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 11/28/2023

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 A onsite complaint investigation survey was conducted from 11/20/23 to 11/21/23. Event ID# 9S3Q11. The credible allegation of IJ removal was validated on 11/28/23. Therefore, the exit date was changed to 11/28/23. The following intakes were investigated NC00209983, NC00209806, NC00209471 and NC00210488. Five (5) of the 11 allegations resulted in a deficiency. Intake #NC00209983, NC00209806, NC00209471 and NC00210488 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J) The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 11/07/23 and was removed on 11/23/23. An partial extended survey was conducted.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		12/23/23

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

Electronically Signed | 12/19/2023

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 11/28/2023

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 580	Continued From page 1	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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 11/28/2023

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 580	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, Nurse Practitioner (NP), Physician's Assistant (PA), and physician (MD) interviews, the facility failed to communicate with Resident #1's Medical Provider about intermittent loose stools following an order for polyethylene glycol (a medication used to treat occasional constipation and soften stool) with a history of Clostridium difficile (a bacterial infection in the colon which have symptoms that range from diarrhea to life-threatening damage to the colon), also known as C-difficile. The facility failed to notify the medical provider of an abnormal stool culture for a resident with C-difficile. The facility failed to notify the medical provider of acute changes in condition consisting of multiple loose stools, increased confusion, disorientation, and new behavior of attempting to climb out of bed on 11/6/23, and low blood pressure that were not at her baseline. Resident #1 was sent to the emergency room and was diagnosed with sepsis (a life-threatening complication of a current infection), hypothermia, and type 2 myocardial infarction (heart attack). Resident #1 expired on 11/10/23. This deficient practice affected 1 of 2 residents reviewed for physician notification. The immediate jeopardy began on 11/7/23 when Resident #1's physician was not notified of acute changes in the resident's condition. The immediate jeopardy was removed on 11/23/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" no actual harm to ensure the completion of education and monitoring systems put into place are effective.	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F580 1. For resident # 1, a stool culture was obtained on 10/30/2023 and resulted as positive C- Difficile. Abnormal laboratory 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 the 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 last 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes in behaviors have been reported to the provider. This will be completed by 11/22/2023. 2. Current residents are at risk 3. Education will be provided by	

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 11/28/2023

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 580	Continued From page 3 The findings included: Resident #1 was admitted to the facility on 10/5/23 with diagnoses that included status post cystitis without hematuria (bladder inflammation without blood present in the urine) and surgical intervention of calculus of the bile duct with chronic cholecystitis without obstruction (gallstones) and abdominal hernia without obstruction or gangrene and a history of C-Difficile colitis. A hospital discharge summary dated 10/5/23 indicated Resident #1 presented to the Emergency Room (ER) with abdominal pain and vomiting which required abdominal surgery for the gallstones. A physician's order dated 10/5/23 indicated Amoxicillin/Clavulanate 500-125 milligrams (mg) (antibiotic used to treat infection) three times per day for 3 days for cystitis. Additionally, Lisinopril (ace-inhibitor used to treat heart failure and blood pressure)10mg daily by mouth was ordered for hypertension. A one-day post admission progress note dated 10/6/23 written by the NP indicated Resident #1 was admitted to the facility after being hospitalized from 9/26/23 through 10/5/23 status post endoscopic retrograde cholangiopancreatography (a procedure using a scope to diagnose and treat problems of the biliary or pancreatic system) on 9/28/23 and cholecystitis with choledocholithiasis (gallstones), incarcerated hiatal hernia (part of intestine trapped in the sac of a hernia which can become life threatening if untreated) on 10/3/23. The note indicated Resident #1 was to receive Amoxicillin/	F 580	11/22/2023, by the Director of Nursing, Staff Development Coordinator, or designee to current licensed full time, part time, as needed, and contracted licensed nursing staff (if applicable). Education will be on proper notification to providers, including abnormal lab results, abnormal vital signs, acute changes in condition and abnormal behaviors from baseline. Education will be provided by 11/22/2023 by the Director of Nursing, Staff Development Coordinator or designee to current full time, part time, as needed and contracted staff (if applicable) certified nursing assistants and therapy staff on reporting acute changes in condition to the charge nurse of the patient immediately and reporting abnormal vital signs The expectation would be to receive orders to address the situation reported to the provider. Staff not working on 11/22/2023 will receive education prior to the start of their shift after 11/22/2023. The Staff Development Coordinator will track and ensure education is provided. No nursing staff or therapy staff will be allowed to work until education is received. New nursing staff or therapy staff will receive education in orientation. 4. Director of Nursing or designee will audit the past 24 hours progress notes for behaviors, labs and vital signs for abnormal values, and acute episodes to ensure provider notification has occurred 5x weekly x 8 weeks, 3x weekly x 8 weeks and weekly x 8 weeks. 5. The Director of Nursing will provide	

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 11/28/2023

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 580	Continued From page 4 Clavulanate 500-125 mg by mouth three times per day from 10/6/23 through 10/9/23. The note also indicated she was positive for constipation as she was pushing and straining to have a bowel movement last night (10/5/23) with her abdomen soft, non-tender, and without hepatospleenomegaly (liver and spleen enlargement). The note also revealed Resident #1 had hospital labs on 10/4/23 which indicated the following values: slightly elevated white blood cells (WBC) 12.07 and a normal creatinine (test used to monitor kidney function) level of 0.9. The assessment listed the following: negative for behaviors, no gastrointestinal (GI) upset with ability to tolerate foods and liquids, and hypertension with systolic blood pressures ranging between 120's to 140's on treatment of Lisinopril daily and monitor blood pressure daily. A physician's order dated 10/7/23 indicated Loperamide 2 mg (medication used to treat loose stools) tablet after each loose stool as needed for diarrhea x 1 day. A review of the nurses' progress notes for 10/07/23 revealed nothing related to loose stools or contacting the Medical Provider to obtain an order for Loperamide. A review of the Medication Administration Record (MAR) dated October 2023 revealed Nurse #6 administered Resident #1 a single dose of Loperamide on 10/7/23. Attempts to contact Nurse #6 were unsuccessful. A skilled progress note written by Nurse #7 dated 10/8/23 at 4:23 PM indicated Resident #1 complained of loose stool after lunch. The note	F 580	Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 6. Date of Compliance 12/23/2023	

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 11/28/2023

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 580	Continued From page 5	F 580		

did not indicate Nurse #7 notified the Medical Provider of Resident #1's loose stools.

A review of the MAR dated October 2023 indicated Nurse #7 administered Resident #1 a single dose of Loperamide on 10/8/23.

An interview on 11/28/23 at 10:00 AM with Nurse #7 revealed she could not recall Resident #1 as she was moved to the South Unit shortly after admission and Nurse #7 had no further involvement with her care. She could not recall notifying the Medical Provider of the loose stools.

A review of the Medication Administration Record (MAR) dated October 2023 indicated Resident #1 received Loperamide 2mg on 10/7/23 at 10:29 AM and again on 10/8/23 at 5:14 PM.

A provider progress note was written by the NP on 10/9/23 indicated Resident #1 was seen for a 3-day post admission visit. The note indicated Resident #1 was not feeling well and had complained to her (the NP) that she began to experience loose stools over the weekend, and she had already experienced 3 diarrhea/ water stools that day prior to the visit. Resident #1 complained of abdominal pain but no nausea or vomiting. Resident #1 felt bloated with indigestion. The note indicated Resident #1 had reported to the NP about her history of C-Difficile on 2/20/23. The note further indicated orders were provided to obtain a stool specimen to test for C-Difficile and discontinue Loperamide that was administered over the weekend.

A physician order dated 10/9/23 indicated obtain stool specimen to test for C-Difficile.

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 11/28/2023

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 580	Continued From page 6	F 580		

A laboratory report dated 10/10/23 indicated Resident #1 was positive for C -difficile colitis.

A progress note written by the NP on 10/11/23 for a 5-day post admission visit. The note indicated Resident #1 continued to complain of diarrhea, abdominal pain, and indigestion. C-Difficile culture continued to be pending at the time of the visit. Resident #1 is currently not able to eat well, continued to have a soft, non-tender abdomen with hyperactive bowel sounds and negative for bladder distention. The note indicated Resident #1 had experienced 6 watery stools that day prior to the visit. The note further indicated new orders were received to start Cholestyramine 1 packet by mouth daily (used off label for bile acid diarrhea) and continue to monitor Resident #1's condition pending C-Difficile laboratory results. The note further indicated Resident #1 had blood pressure of 136/66 and to continue the Lisinopril as ordered.

A nurse progress note written by the Unit Manager dated 10/11/23 indicated she spoke with the family member regarding Resident #1's abnormal lab results and testing positive for C-Difficile colitis and antibiotic therapy would be initiated.

A physician's order dated 10/11/23 indicated Cholestyramine Light Oral Packet 4 grams (GM) give one packet by mouth one time a day related to diarrhea.

A physician's order dated 10/11/23 indicated Vancomycin (antibiotic) 125 milligrams give one tablet four times a day for C-difficile. The order was discontinued on 10/12/23.

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 11/28/2023

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 580	Continued From page 7	F 580		

An admission Minimum Data Set (MDS) dated 10/12/23 indicated Resident #1 was cognitively intact.

An Admission History and Physical (H&P) written by the MD dated 10/12/23 indicated Resident #1 was positive for diarrhea, negative for confusion, and negative for dysuria or bladder distension. It also revealed Resident #1's abdomen was soft, non-tender, and no guarding or rebound present with normal cognition with good memory recall both recent and remote. The note stated Resident #1 had a laboratory test on 10/10/23 which was positive for C-Difficile.

A laboratory report dated 10/12/23 indicated Resident #1's white blood cell (test to determine immune ability to fight infection) count was elevated to 26.7 (normal being 4.1 to 10.9), Creatinine (test for kidney function) was normal at 1.16 (normal being 0.5 to 1.20) and C-reactive protein was 28.70 (test for inflammation in the body- normal being less than 0.50). This report indicated it was reviewed by the Nurse Practitioner on 10/13/23 at 10:31 AM.

A provider progress note written by the NP dated 10/13/23 indicated Resident #1 had been placed on quarantine for C-Difficile and continued to have watery stools, abdominal pain, and now nausea was present. Laboratory results were reviewed with the following noted: elevated WBC of 26.7, low calcium at 8, elevated BUN 21.1, normal creatinine at 1.16, low sodium at 132, and a high CRP of 28.7. At this visit, Resident #1 was positive for weakness and fatigue, decrease strength and mobility, and negative for confusion or bladder distension. Resident #1's plan of care listed included the following: Start intravenous

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 11/28/2023

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 580	Continued From page 8	F 580		

(IV) fluids (Normal Saline 60 cubic centimeters (cc) per hour for 48 hours) secondary to a low sodium level. Repeat CBC and CMP on Monday (10/16/23) to compare trends. Resident was previously prescribed Vancomycin orally, but secondary to high WBC she was switched to Flagyl 500mg IV every 6 hours x 7 days. Discontinue Vancomycin once Flagyl had started. At this visit, Resident #1's blood pressures were reviewed to be between 120's and 140's systolic and staff were to administer Lisinopril as ordered.

A physician's order dated 10/13/23 indicated Sodium Chloride 0.45% intravenous. Give 60 (ml) milliliters per hour for 3 days for dehydration, acute kidney injury and C-Difficile. The order was discontinued on 10/16/23.

A physician's order dated 10/13/23 indicated Flagyl (antibiotic) 500 mg per 100 (ml). Provide 500 mg (IV) intravenously every six hours for Enterocolitis (fecal bacteria) due to C-difficile for 7 days.

A laboratory report dated 10/16/23 indicated Resident #1's white blood cell count was normal at 9.0, C-reactive protein remained elevated at 15.8 and Creatinine was normal at 0.90. These lab reports indicated they were reviewed by both the PA and NP on 10/17/23 at 9:47 AM and 8:37 PM.

