:23 PM in						
	complained of loose s	stool after lunch.			6. Date of Completion 12/23/2023		
		ation Administration Record					
	(MAR) dated October	2023 indicated Resident #1					

received Loperamide 2mg on 10/7/23 at 10:29

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345457	B. WING		,	C 11/28/2023		
	ROVIDER OR SUPPLIER HEALTH CARE CENTER	ł	STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 684	Continued From page AM by Nurse #6 and by Nurse #7. Attempts to contact N An interview on 11/28 #7 revealed she coul she was moved to the admission and Nurse involvement with her A provider progress r 10/9/23 indicated Res 3-day post admission Resident #1 was not complained that loose weekend, and she had diarrhea water stools complained of abdom vomiting. Resident #* indigestion. The note reported a history of were provided to obta for C-Difficile and dis was administered ove A physician order dat stool specimen to tes A laboratory report dat	again on 10/8/23 at 5:14 PM Jurse #6 were unsuccessful. B/23 at 10:00 AM with Nurse do not recall Resident #1 as esouth Unit shortly after at 7 had no further care. Index written by the NP on sident #1 was seen for a resident #1 was seen for a resident #1 was seen for a resident #1 and had estools began over the ad already experienced 3 that day. Resident #1 hinal pain but no nausea or 1 felt bloated with indicated Resident #1 had C-Difficile on 2/20/23. Orders ain a stool specimen to test continue Loperamide that er the weekend. Juice 10/9/23 indicated obtain at for C-Difficile. Juice 10/9/23 indicated obtain at for C-Difficile.	F 68)			
	A progress note was 10/11/23 for a 5-day note indicated Reside of diarrhea, abdomina C-Difficile culture contime of the visit. Res	written by the NP on post admission visit. The ent #1 continued to complain al pain, and indigestion. It indicates to be pending at the ident #1 is currently not able to have a soft, non-tender						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
	345457	B. WING		1	C / 28/2023	
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENT	ER	STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		•		
PREFIX (EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
negative for bladdindicated Resident stools the day prioreceived to start C daily and continue condition pending The note further in pressure of 136/66 as ordered. A nurse progress r Manager dated 10 the family member abnormal lab resul C-Difficile colitis ar initiated. A physician's orde Cholestyramine (u Oral Packet 4 grammouth one time a was discontinued of A physician's orde Vancomycin (antib tablet four times a was discontinued of An admission Mini 10/12/23 indicated intact and no behall and negative for disand ne	eractive bowels sounds and er distention. The note #1 had experienced 6 watery r to the visit. New orders were holestyramine 1 packet orally to monitor Resident #1's C-Difficile laboratory results. dicated Resident #1 had blood and to continue the Lisinopril hote written by the Unit //11/23 indicated she spoke with regarding Resident #1's ts and testing positive for and antibiotic therapy would be r dated 10/11/23 indicated sed for bile acid diarrhea) Light ans (GM) give one packet by day related to diarrhea. If dated 10/11/23 indicated iotic) 125 milligrams give one day for C-difficile. The order on 10/12/23. In the property of	F 68	34			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION	(X3) DATE COMP	SURVEY
		345457	B. WING _			1	C 28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTER			2065	EET ADDRESS, CITY, STATE, ZIP CODE LYON STREET STONIA, NC 28052	<u>,</u>	20/2020
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F 684	which was positive for A laboratory report data Resident #1's white be immune ability to figh elevated to 26.7 (nor Creatinine (test for kid 1.16 (normal being 0. protein was 28.70 (te body- normal being le A provider progress on 10/13/23 indicated Reson quarantine for C-E have watery stools, a nausea. Laboratory of the following noted: ecalcium at 8, elevated creatinine at 1.16, low CRP of 28.7. At this was strength and mobility or bladder distension listed included the fol (Normal Saline 60 cut for 48 hours) secondated Repeat CBC and CM compare for trends. For prescribed Vancomyow WBC she was switch hours x 7 days. Discot Flagyl has started. A blood pressures were 120's and 140's systolisinopril.	oratory test on 10/10/23 r C-Difficile. ated 10/12/23 indicated lood cell (test to determine t infection) count was mal being 4.1 to 10.9), dney function) was normal at 5 to 1.20) and C-reactive st for inflammation in the ess than 0.50). The written by the NP dated esident #1 had been placed Difficile and continued to bidominal pain, and now esults were reviewed with levated WBC of 26.7, low to BUN 21.1, normal w sodium at 132, and a high visit, Resident #1 was and fatigue, decrease and negative for confusion. Resident #1's plan of care lowing: Start IV fluids bic centimeters (cc) per hour ary to a low sodium level. P on Monday (10/16/23) to Resident was previously sin, but secondary to high eed to Flagyl 500mg every 6 ontinue Vancomycin once it this visit, Resident #1's e reviewed to be between	F	584			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345457	B. WING			C 1/28/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		1/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 684	milliliters per hour for acute kidney injury a discontinued on 10/2 A physician's order of Flagyl (antibiotic) 50 Provide 500 mg (IV) for Enterocolitis due A laboratory report of Resident #1's white at 9.0, C-reactive produced to 15.8 and Creatinine A provider progress 10/16/23 indicated From 14-day post admissi during this visit Resimich completed 10. IV and reported the Areview of the laboration of the Italian of the I	5% intravenous. Give 60 r 3 days for dehydration, and C-Difficile. The order was 16/23. dated 10/13/23 indicated 0 mg per 100 milliliters (ML). intravenously every six hours to C-difficile for 7 days. lated 10/16/23 indicated blood cell count was normal otein remained elevated at was normal at 0.90. note written by the NP dated desident #1 was seen for a on visit. The note indicated dent #1 remained on IV fluids //16/23 and Flagyl via midline diarrhea was "uncontrollable". ratory results dated 10/16/23 alues: white blood cell count c-reactive protein remained I Creatinine was normal at re included the following: I completed and addressed a ment in Resident #1's th a normal WBC and atinine, and sodium levels. ted Resident #1's blood between 120's and 140's ed on Lisinopril for treatment.	F 64	34			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345457	B. WING _			C 11/28/2023	
