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 03/22/2018

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# 0W3G11.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to transcribe a medication order for pain management for 1 of 1 sampled resident reviewed for Hospice (Resident #47). Finding included: Resident #47 was admitted to the facility on 07/27/17 with diagnoses that included chronic kidney disease, chronic pain, diabetes, Alzheimer's, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) dated 02/19/18 coded Resident #47 with moderate impairment in cognition. The MDS indicated Resident #47 reported occasional pain that limited his day-to-day activities. Review of the hospital discharge summary dated 03/08/18 for Resident #47 included a signed "consent for hospice services" with the effective date of 03/08/18. Further review revealed an order which read, "morphine sulfate oral concentrate (pain medication) 20 milligrams	F 658	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 centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F658 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited; For resident #47, nursing staff failed to transcribe orders to the Medication Administration Record that were initiated by a hospice order when patient returned to the facility. This is a	4/11/18

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

Electronically Signed | 04/05/2018

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 03/22/2018

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 658	Continued From page 1 (mg)/milliliters (ml) - take 0.25 ml (5 mg) by mouth or under the tongue every 2 hours as needed for pain or shortness of breath." Review of the March 2018 Medication Administration Record (MAR) for Resident #47 revealed no order for morphine sulfate. Review of the Omnicare (pharmacy used by the facility for medications) proof of delivery form for the period 03/08/18 through 03/12/18 revealed an order for morphine sulfate 100 mg/5 ml solution for Resident #47 was received by the facility on 03/08/18 at 11:41 PM. During an interview on 03/21/18 at 4:15 PM the Director of Nursing (DON) confirmed a written order for morphine sulfate for Resident #47 was received from the hospital, faxed to the facility's pharmacy and the medication was received at the facility on 03/08/18. The DON verified the order for morphine sulfate was not entered into Resident #47's electronic medical record or recorded on his MAR. The DON stated she would expect for physician orders to be entered when received. During an interview on 03/22/18 at 11:55 AM Nurse #1 confirmed he worked on 03/08/18 when Resident #47 was readmitted to the facility after a brief hospital stay. Nurse #1 explained he entered medications into Resident #47's electronic medical record based on the medication orders listed on the hospital discharge summary. Nurse #1 stated he "must have missed" entering the order for morphine sulfate into Resident #47's electronic medical record. During an interview on 3/22/18 at 4:31 PM the	F 658	direct result of a lack of attention to detail and education. Patient had no negative outcome from this omission, however, could have resulted in care not being provided that was ordered. At the time of the survey, the Morphine was added to the MAR. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; In order to prevent this from occurring again, all patient charts of hospice patients that were in-house as of March 30, 2018 were checked for consults/hospice orders to ensure there were no orders that were not transcribed. If any missed orders were found the physician and ordering physician were immediately notified and the order transcribed to the MAR/TAR to ensure the order was carried out and care could be documented. The Staff Nurses were educated starting on March 27, 2018 on the following process by the facility Staff Development Coordinator. 1) When a resident returns to the facility from a consult visit or admission to the hospital, nursing will review the consult for orders and place them on the MAR/TAR. 2) The nurse will make a copy of the consult and give to the Director of Nursing who will either check herself or delegate to the Unit Manager or Assistant Unit Manager, Staff Development Coordinator, will check the Consult sheet if provided by the provider for any new orders Monday through Friday. 3) If orders are present then the patients chart will be checked to	

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 03/22/2018

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 658	Continued From page 2 Administrator stated it was his expectation physician's orders were entered when received.	F 658	ensure that the order was transcribed to the patients MAR/TAR if order was obtained during provider visit. 4) If order was present on the consult sheet and not transcribed then documentation of re-education for the first infraction by a nurse and disciplinary action for any further infractions. Nurses not educated on the above process on April 9, 2018 will be removed from schedule until education is received. This process will be included as part of the Orientation program for new hires. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; When a resident returns to the facility from a consult visit or admission, nursing will review the consult for orders and place them on the MAR/TAR. The nurse will make a copy of the consult and give to the Director of Nursing who will either check herself or delegate to the Unit Manager or Assistant Unit Manager, Staff Development Coordinator, will check the Consult sheet if provided by the provider for any new orders Monday through Friday. If orders are present then the patients chart will be checked to ensure that the order was transcribed to the patients MAR/TAR if applicable. If order was present and not transcribed then documentation of re-education for the first time and disciplinary action for further infractions. This audit will continue daily Monday through Friday X 4 weeks, weekly X 4	

