STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345457	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELAIRE HEALTH CARE CENTER	2065 LYON STREET , GASTONIA, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/27/25 through 07/30/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D1A2E-H1.	E0000		
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 07/27/25 through 07/30/25. Event ID #1D1A2E-H1. The following intakes were investigated 869977, 869978, 869981, 869982, 869984, 869985, 2563179. 5 of the 21 complaint allegations resulted in deficiency. Substandard Quality of Care was identified at: CFR 483.24 at tag F679 at scope and severity of H. An extended survey was conducted.	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of	F0550		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0550 SS = D	Continued from page 1 condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provide incontinence care when a resident requested (Resident #44). The facility also failed to provide a privacy cover for urinary drainage bag which allowed the urinary drainage bag contents to be visible (Resident #31). This deficient practice was for 2 of 6 residents reviewed for dignity (Residents #44 and Resident #31). 1. Resident #44 was admitted on 11/27/24 with diagnoses which included cerebrovascular accident (stroke), hypertension (high blood pressure), unspecified mood disorder, recurrent major depressive disorder. A quarterly Minimum Data Set (MDS) dated 06/27/25 revealed Resident #44 was cognitively intact, received a diuretic (a drug that causes the kidneys to make more urine) daily, was always incontinent of bowel and bladder, and required maximal assistance with incontinence care and toileting. A review of Resident #44's skin assessment dated 07/28/2025 revealed redness to bilateral buttocks. An interview with Resident #44 was conducted on 07/30/25 at 1:32 PM. Resident #44 stated that he was	F0550		

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F0550 SS = D	Continued from page 2 incontinent of both bowel and bladder. Resident #44 indicated staff would not change him when he turned on call bell for incontinence care. Resident #44 reported staff would enter his room, turn off the call bell, and tell him they can't change him right now, or they were not his assigned staff and won't provide incontinence care. Resident #44 stated staff refused to provide incontinence care during mealtimes until all trays were picked up. Resident #44 reported he felt self-conscious of odors due to incontinence of bowels. Resident #44 verbalized it was hard to enjoy meals and activities due to concern about odor. Resident #44 reported staff have stated "not again" when he soiled himself but could not recall a specific time or staff. Resident #44 reported that he would be so soiled with stool from waiting, he would have to be taken to the shower to be "hosed off". Resident #44 indicated he asked staff to change him before the 7:00 PM shift started so he would not have to wait for 7:00 PM to 7:00 AM staff to change him before bedtime because it took them so long to answer the call bell. Resident #44 stated he felt the staff "don't care" and it makes him feel like "he can have a nervous breakdown". Resident #44 stated "I lay in the bed at night and think how much I hate this place". An interview with Nursing Assistant (NA) #1 was conducted on 07/29/25 at 1:39 PM. NA #1 was familiar with Resident #44 and stated NAs would change any resident when needed and did not tell residents to wait. NA #1 stated it was hard to change residents during meals because they were busy in the dining room. An interview with the Unit Manager was conducted on 07/29/25 at 1:55 PM. The Unit Manager stated Resident #44 was always incontinent with bowel and bladder. The Unit Manager reported she was not aware Resident #44 reported staff had told him they could not provide him with incontinence care during mealtimes. The Unit Manager indicated staff would change residents while passing trays if Resident #44 requested it, but it was difficult because staff were busy during meals. Resident #44 required 1 staff assistance for toileting and personal hygiene, and staff took him to the bathroom for toileting. An interview with the Director of Nursing (DON) was conducted on 07/29/25 at 2:38 PM. The DON stated Resident #44 was incontinent with bowel and bladder. The DON indicated Resident #44 had not voiced concern about call bell wait times or staff would not provide care. An interview with the Administrator was conducted on	F0550		