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	A physician's order of Flagyl (antibiotic) 50 Provide 500 mg (IV) for Enterocolitis due 3 days. A physician's order of Flagyl 500 mg by more than 100 mg by mg by more than 100 mg by mor	dated 10/20/23 indicated 0 mg per 100 milliliters (ML). intravenously every six hours to C-difficile for an additional dated 10/24/23 indicated buth twice daily for C-difficile. intinued on 10/25/23. It was seen for a follow up and new orders were given for to grams per scoop, a t occasional constipation and the scoop by mouth once a	F 6				
	surgical consult and and give polyethyler a laxative used to treat and soften stool. Give a day related to consultation communot question the ord treatment for C-Diffic A physician's order of the surgical consultation communot question the ord treatment for C-Diffic A physician's order of the surgical consultation communot question the ord treatment for C-Diffic A physician's order of the surgical consultation communot question the order of the surgical consultation communot question the order of the surgical consultation consultati	new orders to advance diet ne glycol 17 grams per scoop, eat occasional constipation re one scoop by mouth once stipation. Arse #4 on 11/28/23 at 9:00 and not recall the order pical consult but entered as from the surgical nication form. Nurse #4 did er because the antibiotic					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER HEALTH CARE CENTE	ER .	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11720/2020	
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F 684	indicated Resident admission visit. The had improved with 0 with on and off diarr semi-formed stools. #1's had completed also indicated Resid remained between continued Lisinopril were given on this variety of the Med (MAR) dated Octobreceived the followin - Amoxicillin/Clavulatevery 8 hours for 3 for a total 8 doses) - Lisinopril 10 mg datexcept 10/20/23, 10 BP was outside of the Loperamide 2 mg as needed for diarrh 10/8/23) - Cholestyramine Lione packet by mout diarrhea (10/12 throen vancomycin 125 med 60 milliliters poshift for acute kidned difficile times three of Flagyl 500 milligra	ten by the NP dated 10/27/23 #1 was seen for a 21-day post noted reflected Resident #1 GI symptoms but continued thea mixed with some The note indicated Resident her IV antibiotics. The note dent #1's blood pressure 120's and 140's systolic and for treatment. No new orders risit. Itication Administration Record er 2023 indicated Resident #1 ng: anate 500-125 mg one tablet days (10/6/23 through 10/8/23 aily (10/6/23 through 10/31/23 because the parameters) tablet after each loose stool nea x 1 day (10/7/23 and	F 684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	(X3	COMPLETED		
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	ROVIDER OR SUPPLIER HEALTH CARE CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	COMPL C 11/2 REET ADDRESS, CITY, STATE, ZIP CODE S5 LYON STREET		
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F 684	doses, 10/15/23-10 10/24/23 x 1 dose) - Flagyl 500 mg by (10/24/23 x 2 doses - Polyethylene glycone scoop by moutl constipation (10/25/24) A nurse progress not 10/29/23 indicated have yellow liquid jeindicated Resident antibiotics for C-difficen collected. A review of the daily indicated Nurse #5 #1 on 10/29/23. Nurse #5 was unav An interview on 11/2 #1 revealed she han urse (7:00 AM to 7 10/29/23 where Reindicated she recall for C difficile and halast month due to reinfection. Nurse #1 baseline, alert and time and event), including taken off prec 10/29/23, she place	mouth twice daily for C difficile (s) ol 17 grams per scoop. Give in once a day related to (23-10/31/23) of the written by Nurse #5 dated Resident #1 was noted to felly like stool. The note also it is and a stool sample had it is and a stool sample had of nurse assignment sheets was being oriented by Nurse dependent #1 was noted by Nurse was being oriented by Nurse assignment sheets was being oriented by Nurse dependent #1 was positive and been the primary day shift (200 PM) on the South Unit on sident #1 resided. Nurse #1 and been transferred to her unit requirements of isolation for the stated Resident #1 was, at coriented x 4 (person, place, continent of bowel and bladder ose stools containing a mucus curse #1 said that she recalled and to have loose stools after cautions and therefore on and a note in the medical	F 6	84			
	indicated she recall for C difficile and ha last month due to re infection. Nurse #1 baseline, alert and time and event), incand had frequent lo while on her unit. N Resident #1 continubeing taken off precallo/29/23, she place provider's binder to loose stools so they	ed Resident #1 was positive and been transferred to her unit equirements of isolation for the stated Resident #1 was, at priented x 4 (person, place, continent of bowel and bladder cose stools containing a mucus surse #1 said that she recalled and to have loose stools after cautions and therefore on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345457	B. WING _			C 11/28/2023	
	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP COL 2065 LYON STREET GASTONIA, NC 28052	DE	11/20/2020	
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F 684	Continued From pag	e 45	F 6	884			
		ed a stool sample at that e laboratory to test for					
		to interview Nurse #8 who PM- 7:00 AM) without					
		ntation dated 10/29/23 1 had four loose/diarrhea					
	A nurse's progress note written by Nurse #4 dated 10/30/23 indicated Resident #1's orientation (ability to recall person, place, time, and event) changed throughout the day and had semi formed stools on day shift.						