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 03/22/2018

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 658	Continued From page 3	F 658	weeks and then bi-weekly X 10 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 4 months, for review and revision as needed.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		4/11/18

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 03/22/2018

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 761	Continued From page 4 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to remove 1 vial of opened and expired Novolog from 1 of 2 medication storage rooms in the facility and failed to discard 1 box of opened and expired Advair Diskus inhaler, 1 bottle of opened and expired glucometer control solution, 1 opened Novolog FlexPen without opening date, and 1 bottle of opened bacteriostatic 0.9% Sodium Chloride solution without a label in 3 of 5 medication carts in the facility. Findings included: A review of the facility policy section 5.3 regarding Storage and Expiration of Medications, Biological, Syringes and Needles dated 11/14/17 indicated that the facility should ensure that medications and biologicals had an expiration date on the label, had not been retained longer than recommended by the manufacturer or supplier guidelines and had not been contaminated or deteriorated. It also indicated that once any medication or biological package was opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications and the facility staff should record the date opened on the medication container when the medication had a shortened expiration date once opened. A review of the facility protocol titled Insulin Storage Recommendation with revision dated	F 761	F761 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: Facility failed to discard a vial of expired Novolog Insulin, 1 box of opened and expired Advair Diskus inhaler, 1 bottle of opened and expired glucometer solution, 3 bottles of opened bacteriostatic 0.9% Sodium Chloride solution, 1 opened Novolog FlexPen without an opening date. This is a direct result of the lack of attention to detail when preparing med charts for med pass. The Procedure for implementing the acceptable plan of correction for the specific deficiency cited: Drugs and biologicals in each medication cart were audited, and any expired items, unlabeled or not dated items, or loose pills items were removed and disposed of per facility policy. Nurses were in-serviced on Pharmacy Policy 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, 5.0 Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication	

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 03/22/2018

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 761	Continued From page 5 03/31/2015 indicated that Novolog vials and Novolog Flex Pens should be labeled with date opened and were to be discarded after 28 days. A review of the facility protocol titled Recommended Minimum Medication Storage Parameters (based on manufacturer guidance) Inhaled Medications with revision dated 03/31/15 indicated that Advair Diskus should be dated when removed from the foil pouch and discarded 1 month after removal from the foil pouch or after all blisters had been used, whichever came first. 1. a. Resident #37 was admitted to the facility on 05/10/13 with diagnoses included diabetes mellitus (DM). A physician's order dated 01/27/17 indicated that Resident #37 was to receive Novolog per sliding scale before meals and at bedtime subcutaneously four times daily related to type II DM. On 03/21/18 at 09:53 AM an expired vial of Novolog for Resident #37's was found in the refrigerator of Main medication storage room on North unit. There was a yellow sticker located on the opened Novolog vial indicated it was opened on 02/13/18 and the space for expiration was blank. The sticker stated the Novolog vial should be refrigerated until opened and discarded unused insulin after 28 days. On 03/21/18 at 09:59 AM an interview was conducted with Nurse #2. She acknowledged that the vial of Novolog was expired and had to be discarded. She stated each nurses were instructed to check the expiration of the medication before administration and to check	F 761	has a shortened expiration date once opened. 5.1 Facility Staff may record the calculated expiration date based on date opened on the medication container, 5.2 Medications with a manufacturers expiration date expressed in month and year (e.g. May, 2019) will expire the last day of the month.. Nurses during in-service were given a copy of the Omnicare Insulin Storage Recommendations. The Facility will require that nursing personnel will inspect nursing station storage areas for proper storage compliance on a regularly on a weekly basis. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected/and or in compliance with the regulatory requirements: Director of Nursing, RN Unit manager, or House Supervisor will conduct audit of drugs and biologicals on each medication cart Monday - Friday X 4 weeks, Weekly X 4 weeks and bi-weekly X 10 months. Results of audits will be reviewed at Weekly Quality Assurance Risk meeting for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of drugs and biologicals. The Title of the person responsible for implementing the acceptable plan of correction: Director of Nursing will be responsible to ensure that the plan of correction is	

