STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345457	A. BUILDING _____ B. WING _____	C 04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELAIRE HEALTH CARE CENTER	**2065 LYON STREET GASTONIA, NC 28052**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #TJ1711.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the facility failed communicate with the dialysis center to obtain and review weights, to obtain completed dialysis communication forms,and to obtain and review any laboratory results completed by the dialysis center for one of one resident, Resident #229, reviewed for dialysis services. Findings included: A review of the Skilled Nursing Facility/Long Term Care Facility Outpatient Dialysis Services Agreement between the nursing facility and the and the dialysis center, Policy-C-FDS-002, effective 07/01/2000, revealed in section 1 on page 2 of the agreement that "The Nursing Facility shall ensure that all approrpiate medical and administrative information accompany all residents at the time of transfer or referrl to the ESRD (End-Stage Renal Disease) Dialysis Unit. On page 3 under section 2, the agreement stated, "The Nursing Facility will provide for the	F 309	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. How the corrective action will be accomplished for the resident(s) affected. The information for resident #229 was obtained from the dialysis center to include pre and post weights and lab work on 4/15/2015	5/7/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/01/2015

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F 309	Continued From page 1 interchange of information useful or necessary for the care of the resident and will inform the ESRD Dialysis Unit of a contat person at the Nursing Facility whose responsibilities include oversight of provision of dialysis services by the Company and the ESRD Dialysis Unit to the residents of the Nursing Facility." On page 3 under section 3, the agreement stated, "The Nursing Facility shall be responsible for ensuring that the resident is medically stable to undergo such transportation and for treatment at the ESRD Dialysis Unit..." A review of the Minimum Data Set (MDS) entry assessment dated 04/02/2015 revealed Resident #229 was admitted to the facility on 04/02/2015 from the local hospital. The 5-Day Admission MDS assessment was not complete at the time of the review. A review of the medical record for Resident #229 revealed a list of diagnoses included in part, end-stage renal disease, chronic airway obstruction, and congestive heart failure. In addition, a progress note dated 04/03/2015 indicated that the resident's primary diagnosis was end-stage renal disease with a recent initiation of hemodialysis and that the resident was receiving dialysis treatments three days per week. A review of the resident's nursing care plan which was initiated on 04/02/2015 and revised on 04/07/2015 revealed there were interventions in place to address the resident's risk for weight fluctuation related to her recent hospitalization, her end-stage renal disease with hemodialysis, and her diagnosis of congestive heart failure. The goal related to these problems was that the resident would avoid significant weight changes,	F 309	2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Dialysis residents charts were audited to ensure information including weights have been obtained from the dialysis center. Residents that are scheduled for dialysis have a Dialysis Communication form to accompany the resident, active orders and any information pertinent to the care of the resident. Any dialysis residents admitted to the facility will have an information packet started to include face sheet, Physicians orders and the dialysis communication form completed by the charge nurse at the time of the transfer to the dialysis center. The charge nurse will ensure that the dialysis form is returned with the resident. The DON, Unit Manager or designee will be responsible to call the dialysis center to obtain this information if it is not returned to the center. All licensed nursing staff will be re-educated by the SDC/DON/ Designee by 5/7/2015. The education will include policy 1516 General Care of Hemodialysis- which states services of the dialysis resident, the Dialysis communication form, Assessment/status of the shunt upon return of the resident to the facility thrill/bruit, vital signs and weights. The DON will be the coordinator of services between the facility and the dialysis center. 3. Measures in place to ensure practices	

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F 309	Continued From page 2 and one of the interventions included to address this problem was to obtain weekly weights for four weeks. Further review of the resident's nursing care plan revealed there was a goal with interventions to address the resident's needs for dialysis services. The goal listed on the nursing care plan was that Resident #229 would have no signs or symptoms from dialysis treatment. Some of the interventions included checking the resident's dressing, checking the right subclavian dialysis catheter for secure end caps, and to obtain lab work as ordered. A review of Resident #229's medical record revealed the resident had been receiving hemodialysis three days per week since 04/04/2014. Additional review revealed there was one weight of 206.3 pounds recorded for the resident on 04/03/2015 after admission. There were no other weights recorded for the resident, and there was no record of pre-dialysis or post-dialysis weights in the facility's medical record for the resident. In an interview with Nurse #1 on 04/15/2015 at 10:44 AM, she explained that whenever a resident was transported to the dialysis center for treatment, a Dialysis Communication Form was sent with the resident, and that the communication form would be completed by the dialysis center. Nurse #1 stated the completed communication form would be returned with the resident to the nursing facility after the dialysis treatment for the nurse to review. A blank copy of a Dialysis Communication Form was provided by Nurse #1 for review. A review of the blank Dialysis Communication Form revealed there were three sections on the	F 309	will not re-occur. DON/Unit Manager/Designee will audit dialysis information daily 6 times per week for 2 weeks, 3 times a week times 2 weeks, weekly times 4 weeks, then quarterly times 3. Any breaches of information not sent to dialysis or received from dialysis will be addressed at that time with re-education/discipline and or contacting the dialysis center to obtain resident information. Newly hired licensed staff will be in-serviced during orientation by the SDC or designee. 4. How the facility plans to monitor and ensure correction is achieved and sustained. Information obtained during the audits of the dialysis resident will be reviewed during the Quality Assessment and Assurance (QA&A) committee monthly times 3 months then quarterly times 2 for continued Compliance or revision to the plan. 5. POC correction date 5/7/2015	