	AM revealed worked she could not recall	urse #4 on 11/28/23 at 9:00 day shift on 10/30/23 and the resident other than what ng orientation changes.					
		ntation dated 10/30/23 1 had six loose/diarrhea					
	Aide (NA) #1 revealed where Resident #1 remonths on day shift of following days in Oct 10/14/23, 10/15/23, and 10/29/23. NA#1 any specific day, but alert and oriented, all known, incontinent of multiple loose stools	0/23 at 11:25 AM with Nurse ed she had worked the unit esided for approximately 4 and documented on the tober 2023: 10/13/23, 10/19/23, 10/24/23, 10/28/23, indicated she could not recall Resident #1 was normally ble to make her needs f bowel and bladder with which frequently contained ne she had been on the					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION DING		
		345457	B. WING _				28/ 2023
	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CI 2065 LYON STREET GASTONIA, NC 28			20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH C	VIDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	An interview with Nu 11/20/23 at 11:55 AN on the South unit on on 10/17/23, 10/18/2 10/26/23, 10/27/23, a indicated Resident # rang the call light fre NA #2 described the NA #2 stated she ma stools but could not in nurse daily. An interview with Nu 11/20/23 at 1:45 PM South unit where Re documented on nigh in October 2023: 10/10/24/23, 10/25/23, NA #3 stated Reside like stools on each salerted the nurse on recall the names of a A laboratory report d Resident #1 was pos reflected the laborate abnormal lab and sp 10/30/23 at 9:34 PM reviewed by the Phy at 1:18 PM. Attempts were made without success. A review of Resident	ated she made Nurse #1 gloose stools. rse Aide #2 (NA #2) on I revealed that she worked night shift and documented 3, 10/22/23, 10/23/23,	F	584			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE COMP	
		345457	B. WING _			11/2	28/2023
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(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRIA		(X5) COMPLETION DATE
F 684	or NP of the abnormator medical intervential An interview with the revealed she was not and had not provided. The PA stated becaupositive for C-Difficile not have treated her loose stools. A review of Resident revealed the last time provider was on 10/2 physician orders for toolitis after the positive on 10/30/23. An interview with the 11/21/23 at 3:24 PM was familiar with Resident and she ordered a lawhich resulted as poordered at the time. It treatment was for Valboth IV and oral. The continuing to have located another provider had therefore did not orde NP could not recall a another provider had nor being aware of or 10/30/23. An interview with the	se #2 had not notified the MD al lab or received any orders ons. PA on 11/21/23 at 11:20 AM the familiar with Resident #1 her with any direct care. See a resident can test of or up to 90 days she would with ongoing intermittent #1's medical record the she was seen by a medical ray and there were nown he treatment of C-Difficile we test results were received. Nurse Practitioner (NP) on and 4:02 PM revealed she ident #1 and recalled her to a x 4. The NP stated shortly began having loose stools boratory test for C-Difficile sitive, and treatment was	F 6	is 84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		OATE SURVEY OMPLETED
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	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	· · · · · · · · · · · · · · · · · · ·	11/20/2023
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F 684	had been treated for admission; however aware of the abnorm 10/30/23 and did no ongoing loose stools loose stools could he Polyethylene gly at Resident #1's folk 10/25/23. He acknow with Resident #1 warecall any further up condition. The MD in lab to be reviewed be monitoring or interver. A nurse's progress or Resident #1 had ser Nurse Aide document reflected Resident # stools. A review of the MAR indicated Resident # - Lisinopril 10mg dai - Loperamide 2 mg to as needed for diarrher - Cholestyramine Ligone packet by mouth diarrhea (11/1/23 this - Polyethylene glycomes in the stools of the mouth of the packet by mouth diarrhea (11/1/23 this - Polyethylene glycomes is the short of the stools of the packet by mouth diarrhea (11/1/23 this - Polyethylene glycomes is the short of the short of the short of the stools.	r C-Difficile shortly after her, he had not been made nal laboratory results on the prescribe treatment for the state of t	F	384		
	11/1/23 indicated Re oriented with a blood gastrointestinal obse	ate written by Nurse #1 dated esident #1 was alert and d pressure of 137/65. A ervation revealed all 4 domen were normal and				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	11/20/2023	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE	ETION