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 03/22/2018

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 761	Continued From page 6 their respective medication cart each shift to ensure it was free of expired medication. She did not understand why this vial of Novolog was stored in the refrigerator of the Main medication storage room. Review of Medication Administration Record (MAR) revealed Resident #37 had been receiving Novolog subcutaneously per sliding scale as ordered and her blood glucose (BG) levels in the past one month had remained at the baseline. b. Resident #18 was admitted to the facility on 04/04/16 with diagnoses included type II DM. A physician's order dated 09/26/16 indicated that Resident #18 was to receive Novolog per sliding scale subcutaneously one times daily at noon related to type II DM. On 03/21/18 at 10: 26 AM an opened Novolog FlexPen was found in the medication cart #3 on North Unit and it was undated. There was a yellow sticker located on the opened Novolog FlexPen with a space for date opened and it was blank. On 03/21/18 at 01:00 PM an interview was conducted with Nurse #3. She confirmed that she had used the Novolog FlexPen located on Medication Cart #3 for Resident #18 yesterday at noon. She stated that the yellow sticker should have indicated the date opened and without an opening date, she would unable to determine the expiration date. Nurse #3 added she had received training and in-services related to expired medications but was not aware of any scheduled assignment to check her medication cart on regular basis.	F 761	implemented. The Administrator will ensure that the audits are reviewed and discussed at the Quality Assurance Performance Improvement Committee Meeting, monthly for 4 months and at a minimum quarterly thereafter for a period of 8 months.	

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 03/22/2018

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 761	Continued From page 7	F 761		

Review of MAR revealed Resident #18 had been receiving Novolog subcutaneously per sliding scale as ordered and her BG levels in the past one month had remained at the baseline.

c. Resident #8 was admitted to the facility on 06/09/17 with diagnoses included dyspnea and respiratory failure.

A physician's order dated 06/0917 indicated that Resident #8 was to receive Adviair Diskus 250/50 micrograms (Mcg) 1 pump by mouth every 12 hours for dyspnea and respiratory failure.

On 03/21/18 at 10:34 AM an expired box of Advair Diskus 250/50 mcg was found in the medication cart #3 on North Unit. There was a sticker on the inhaler box indicated it was opened on 02/15/18 and stated it would be expired 1 month after opening.

On 03/21/18 at 01:00 PM an interview was conducted with Nurse #3. She confirmed that she had used the Advair Diskus 250/50 mcg located on Medication Cart #3 for Resident #18 this morning. She thought Advair could be used after it was opened for 48 days instead of 30 days. She had been instructed to check the expiration dates of each medication before administration but she was no sure who was responsible and the frequency to check the entire medication cart on regular basis.

d. On 03/21/18 at 10:59 AM an opened bottle of 30 millimeter (ML) multiple dose bacteriostatic 0.9% sodium chloride solution for injection without label was found in medication cart #1 on North Unit.

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 03/22/2018

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 761	Continued From page 8	F 761		

On 03/21/18 at 12:52 PM an interview was conducted with Nurse #1. He could not recall when the multiple dose bacteriostatic 0.9% sodium chloride solution was used recently. He stated he would check the expiration date for each medication before administration. He added there was no set time to check expired medication on regular basis.

e. On 03/21/18 at 11:27 AM an expired bottle of Assure high dose level 2 glucometer control solution was found in the medication cart #2 on North Unit. There was a sticker on the opened glucometer control solution indicated it was opened on 08/10/17. According to the manufacturer's specification on the bottle, it was expired on 10/31/17. In addition, there was a sticker on the bottle indicated it should be used 90 days of first opening.