A provider progress note written by the NP dated 10/16/23 indicated Resident #1 was seen for a 14-day post admission visit. The note indicated during this visit Resident #1 remained on IV fluids which completed 10/16/23 and Flagyl via midline IV and reported the diarrhea was "uncontrollable". A review of the laboratory results dated 10/16/23

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 11/28/2023

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 580	Continued From page 9	F 580		

listed the following values: white blood cell count was normal at 9.0, C-reactive protein (a protein produced by the liver) remained elevated at 15.8 and Creatinine was normal at 0.90. The plan of care included the following: Continue Flagyl until completed and addressed a significant improvement in Resident #1's laboratory results with a normal WBC and improving BUN, Creatinine, and sodium levels. The note also indicated Resident #1's blood pressure remained between 120's and 140's systolic and continued on Lisinopril for treatment. No new orders were given on this visit.

A provider progress note written by the NP dated 10/20/23 indicated Resident #1 had a slight improvement but continued to have diarrhea with staff reports of decrease odorous stools. New orders included: extend the Flagyl IV for a total of 10 days.

A physician's order dated 10/20/23 indicated Flagyl (antibiotic) 500 mg per 100 milliliters (ML). Provide 500 mg (IV) intravenously every six hours for Enterocolitis due to C-difficile for an additional 3 days.

A physician's order dated 10/24/23 indicated Flagyl 500 mg by mouth twice daily for C-difficile. The order was discontinued on 10/25/23.

A surgeon's consultation form dated 10/25/23 indicated Resident #1 was seen for a follow up with "constipation "and new orders were given for polyethylene glycol 17 grams per scoop. Give one scoop by mouth once a day related to constipation.

A nurse progress note written by Nurse #4 dated

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 11/28/2023

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 580	Continued From page 10	F 580		

10/25/23 indicated Resident #1 was seen for a surgical consult and new orders to advance diet and give polyethylene glycol 17 grams per scoop. Give one scoop by mouth once a day related to constipation. The note did not indicate Nurse #4 notified the Medical Provider of the new order or ongoing loose stools following antibiotic therapy.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed she could not recall the order provided by the surgical consult but entered as previously educated from the surgical consultation communication form. Nurse #4 did not question the order because the antibiotic treatment for C-Difficile was completed. Nurse #4 also could not recall if she notified the Medical Provider of the new order or that Resident #1 continued to have loose stools following antibiotic therapy.

A physician's order dated 10/25/23 indicated polyethylene glycol 17 grams per scoop. Give one scoop by mouth once a day related to constipation.

A provider note written by the NP dated 10/27/23 indicated Resident #1 was seen for a 21-day post admission visit. The noted reflected Resident #1 had improved with GI symptoms but continued with on and off diarrhea mixed with some semi-formed stools. The note indicated Resident #1's had completed her IV antibiotics. The note also indicated Resident #1's blood pressure remained between 120's and 140's systolic and continued Lisinopril for treatment. No new orders were given on this visit.

A review of the Medication Administration Record (MAR) dated October 2023 indicated Resident #1

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 11/28/2023

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 580	Continued From page 11	F 580		

received the following:
- Amoxicillin/Clavulanate 500-125 mg one tablet every 8 hours for 3 days (10/6/23 through 10/8/23 for a total 8 doses)
- Lisinopril 10 mg daily (10/6/23 through 10/31/23 except 10/20/23, 10/21/23, and 10/22/23 because BP was outside of the parameters)
- Cholestyramine Light Oral Packet 4 GM give one packet by mouth one time a day related to diarrhea (10/12 through 10/31)
- Vancomycin 125 milligrams give one tablet. Four times a day for C difficile (10/12 and 10/13)
- Sodium chloride intravenous solution 0.4%. Used 60 milliliters per hour intravenously every shift for acute kidney injury, dehydration, and C difficile times three days (10/13 through 10/16)
- Flagyl 500 milligrams per 10ML. Provide 500 milligrams intravenously every six hours for Enterocolitis due to C difficile (10/14/23 x 2 doses, 10/15/23-10/23/23 x 4 doses, and 10/24/23 x 1 dose)
- Flagyl 500 mg by mouth twice daily for C difficile (10/24/23 x 2 doses)
- Polyethylene glycol 17 grams per scoop. Give one scoop by mouth once a day related to constipation (10/25/23-10/31/23)

A nurse progress note written by Nurse #5 dated 10/29/23 indicated Resident #1 was noted to have yellow liquid jelly like stool. The note also indicated Resident #1 had recently stopped IV antibiotics for C-difficile and a stool sample had been collected. The note did not indicate that a Medical Provider was contacted about the ongoing loose stools or that the order had been obtained from the Medical Provider for the stool culture.

A review of the daily nurse assignment sheets

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 11/28/2023

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 580	Continued From page 12	F 580		

indicated Nurse #5 was being oriented by Nurse #1 on 10/29/23.
Nurse #5 was unavailable for interview.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed she had been the primary day shift nurse (7:00 AM to 7:00 PM) on the South Unit on 10/29/23 where Resident #1 resided. Nurse #1 indicated she recalled Resident #1 was positive for C difficile and had been transferred to her unit last month due to requirements of isolation for the infection. Nurse #1 stated Resident #1 was, at baseline, alert and oriented x 4 (person, place, time and event), incontinent of bowel and bladder and had frequent loose stools containing a mucus while on her unit. Nurse #1 said that she recalled Resident #1 continued to have loose stools after being taken off precautions and therefore on 10/29/23, she placed a note in the medical provider's binder to alert them of the ongoing loose stools so they would provide an order for the laboratory test for C-Difficile but did not contact a Medical Provider in person or via telephone. Nurse #1 explained she obtained a stool sample at that time and sent it to the laboratory to test for C-Difficile.

Attempts were made to interview Nurse #8 who worked 10/29/23 (7:00 PM- 7:00 AM) without success.

Nurse Aide documentation dated 10/29/23 reflected Resident #1 had four loose/diarrhea stools.

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

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 11/28/2023

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 580	Continued From page 13	F 580		

semi formed stools on day shift. The note did not reflect the Medical Provider was notified of the ongoing loose stools or Resident #1's orientation changes.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed worked day shift on 10/30/23 and she could not recall the resident other than what was charted regarding orientation changes. She recalled throughout Resident #1's stay, she experienced diarrhea so frequently that after a while she no longer got out of bed.

Nurse Aide documentation dated 10/30/23 reflected Resident #1 had six loose/diarrhea stools.

An interview on 11/20/23 at 11:25 AM with Nurse Aide (NA) #1 revealed she had worked the unit where Resident #1 resided for approximately 4 months on day shift and documented on the following days in October 2023: 10/13/23, 10/14/23, 10/15/23, 10/19/23, 10/24/23, 10/28/23, and 10/29/23. NA#1 indicated she could not recall any specific day, but Resident #1 was normally alert and oriented, able to make her needs known, incontinent of bowel and bladder with multiple loose stools which frequently contained mucous the entire time she had been on the South Unit. NA #1 stated she made Nurse #1 aware of the ongoing loose stools.

An interview with Nurse Aide #2 (NA #2) on 11/20/23 at 11:55 AM revealed that she worked on the South unit on night shift and documented on 10/17/23, 10/18/23, 10/22/23, 10/23/23, 10/26/23, 10/27/23, and 10/31/23. NA #2 indicated Resident #1 was alert and oriented but rang the call light frequently due to loose stools.

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 11/28/2023

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 580	Continued From page 14	F 580		

NA #2 described the stools as "slimy and thick. NA #2 stated she made the nurse aware of loose stools but could not recall the names of each nurse daily.

An interview with Nurse Aide #3 (NA #3) on 11/20/23 at 1:45 PM revealed she worked on the South unit where Resident #1 resided and documented on night shift on the following dates in October 2023: 10/16/23, 10/19/23, 10/20/23, 10/24/23, 10/25/23, 10/28/23, 10/29/23, 10/30/23. NA #3 stated Resident #1 diarrhea and mucous like stools on each shift she worked and had alerted the nurse on duty each shift but could not recall the names of all nurses she alerted.

A laboratory report dated 10/30/23 indicated Resident #1 was positive for C difficile. The report reflected the laboratory notified the facility of the abnormal lab and spoke with Nurse #2 on 10/30/23 at 9:34 PM. The report indicated it was reviewed by the Physician's Assistant on 10/31/23 at 1:18 PM. It however did not indicate a provider was notified of the abnormality on 10/30/23 when the laboratory notified Nurse #2 of the critical results.

A review of Resident #1's medical record revealed she was not seen by a facility Medical Provider after the abnormal C. difficile result.

Attempts were made to interview Nurse #2 without success.

A review of Resident #1's medical record did not reflect Nurse #2 assessed Resident #1. The review of the nurses' progress notes indicated Nurse #2 had not notified the MD or NP of the abnormal lab or received any orders for medical

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 11/28/2023

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 580	Continued From page 15	F 580		

interventions.

An interview with the PA on 11/21/23 at 11:20 AM revealed she was not familiar with Resident #1 and had not provided her with any direct care. The PA stated because a resident can test positive for C-Difficile for up to 90 days she would not have treated her with Resident #1 experiencing ongoing intermittent loose stools.

A review of Resident #1's medical record revealed the last time she was seen by a medical provider was on 10/27/23 and there were no physician orders for the treatment of C-Difficile colitis after the positive test results were received.

An interview with the Nurse Practitioner (NP) on 11/21/23 at 3:24 PM and 4:02 PM revealed she was familiar with Resident #1 and recalled her to be alert and oriented x 4 (accurately aware of person, place, time and event). The NP stated shortly after her admission she began having loose stools and she ordered a laboratory test for C-Difficile which resulted as positive, and treatment was ordered at the time. The NP indicated the treatment was for Vancomycin oral and Flagyl both IV and oral. The NP recalled Resident #1 continuing to have loose stools but thought another provider had placed her on treatment following the second positive stool culture and therefore did not order any further treatment. The NP could not recall anything other than thinking another provider had handled the 2nd C-Diff lab nor being aware of orientation changes noted on 10/30/23.

An interview with the Physician (MD) on 11/21/23 at 4:08 PM revealed he was aware Resident #1 had been treated for C-Difficile shortly after her

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 11/28/2023

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 580	Continued From page 16	F 580		

admission; however, he had not been made aware of the abnormal laboratory results on 10/30/23 and did not prescribe treatment for the ongoing loose stools. The MD stated the ongoing loose stools could have been exacerbated from the Polyethylene glycol prescribed by the surgeon at Resident #1's follow-up appointment on 10/25/23. He acknowledged the only visit he had with Resident #1 was on 10/12/23. He did not recall any further updates to Resident #1's condition. The MD indicated he would expect the lab to be reviewed by the PA and proper monitoring or interventions to be placed.

A nurse's progress note dated 10/31/23 indicated Resident #1 had semi formed stools on day shift. The note did not indicate a Medical Provider was notified of the stools.

Nurse Aide documentation dated 10/31/23 reflected Resident #1 had seven loose/diarrhea stools.

A review of the MAR dated November 2023 indicated Resident #1 received the following:
- Lisinopril 10mg daily (11/1/23 through 11/7/23)
- Loperamide 2 mg tablet after each loose stool as needed for diarrhea x 1 day (11/3/23)
- Cholestyramine Light Oral Packet 4 GM give one packet by mouth one time a day related to diarrhea (11/1/23 through 11/7/23)
- Polyethylene glycol 17 grams per scoop. Give one scoop by mouth one time a day related to Constipation (11/1/23, 11/3/23, 11/4/23)

A nurse progress note written by Nurse #1 dated 11/1/23 indicated Resident #1 was alert and oriented with a blood pressure of 137/65. A gastrointestinal observation revealed all 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 11/28/2023

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 580	Continued From page 17	F 580		

quadrants of the abdomen were normal and Resident #1 had incontinence with diarrhea. The note indicated MD was aware and staff should continue to monitor.