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F0550 SS = D	Continued from page 3 07/30/25 at 3:48 PM. The Administrator stated he expected staff to answer call bells in a timely manner. The Administrator stated, “it takes no special skill to answer the call bell”. The Administrator indicated the Ombudsman came in recently and reported residents had complained of lack of incontinence care and waiting for long periods of time for call bells to be answered. The Administrator stated staff should answer the call bell and if they were not able to provide the care, they need to find the staff qualified to do so. Staff should go back and tell the residents what they did and who would follow up to provide care. 2. Resident #31 was admitted on 12/24/24 with diagnoses which included cerebral infarction due to thrombus (stroke due to a blood clot), anxiety disorder, recurrent major depressive disorder, and neuromuscular dysfunction of the bladder (a condition when nerve damage impairs the bladder’s ability to store and release urine properly). A quarterly MDS dated 07/28/25 revealed Resident #31 was moderately cognitively impaired, had an indwelling catheter, was always incontinent of bowel, and required assistance for hygiene. Resident #31’s care plan dated 12/20/24 revealed plans for assistance with activities of daily living (ADLs), indwelling urinary catheter, and bowel incontinence. Urinary catheter care plan stated goal was to prevent complications due to catheter use. Interventions listed included maintain catheter privacy bag. An initial observation of Resident #31 was conducted on 07/27/25 at 9:07 AM when the Survey Team entered the facility. Resident #31 was seated in a wheelchair outside the facility entrance patio. Resident #31’s urinary drainage bag was observed hanging below the wheelchair and was fully exposed and half full of urine. A second observation of Resident #31 on 07/27/25 at 11:02 AM. Resident #31 was propelling himself down the main hallway in his wheelchair. Resident #31’s urinary drainage bag was observed hanging below wheelchair fully exposed and half full of urine. An interview with NA #1 was conducted on 07/29/25 at 1:39 PM. NA #1 was familiar with Resident #31 and stated she had not realized that Resident #31 did not have a privacy cover on his bedside drainage bag on 07/27/25. An interview was conducted with Resident #31 on	F0550		

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F0550 SS = D	Continued from page 4 07/30/25 at 1:32 PM. Resident #31 stated it bothered him when his urine was visible in the urinary drainage bag while he was in his wheelchair. Resident #31 indicated that the staff applied a leg bag to his catheter on 07/30/25. Resident #31 stated he preferred the bedside drainage bag, but the leg bag could not be seen by others. An interview with the DON was conducted on 07/29/25 at 2:38 PM. The DON stated Resident #31 had an indwelling urinary catheter. The DON stated all residents with catheters should have a privacy cover on bedside drainage bag. The DON indicated Resident #31 had not voiced concern about the urinary catheter before to her.	F0550		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility	F0627		

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F0627 SS = D	Continued from page 5 may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient	F0627		

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F0627 SS = D	Continued from page 6 preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (ii)If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth	F0627		

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F0627 SS = D	Continued from page 7 at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data,	F0627		

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F0627 SS = D	Continued from page 8 data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, and Hospital Case Manager, Emergency Medical Services (EMS) Transporter, and staff interviews, the facility failed to allow a resident to return to the first available bed at the facility after being sent to the hospital for a medical and psychiatric evaluation. The resident remained in the hospital for over two weeks despite being cleared to return to the nursing home on the same day. This deficient practice was evidenced for 1 of 3 residents reviewed for transfer and discharge (Resident #92). Findings included: Resident #92 was admitted to the facility on 4/08/25 and discharged on 4/09/25 with diagnoses including intellectual disability, muscle weakness, and spinal cord disease. Review of 5-day Minimum Data Set (MDS) dated 4/09/25 revealed Resident #92 was severely cognitively impaired	F0627		

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F0627 SS = D	Continued from page 9 with wandering, verbal, and physical behaviors towards others. Review of nursing progress note written by Nurse #3 dated 4/09/25 revealed Resident #92 was combative with nursing staff. One-to-one interventions attempted with no changes in combative behavior. Resident #92 was yelling, screaming, hitting, and kicking staff. Diversional activities attempted with snacks, games, reading, and music not effective. Provider to evaluate. Resident #92 was currently at the nurse's station for high viewing area and one-to-one staff care. Resident #92 continues to hit, kick, yell, and scream and attempting to get out of her chair several times. Review of Nurse Practitioner (NP) progress noted dated 4/09/25 revealed Resident #92 seen for altered mental status. Nursing observations, evaluations, and recommendations are combative to self and to others. Hitting, kicking, spitting, punching, running, attempting to exit the facility, throwing self onto floor, and risk for hurting self and others. Recommendations to send to emergency room (ER) for evaluation and treatment for altered mental status and risk of hurting self and others. Review of the NP order dated 4/09/25 revealed Resident #92 was to be sent out to hospital for evaluation and treatment for altered mental status. Review of nursing progress note written by Nurse #3 dated 4/09/25 revealed Resident #92 was being sent to the ER for evaluation and treatment for altered mental status and risk of hurting self and others. Left a message for Resident #92's responsible person requesting a return call to the facility. Emergency Medical Services (EMS) transported Resident #92 to ER for evaluation and treatment. Attempts to contact Nurse #3 for interview were not successful. Review of EMS transport records dated 4/09/25 revealed at 12:43 PM EMS was dispatched to the facility. Chief complaint was about a resident with behavioral issues. Upon arrival, Resident #92 presented with behavioral issues that facility stated began approximately at 12:00 PM on this date with a duration of about 1 hour. Additionally, a general exam was conducted, lasting approximately 10 minutes. Resident #92 reported no possible injuries and was experiencing mild distress. There were no abnormalities upon examination. The primary impression was a behavioral/psychiatric episode, with a secondary impression of a general exam.	F0627		