F 684	note indicated MD continue to monitor Nurse Aide docume reflected Resident stools. A nurse's progress dated 11/2/23 indicand oriented and higastrointestinal obsiquadrants of the above Resident #1 had lo Polyethylene glyco Nurse Aide docume reflected Resident stools. An interview on 11/Aide (NA) #1 reveau where Resident #1 months on day shift following days in Nil/2/23. NA #1 indinurse on duty aware each shift although names of each nurse's	continence with diarrhea. The was aware and staff should continence with diarrhea. The was aware and staff should continence with diarrhea was aware and staff should continence witten by Nurse #1 ated Resident #1 was alert er BP was 121/79. A servation revealed all 4 should be domen were normal and continence of the standard was held due to loose stools. Entation dated 11/2/23 #1 had eight loose/diarrhea 20/23 at 11:25 AM with Nurse alled she had worked the unit resided for approximately 4 the and was on duty on the covember 2023: 11/1/23 and coated she had made the hall the of the ongoing loose stools she could not recall the	F 68	<u>'</u>		
	Nurse #4 dated 11/ was alert and orien status and her blood gastrointestinal obsequadrants of the ale Resident #1 had in					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345457	B. WING _			C 11/28/2023
	NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 50 Nurse Aide documentation dated 11/3/23 reflected Resident #1 had thirteen loose/diarrhea stools. A nurse's progress note written by Nurse #4 dated 11/4/23 indicated Resident #1 was alert and oriented with inconsistent cognitive status and her blood pressure was 110/54. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and Resident #1 had incontinence with a mixture of diarrhea stools and semi formed stools during day shift. Nurse Aide documentation dated 11/4/23 reflected Resident #1 had one loose/diarrhea stools. A nurse's progress note written by Nurse #4 dated 11/5/23 did not indicate Resident #1's cognitive status. Her blood pressure was listed as			STREET ADDRESS, CITY, STATE, ZIP 2065 LYON STREET GASTONIA, NC 28052	CODE	11720222
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BI	DATE
F 684	. •		F 6	684		
		l had thirteen loose/diarrhea				
	dated 11/4/23 indicat and oriented with inc and her blood pressu gastrointestinal obse quadrants of the abd Resident #1 had inco	ed Resident #1 was alert onsistent cognitive status ure was 110/54. A rvation revealed all 4 omen were normal and ontinence with a mixture of				
	Nurse Aide documen					
	dated 11/5/23 did not cognitive status. Her 90/50. A gastrointes 4 quadrants of the ab Resident #1 had inco	indicate Resident #1's				
	AM revealed she rec #1's stay, she experie	rse #4 on 11/28/23 at 9:00 alled throughout Resident enced diarrhea so frequently no longer got out of bed.				
	Nurse Aide documen reflected Resident #1 stools.	tation dated 11/5/23 I had six loose/diarrhea				
		ote written by Nurse #2 ed on night shift (11/5/23 at				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345457	B. WING			C 11/28/2023
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F 684	was alert and oriente known. Resident#1 h 110/56. A gastrointes 4 quadrants of the abshe had multiple loos. The note indicated In without any favorable. Attempts to interview unsuccessful. A nurse progress not 11/6/23 indicated Resoriented and able to Resident #1's blood gastrointestinal obse quadrants of the abdhad multiple loose sto Polyethylene Glycol stools. A review of Resident revealed no progress on 11/6/23. A telephone interview at 9:38 AM revealed worked the South unbut could not recall Resident with and her with the stools or behaviors of all the units and her with the stools.	d and able to make needs and a blood pressure of stinal observation revealed all odomen were normal and se stools during night shift. Incodium AD was administered e effects. Nurse #2 were e written by Nurse #1 dated sident #1 was alert and make her needs known. Oressure was 161/88. A rivation revealed all 4 omen were normal and she bools during day shift and was held secondary to loose #1's medical record anotes written by Nurse #3 with Nurse #3 on 11/21/23 ashe acknowledged she it on 11/6/23 on night shift desident #1 to include any in 11/6/23 due to her working working on an as needed	F	584		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	, ,	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER HEALTH CARE CENTER	2		STREET ADDRESS, CITY, STATE, ZIP CO 2065 LYON STREET GASTONIA, NC 28052	ODE CORRECTION ON SHOULD BE HE APPROPRIATE	11/25/2020