Nurse Aide documentation dated 11/1/23 reflected Resident #1 had six loose/diarrhea stools.

A nurse's progress note written by Nurse #1 dated 11/2/23 indicated Resident #1 was alert and oriented and her BP was 121/79. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and Resident #1 had loose stools during day shift and Polyethylene glycol was held due to loose stools. The note did not indicate a Medical Provider was notified of the loose stools or that Polyethylene glycol was held.

Nurse Aide documentation dated 11/2/23 reflected Resident #1 had eight loose/diarrhea stools.

A late entry nurse's progress note written by Nurse #4 dated 11/3/23 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. The note did not indicate a Medical Provider was notified of the loose stools.

Nurse Aide documentation dated 11/3/23 reflected Resident #1 had thirteen loose/diarrhea stools.

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 11/28/2023

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 580	Continued From page 18	F 580		

An interview on 11/20/23 at 11:25 AM with Nurse Aide (NA) #1 revealed she had worked the unit where Resident #1 resided for approximately 4 months on day shift and was on duty on the following days in November 2023: 11/1/23 and 11/2/23. NA #1 indicated she had made the hall nurse on duty aware of the ongoing loose stools each shift although she could not recall the names of each nurse daily.

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. The note did not indicate a Medical Provider was notified of the loose stools.

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 90/50. 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. The note did not indicate a Medical Provider was notified of the loose stools or that Resident #1 had experienced a low blood pressure.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed she could not recall the resident

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 11/28/2023

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 580	Continued From page 19	F 580		

other than what was charted regarding orientation changes or low blood pressure. She recalled throughout Resident #1's stay, she experienced diarrhea so frequently that after a while she no longer got out of bed.

Nurse Aide documentation dated 11/5/23 reflected Resident #1 had six loose/diarrhea stools.

A nurse's progress note written by Nurse #2 dated 11/6/23 indicated on night shift (11/5 at 7:00 PM through 11/6 at 7:00 AM) Resident #1 was alert and oriented and able to make needs known. Resident#1 had a blood pressure of 110/56. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and she had multiple loose stools during night shift. The note indicated Loperamide was administered without any favorable effects. The note did not indicate a Medical Provider was notified of the loose stools or that Loperamide had to be administered.

Attempts to interview Nurse #2 were unsuccessful.

A nurse's Progress note written by Nurse #1 dated 11/6/23 indicated Resident #1's Polyethylene glycol was held secondary to loose stools on day shift. The note did not indicate a Medical Provider was notified of the loose stools or that Polyethylene glycol was held.

A nurse progress note written by Nurse #1 dated 11/6/23 indicated Resident #1 was alert and oriented and able to make her needs known. Resident #1's blood pressure was 161/88. A gastrointestinal observation revealed all 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 11/28/2023

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 580	Continued From page 20	F 580		

quadrants of the abdomen were normal and she had multiple loose stools during day shift and Polyethylene Glycol was held secondary to loose stools. The note did not indicate a Medical Provider was notified of the loose stools or that Polyethylene glycol was held.

A review of Resident #1's medical record revealed no progress notes written by Nurse #3 on 11/6/23.

A telephone interview with Nurse #3 on 11/21/23 at 9:38 AM revealed she acknowledged she worked the South unit on 11/6/23 on night shift but could not recall Resident #1 to include any stools or behaviors on 11/6/23 due to her working all the units and her working on an as needed basis only. She could not recall notifying the Medical Provider of Resident #1's loose stools, change in cognition, or behaviors.

Nurse Aide documentation dated 11/6/23 reflected Resident #1 had six loose/diarrhea stools.

An interview with Nurse Aide #2 (NA #2) on 11/20/23 at 11:55 AM revealed that she worked on the South unit on night shift and documented on the following dates in November 2023: 11/1/23, 11/4/23, 11/5/23, and 11/6/23. NA #2 indicated Resident #1 was alert and oriented but rang the call light frequently due to loose stools. NA #2 described the stools as "slimy and thick." NA #2 stated she was aware Resident #1 had C-Difficile and therefore alerted Nurse #2 of the resident having loose stools but did not alert the nurse with each loose stool because they were aware of them.

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 11/28/2023

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 580	Continued From page 21	F 580		

An interview with Nurse Aide #3 (NA #3) on 11/20/23 at 1:45 PM revealed she worked on the South unit where Resident #1 resided on night shift on 11/6/23. NA #3 stated on the night of 11/6/23, Resident #1 was more confused than normal. She indicated during her shift, Resident #1 continued to have mucous stools but did not ring her light to be changed as she normally would, was disoriented and trying to climb out of bed. NA #3 said she told Nurse #2.
Attempts were made to contact Nurse #2 without success.

A review of Resident #1's medical record did not reflect Nurse #2 assessed Resident #1. The review indicated Nurse #2 had not notified the MD or NP of the abnormal lab or received any orders for medical interventions.

Attempts to interview Nurse #2 were unsuccessful.

Nurse Aide documentation dated 11/7/23 reflected Resident #1 eight had loose/diarrhea stools.

A nurse's Progress note written by Nurse #1 dated 11/7/23 at 2:30 PM indicated Resident #1 was alert and oriented and able to make her needs known. Resident #1's blood pressure was 107/48. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and she had multiple loose stools during day shift and Polyethylene Glycol was held secondary to loose stools. The note did not indicate a Medical Provider was notified of the loose stools or that Polyethylene glycol was held.

A late entry nurse progress note written by Nurse

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 11/28/2023

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 580	Continued From page 22	F 580		

#1 on 11/13/23 at 3:19 PM indicated on 11/7/23 at approximately 3:30 PM, Nurse #1 was informed that Resident #1 had a low blood pressure and appeared confused. The note indicated Nurse #1 assessed Resident #1's blood pressure manually and found the value to be at baseline for the patient at 106/51. Confusion noted also to be at baseline. The note did not indicate a Medical Provider was notified of Resident #1's low blood pressure, lethargy, confusion, behaviors, her inability to take her morning medications, or ongoing loose stools.

An interview on 11/20/23 at 1:00 PM with Physical Therapy Assistant #1 revealed he was assigned to Resident #1's therapy treatment for physical therapy on 11/7/23. PTA #1 indicated when he entered the room between 3:00 and 4:00 PM, he noticed Resident #1 was not herself as she had previously had a very social based personality when he had worked with her a couple of weeks prior. PTA #1 indicated on this date, Resident #1 appeared more lethargic and confused. PTA #1 stated he made attempts to sit Resident #1 on the edge of the bed thinking she would arouse to her normal self with stimulation. He indicated he alerted Certified Occupational Therapy Assistant (COTA #1) who was nearby and asked him to look at obvious concerns of Resident #1's change from the previous time he had worked with her. He indicated that COTA #1 entered the room and agreed that Resident #1 was not at her baseline as he routinely provided therapy for her. During this discussion between PTA #1 and COTA #1, Nurse #1 entered the room to give Resident #1 her medications. He said he mentioned to Nurse #1 that Resident #1 was acting "different", but the nurse did not respond to his statement. PTA #1 stated when medications were administered by

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 11/28/2023

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 580	Continued From page 23	F 580		

Nurse #1, Resident #1 spit the medications out, the nurse collected the pills, and the nurse left the room. PTA #1 indicated Resident #1 continued to remain confused and uncooperative with therapy after the nurse left the room. He explained he and COTA #1 obtained vital signs using the robot-nurse. He stated it took them approximately 20 minutes or so to obtain two blood pressures due to Resident #1 was fidgety and restless. Resident #1's blood pressure was obtained and readings for blood pressure reflected between the 60s and 70s mmHg (millimeters of mercury) systolic (normal being greater than 90/60). PTA #1 stated he and COTA #1 placed Resident #1 back in a supine position in bed and left the room to locate Nurse #1. PTA #1 stated Resident #1 was fidgety and agitated during the therapy treatment but did not recall any behaviors such as hollering out while he was in her room. PTA #1 stated he approached Nurse #1 who was at her medication cart in the hallway and alerted her that Resident #1's blood pressure readings had been low, stated what they were, and she had increase confusion, not acting like herself, and was unable to participate in therapy. PTA #1 stated Nurse #1 replied to him that Resident #1's blood pressure was normally low at baseline and did not appear concerned with reports by him. PTA #1 stated Nurse #1 never told him that she would assess Resident #1 and evaluate his concerns of the change of condition. PTA #1 stated he left the nurse at the medication cart and proceeded towards the therapy room. When he passed the MDS Nurse Coordinator's office, he entered the office and requested the nurse to review Resident #1's previous blood pressures and alerted her of the low blood pressure readings that he and COTA #1 had obtained. PTA #1 stated the MDS Nurse noted the blood pressures obtained by the

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 11/28/2023

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 580	Continued From page 24	F 580		

PTA #1 and COTA #1 were lower than Resident #1's baseline. PTA #1 stated the MDS Nurse contacted the Staff Development Coordinator (SDC) Nurse via phone who said she was leaving for the day but would go and recheck Resident #1's blood pressure.

An interview with COTA #1 on 11/20/23 at 12:30 PM revealed he was alerted on 11/7/23 in the afternoon (he could not recall exact time) by PTA #1 that he was concerned that Resident #1 was not her "normal self." COTA #1 stated he entered Resident #1's room with PTA #1 and recognized Resident #1 appeared drowsy, confused, and agitated. He said while he and PTA #1 were in the room the hall nurse (Nurse #1) entered the room with the resident's medications and attempted to administer them, but Resident #1 spit them all out on her clothes. COTA #1 stated while Nurse #1 was in the room, PTA #1 mentioned to Nurse #1 that Resident #1 did not seem to be at her baseline, but Nurse #1 did not acknowledge the statement, but instead quickly retrieved the medications Resident #1 spit out and left the room. COTA #1 indicated he and PTA #1 continued to attempt to get Resident #1 to participate without success then decided to obtain vital signs on Resident #1. COTA #1 indicated he and PTA #1 obtained two sets of vital signs secondary to the first blood pressure reading being abnormally low. He recalled the blood pressure readings were around 60's and 70's systolic and the readings concerned him and PTA #1, so they left the room to find the nurse. COTA #1 stated they approached the nurse and told her they thought something was abnormal about Resident #1 and that her blood pressure had been low. COTA #1 indicated Nurse #1 was at her medication cart and simply stated Resident #1's

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 11/28/2023

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 580	Continued From page 25	F 580		

blood pressure at baseline was low, but she did not go assess Resident #1 at the time. COTA #1 stated he and PTA #1 were returning to the therapy gym when they stopped at the MDS Nurse's office and told her about Resident #1's blood pressure being low. COTA #1 stated the MDS Nurse reviewed Resident #1's vital history and was concerned with the blood pressure as well. COTA #1 stated she called the SDC Nurse to assess Resident #1, then he and PTA #1 left the office and continued to the therapy gym.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed she explained she had not observed any abnormal behaviors by Resident #1 prior to 11/7/23 (the date of her discharge), but had received report from the night shift nurse (Nurse #3) that she had exhibited behaviors and increase confusion the night before but Nurse #1 could not recall what behaviors Nurse #1 stated Resident #1 had not made any previous attempts to get up as she required assistance for all transfers. Nurse #1 stated she entered Resident #1's room to administer her morning medications. Nurse #1 stated she attempted to administer the medications whole and Resident #1 spit them out. Nurse #1 stated she had forgotten that Resident #1 took her medications crushed so she collected the pills and left the room. Nurse #1 stated on 11/7/23 between 3:30 PM and 4:00 PM, two Therapy staff (PTA and COTA) approached her at her medication cart and made her aware Resident #1's blood pressure had been obtained and resulted in low readings around 70-80s systolic, but she normally had low blood pressure and she did not go directly to re-check the blood pressure at that time. Nurse #1 stated she later went back into Resident #1's room and administered the medications crushed which

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 11/28/2023

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 580	Continued From page 26	F 580		

Resident #1 had previously spit out earlier when therapy was in the room. When asked Nurse #1 what medications she administered that afternoon, she stated Resident #1's morning medications because she had been unable to administer them earlier due to Resident #1 being lethargic. Nurse #1 stated she did not contact the provider about the new behaviors, Resident #1's inability to take her medication that morning due to lethargy, nor that Resident #1's blood pressure had been reported as low in order to obtain clarification orders whether to administer the Lisinopril at that time.