On 03/21/18 at 01:32 PM an interview was conducted with Nurse #4. She stated she was working part-time for 2-3 shifts per week. She had been instructed to check the entire medication cart thoroughly but was not sure about the frequency. She had been trained to maintain her medication cart free of expired medications and she was aware of her responsibility. She could not recall when the glucometer control solution was used recently. She agreed that the glucometer control solution had expired and should be discarded. She attributed the incident as an oversight.

On 03/21/18 at 11:57 AM an interview was conducted with the Director of Nursing (DON). She stated all the nurses had been instructed to date when they opened date sensitive

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 03/22/2018

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 761	Continued From page 9 medications like insulin or inhaler, to ensure each medications that were readied for use in the medication carts were labeled, and to discard expired medications according to manufacturer's specifications in a timely manner. All the nursing staff had been educated to check the expiration date for each medication before dispensing and they were supposed to check their respective medication cart at least once every shift. In addition, unit managers would perform follow-up checks once per week for all the medication carts and storage rooms in the facility. The pharmacy would send staff to the facility to check for expired medication only on request. The DON attributed the incident as lack of attentiveness when nursing staff were conducting expired medication checks. It was her expectation for all the medication carts and storage rooms to be free of expired medication and to ensure all medications in the medication carts were labeled according to facility protocol. On 03/22/18 at 03:59 PM an interview was conducted with the Administrator. He stated the facility had a system for medication storage in place. However, due to turnovers in leadership position that resulted in lack of clinical leadership to execute the plan, expired and unlabeled medications still being found in the facility. It was his expectation for all the medication carts and storage rooms to be free of expired medication and all medications readied for use in medications cart were labeled.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		4/11/18

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 03/22/2018

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 867	Continued From page 10 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place. This failure related to two recited deficiencies that were originally cited following the 04/16/17 recertification survey, recited following the 01/05/18 complaint investigation and recited again on the current recertification and complaint investigation survey. The recited deficiencies were in the areas of providing care according to professional standards and label/store drugs and biologicals. The continued failure of the facility during three federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: 1. a. 483.21 Providing Care According to Professional Standards: Based on observations, record review and staff interviews, the facility failed to transcribe a medication order for pain management for 1 of 1 sampled resident reviewed for Hospice (Resident #47). During the complaint investigation of 01/05/18 the facility was cited for failure to transcribe orders for wound care.	F 867	F867 The plan of correcting the specific deficiency. For resident #47, nursing staff failed to transcribe orders to the Medication Administration Record that were initiated by a hospice order when patient returned to the facility. This is a direct result of a lack of attention to detail and education. Patient had no negative outcome from this omission, however, could have resulted in care not being provided that was ordered. At the time of the survey the Morphine was added to the MAR. Nursing staff failed to discard a vial of expired Novolog Insulin, 1 box of opened and expired Advair Diskus inhaler, 1 bottle of opened and expired glucometer solution, 3 bottles of opened bacteriostatic 0.9% Sodium Chloride solution, 1 opened Novolog FlexPen without an opening date. This is a direct result of the lack of attention to detail when preparing med charts for med pass. The procedure for implementing the acceptable plan of correction for the specific deficiency cited; In order to prevent this from occurring again, all patient charts of hospice patients that were in-house as of March 30, 2018 were checked for	