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F 684	night shift and docum in November 2023: 1 11/6/23. NA #2 indicated and oriented but range to loose stools. NA # "slimy and thick." NA Resident #1 had C-D Nurse #2 of the resided in the alert the nurse because they were at the animal state of the resided and the alert the nurse because they were at the animal state on the night was more confused the animal state on the night was more confused the animal state of the animal	rked on the South unit on hented on the following dates 1/1/23, 11/4/23, 11/5/23, and ated Resident #1 was alert to the call light frequently due 2 described the stools as #2 stated she was aware bifficile and therefore alerted ent having loose stools but the with each loose stool ware of them. #3 on 11/20/23 at 1:45 PM on the South unit where on night shift on 11/6/23. NA at of 11/6/23, Resident #1 han normal. She indicated dent #1 continued to have donot ring her light to be hally would, was disoriented at of bed. NA #3 said she told #1's medical record did not essed Resident #1. The se #2 had not notified the MD all lab or received any orders ons. to interview Nurse #2	F 68	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345457	B. WING				28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 2065 LYON STREET GASTONIA, NC 28052	- NTE, ZIP CODE	<u> 117.</u>	26/2023
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F 684	Continued From pageneeds known. Reside 107/48. A gastrointes 4 quadrants of the abshe had multiple loos Polyethylene Glycol stools. A late entry nurse pro#1 on 11/13/23 at 3:1 approximately 3:30 Fthat Resident #1 had appeared confused. assessed Resident # and found the value patient at 106/51. Cobaseline. An interview on 11/20 Therapy Assistant #1 to Resident #1's ther therapy on 11/7/23. Fentered the room beforticed Resident #1 previously had a very when he had worked prior. PTA #1 indicate appeared more lethal stated he made attersions.	e 53 ent #1's blood pressure was stinal observation revealed all odomen were normal and se stools during day shift and was held secondary to loose ogress note written by Nurse 19 PM indicated on 11/7/23 at 19 PM, Nurse #1 was informed a low blood pressure and The note indicated Nurse #1 it's blood pressure manually to be at baseline for the enfusion noted also to be at 19 PM with Physical 19 PM with Phy				ATE	DATE
	her normal self with salerted Certified Occ (COTA #1) who was look at obvious concernor the previous time. He indicated that CO agreed that Resident as he routinely provide this discussion between	hinking she would arouse to stimulation. He indicated he upational Therapy Assistant nearby and asked him to erns of Resident #1's change the had worked with her. TA #1 entered the room and the #1 was not at her baseline ded therapy for her. During the PTA #1 and COTA #1, the room to give Resident #1					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345457	B. WING			l	28/2023
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					065 LYON STREET		
BELAIRE	HEALTH CARE CENTER	R			GASTONIA, NC 28052		
()(1) ID	QUIMMADV QT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
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F 684	Continued From page	e 54	Ĺ	684			
		said he mentioned to Nurse		004			
		vas acting "different", but the					
		d to his statement. PTA #1					
		ions were administered by					
		^t 1 spit the medications out,					
	I .	ne pills, and the nurse left the					
		ed Resident #1 continued to					
	remain confused and	uncooperative with therapy					
	I .	e room. He explained he and					
	COTA #1 obtained vit	•					
	I .	ed it took them approximately					
	I .	btain two blood pressures					
	I .	as fidgety and restless.					
	1	oressure was obtained and					
		essure reflected between the millimeters of mercury)					
		g greater than 90/60). PTA					
	,	TA #1 placed Resident #1					
		ition in bed and left the room					
		PTA #1 stated Resident #1					
		ited during the therapy					
		recall any behaviors such as					
	I .	was in her room. PTA#1					
	stated he approached	d Nurse #1 who was at her					
		e hallway and alerted her that					
		oressure readings had been					
		were, and she had increase					
	,	like herself, and was unable					
	1	py. PTA #1 stated Nurse #1					
	'	esident #1's blood pressure					
		paseline and did not appear					
	1	ts by him. PTA #1 stated nim that she would assess					
		luate his concerns of the					
	I .	PTA #1 stated he left the					
	1	on cart and proceeded					
	I .	room. When he passed the					
	1	ator's office, he entered the					
	I .	the nurse to review Resident					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345457	B. WING			11/	28/2023
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
BELAIRE	HEALTH CARE CENTER				2065 LYON STREET		
D		•		(GASTONIA, NC 28052		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
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F 684	Continued From page	e 55	F	684			
	#1's previous blood p	ressures and alerted her of					
		e readings that he and					
	COTA #1 had obtaine	ed. PTA #1 stated the MDS					
	Nurse noted the blood	d pressures obtained by the					
	PTA #1 and COTA #1	were lower than Resident					
		stated the MDS Nurse					
		evelopment Coordinator					
	' ' '	ne who said she was leaving					
		go and recheck Resident					
	#1's blood pressure.						