An interview with the MDS Nurse on 11/20/23 at 2:00 PM revealed she had not had many interactions with Resident #1; however, on 11/7/23 around 4:00 PM, PTA #1 and COTA #1 approached her office and notified her of Resident #1's low blood pressure and did not seem like herself. The MDS Nurse stated she looked in Resident #1's medical record and noticed the blood pressures obtained by the therapy staff were lower than her normal. The MDS Nurse stated she attempted to notify the Director of Nursing (DON), but she had already left the building, so she notified SDC Nurse to assess her. The MDS Nurse stated after the SDC Nurse agreed to assess her, she had no further involvement with Resident #1.

An interview with the SDC Nurse on 11/20/23 at 3:50 PM revealed she was notified by the MDS Nurse on 11/7/23 around 4:00 PM that Resident #1 was more confused than normal and had a low blood pressure in therapy. The SDC Nurse called the South unit nurses' station and spoke to Nurse #1. The SDC Nurse stated she spoke with Nurse #1 who said she would go check Resident

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 11/28/2023

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 580	Continued From page 27	F 580		

#1 in about 5 minutes. The SDC Nurse explained she was concerned and went to assess Resident #1. The SDC Nurse explained she approached the hall and saw Nurse #1 in a nearby room admitting a new resident but poked her head out of the door and the SDC Nurse asked Nurse #1 if she had been in to assess Resident #1 yet. The SDC Nurse stated Nurse #1 told her she had not been in yet but would shortly. The SDC Nurse indicated she then entered Resident #1's room and obtained Resident #1's blood pressure and it was near her baseline although she could not recall what Resident #1's blood pressure was on 11/7/23. The SDC Nurse could not recall if Resident #1 was confused when she obtained her blood pressure, but stated she was not in any apparent distress. The SDC Nurse left the room and alerted Nurse #1 to continue to monitor her then left the unit.

An interview with Resident #1's Family Member on 11/20/23 at 10:09 AM was conducted. The Family Member stated she visited Resident #1 weekly and had been to see her approximately a week before discharge and Resident #1 had a good memory without obvious confusion or behaviors during her visit. The Family Member stated she had contacted the facility earlier in the evening (she could not recall the exact time but recalled it was prior to supper trays being delivered) and spoke with Nurse #1. The Family Member stated told Nurse #1 she was concerned because she was on the phone with Resident #1 in the last 5 minutes and Resident #1 was yelling out and it sounded like she may have fallen when she dropped the phone. The Family Member said Nurse #1 walked to Resident #1's room and was told by Nurse #1 that Resident #1 was in the bed and although she was yelling out, she had not fell

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 11/28/2023

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 580	Continued From page 28	F 580		

and she was fine. Family Member #1 stated that she was called shortly before midnight on 11/7/23 that Resident #1 had been sent to the emergency room for evaluation. The Family Member indicated that when she arrived at the hospital shortly after being notified, Resident #1 was extremely confused and complaining of pain to her lower extremities.

A nurse's note written by Nurse #1 dated 11/7/23 at 9:57 PM indicated Resident #1 was found on the floor adjacent to the bed with vital signs listed as follows: BP 106 / 51, temperature 97.8, Pulse 91 bpm, and oxygen saturation at 92%. Resident #1 had skin tears to bilateral knees. Immediate interventions were put in place for frequent rounding, keep personal items within reach and place Resident #1 at nurses' station when awake. The confusion noted was a new onset. A message was left for Resident #1's daughter to return a call to the facility. This note did not indicate a Medical Provider was notified regarding Resident #1's change in condition or behaviors.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed on 11/7/23 around 5:00 PM, she recalled speaking to Resident #1's daughter, who had called and stated she believed her mom had fallen, but Nurse #1 stated when she went to the room Resident #1 was in the bed, hollering out, but unable to articulate what she needed. Nurse #1 stated she thought Resident #1 was just hollering and therefore she reassured the daughter that she had not fallen and was fine. Nurse #1 indicated Resident #1 continued to holler out and cursed at staff following that time and she was trying to get up from the bed without assistance. Nurse #1 stated Resident #1 had frequent loose stools and her Polyethylene Glycol

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 11/28/2023

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 580	Continued From page 29	F 580		

as held. Nurse #1 said later in the shift (around 9:00 PM) Resident #1 was found on the floor between her bed and the wall. Nurse #1 explained Resident #1 was found to be on the floor, she was assessed to have bleeding to her bilateral lower extremities with hematomas to both legs. Nurse #1 stated Resident #1 continued to say, "Help me, help me" and "G** D******" which was abnormal for Resident #1. Nurse #1 stated at the time of the fall, she did not feel the resident needed to go to the hospital, so she cleaned the wounds, bandaged them, and placed her back to bed. Nurse #1 indicated she did not notify the on-call MD at the time of the fall or of Resident #1's change of condition. Nurse #1 stated she did notice that Resident #1 had increased confusion which was new for Resident #1 and thought she may have a urinary tract infection and was going to request a urinalysis when she had time. At 10:30 to 11PM, Nurse #1 recognized Resident #1 was having a change of condition because she was yelling, unable to articulate her needs and contacted the DON who provided orders to send Resident #1 to the emergency room for evaluation.

A Situation Background Assessment Recommendation (SBAR) form dated 11/7/23 at 10:49 PM written by Nurse #1 indicated Resident #1 had increase confusion as oriented x 2-3 (person, place, and time) at baseline, generalized weakness post fall, and personality changes which was a change from her baseline. Vital signs listed Resident #1's blood pressure was 106/51.

A late entry progress note written by the Director of Nursing on 11/10/23 at 11:07 AM indicated on 11/7/23, Resident #1 was yelling and screaming

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 11/28/2023

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 580	Continued From page 30	F 580		

and cussing at staff which was unusual for her. Resident #1 was normally alert and oriented. Resident #1 had a fall around 9 PM but at the time of the fall she could not tell staff what she was trying to do. When she fell, Resident #1 continued to curse the staff and tried to get out of bed and the MD gave orders to send Resident #1 to the emergency room for evaluation related to altered mental status. The note did not indicate she notified the Medical Provider of a change in condition for Resident #1.

The hospital emergency room report dated 11/7/23 indicated Resident #1 arrived at the hospital with altered mental status, hypotensive (low blood pressure) with blood pressure 80s over 60s, a blood glucose level of 29, elevated WBC 53.8, positive urine culture reflected a urinary tract infection, elevated creatinine of 3.4, low sodium of 122, hypothermic with a temperature of 94.46 Fahrenheit (normal range between 97-99 degrees) rectally and status post (s/p) a fall resulting in bruises to bilateral lower extremities (legs) with pain noted to the left hip and left lower extremity and was diagnosed with sepsis with acute organ dysfunction (severe sepsis) with possible causes related to acute cystitis with hematuria (blood in the urine) or pseudomembranous colitis (inflammation of the colon related to bacteria) with a strong suspicion of C difficile colitis, acute kidney injury/acute renal failure secondary to elevated creatinine levels, acute encephalopathy (brain dysfunction) secondary to infectious process, hypothermia, and type 2 myocardial infarction (imbalance between oxygen supply and demand not related to plaque rupture).

A hospital death note dated 11/10/23 at 6:10 PM

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 11/28/2023

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 580	Continued From page 31	F 580		

indicated Resident #1 expired at the hospital. The note indicated Resident #1 had been admitted to the hospital with altered mental status and C difficile. Resident #1 was started on antibiotics, including oral vancomycin and volume resuscitated (fluids given to replace the volume depleted). Resident #1 ultimately required vasopressors (medications used to constrict the blood vessels in patients with low blood pressure) for hypotension despite adequate volume resuscitation. She remained on vasopressors with worsening clinical status, increasing white blood cell count, and poor response to treatment. Conversations occurred between the care team and family regarding goals of treatment and the family agreed to transition care to comfort measures only. Resident #1 subsequently expired as documented in the record.

An interview with the PA on 11/21/23 at 11:20 AM revealed she would not have been concerned with the change of condition noted by multiple staff on 11/7/23 because "the change had not lasted greater than 24 hours and if it continued for 3 or 4 days then she would have addressed it."

An interview with the NP on 11/21/23 at 4:02 PM revealed she was not in duty on 11/7/23; however, the PA should have been notified of the change of condition by Nurse #1. The NP stated she was not aware Resident #1 had been discharged.

An interview with the Physician (MD) on 11/21/23 at 4:08 PM revealed he was not made aware of Resident #1's condition on 11/7/23.

An interview with the Director of Nursing (DON) and the Regional Director of Clinical Services on

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 11/28/2023

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 580	Continued From page 32	F 580		

11/28/23 at 10:00 AM revealed they had been made aware of the concerns with Resident #1. The DON stated she was aware Resident #1 had intermittent ongoing loose stools and she was aware of the abnormal laboratory values. She stated she was notified of Resident #1's condition on the evening of 11/7/23 after she fell. The DON stated Nurse #1 told her Resident #1 had fallen and was confused so the DON told Nurse #1 to transfer to the emergency room.

The Administrator and Director of Nursing were notified of the immediate jeopardy on 11/21/23 at 2:30 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

For resident # 1, a stool culture was obtained on 10/30/2023 and resulted as positive C- Difficile. Abnormal laboratory 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 the 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 last 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes in behaviors have been reported to the provider. This will be completed by 11/22/2023.

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 11/28/2023

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 580	Continued From page 33	F 580		

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete;

Education will be provided by 11/22/2023, by the Director of Nursing, Staff Development Coordinator, or designee to current licensed full time, part time, as needed, and contracted licensed nursing staff (if applicable). Education will be on proper notification to providers, including abnormal lab results, abnormal vital signs, acute changes in condition and abnormal behaviors from baseline. Education will be provided by 11/22/2023 by the Director of Nursing, Staff Development Coordinator or designee to current full time, part time, as needed and contracted staff (if applicable) certified nursing assistants and therapy staff on reporting acute changes in condition to the charge nurse of the patient immediately and reporting abnormal vital signs The expectation would be to receive orders to address the situation reported to the provider. Staff not working on 11/22/2023 will receive education prior to the start of their shift after 11/22/2023. The Staff Development Coordinator will track and ensure education is provided.

Alleged date of IJ removal is November 23, 2023.