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F0627 SS = D	Continued from page 10 Resident #92 was safely transferred to the ambulance using a stretcher. Resident #92 was transported to the closest hospital facility by non-emergent transport. Upon arrival at the destination, Resident #92's condition remained unchanged. On 4/09/25 at 3:29 PM EMS was dispatched to the hospital for medical transport back to nursing facility. Upon arrival, Resident #92 was found in assigned room and was transferred from bed onto the stretcher. Resident #92 was alert and oriented to residents normal. Resident #92 had no complaints throughout duration of transport other than wanting to go back to the group home where she had been for several years. Upon arrival at the nursing facility at 4:15 PM, EMS was met outside of the facility by nursing staff (no name listed) and was told Resident #92 was not allowed on the property and EMS were not to bring her inside. EMS called their supervisor and Adult Protective Services (APS) were contacted and were told to standby while arrangements were made for Resident #92. After contacting the hospital staff, EMS were advised to return Resident #92 to the ER until further arrangements could be made. EMS cleared facility at 5:03 PM transported Resident #92 back to hospital facility. Resident #92 arrived at hospital facility at 5:23 PM, alert and oriented and no complaints during transport. A telephone interview with the EMS transporter on 7/30/25 at 8:45 AM revealed EMS received a telephone call on 4/09/25 at 12:43 PM from the facility to transport Resident #92 to the ER for altered mental status and combative behaviors. He stated EMS arrived at the facility at 12:59 PM and Resident #92 was transported to the hospital ER for evaluation and treatment. He revealed EMS received a telephone call on 4/09/25 at 3:29 PM from the hospital to transport Resident #92 back to the facility. The EMS transporter stated upon arrival at the facility on 4/09/25 at 4:15 PM they were met outside by a nursing staff (no name listed) and were informed they were not taking Resident #92 back at the facility, Resident #92 was not allowed on the facility property and EMS was not allowed to come inside with Resident #92. He revealed they called the EMS supervisor who instructed them to contact Adult Protective Services (APS). He stated they contacted APS and were informed the facility was not allowed to refuse to take Resident #92 back and if they continued to refuse to take her back, to contact the hospital to see if they would allow Resident #92 to come back until other arrangements could be made. The EMS transporter revealed the staff at the facility continued to refuse to allow Resident #92 back into the facility, so they	F0627		

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BELAIRE HEALTH CARE CENTER	2065 LYON STREET , GASTONIA, North Carolina, 28052