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F 309	Continued From page 3	F 309		

form, sections A, B, and C. Section A was entitled, "Pre-Dialysis (to be completed by Health and Rehab Center)", and there were spaces on this section to indicate whether a meal had been provided to take to dialysis, whether medication was required before dialysis, whether the resident had a chane in condition before going to dialysis, and whether medication were to be given during dialysis. There was also space for a signature for section A. Section B of the same form was entitled, "Dialysis (to be completed by Dialysis Center." Section B included spaces to record a pre-dialysis weight, vital signs, labs/results, whether a meal was consumed, the time dialysis started and was completed, and the post-dialysis weight and vital signs. There was also a line in Section B for a signature. Section C of the form was entitled, "Post-Dialysis (to be completed by Health and Rehab Center). There was a directive in this section for the nursing/rehab facility to document the resident's vital signs, assess the Dialysis Access Site/AV (arteriovenous) fistula dressing, drainage, bruit, thrill, distal pulse, and to document pre- and post- ialysis weights, and to assess the skin.

A review of the resident's paper and electronic charts revealed there were no completed Dialysis Communication Forms present.

In an interview with Nurse #2 on 04/15/2015 at 10:50 AM, he was not sure where completed dialysis forms were kept and suggested the forms might be on the resident's chart.

In an interview with Nurse #1 on 04/15/2015 at 11:53 AM, she stated that Resident #229 usually left the nursing facility during the 7:00 AM to 3:00 PM shift for her hemodialysis appointment and

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also that returned to the facility during the same shift. Nurse #1 also explained that when the resident returned to the nursing facility, she made sure the resident had something to eat, checked her blood pressure and other vital signs, checked her weight, and checked her fistual site. Nurse #1 further stated that she would document on the Dialysis Communication Form and in the progress notes regarding the resident's post-dialysis assessment. Nurse #1 stated she was not sure that she recalled actually seeing any Dialysis Communication Forms recently when the resident to the nursing facility after dialysis treatment.

A review of the Progress Notes revealed there were no post-dialysis assessments which included information from the Dialysis Communication Forms such as vital signs, assessments of the Dialysis Access Site for the dressing, drainage, bruit, thrill, distal pulse, or any post-dialysis skin assessments.

An interview was conducted with the Director of Nursing (DON) on 04/15/2015 at 12:00 PM. During the interview, the DON explained that upon return to the nursing facility after dialysis, the nurse makes an assessment of the resident and documents the assessment in the progress notes. The DON stated that all of Resident #229's weights should be present in the chart. In addition, she stated that the Dialysis Communication Form should be present in the resident's chart under the Progress Notes tab. The DON also stated that the pre-dialysis and post-dialysis weights were completed by the dialysis unit, and that the nursing faclity might have other weights for Resident #229 which had not yet been recorded. The DON stated she

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F 309	Continued From page 5 would check to see if there were some completed communication forms which had not yet been filed and for any additional weights for Resident #229 which had not been recorded. In an interveiw with the DON on 04/15/2015, she reported she had not located any of the completed Dialysis Communication Forms or additional weights for the resident. In an interview with the DON on 04/16/2015 at 1:00 PM, she stated she still had not located any other weights or completed Dialysis Communication Forms, and the the communication form was the primary tool the facility used for communication with the dialysis center. The DON stated that she called the dialysis center that day to tell them that the forms should be completed and returned to the facility. In addition, the DON stated that she had spoken with Nurse #1 and that she documented in the Progress Notes that morning that she sent a Dialysis communication Form with the resident to dialysis that day. The DON stated that the information included on the Dialysis Communication Forms was the primary tool for communication with the dialysis center and that the information was needed to appropriately assess the resident.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition	F 325		5/7/15

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F 325	Continued From page 6 demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide 1 of 3 sampled residents (Resident #29) who experienced weight loss with a nutritional supplement (sandwich) which was ordered to help prevent continuing weight loss. Findings included: Record review revealed Resident #29 was admitted to the facility on 02/04/15. The resident's documented diagnoses included protein-calorie malnutrition, stage II pressure ulcer, anemia, vitamin D deficiency, and congestive heart failure. Review of Resident #29's medication administration record (MAR) revealed he was admitted to the facility with an order to receive l0 milliliters (mL) of Megace oral suspension (appetite stimulant) 40 milligrams per milliliter (mg/mL) daily. The resident's weight summary documented he weighed 148.2 pounds on 02/04/15 and 144.3 pounds on 02/09/15. The resident's 02/11/15 admission minimum data set (MDS) documented he had moderate cognitive impairment, required staff assistance with meal setup only when eating, and his weight was stable.	F 325	How the corrective action will be accomplished for the resident(s) affected. The Dietary Manager (DM) immediately corrected resident #29 tray slip to include the sandwich for lunch and dinner How corrective action will be accomplished for those residents with the potential to be affected by the same practice. The Dietary Manager and Registered Dietician performed an audit on all residents for preferences and supplements to ensure all information was visible to the dietary staff on the tray slips on 4/16/2015 Measures in place to ensure practices will not re-occur The Dietary manager will educate all dietary employees to review all tray slips for accuracy to ensure residents are receiving supplements and preferences as ordered. Education will be completed on 4/29/2015. The Dietary Manager will perform tray line audits 2 times per week for 4 weeks, 1 time a week for 4 weeks then monthly times 3 months. The Dietary Manager/Registered dietician will audit	