Person responsible for implementation is the Administrator

The validation of the credible allegation for notification of change was conducted in the facility on 11/28/23. Staff interviewed and record review verified all licensed staff and unlicensed

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 11/28/2023

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 580	Continued From page 34 staff had been educated on the facility policy regarding the requirements for notification of the Physician following a change of condition and to seek clarification for all new orders from hospital discharge summaries and consulting providers. It also included educating Nursing Assistants on identifying a change in resident condition and reporting to the Licensed Nurse immediately. Education was given to licensed nurses regarding when a change of condition is noted or when a resident presents different than known baseline, lethargic, restless, or short of breath, low blood pressure, behaviors, falls, new orders, and abnormal bodily elimination concerns to call the physician, even if during the night when there is a serious or life-threatening change of condition. The immediate jeopardy removal date of 11/23/23 was validated.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and family, staff, Nurse Practitioner (NP), Physician Assistant (PA), and physician (MD) interviews, the facility failed to complete comprehensive assessments and determine the need for medical interventions for a	F 684	F684 1. On 10/25/2023, resident #1 went to a follow up surgeon appointment and was ordered Miralax for constipation. The facility initiated the medication without	12/23/23

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 11/28/2023

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 684	Continued From page 35 resident who continued to experience loose stools post antibiotic treatment for Clostridium Difficile (C-Difficile) which ended on 10/24/23. (C-difficile is a bacterium that causes an infection of the colon. Symptoms can range from diarrhea to life-threatening damage to the colon.). The afternoon of 11/07/23 the resident had a significant change in condition including increased lethargy and confusion, low blood pressure, spitting out her pills and hollering out. There was no comprehensive assessment completed to determine if there was the need to seek medical attention. Staff did not recognize the significant change in condition until late in the evening on 11/07/23 and the resident was sent to the hospital for an evaluation. Hospital records dated 11/7/23 indicated the resident was diagnosed with sepsis with acute organ dysfunction, acute encephalopathy secondary to infectious process, hypothermia, and type 2 myocardial infarction (heart attack). The resident expired on 11/10/23. This deficient practice occurred for 1 of 2 residents reviewed for quality of care/providing care according to professsional standards (Resident #1). The immediate jeopardy began on 11/7/23 when the facility failed to effectively respond to and seek medical attention when Resident #1 had a significant change in condition. The immediate jeopardy was removed on 11/23/23 when the facility implemented a credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity of "D" no actual harm to ensure the completion of education and monitoring systems put into place are effective. This deficient practice occurred for 1 of 2 residents reviewed for quality of care.	F 684	getting clarification from the in-house provider. Miralax was held at times due to loose stools. The in-house provider was 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 and did not receive adequate intervention to treat the C-Difficile. Resident #1 was noted to have increased confusion by the weekend supervisor. The increased confusion was not assessed by facility staff. The resident noted to have intermittent confusion on 11/06 and 11/07 and was not assessed appropriately to get 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 to 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 last 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes in behaviors have been reviewed to ensure proper assessments and interventions have been completed and provider notification. Outside provider consults for the last 14 days were reviewed with the	

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 11/28/2023

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 684	Continued From page 36 The findings included: A hospital discharge summary dated 10/5/23 indicated Resident #1 presented to the Emergency Room (ER) with abdominal pain and vomiting which required abdominal surgery for the gallstones. The discharge summary reflected Resident #1 received intravenous (IV) antibiotics for chronic leukocytosis (high white blood cell count) (WBC 11.41) and cholecystitis (inflammation of the gall bladder) which was corrected with the cholecystectomy (surgical removal of the gallbladder). It also listed cystitis without hematuria as resolved and orders for Amoxicillin-Clavulanate (antibiotic) 500-125 milligrams (mg) 1 tablet by mouth every 8 hours for 3 days. Resident #1 was admitted to the facility on 10/5/23 with diagnoses that included status post cystitis without hematuria (bladder inflammation without blood present in the urine) and surgical intervention of calculus of the bile duct with chronic cholecystitis without obstruction (gallstones) and abdominal hernia without obstruction or gangrene and hypertension. A physician's order dated 10/5/23 indicated Amoxicillin 500-125 milligrams (mg) three times per day for 3 days for cystitis. Additionally, Lisinopril 10mg daily by mouth was ordered for hypertension. A one-day post admission progress note dated 10/6/23 written by the NP indicated Resident #1 was admitted to the facility after being hospitalized from 9/26/23 through 10/5/23 status post endoscopic retrograde	F 684	attending providers by the Director of Nursing to ensure proper medical intervention was provided. . This will be completed by 11/22/2023. 2. Current Residents are at Risk 3. Education will be provided by 11/22/2023, by the Director of Nursing, Staff Development Coordinator, or designee to current licensed full time, part time, as needed, and contracted licensed nursing staff (if applicable). Education will be on assessing acute medical changes and acute changes in condition including abnormal vital signs, abnormal labs, and abnormal behaviors from baseline. Licensed nurses will be educated on the use of the Interact clinical pathways on assessment and intervention of conditions. The Interact pathways are located at each nursing station. The pathways contain suggestions on treatment option after assessments. Nurses will follow the suggested treatment pathways and notify the providers for further instruction. Education will also be provided to current licensed nurses on notification of provider when receiving orders from outside consults before transcribing the order into the electronic health record. Education to licensed nursing staff will include abnormal blood pressure parameters and when to not administer blood pressure medication. Education will be provided by 11/22/2023 by the Director of Nursing, Staff Development Coordinator or designee to current full time, part time, as needed and	

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 11/28/2023

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 684	Continued From page 37 cholangiopancreatography (a procedure using a scope to diagnose and treat problems of the biliary or pancreatic system) on 9/28/23 and cholecystitis with choledocholithiasis (gallstones), incarcerated hiatal hernia (part of intestine trapped in the sac of a hernia which can become life threatening if untreated) on 10/3/23. The note indicated Resident #1 was to receive Amoxicillin 500/125 by mouth three times per day from 10/6/23 through 10/9/23. The note also indicated she was positive for constipation as she was pushing and straining to have a bowel movement last night (10/5/23) with her abdomen soft, non-tender, and without hepatospleenomegaly. The note also revealed Resident #1 had hospital labs on 10/4/23 which indicated the following values: slightly elevated white blood cells (WBC) 12.07 and a normal creatinine level of 0.9. The assessment listed the following: negative for behaviors, no gastrointestinal (GI) upset with ability to tolerate foods and liquids, and hypertension with systolic blood pressures ranging between 120's to 140's on treatment of Lisinopril daily and monitor blood pressure daily. A physician's order dated 10/7/23 indicated Loperamide 2 mg tablet after each loose stool as needed for diarrhea x 1 day. A review of the nurses' progress notes for 10/07/23 revealed nothing related to loose stools. A skilled progress note written by Nurse #7 dated 10/8/23 at 4:23 PM indicated Resident #1 complained of loose stool after lunch. A review of the Medication Administration Record (MAR) dated October 2023 indicated Resident #1 received Loperamide 2mg on 10/7/23 at 10:29	F 684	contracted staff (if applicable) certified nursing assistants and therapy staff on reporting acute changes in condition to the charge nurse of the patient immediately including what abnormal behaviors consist of and reporting abnormal vital signs. Education will contain signs and symptoms of identifying an acute change in condition. Staff not working on 11/22/2023 will receive education prior to the start of their shift after 11/22/2023. The Staff Development Coordinator will track and ensure education is provided. No nursing staff or therapy staff will be allowed to work until education is received. New nursing staff or therapy staff will receive education in orientation. 4. Director of Nursing or designee will audit the past 24 hours of progress notes for behaviors, labs and vital signs for abnormal values, and acute episodes to ensure that abnormal findings have been assessed and interventions provided with provider notification 5x weekly x 8 weeks, 3x weekly x 8 weeks and weekly x 8 weeks. 5. The Director of Nursing will provide Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed. 6. Date of Completion 12/23/2023	

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 11/28/2023

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 684	Continued From page 38	F 684		

AM by Nurse #6 and again on 10/8/23 at 5:14 PM by Nurse #7.

Attempts to contact Nurse #6 were unsuccessful.

An interview on 11/28/23 at 10:00 AM with Nurse #7 revealed she could not recall Resident #1 as she was moved to the South Unit shortly after admission and Nurse #7 had no further involvement with her care.

A provider progress note written by the NP on 10/9/23 indicated Resident #1 was seen for a 3-day post admission visit. The note indicated Resident #1 was not feeling well and had complained that loose stools began over the weekend, and she had already experienced 3 diarrhea water stools that day. Resident #1 complained of abdominal pain but no nausea or vomiting. Resident #1 felt bloated with indigestion. The note indicated Resident #1 had reported a history of C-Difficile on 2/20/23. Orders were provided to obtain a stool specimen to test for C-Difficile and discontinue Loperamide that was administered over the weekend.

A physician order dated 10/9/23 indicated obtain stool specimen to test for C-Difficile.

A laboratory report dated 10/10/23 indicated Resident #1 was positive for C -difficile colitis.

A progress note was written by the NP on 10/11/23 for a 5-day post admission visit. The note indicated Resident #1 continued to complain of diarrhea, abdominal pain, and indigestion. C-Difficile culture continued to be pending at the time of the visit. Resident #1 is currently not able to eat well. Continues to have a soft, non-tender

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 11/28/2023

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 684	Continued From page 39	F 684		

abdomen with hyperactive bowels sounds and negative for bladder distention. The note indicated Resident #1 had experienced 6 watery stools the day prior to the visit. New orders were received to start Cholestyramine 1 packet orally daily and continue to monitor Resident #1's condition pending C-Difficile laboratory results. The note further indicated Resident #1 had blood pressure of 136/66 and to continue the Lisinopril as ordered.

A nurse progress note written by the Unit Manager dated 10/11/23 indicated she spoke with the family member regarding Resident #1's abnormal lab results and testing positive for C-Difficile colitis and antibiotic therapy would be initiated.

A physician's order dated 10/11/23 indicated Cholestyramine (used for bile acid diarrhea) Light Oral Packet 4 grams (GM) give one packet by mouth one time a day related to diarrhea.

A physician's order dated 10/11/23 indicated Vancomycin (antibiotic) 125 milligrams give one tablet four times a day for C-difficile. The order was discontinued on 10/12/23.

An admission Minimum Data Set (MDS) dated 10/12/23 indicated Resident #1 was cognitively intact and no behaviors were noted.

An Admission History and Physical (H&P) written by the MD dated 10/12/23 indicated Resident #1 was positive for diarrhea, negative for confusion, and negative for dysuria or bladder distention. It also revealed Resident #1's abdomen was soft, non-tender, and no guarding or rebound present with normal cognition with good memory recall

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 11/28/2023

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 684	Continued From page 40	F 684		

both recent and remote. The note stated Resident #1 had a laboratory test on 10/10/23 which was positive for C-Difficile.

A laboratory report dated 10/12/23 indicated Resident #1's white blood cell (test to determine immune ability to fight infection) count was elevated to 26.7 (normal being 4.1 to 10.9), Creatinine (test for kidney function) was normal at 1.16 (normal being 0.5 to 1.20) and C-reactive protein was 28.70 (test for inflammation in the body- normal being less than 0.50).

A provider progress note written by the NP dated 10/13/23 indicated Resident #1 had been placed on quarantine for C-Difficile and continued to have watery stools, abdominal pain, and now nausea. Laboratory results were reviewed with the following noted: elevated WBC of 26.7, low calcium at 8, elevated BUN 21.1, normal creatinine at 1.16, low sodium at 132, and a high CRP of 28.7. At this visit, Resident #1 was positive for weakness and fatigue, decrease strength and mobility, and negative for confusion or bladder distension. Resident #1's plan of care listed included the following: Start IV fluids (Normal Saline 60 cubic centimeters (cc) per hour for 48 hours) secondary to a low sodium level. Repeat CBC and CMP on Monday (10/16/23) to compare for trends. Resident was previously prescribed Vancomycin, but secondary to high WBC she was switched to Flagyl 500mg every 6 hours x 7 days. Discontinue Vancomycin once Flagyl has started. At this visit, Resident #1's blood pressures were reviewed to be between 120's and 140's systolic and continued on Lisinopril.

A physician's order dated 10/13/23 indicated

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 11/28/2023

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 684	Continued From page 41	F 684		

Sodium Chloride 0.45% intravenous. Give 60 milliliters per hour for 3 days for dehydration, acute kidney injury and C-Difficile. The order was discontinued on 10/16/23.