	An interview with CO	TA #1 on 11/20/23 at 12:30					
		alerted on 11/7/23 in the					
		ot recall exact time) by PTA					
	,	rned that Resident #1 was					
	not her "normal self."	COTA #1 stated he entered					
	Resident #1's room w	vith PTA #1 and recognized					
	Resident #1 appeare	d drowsy, confused, and					
	agitated. He said whi	le he and PTA #1 were in the					
		Nurse #1) entered the room					
		edications and attempted to					
		Resident #1 spit them all out					
		x #1 stated while Nurse #1					
		#1 mentioned to Nurse #1					
	that Resident #1 did r	10 seem to be at her 11 did not acknowledge the					
	′	d quickly retrieved the					
		t #1 spit out and left the					
	room. COTA #1 indica						
	continued to attempt						
		ccess then decided to obtain					
		nt #1. COTA #1 indicated he					
	_	two sets of vital signs					
		blood pressure reading					
		. He recalled the blood					
		ere around 60's and 70's					
		ngs concerned him and PTA					
		om to find the nurse. COTA				ĺ	
	#1 stated they approa	ached the nurse and told her					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION IG		ATE SURVEY DMPLETED
		345457	B. WING _			C 11/28/2023
	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052		11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag		F 6	884		
	Resident #1 and that been low. COTA #1 i medication cart and shood pressure at ba not go assess Reside stated he and PTA # therapy gym when the Nurse's office and to blood pressure being MDS Nurse reviewed and was concerned well. COTA #1 stated to assess Resident # the office and continual An interview on 11/20 #1 revealed she explany abnormal behavior	ing was abnormal about ther blood pressure had indicated Nurse #1 was at her simply stated Resident #1's seline was low, but she did ent #1 at the time. COTA #1 were returning to the resident #1's returning to the returning to				
	received report from #3) that she had exh increase confusion the could not recall what Resident #1 had not to get up as she requiransfers. Nurse #1 stated she medications whole at Nurse #1 stated she #1 took her medication the pills and left the right 11/7/23 between 3:30 Therapy staff (PTA at her medication cart at Resident #1's blood and resulted in low resident #1 low resulted in low resulted	behaviors Nurse #1 behaviors Nurse #1 stated made any previous attempts uired assistance for all stated she entered Resident ter her morning medications. attempted to administer the nd Resident #1 spit them out. had forgotten that Resident oom. Nurse #1 stated on D PM and 4:00 PM, two nd COTA) approached her at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	· ·		
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F 684	and she did not go of pressure at that time went back into Resident medications what medications she afternoon, she state medications because administer them earliethargic. Nurse #1 sprovider about the ninability to take her rito lethargy, nor that had been reported a clarification orders with Lisinopril at that time. An interview with the 2:00 PM revealed shinteractions with Resident #1's low bluseem like herself. The looked in Resident moticed the blood protherapy staff were lowed by the process of Nurse stated so Director of Nursing (left the building, so sassess her. The MD Nurse agreed to assinvolvement with Resident moticed the second did not reflect MDS Nurse to reflect motions.	lirectly to re-check the blood a. Nurse #1 stated she later dent #1's room and dications crushed which viously spit out earlier when com. When asked Nurse #1 de had administered that de Resident #1's morning de she had been unable to lier due to Resident #1 being stated she did not contact the dew behaviors, Resident #1's medication that morning due Resident #1's blood pressure solow in order to obtain whether to administer the debta when debta wh	F 68-	4			

	F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED		
		345457	B. WING			C 1 1/28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2065 LYON STREET GASTONIA, NC 28052	•	11/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	An interview with the 3:50 PM revealed sh Nurse on 11/7/23 ard #1 was more confuse low blood pressure in called the South unit Nurse #1. The SDC I Nurse #1 who said sl #1 in about 5 minutes she was concerned a #1. The SDC Nurse #1 the hall and saw Nurse admitting a new reside of the door and the Sishe had been in to as SDC Nurse stated Nobeen in yet but would indicated she then er and obtained Reside was near her baselin recall what Resident 11/7/23. The SDC Notes Resident #1 was conher blood pressure, it apparent distress. The and alerted Nurse #1 then left the unit. A review of Resident record did not reflect SDC Nurse to reflect by her on 11/7/23. An interview with Resident 11/20/23 at 10:09 Family Member states.	specified by the MDS and the was notified by the MDS and 4:00 PM that Resident and than normal and had a strategy. The SDC Nurse nurses' station and spoke to Nurse stated she spoke with the would go check Resident and went to assess Resident explained she approached she #1 in a nearby room and the but poked her head out apply the but poked her she had not a shortly. The SDC Nurse and it we although she could not #1's blood pressure and it we although she could not #1's blood pressure was on anse could not recall if a fused when she obtained out stated she was not in any the SDC Nurse left the room to continue to monitor her which was conducted. The and she visited Resident #1 was assessed sident #1's Family Member AM was conducted. The ad she visited Resident #1 in to see her approximately a	F 6	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		DNSTRUCTION	(X3) DATE COMP	SURVEY
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		345457	B. WING			11/	28/2023
	ROVIDER OR SUPPLIER HEALTH CARE CENTE	ĒR		2065	EET ADDRESS, CITY, STATE, ZIP CODE 5 LYON STREET STONIA, NC 28052	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	good memory without behaviors during he stated she had come vening (she could recalled it was prior delivered) and spokember stated told because she was on in the last 5 minutes out and it sounded she dropped the pholium out and although she wand although she wand she was fine. Find she was called should that Resident #1 har oom for evaluation indicated that when shortly after being rextremely confused her lower extremition. A nurse's note writted at 9:57 PM indicated the floor adjacent to as follows: BP 106 91 bpm, and oxyge #1 had skin tears to interventions were prounding, keep persplace Resident #1 at The confusion note message was left for return a call to the form.	arge and Resident #1 had a put obvious confusion or er visit. The Family Member tacted the facility earlier in the not recall the exact time but to supper trays being with Nurse #1. The Family Nurse #1 she was concerned in the phone with Resident #1 so and Resident #1 was yelling like she may have fallen when none. The Family Member said of Resident #1's room and was at Resident #1 was in the bed was yelling out, she had not fell family Member #1 stated that ritly before midnight on 11/7/23 and been sent to the emergency of the Family Member and bear trived at the hospital motified, Resident #1 was found on the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of the bed with vital signs listed of 51, temperature 97.8, Pulse of 51, tem	F	584			
	An interview on 11/	•					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345457	B. WING				28/2023
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2020
					065 LYON STREET		
BELAIRE	HEALTH CARE CENTER	1			SASTONIA, NC 28052		
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F 684	Continued From page	a 60		684			
1 001				004			
		Resident #1's daughter, who					
		I she believed her mom had					
		stated when she went to the us in the bed, hollering out,					
		te what she needed. Nurse					
		t Resident #1 was just					
	hollering and therefor	•					
	_	d not fallen and was fine.					