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F 325	Continued From page 7 In his 02/13/15 note/assessment the registered dietitian (RD) documented Resident #29 was receiving a heart healthy mechanical soft diet with nectar thick liquids and Boost nutritional supplement three times daily (TID), was eating 50 - 75% of his meals, and denied nausea/vomiting, chewing and swallowing problems. The resident himself reported his appetite was"not too good". The RD also documented the resident received Megace for appetite stimulation, and reported a usual body weight of 155 pounds. The RD recommended changing Boost to the facility equivalent of Ensure Plus, liberalizing the resident's diet to mechanical soft, and adding a multi-vitamin. On 02/16/15 Resident #29's care plan identified weight fluctuation due to a recent hospitalization, recent fractures, and fluctuating intake of food as a problem. Interventions to this problem included, "Provide and serve supplements as ordered. Provide and serve diet as ordered." The resident's weight summary documented he weighed 130.5 pounds on 02/16/15 and 123.1 pounds on 02/23/15. A 03/06/15 weight change progress note documented Resident #29 had lost 20 pounds since admission, and was consuming less than 50% of his meals. Magic Cups (frozen nutritional supplement similar to ice cream) were added twice daily (BID) A 03/19/15 physician order discontinued Resident #29's Megace due to a pharmacy recommendation since it posed possible negative interactions with his other medications.	F 325	resident profiles in meal tracker system to ensure tray slips are updated with preferences, supplements weekly times 1 month to ensure residents are receiving preferences and, supplements as requested or ordered. The DON/SDC or designee will educate current licensed nursing staff on dietary communication forms. These forms should be completed on any changes to the resident□s diet, supplements or preferences to ensure accurate tray slips. Education will be completed by 5/7/2015. Any lack of compliance noted will be addressed at that time and will result in re-education or disciplinary action as indicated by Dietary Manager/DON. New nursing employees will be educated by the SDC during orientation on Dietary Communication Slips.. How the facility plans to monitor and ensure correction is achieved and sustained. The dietary manager/DON will bring all information from audits to be reviewed during QA&A committee monthly times 3 months then quarterly times 2.	

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The resident's weight summary documented he weighed 122.5 pounds on 04/01/15.

A 04/07/15 weight change progress note documented Resident #29 had lost 25.7 pounds in the past two months, and was consuming less than 50% of his meals. A sandwich was added to the resident's lunch and supper meals as an intervention to help prevent further weight loss. The nurse practitioner signed off on the sandwich recommendation on 04/08/15.

The resident's weight summary documented he weighed 121 pounds on 04/08/15.

At 5:40 PM on 04/14/15 there was no sandwich or Magic Cup on Resident #29's supper tray, and the resident's tray slip did not document he was supposed to receive a sandwich.

At 11:53 AM on 04/15/15 there was no sandwich on Resident #29's lunch try, and the resident's tray slip did not document he was supposed to receive a sandwich. The resident did receive his Magic Cup.

At 5:12 PM on 04/15/15 there was no sandwich on Resident #29's supper try, and the resident's tray slip did not document he was supposed to receive a sandwich. The resident did receive his Magic Cup.

At 5:18 PM on 04/15/15 the dietary manager (DM) stated dietary was not aware that Resident #29 was supposed to receive a sandwich at lunch and supper. She pulled up the resident's tray slips, and reported the sandwiches were not documented on them. The DM went into the

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computer system, and found where the RD entered the sandwiches for Resident #29 into the electronic record. However, she commented the problem was the RD documented the sandwiches in a section which did not transfer information onto the tray slips. According to the DM, the tray slips were the only way the supplement sandwiches could be communicated to the dietary staff preparing resident trays at the trayline.

At 11:34 AM on 04/16/15 the RD stated Resident #29 was losing weight since admission, but the facility and physician were unable to determine the reason why. He reported a liquid nutritional supplement was added between the resident's meals, Magic Cups were added to tempt the resident with a sweet dessert-type supplement, and sandwiches were added with lunch and supper meals because the resident was still losing weight. The RD explained the kitchen supplied the Magic Cups and sandwiches. He stated he communicated the addition of Magic Cups and sandwiches to the kitchen by entering them into the tray tracker system which electronically transferred them to resident tray slips.