A physician's order dated 10/13/23 indicated Flagyl (antibiotic) 500 mg per 100 milliliters (ML). Provide 500 mg (IV) intravenously every six hours for Enterocolitis due to C-difficile for 7 days.

A laboratory report dated 10/16/23 indicated Resident #1's white blood cell count was normal at 9.0, C-reactive protein remained elevated at 15.8 and Creatinine was normal at 0.90.

A provider progress note written by the NP dated 10/16/23 indicated Resident #1 was seen for a 14-day post admission visit. The note indicated during this visit Resident #1 remained on IV fluids which completed 10/16/23 and Flagyl via midline IV and reported the diarrhea was "uncontrollable". A review of the laboratory results dated 10/16/23 listed the following values: white blood cell count was normal at 9.0, C-reactive protein remained elevated at 15.8 and Creatinine was normal at 0.90. The plan of care included the following: Continue Flagyl until completed and addressed a significant improvement in Resident #1's laboratory results with a normal WBC and improving BUN, Creatinine, and sodium levels. The note also indicated Resident #1's blood pressure remained between 120's and 140's systolic and continued on Lisinopril for treatment. No new orders were given on this visit.

A provider progress note written by the NP dated 10/20/23 indicated Resident #1 had a slight improvement but continued to have diarrhea with staff reports of decrease odorous stools. New

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 11/28/2023

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 684	Continued From page 42	F 684		

orders included: extend the Flagyl IV for a total of 10 days.

A physician's order dated 10/20/23 indicated Flagyl (antibiotic) 500 mg per 100 milliliters (ML). Provide 500 mg (IV) intravenously every six hours for Enterocolitis due to C-difficile for an additional 3 days.

A physician's order dated 10/24/23 indicated Flagyl 500 mg by mouth twice daily for C-difficile. The order was discontinued on 10/25/23.

A surgeon's consultation form dated 10/25/23 indicated Resident #1 was seen for a follow up with "constipation "and new orders were given for polyethylene glycol 17 grams per scoop, a laxative used to treat occasional constipation and soften stool. Give one scoop by mouth once a day related to constipation.

A nurse progress note written by Nurse #4 dated 10/25/23 indicated Resident #1 was seen for a surgical consult and new orders to advance diet and give polyethylene glycol 17 grams per scoop, a laxative used to treat occasional constipation and soften stool. Give one scoop by mouth once a day related to constipation.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed she could not recall the order provided by the surgical consult but entered as previously educated from the surgical consultation communication form. Nurse #4 did not question the order because the antibiotic treatment for C-Difficile was completed.

A physician's order dated 10/25/23 indicated polyethylene glycol 17 grams per scoop. Give one

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 11/28/2023

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 684	Continued From page 43	F 684		

scoop by mouth once a day related to constipation.

A provider note written by the NP dated 10/27/23 indicated Resident #1 was seen for a 21-day post admission visit. The noted reflected Resident #1 had improved with GI symptoms but continued with on and off diarrhea mixed with some semi-formed stools. The note indicated Resident #1's had completed her IV antibiotics. The note also indicated Resident #1's blood pressure remained between 120's and 140's systolic and continued Lisinopril for treatment. No new orders were given on this visit.

A review of the Medication Administration Record (MAR) dated October 2023 indicated Resident #1 received the following:
- Amoxicillin/Clavulanate 500-125 mg one tablet every 8 hours for 3 days (10/6/23 through 10/8/23 for a total 8 doses)
- Lisinopril 10 mg daily (10/6/23 through 10/31/23 except 10/20/23, 10/21/23, and 10/22/23 because BP was outside of the parameters)
- Loperamide 2 mg tablet after each loose stool as needed for diarrhea x 1 day (10/7/23 and 10/8/23)
- Cholestyramine Light Oral Packet 4 GM give one packet by mouth one time a day related to diarrhea (10/12 through 10/31)
- Vancomycin 125 milligrams give one tablet. Four times a day for C difficile (10/12 and 10/13)
- Sodium chloride intravenous solution 0.4%. Used 60 milliliters per hour intravenously every shift for acute kidney injury, dehydration, and C difficile times three days (10/13 through 10/16)
- Flagyl 500 milligrams per 10ML. Provide 500 milligrams intravenously every six hours for Enterocolitis due to C difficile (10/14/23 x 2

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 11/28/2023

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 684	Continued From page 44	F 684		

doses, 10/15/23-10/23/23 x 4 doses, and 10/24/23 x 1 dose)
- Flagyl 500 mg by mouth twice daily for C difficile (10/24/23 x 2 doses)
- Polyethylene glycol 17 grams per scoop. Give one scoop by mouth once a day related to constipation (10/25/23-10/31/23)

A nurse progress note written by Nurse #5 dated 10/29/23 indicated Resident #1 was noted to have yellow liquid jelly like stool. The note also indicated Resident #1 had recently stopped IV antibiotics for C-difficile and a stool sample had been collected.

A review of the daily nurse assignment sheets indicated Nurse #5 was being oriented by Nurse #1 on 10/29/23.

Nurse #5 was unavailable for interview.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed she had been the primary day shift nurse (7:00 AM to 7:00 PM) on the South Unit on 10/29/23 where Resident #1 resided. Nurse #1 indicated she recalled Resident #1 was positive for C difficile and had been transferred to her unit last month due to requirements of isolation for the infection. Nurse #1 stated Resident #1 was, at baseline, alert and oriented x 4 (person, place, time and event), incontinent of bowel and bladder and had frequent loose stools containing a mucus while on her unit. Nurse #1 said that she recalled Resident #1 continued to have loose stools after being taken off precautions and therefore on 10/29/23, she placed a note in the medical provider's binder to alert them of the ongoing loose stools so they would provide an order for the laboratory test for C-Difficile. Nurse #1

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 11/28/2023

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 684	Continued From page 45	F 684		

explained she obtained a stool sample at that time and sent it to the laboratory to test for C-Difficile.

Attempts were made to interview Nurse #8 who worked 10/29 (7:00 PM- 7:00 AM) without success.

Nurse Aide documentation dated 10/29/23 reflected Resident #1 had four loose/diarrhea stools.

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.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed worked day shift on 10/30/23 and she could not recall the resident other than what was charted regarding orientation changes.

Nurse Aide documentation dated 10/30/23 reflected Resident #1 had six loose/diarrhea stools.

An interview on 11/20/23 at 11:25 AM with Nurse Aide (NA) #1 revealed she had worked the unit where Resident #1 resided for approximately 4 months on day shift and documented on the following days in October 2023: 10/13/23, 10/14/23, 10/15/23, 10/19/23, 10/24/23, 10/28/23, and 10/29/23. NA#1 indicated she could not recall any specific day, but Resident #1 was normally alert and oriented, able to make her needs known, incontinent of bowel and bladder with multiple loose stools which frequently contained mucous the entire time she had been on the

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 11/28/2023

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 684	Continued From page 46	F 684		

South Unit. NA #1 stated she made Nurse #1 aware of the ongoing loose stools.

An interview with Nurse Aide #2 (NA #2) on 11/20/23 at 11:55 AM revealed that she worked on the South unit on night shift and documented on 10/17/23, 10/18/23, 10/22/23, 10/23/23, 10/26/23, 10/27/23, and 10/31/23. NA #2 indicated Resident #1 was alert and oriented but rang the call light frequently due to loose stools. NA #2 described the stools as "slimy and thick". NA #2 stated she made the nurse aware of loose stools but could not recall the names of each nurse daily.

An interview with Nurse Aide #3 (NA #3) on 11/20/23 at 1:45 PM revealed she worked on the South unit where Resident #1 resided and documented on night shift on the following dates in October 2023: 10/16/23, 10/19/23, 10/20/23, 10/24/23, 10/25/23, 10/28/23, 10/29/23, 10/30/23. NA #3 stated Resident #1 diarrhea and mucous like stools on each shift she worked and had alerted the nurse on duty each shift but could not recall the names of all nurses she alerted.

A laboratory report dated 10/30/23 indicated Resident #1 was positive for C-difficile. The report reflected the laboratory notified the facility of the abnormal lab and spoke with Nurse #2 on 10/30/23 at 9:34 PM. The report indicated it was reviewed by the Physician Assistant on 10/31/23 at 1:18 PM.

Attempts were made to interview Nurse #2 without success.

A review of Resident #1's medical record did not reflect Nurse #2 assessed Resident #1. The

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 11/28/2023

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 684	Continued From page 47	F 684		

review indicated Nurse #2 had not notified the MD or NP of the abnormal lab or received any orders for medical interventions.

An interview with the PA on 11/21/23 at 11:20 AM revealed she was not familiar with Resident #1 and had not provided her with any direct care. The PA stated because a resident can test positive for C-Difficile for up to 90 days she would not have treated her with ongoing intermittent loose stools.

A review of Resident #1's medical record revealed the last time she was seen by a medical provider was on 10/27/23 and there were no physician orders for the treatment of C-Difficile colitis after the positive test results were received on 10/30/23.

An interview with the Nurse Practitioner (NP) on 11/21/23 at 3:24 PM and 4:02 PM revealed she was familiar with Resident #1 and recalled her to be alert and oriented x 4. The NP stated shortly after admission she began having loose stools and she ordered a laboratory test for C-Difficile which resulted as positive, and treatment was ordered at the time. The NP indicated the treatment was for Vancomycin oral and Flagyl both IV and oral. The NP recalled Resident #1 continuing to have loose stools but thought another provider had placed her on treatment and therefore did not order any further treatment. The NP could not recall anything other than thinking another provider had handled the 2nd C-Diff lab nor being aware of orientation changes noted on 10/30/23.

An interview with the Physician (MD) on 11/21/23 at 4:08 PM revealed he was aware Resident #1

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 11/28/2023

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 684	Continued From page 48	F 684		

had been treated for C-Difficile shortly after her admission; however, he had not been made aware of the abnormal laboratory results on 10/30/23 and did not prescribe treatment for the ongoing loose stools. The MD stated the ongoing loose stools could have been exacerbated from the Polyethylene glycol prescribed by the surgeon at Resident #1's follow-up appointment on 10/25/23. He acknowledged the only visit he had with Resident #1 was on 10/12/23. He did not recall any further updates to Resident #1's condition. The MD indicated he would expect the lab to be reviewed by the PA and proper monitoring or interventions to be placed.

A nurse's progress note dated 10/31/23 indicated Resident #1 had semi formed stools on day shift.

Nurse Aide documentation dated 10/31/23 reflected Resident #1 had seven loose/diarrhea stools.

A review of the MAR dated November 2023 indicated Resident #1 received the following:
- Lisinopril 10mg daily (11/1/23 through 11/7/23)
- Loperamide 2 mg tablet after each loose stool as needed for diarrhea x 1 day (11/3/23)
- Cholestyramine Light Oral Packet 4 GM give one packet by mouth one time a day related to diarrhea (11/1/23 through 11/7/23)
- Polyethylene glycol 17 grams per scoop. Give one scoop by mouth one time a day related to Constipation (11/1/23, 11/3/23, 11/4/23)

A nurse progress note written by Nurse #1 dated 11/1/23 indicated Resident #1 was alert and oriented with a blood pressure of 137/65. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and

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 11/28/2023

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 684	Continued From page 49	F 684		

Resident #1 had incontinence with diarrhea. The note indicated MD was aware and staff should continue to monitor.

Nurse Aide documentation dated 11/1/23 reflected Resident #1 had six loose/diarrhea stools.

A nurse's progress note written by Nurse #1 dated 11/2/23 indicated Resident #1 was alert and oriented and her BP was 121/79. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and Resident #1 had loose stools during day shift and Polyethylene glycol was held due to loose stools.