	•	esident #1 continued to					
	**	at staff following that time					
		get up from the bed without					
	, , ,	stated Resident #1 had					
	frequent loose stools	and her Polyethylene Glycol					
	as held. Nurse #1 sai	d later in the shift (around					
	9:00 PM) Resident #1	1 was found on the floor					
	between her bed and						
		1 was found to be on the					
	· ·	sed to have bleeding to her					
		nities with hematomas to					
		stated Resident #1 continued					
		p me" and "G** D***'**"					
		for Resident #1. Nurse #1					
		he fall, she did not feel the					
	_	to the hospital, so she					
		bandaged them, and placed se #1 indicated she did not				ĺ	
		at the time of the fall or of					
		e of condition. Nurse #1					
	stated she did notice						
		which was new for Resident					
		nay have a urinary tract					
	_	ng to request a urinalysis					
		At 10:30 to 11PM, Nurse #1					
		#1 was having a change of					
	_	e was yelling, unable to					
		and contacted the DON who					
	provided orders to se	nd Resident #1 to the					
	emergency room for a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 2065 LYON STREET GASTONIA, NC 28052)E	1117.	20/2023		
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F 684	10:49 PM written by N #1 had increase confi (person, place, and ti weakness post fall, al which was a change signs listed Resident 106/51. An interview with NA revealed she could no behaviors by Resider A late entry progress of Nursing on 11/10/2 11/7/23, Resident #1 and cussing at staff w Resident #1 was norr Resident #1 had a fal time of the fall she co was trying to do. Whe continued to curse the bed and the MD gave to the emergency roo altered mental status The hospital emerger 11/7/23 indicated Res hospital with altered r (low blood pressure) over 60s, a blood glue WBC 53.8, positive u urinary tract infection low sodium of 122, hy temperature of 94.46 between 97-99 degre (s/p) a fall resulting in	and Assessment BAR) form dated 11/7/23 at Nurse #1 indicated Resident usion as oriented x 2-3 me) at baseline, generalized and personality changes from her baseline. Vital #1's blood pressure was #1 on 11/20/23 at 11:25 AM of recall any falls or at #1 prior to 11/7/23. note written by the Director at at 11:07 AM indicated on awas yelling and screaming which was unusual for her. mally alert and oriented. I around 9 PM but at the all und not tell staff what she are she fell, Resident #1 are staff and tried to get out of a orders to send Resident #1 am for evaluation related to ancy room report dated sident #1 arrived at the mental status, hypotensive with blood pressure 80s cose level of 29, elevated rine culture reflected a gelevated creatinine of 3.4,	F	584				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345457	B. WING _			C 11/28/2023		
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 2065 LYON STREET GASTONIA, NC 28052	DDE	11720/2020		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE		
F 684	sepsis with acute or sepsis) with possible cystitis with hematur pseudomembranous colon related to back of C difficile colitis, a failure secondary to acute encephalopath secondary to infection and type 2 myocardibetween oxygen superior to plaque rupture). A hospital death not indicated Resident #1 including oral vancoresuscitated (fluids of depleted). Resident vasopressors (mediciblood vessels in patifor hypotension despresuscitation. She reworsening clinical statell count, and poor Conversations occur and family regarding family agreed to transmeasures only. Response as documented in the An interview with the revealed she would with the change of cestaff on 11/7/23 becars.	nity and was diagnosed with gan dysfunction (severe e causes related to acute ia (blood in the urine) or colitis (inflammation of the teria) with a strong suspicion acute kidney injury/acute renal elevated creatinine levels, by (brain dysfunction) ous process, hypothermia, all infarction (imbalance oply and demand not related at the hospital. The lent #1 had been admitted to be tred mental status and C was started on antibiotics, mycin and volume given to replace the volume #1 ultimately required cations used to constrict the lents with low blood pressure) obte adequate volume emained on vasopressors with atus, increasing white blood response to treatment. The lent #1 subsequently expired in the lent #1 s	F	584				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345457	B. WING _				28/2023	
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER				STREET ADDRESS, C 2065 LYON STREET GASTONIA, NC 26		<u>, 11/</u>	20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	An interview with the revealed she was no however, the PA sho change of condition is she was not aware R discharged. An interview with the at 4:08 PM revealed Resident #1's condition in the Regional Director of the condition in the Regional Director of the condition in the Regional Director of the DON stated she intermittent ongoing aware of the abnorm stated she was notified in 11/7/23 after she was notified in the Resident confused so the DON the emergency room. The Administrator and notified of the immediated of the immediated in the rector of the confused so the DON the emergency room. The facility provided allegation of immediated in the immediated in the rector of the noncondition in the no	would have addressed it." NP on 11/21/23 at 4:02 PM to in duty on 11/7/23; uld have been notified of the by Nurse #1. The NP stated desident #1 had been Physician (MD) on 11/21/23 he was not made aware of on on 11/7/23. Director of Nursing (DON) ector of Clinical Services on M revealed they had been concerns with Resident #1. It was aware Resident #1 had doose stools and she was all laboratory values. She ed of Resident #1's condition fell. The DON stated Nurse #1 had fallen and was N told Nurse #1 to transfer to to d. If the DON stated Nurse #1 to transfer to the dilution of the property on 11/21/23 at the following credible atteriors adverse outcome as mpliance:	F	584				