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 03/22/2018

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 867	Continued From page 11 b. 483.45 Label/Store Drugs and Biologicals: Based on observations, record review and staff interviews the facility failed to remove one vial of opened and expired Novolog from 1 of 2 medication storage rooms in the facility and failed to discard one box of opened and expired Advair Diskus inhaler, one bottle of opened and expired glucometer control solution, one opened Novolog FlexPen withoug opening date, and one bottle of opened bacteriostatic 0.9% sodium chloride solution without a label in 3 of 5 medication carts in the facility. During the recertification survey of 04/06/17 the facility was cited for failure to remove opened and undated insulin pens and an expired oral inhaler from medication carts, failure to discard an opened and undated vial of Influenza vaccine and an expired injectable pen from medication storage refrigerators, and failure to discard opened cartons of liquid supplement stored at room temperature. During an interview on 03/22/18 at 4:21 PM the Administrator stated after the recertification survey and complaint investigation the QAA met to review the areas of concern and systems were put into place to correct the deficiencies cited. He explained during the past year the facility had turnover with clinical leadership and have noticed improvement since the Director of Nursing started her employment. He added he was confident they were moving in the right direction now that the facility had strong leadership. The Administrator indicated systems would be developed and monitored to address issues identified.	F 867	consults/hospice orders to ensure there were no orders that were not transcribed. If any missed orders were found the physician and ordering physician were immediately notified and the order transcribed to the MAR/TAR to ensure the order was carried out and care could be documented. The Staff Nurses were educated starting on March 27 , 2018 on the following process by the facility Staff Development Coordinator. 1) When a resident returns to the facility from a consult visit or admission to the hospital, nursing will review the consult for orders and place them on the MAR/TAR. 2) The nurse will make a copy of the consult and give to the Director of Nursing who will either check herself or delegate to the Unit Manager or Assistant Unit Manager, or Staff Development Coordinator, will check the Consult sheet if provided by the provider for any new orders Monday through Friday. 3) If orders are present then the patients chart will be checked to ensure that the order was transcribed to the patients MAR/TAR if order was obtained during provider visit. 4) If order was present on the consult sheet and not transcribed then documentation of re-education for the first infraction by a nurse and disciplinary action for any further infractions. Nurses not educated on the above process on April 9, 2018 will be removed from schedule until education is received. This process will be included as part of the Orientation program for new hires. Drugs and biologicals in each medication	

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 03/22/2018

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 867	Continued From page 12	F 867		

cart were audited, and any expired items, unlabeled or not dated items, or loose pills items were removed and disposed of per facility policy.
Nurses were in-serviced on Pharmacy Policy 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, 5.0 Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 5.1 Facility Staff may record the calculated expiration date based on date opened on the medication container, 5.2 Medications with a manufacturers expiration date expressed in month and year (e.g. May, 2019) will expire the last day of the month.. Nurses during in-service were given a copy of the Omnicare Insulin Storage Recommendations. The Facility will require that nursing personnel will inspect nursing station storage areas for proper storage compliance on a regularly on a weekly basis.
The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements; When a resident returns to the facility from a consult visit or admission, nursing will review the consult for orders and place them on the MAR/TAR. The nurse will make a copy of the consult and give to the Director of

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 03/22/2018

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 867	Continued From page 13	F 867	Nursing who will either check herself or delegate to the Unit Manager or Assistant Unit Manager, Staff Development Coordinator, will check the Consult sheet if provided by the provider for any new orders Monday through Friday. If orders are present then the patients chart will be checked to ensure that the order was transcribed to the patients MAR/TAR if applicable. If order was present and not transcribed then documentation of re-education for the first time and disciplinary action for further infractions. This audit will continue daily Monday through Friday X 4 weeks, weekly X 4 weeks and then bi-weekly X 10 months. Director of Nursing, RN Unit manager, or House Supervisor will conduct audit of drugs and biologicals on each medication cart Monday - Friday X 4 weeks, Weekly X 4 weeks and bi-weekly X 10 months. Results of audits will be reviewed at Weekly Quality Assurance Risk meeting for further problem resolution if needed. All new hire licensed nurses will be educated in general orientation on storage and expiration of drugs and biologicals. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: The administrator will be responsible to ensure that the plan of correction is implemented. Audits of findings will be reviewed at the Quality Assurance Performance Improvement Committee meeting, monthly for 4 months, for review and revision as needed.	