Nurse Aide documentation dated 11/2/23 reflected Resident #1 had eight loose/diarrhea stools.

An interview on 11/20/23 at 11:25 AM with Nurse Aide (NA) #1 revealed she had worked the unit where Resident #1 resided for approximately 4 months on day shift and was on duty on the following days in November 2023: 11/1/23 and 11/2/23. NA #1 indicated she had made the hall nurse on duty aware of the ongoing loose stools each shift although she could not recall the names of each nurse daily.

A late entry nurse's progress note written by Nurse #4 dated 11/3/23 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.

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 11/28/2023

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 684	Continued From page 50	F 684		

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 90/50. 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.

An interview with Nurse #4 on 11/28/23 at 9:00 AM revealed she recalled throughout Resident #1's stay, she experienced diarrhea so frequently that after a while she no longer got out of bed.

Nurse Aide documentation dated 11/5/23 reflected Resident #1 had six loose/diarrhea stools.

A nurse's progress note written by Nurse #2 dated 11/6/23 indicated on night shift (11/5/23 at

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 11/28/2023

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 684	Continued From page 51	F 684		

7:00 PM through 11/6/23 at 7:00 AM) Resident #1 was alert and oriented and able to make needs known. Resident#1 had a blood pressure of 110/56. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and she had multiple loose stools during night shift. The note indicated Imodium AD was administered without any favorable effects.

Attempts to interview Nurse #2 were unsuccessful.

A nurse progress note written by Nurse #1 dated 11/6/23 indicated Resident #1 was alert and oriented and able to make her needs known. Resident #1's blood pressure was 161/88. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and she had multiple loose stools during day shift and Polyethylene Glycol was held secondary to loose stools.

A review of Resident #1's medical record revealed no progress notes written by Nurse #3 on 11/6/23.

A telephone interview with Nurse #3 on 11/21/23 at 9:38 AM revealed she acknowledged she worked the South unit on 11/6/23 on night shift but could not recall Resident #1 to include any stools or behaviors on 11/6/23 due to her working all the units and her working on an as needed basis only.

Nurse Aide documentation dated 11/6/23 reflected Resident #1 had six loose/diarrhea stools.

An interview with NA #2 on 11/20/23 at 11:55 AM

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 11/28/2023

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 684	Continued From page 52	F 684		

revealed that she worked on the South unit on night shift and documented on the following dates in November 2023: 11/1/23, 11/4/23, 11/5/23, and 11/6/23. NA #2 indicated Resident #1 was alert and oriented but rang the call light frequently due to loose stools. NA #2 described the stools as "slimy and thick." NA #2 stated she was aware Resident #1 had C-Difficile and therefore alerted Nurse #2 of the resident having loose stools but did not alert the nurse with each loose stool because they were aware of them.

An interview with NA #3 on 11/20/23 at 1:45 PM revealed she worked on the South unit where Resident #1 resided on night shift on 11/6/23. NA #3 stated on the night of 11/6/23, Resident #1 was more confused than normal. She indicated during her shift, Resident #1 continued to have mucous stools but did not ring her light to be changed as she normally would, was disoriented and trying to climb out of bed. NA #3 said she told Nurse #2.

A review of Resident #1's medical record did not reflect Nurse #2 assessed Resident #1. The review indicated Nurse #2 had not notified the MD or NP of the abnormal lab or received any orders for medical interventions.

Attempts were made to interview Nurse #2 without success.

Nurse Aide documentation dated 11/7/23 reflected Resident #1 eight had loose/diarrhea stools.

A nurse's Progress note written by Nurse #1 dated 11/7/23 at 2:30 PM indicated Resident #1 was alert and oriented and able to make her

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 11/28/2023

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 684	Continued From page 53	F 684		

needs known. Resident #1's blood pressure was 107/48. A gastrointestinal observation revealed all 4 quadrants of the abdomen were normal and she had multiple loose stools during day shift and Polyethylene Glycol was held secondary to loose stools.

A late entry nurse progress note written by Nurse #1 on 11/13/23 at 3:19 PM indicated on 11/7/23 at approximately 3:30 PM, Nurse #1 was informed that Resident #1 had a low blood pressure and appeared confused. The note indicated Nurse #1 assessed Resident #1's blood pressure manually and found the value to be at baseline for the patient at 106/51. Confusion noted also to be at baseline.

An interview on 11/20/23 at 1:00 PM with Physical Therapy Assistant #1 revealed he was assigned to Resident #1's therapy treatment for physical therapy on 11/7/23. PTA #1 indicated when he entered the room between 3:00 and 4:00 PM, he noticed Resident #1 was not herself as she had previously had a very social based personality when he had worked with her a couple of weeks prior. PTA #1 indicated on this date, Resident #1 appeared more lethargic and confused. PTA #1 stated he made attempts to sit Resident #1 on the edge of the bed thinking she would arouse to her normal self with stimulation. He indicated he alerted Certified Occupational Therapy Assistant (COTA #1) who was nearby and asked him to look at obvious concerns of Resident #1's change from the previous time he had worked with her. He indicated that COTA #1 entered the room and agreed that Resident #1 was not at her baseline as he routinely provided therapy for her. During this discussion between PTA #1 and COTA #1, Nurse #1 entered the room to give Resident #1

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 11/28/2023

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 684	Continued From page 54	F 684		

her medications. He said he mentioned to Nurse #1 that Resident #1 was acting "different", but the nurse did not respond to his statement. PTA #1 stated when medications were administered by Nurse #1, Resident #1 spit the medications out, the nurse collected the pills, and the nurse left the room. PTA #1 indicated Resident #1 continued to remain confused and uncooperative with therapy after the nurse left the room. He explained he and COTA #1 obtained vital signs using the robot-nurse. He stated it took them approximately 20 minutes or so to obtain two blood pressures due to Resident #1 was fidgety and restless. Resident #1's blood pressure was obtained and readings for blood pressure reflected between the 60s and 70s mmHg (millimeters of mercury) systolic (normal being greater than 90/60). PTA #1 stated he and COTA #1 placed Resident #1 back in a supine position in bed and left the room to locate Nurse #1. PTA #1 stated Resident #1 was fidgety and agitated during the therapy treatment but did not recall any behaviors such as hollering out while he was in her room. PTA #1 stated he approached Nurse #1 who was at her medication cart in the hallway and alerted her that Resident #1's blood pressure readings had been low, stated what they were, and she had increase confusion, not acting like herself, and was unable to participate in therapy. PTA #1 stated Nurse #1 replied to him that Resident #1's blood pressure was normally low at baseline and did not appear concerned with reports by him. PTA #1 stated Nurse #1 never told him that she would assess Resident #1 and evaluate his concerns of the change of condition. PTA #1 stated he left the nurse at the medication cart and proceeded towards the therapy room. When he passed the MDS Nurse Coordinator's office, he entered the office and requested the nurse to review Resident

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 11/28/2023

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 684	Continued From page 55	F 684		

#1's previous blood pressures and alerted her of the low blood pressure readings that he and COTA #1 had obtained. PTA #1 stated the MDS Nurse noted the blood pressures obtained by the PTA #1 and COTA #1 were lower than Resident #1's baseline. PTA #1 stated the MDS Nurse contacted the Staff Development Coordinator (SDC) Nurse via phone who said she was leaving for the day but would go and recheck Resident #1's blood pressure.

An interview with COTA #1 on 11/20/23 at 12:30 PM revealed he was alerted on 11/7/23 in the afternoon (he could not recall exact time) by PTA #1 that he was concerned that Resident #1 was not her "normal self." COTA #1 stated he entered Resident #1's room with PTA #1 and recognized Resident #1 appeared drowsy, confused, and agitated. He said while he and PTA #1 were in the room the hall nurse (Nurse #1) entered the room with the resident's medications and attempted to administer them, but Resident #1 spit them all out on her clothes. COTA #1 stated while Nurse #1 was in the room, PTA #1 mentioned to Nurse #1 that Resident #1 did not seem to be at her baseline, but Nurse #1 did not acknowledge the statement, but instead quickly retrieved the medications Resident #1 spit out and left the room. COTA #1 indicated he and PTA #1 continued to attempt to get Resident #1 to participate without success then decided to obtain vital signs on Resident #1. COTA #1 indicated he and PTA #1 obtained two sets of vital signs secondary to the first blood pressure reading being abnormally low. He recalled the blood pressure readings were around 60's and 70's systolic and the readings concerned him and PTA #1, so they left the room to find the nurse. COTA #1 stated they approached the nurse and told her

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 11/28/2023

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 684	Continued From page 56	F 684		

they thought something was abnormal about Resident #1 and that her blood pressure had been low. COTA #1 indicated Nurse #1 was at her medication cart and simply stated Resident #1's blood pressure at baseline was low, but she did not go assess Resident #1 at the time. COTA #1 stated he and PTA #1 were returning to the therapy gym when they stopped at the MDS Nurse's office and told her about Resident #1's blood pressure being low. COTA #1 stated the MDS Nurse reviewed Resident #1's vital history and was concerned with the blood pressure as well. COTA #1 stated she called the SDC Nurse to assess Resident #1, then he and PTA #1 left the office and continued to the therapy gym.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed she explained she had not observed any abnormal behaviors by Resident #1 prior to 11/7/23 (the date of her discharge), but had received report from the night shift nurse (Nurse #3) that she had exhibited behaviors and increase confusion the night before but Nurse #1 could not recall what behaviors Nurse #1 stated Resident #1 had not made any previous attempts to get up as she required assistance for all transfers. Nurse #1 stated she entered Resident #1's room to administer her morning medications. Nurse #1 stated she attempted to administer the medications whole and Resident #1 spit them out. Nurse #1 stated she had forgotten that Resident #1 took her medications crushed so she collected the pills and left the room. Nurse #1 stated on 11/7/23 between 3:30 PM and 4:00 PM, two Therapy staff (PTA and COTA) approached her at her medication cart and made her aware Resident #1's blood pressure had been obtained and resulted in low readings around 70-80s systolic, but she normally had low blood pressure

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 11/28/2023

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 684	Continued From page 57	F 684		

and she did not go directly to re-check the blood pressure at that time. Nurse #1 stated she later went back into Resident #1's room and administered the medications crushed which Resident #1 had previously spit out earlier when therapy was in the room. When asked Nurse #1 what medications she had administered that afternoon, she stated Resident #1's morning medications because she had been unable to administer them earlier due to Resident #1 being lethargic. Nurse #1 stated she did not contact the provider about the new behaviors, Resident #1's inability to take her medication that morning due to lethargy, nor that Resident #1's blood pressure had been reported as low in order to obtain clarification orders whether to administer the Lisinopril at that time.

An interview with the MDS Nurse on 11/20/23 at 2:00 PM revealed she had not had many interactions with Resident #1; however, on 11/7/23 around 4:00 PM, PTA #1 and COTA #1 approached her office and notified her of Resident #1's low blood pressure and did not seem like herself. The MDS Nurse stated she looked in Resident #1's medical record and noticed the blood pressures obtained by the therapy staff were lower than her normal. The MDS Nurse stated she attempted to notify the Director of Nursing (DON), but she had already left the building, so she notified SDC Nurse to assess her. The MDS Nurse stated after the SDC Nurse agreed to assess her, she had no further involvement with Resident #1.

A review of Resident #1's electronic medical record did not reflect any notes written by the MDS Nurse to reflect Resident #1 was assessed by her or that she had been made aware 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 11/28/2023

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 684	Continued From page 58	F 684		

Resident #1's low blood pressure on 11/7/23.