	on 10/25/2023, residual surgeon appointment	lent #1 went to a follow up t and was ordered						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345457	B. WING _				C 28/2023	
	ROVIDER OR SUPPLIER	2		20	TREET ADDRESS, CITY, STATE, ZIP CODE 065 LYON STREET 6ASTONIA, NC 28052		20/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	initiated the medicatic clarification from the Polyethylene glycol vloose stools. The in-Inotified of holding the 10/30/2023, resident culture for C-Difficile, adequately assessed adequate intervention Resident #1 was not confusion by the week increased confusion staff. The resident no confusion on 11/06 a assessed appropriate intervention. Reside low blood pressure be nurse gave resident; medication with a low nurse failed to assess the blood pressure man acute change in cowas not assessed at condition. This result The Director of Nursic Coordinator and Reg Services reviewed la lab results, and vital labs; abnormal vital se behaviors have been assessments and introprovider consultation reviewed with the attribirector of Nursing to	or constipation. The facility on without getting in-house provider. was held at times due to house provider was not a Polyethylene glycol. On #1 received a positive stool the patient was not and did not receive in to treat the C-Difficile. We do have increased extend supervisor. The was not assessed by facility of the dot have intermittent ind 11/07 and was not ely to get adequate in #1 was noted to have a y therapy staff. The charge in the patient prior to giving its dood pressure. The charge is the patient prior to giving its dood pressure. The charge is the patient prior to giving its dood in a hospital transfer. Ing/ Staff Development ional Director of Clinical st 14 days of progress notes, signs to ensure all abnormal	F	584				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345457	B. WING _				28/ 2023
NAME OF PROVIDER OR SUPPLIER BELAIRE HEALTH CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 2065 LYON STREET GASTONIA, NC 28052	DE	1	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 684	Continued From page	÷ 65	F 6	584			
	process or system fai adverse outcome from when the action will be Education will be prov	vided by 11/22/2023, by the					
	time, part time, as new	nee to current licensed full					
	vital signs, abnormal behaviors from baseli educated on the use	ne. Licensed nurses will be					
	conditions. The Intera each nursing station. suggestions on treatn	ct pathways are located at The pathways contain					
	treatment pathways a further instruction. Ec provided to current lic	nd notify the providers for					
	electronic health reco nursing staff will inclu	cribing the order into the rd. Education to licensed de abnormal blood pressure to not administer blood					
	pressure medication. by 11/22/2023 by the Development Coordir	Education will be provided Director of Nursing, Staff nator or designee to current					
	staff (if applicable) ce and therapy staff on r condition to the charg	needed and contracted rtified nursing assistants eporting acute changes in e nurse of the patient					
	consist of and reporti	what abnormal behaviors ng abnormal vital signs. I signs and symptoms of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345457	B. WING _			C 11/28/2023		
	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 2065 LYON STREET GASTONIA, NC 28052	<u>'</u>	11/20/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 684	working on 11/22/20 to the start of their si Staff Development Censure education is The alleged date of I 2023. The person responsi Administrator. The validation of the of care/proving care standards was conditively 1/28/23. Staff interverified all licensed sheen educated on the requirements for assuse of the Interact Pof condition and to sorders from hospital consulting providers. Nursing Assistants or resident condition ar Nurse immediately. License Nurses whe	change in condition. Staff not 23 will receive education prior nift after 11/22/2023. The Coordinator will track and	F6	<u> </u>				
	breath, low blood pre orders, and abnorma to perform and docu residents electronic immediate interventi- the night when there life-threatening chan							

		IDENTIFICATION NUMBER		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
			D WING		С	
		345457	B. WING		11/28/2023	
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BELAIRE H	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	