An interview with the SDC Nurse on 11/20/23 at 3:50 PM revealed she was notified by the MDS Nurse on 11/7/23 around 4:00 PM that Resident #1 was more confused than normal and had a low blood pressure in therapy. The SDC Nurse called the South unit nurses' station and spoke to Nurse #1. The SDC Nurse stated she spoke with Nurse #1 who said she would go check Resident #1 in about 5 minutes. The SDC Nurse explained she was concerned and went to assess Resident #1. The SDC Nurse explained she approached the hall and saw Nurse #1 in a nearby room admitting a new resident but poked her head out of the door and the SDC Nurse asked Nurse #1 if she had been in to assess Resident #1 yet. The SDC Nurse stated Nurse #1 told her she had not been in yet but would shortly. The SDC Nurse indicated she then entered Resident #1's room and obtained Resident #1's blood pressure and it was near her baseline although she could not recall what Resident #1's blood pressure was on 11/7/23. The SDC Nurse could not recall if Resident #1 was confused when she obtained her blood pressure, but stated she was not in any apparent distress. The SDC Nurse left the room and alerted Nurse #1 to continue to monitor her then left the unit.

A review of Resident #1's electronic medical record did not reflect any notes written by the SDC Nurse to reflect Resident #1 was assessed by her on 11/7/23.

An interview with Resident #1's Family Member on 11/20/23 at 10:09 AM was conducted. The Family Member stated she visited Resident #1 weekly and had been to see her approximately a

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 11/28/2023

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 684	Continued From page 59	F 684		

week before discharge and Resident #1 had a good memory without obvious confusion or behaviors during her visit. The Family Member stated she had contacted the facility earlier in the evening (she could not recall the exact time but recalled it was prior to supper trays being delivered) and spoke with Nurse #1. The Family Member stated told Nurse #1 she was concerned because she was on the phone with Resident #1 in the last 5 minutes and Resident #1 was yelling out and it sounded like she may have fallen when she dropped the phone. The Family Member said Nurse #1 walked to Resident #1's room and was told by Nurse #1 that Resident #1 was in the bed and although she was yelling out, she had not fell and she was fine. Family Member #1 stated that she was called shortly before midnight on 11/7/23 that Resident #1 had been sent to the emergency room for evaluation. The Family Member indicated that when she arrived at the hospital shortly after being notified, Resident #1 was extremely confused and complaining of pain to her lower extremities.

A nurse's note written by Nurse #1 dated 11/7/23 at 9:57 PM indicated Resident #1 was found on the floor adjacent to the bed with vital signs listed as follows: BP 106 / 51, temperature 97.8, Pulse 91 bpm, and oxygen saturation at 92%. Resident #1 had skin tears to bilateral knees. Immediate interventions were put in place for frequent rounding, keep personal items within reach and place Resident #1 at nurses' station when awake. The confusion noted was a new onset. A message was left for Resident #1's daughter to return a call to the facility.

An interview on 11/20/23 at 11:30 AM with Nurse #1 revealed on 11/7/23 around 5:00 PM, she

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 11/28/2023

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 684	Continued From page 60	F 684		

recalled speaking to Resident #1's daughter, who had called and stated she believed her mom had fallen, but Nurse #1 stated when she went to the room Resident #1 was in the bed, hollering out, but unable to articulate what she needed. Nurse #1 stated she thought Resident #1 was just hollering and therefore she reassured the daughter that she had not fallen and was fine. Nurse #1 indicated Resident #1 continued to holler out and cursed at staff following that time and she was trying to get up from the bed without assistance. Nurse #1 stated Resident #1 had frequent loose stools and her Polyethylene Glycol as held. Nurse #1 said later in the shift (around 9:00 PM) Resident #1 was found on the floor between her bed and the wall. Nurse #1 explained Resident #1 was found to be on the floor, she was assessed to have bleeding to her bilateral lower extremities with hematomas to both legs. Nurse #1 stated Resident #1 continued to say, "Help me, help me" and "G** D***'**" which was abnormal for Resident #1. Nurse #1 stated at the time of the fall, she did not feel the resident needed to go to the hospital, so she cleaned the wounds, bandaged them, and placed her back to bed. Nurse #1 indicated she did not notify the on-call MD at the time of the fall or of Resident #1's change of condition. Nurse #1 stated she did notice that Resident #1 had increased confusion which was new for Resident #1 and thought she may have a urinary tract infection and was going to request a urinalysis when she had time. At 10:30 to 11PM, Nurse #1 recognized Resident #1 was having a change of condition because she was yelling, unable to articulate her needs and contacted the DON who provided orders to send Resident #1 to the emergency room for evaluation.

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 11/28/2023

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 684	Continued From page 61	F 684		

A Situation Background Assessment Recommendation (SBAR) form dated 11/7/23 at 10:49 PM written by Nurse #1 indicated Resident #1 had increase confusion as oriented x 2-3 (person, place, and time) at baseline, generalized weakness post fall, and personality changes which was a change from her baseline. Vital signs listed Resident #1's blood pressure was 106/51.

An interview with NA #1 on 11/20/23 at 11:25 AM revealed she could not recall any falls or behaviors by Resident #1 prior to 11/7/23.

A late entry progress note written by the Director of Nursing on 11/10/23 at 11:07 AM indicated on 11/7/23, Resident #1 was yelling and screaming and cussing at staff which was unusual for her. Resident #1 was normally alert and oriented. Resident #1 had a fall around 9 PM but at the time of the fall she could not tell staff what she was trying to do. When she fell, Resident #1 continued to curse the staff and tried to get out of bed and the MD gave orders to send Resident #1 to the emergency room for evaluation related to altered mental status.

The hospital emergency room report dated 11/7/23 indicated Resident #1 arrived at the hospital with altered mental status, hypotensive (low blood pressure) with blood pressure 80s over 60s, a blood glucose level of 29, elevated WBC 53.8, positive urine culture reflected a urinary tract infection, elevated creatinine of 3.4, low sodium of 122, hypothermic with a temperature of 94.46 Fahrenheit (normal range between 97-99 degrees) rectally and status post (s/p) a fall resulting in bruises to bilateral lower extremities (legs) with pain noted to the left hip

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 11/28/2023

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 684	Continued From page 62	F 684		

and left lower extremity and was diagnosed with sepsis with acute organ dysfunction (severe sepsis) with possible causes related to acute cystitis with hematuria (blood in the urine) or pseudomembranous colitis (inflammation of the colon related to bacteria) with a strong suspicion of C difficile colitis, acute kidney injury/acute renal failure secondary to elevated creatinine levels, acute encephalopathy (brain dysfunction) secondary to infectious process, hypothermia, and type 2 myocardial infarction (imbalance between oxygen supply and demand not related to plaque rupture).

A hospital death note dated 11/10/23 at 6:10 PM indicated Resident #1 expired at the hospital. The note indicated Resident #1 had been admitted to the hospital with altered mental status and C difficile. Resident #1 was started on antibiotics, including oral vancomycin and volume resuscitated (fluids given to replace the volume depleted). Resident #1 ultimately required vasopressors (medications used to constrict the blood vessels in patients with low blood pressure) for hypotension despite adequate volume resuscitation. She remained on vasopressors with worsening clinical status, increasing white blood cell count, and poor response to treatment. Conversations occurred between the care team and family regarding goals of treatment and the family agreed to transition care to comfort measures only. Resident #1 subsequently expired as documented in the record.

An interview with the PA on 11/21/23 at 11:20 AM revealed she would not have been concerned with the change of condition noted by multiple staff on 11/7/23 because "the change had not lasted greater than 24 hours and if it continued 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 11/28/2023

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 684	Continued From page 63	F 684		

3 or 4 days then she would have addressed it."

An interview with the NP on 11/21/23 at 4:02 PM revealed she was not in duty on 11/7/23; however, the PA should have been notified of the change of condition by Nurse #1. The NP stated she was not aware Resident #1 had been discharged.

An interview with the Physician (MD) on 11/21/23 at 4:08 PM revealed he was not made aware of Resident #1's condition on 11/7/23.

An interview with the Director of Nursing (DON) and the Regional Director of Clinical Services on 11/28/23 at 10:00 AM revealed they had been made aware of the concerns with Resident #1. The DON stated she was aware Resident #1 had intermittent ongoing loose stools and she was aware of the abnormal laboratory values. She stated she was notified of Resident #1's condition on 11/7/23 after she fell. The DON stated Nurse #1 told her Resident #1 had fallen and was confused so the DON told Nurse #1 to transfer to the emergency room.

The Administrator and Director of Nursing were notified of the immediate jeopardy on 11/21/23 at 2:30 PM.

The facility provided the following credible allegation of immediate jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

On 10/25/2023, resident #1 went to a follow up surgeon appointment and was ordered

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 11/28/2023

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 684	Continued From page 64	F 684		

Polyethylene glycol for constipation. The facility initiated the medication without getting clarification from the in-house provider. Polyethylene glycol was held at times due to loose stools. The in-house provider was not notified of holding the Polyethylene glycol. On 10/30/2023, resident #1 received a positive stool culture for C-Difficile, the patient was not adequately assessed and did not receive adequate intervention to treat the C-Difficile. Resident #1 was noted to have increased confusion by the weekend supervisor. The increased confusion was not assessed by facility staff. The resident noted to have intermittent confusion on 11/06 and 11/07 and was not assessed appropriately to get 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 to 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 last 14 days of progress notes, lab results, and vital signs to ensure all abnormal labs; abnormal vital signs and changes in behaviors have been reviewed to ensure proper assessments and interventions have been completed and provider notification. Outside provider consultations for the last 14 days were reviewed with the attending providers by the Director of Nursing to ensure proper medical intervention was provided. This will be completed by 11/22/2023.

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 11/28/2023

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 684	Continued From page 65 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: Education will be provided by 11/22/2023, by the Director of Nursing, Staff Development Coordinator, or designee to current licensed full time, part time, as needed, and contracted licensed nursing staff (if applicable). Education will be on assessing acute medical changes and acute changes in condition including abnormal vital signs, abnormal labs, and abnormal behaviors from baseline. Licensed nurses will be educated on the use of the Interact clinical pathways on assessment and intervention of conditions. The Interact pathways are located at each nursing station. The pathways contain suggestions on treatment option after assessments. Nurses will follow the suggested treatment pathways and notify the providers for further instruction. Education will also be provided to current licensed nurses on notification of provider when receiving orders from outside consults before transcribing the order into the electronic health record. Education to licensed nursing staff will include abnormal blood pressure parameters and when to not administer blood pressure medication. Education will be provided by 11/22/2023 by the Director of Nursing, Staff Development Coordinator or designee to current full time, part time, as needed and contracted staff (if applicable) certified nursing assistants and therapy staff on reporting acute changes in condition to the charge nurse of the patient immediately including what abnormal behaviors consist of and reporting abnormal vital signs. Education will contain signs and symptoms of	F 684		

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 11/28/2023

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 684	Continued From page 66	F 684		

identifying an acute change in condition. Staff not working on 11/22/2023 will receive education prior to the start of their shift after 11/22/2023. The Staff Development Coordinator will track and ensure education is provided.

The alleged date of IJ removal is November 23, 2023.

The person responsible for implementation is the Administrator.

The validation of the credible allegation for quality of care/proving care according to professional standards was conducted in the facility on 11/28/23. Staff interviews and record review verified all licensed staff and unlicensed staff had been educated on the facility policy regarding the requirements for assessment of a resident with use of the Interact Pathways following a change of condition and to seek clarification for all new orders from hospital discharge summaries and consulting providers. It also included educating Nursing Assistants on identifying a change in resident condition and reporting to the Licensed Nurse immediately. Education was given to License Nurses when a change of condition is noted or when a resident presents different than known baseline, lethargic, restless, or short of breath, low blood pressure, behaviors, falls, new orders, and abnormal bodily elimination concerns to perform and documents all changes in the residents electronic medical record and place immediate interventions in place even if during the night when there is a serious or life-threatening change of condition. The immediate jeopardy removal date of 11/23/23 was validated.

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 11/28/2023

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