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F0627 SS = D	Continued from page 11 transported Resident #92 back to the hospital and notified hospital staff the facility was refusing to take Resident #92 back. He stated they left Resident #92 at the hospital and to his knowledge she was admitted back into the hospital until other arrangements could be made. Review of hospital case manager notes for Resident #92 dated 4/09/25 revealed the following: 4/09/25- Resident #92 was brought into hospital ER via EMS transport from nursing facility for complaints of altered mental status, combative behavior, and risk to self or others. Upon assessment, Resident #92 a was alert and oriented to baseline, no threats of harm to self or others, and no behaviors present. Resident #92 showed no signs of injury and no complaints of pain. (CBC), urinalysis, and lithium level check were completed, and ranges were within normal limits. Medications reviewed with no changes. Recommendations for Resident #92 discharge back to skilled nursing facility and follow up with psych and primary care physician. Resident #92 discharged and transported back to skilled nursing facility via EMS. 4/09/25- Resident #92 was brought back to hospital ER via EMS transport from nursing facility. EMS transport reported nursing facility refused Resident #92 and would not allow her back at their facility. Resident #92 was currently resting in ER, alert and oriented to baseline, no behaviors present, and no complaints of injury or pain. Attempted contact with nursing facility with no answer. Contacted previous assisted living facility, unable to take Resident #92 due to requiring rehab services and skilled nursing level of care. Resident #92 was admitted to hospital for treatment until alternative placement could be arranged. 4/21/25- Resident #92 discharged from and transported via EMS to previous assisted living facility. Resident #92 referral for home health to continue therapy and nursing services. Follow-up with psych and primary care physician. A telephone interview with the hospital case manager on 7/30/25 at 9:15 AM revealed she was familiar with Resident #92. She stated on 4/09/25 Resident #92 was brought into the ER for altered mental status. She revealed Resident #92 was assessed by the hospital provider, lab work was completed, lithium levels were	F0627		

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F0627 SS = D	Continued from page 12 checked, and all were within normal limits. Medications were reviewed with no changes. She revealed Resident #92 appeared to be at baseline with no behaviors present while at the hospital. The hospital case manager stated the hospital provider recommended Resident #92 to be discharged back to the facility and to follow up with psych and her primary physician. She revealed Resident #92 was transported back to the facility by EMS at 3:30 PM. She stated typically the ER nurse would notify the facility when a resident was being discharged and transported back to the facility but there was no note entered to state if the ER nurse contacted the facility regarding Resident #92's return to the facility. The hospital case manager revealed on 4/09/25 around 5:30 PM, EMS transported Resident #92 back to the hospital stating the facility refused to take her back and would not allow Resident #92 back into their facility. She stated they attempted to contact the facility but could not get anyone from the facility to answer their call. She revealed they also attempted to contact Resident #92's previous assisted living facility about placement but they could not accept Resident #92 due to her requiring rehab services and skilled level of care. The hospital case manager stated Resident #92 had to be admitted to the hospital since the facility refused to take her back and they were unable to locate an alternative placement. She revealed during Resident #92's hospital stay she received the treatments and therapy services she was supposed to receive at the facility, and she was able to be discharged back to her assisted living facility on 4/21/25. An interview conducted with the Director of Nursing (DON) on 7/30/25 at 12:33 PM revealed she was out of the facility during the week of 4/07/25 through 4/10/25 and was not familiar with Resident #92's admission or discharge. She stated she had no knowledge of Resident #92 ever being sent out to the hospital or not allowed to return. When asked if she believed Nurse #3 or any of the other nursing staff would have spoken with EMS and refused to take Resident #92 back, she stated Nurse #1 only worked the 7:00 AM to 3:00 PM shift and was not at the facility when EMS transported Resident #92 back. She revealed all nursing staff were aware that only herself or the Administrator have the authority to admit or discharge a resident, and she did not believe that any of her nursing staff would make the decision to refuse to take a resident back or notify EMS the facility was refusing to take a resident back. The DON stated no resident should be refused to return back to the facility and Resident #92 should have been allowed to return until an alternative placement if needed	F0627		

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F0627 SS = D	Continued from page 13 could have been located. An interview conducted with the Admission Coordinator on 7/30/25 at 1:10 PM revealed she had begun her position at the facility in May 2025 and was not familiar with Resident #92. An interview conducted with the Social Worker on 7/30/25 at 1:20 PM revealed she was not familiar with Resident #92 and was not aware of anyone from the facility refusing to allow a resident to return to the facility after a hospital stay. The SW stated she had never received a telephone call or voicemail from the hospital regarding Resident #92 and typically anytime she received a telephone call from the hospital about a resident discharge to the facility, she would typically transfer the call to the DON or Administrator. An interview conducted with Unit Manager (UM) #1 on 7/30/25 at 2:10 PM revealed she believed she was working on 4/09/25 from 7:00 AM to 7:00 PM. She stated she could not really recall Resident #92 specifically but did remember an incident with a female resident who was sitting at the nurse's desk and having combative behavior towards staff and trying to throw herself from her wheelchair into the floor. She revealed she believed the nurse working the day shift (could not recall which nurse) had informed the NP of the resident's behaviors and received an order for the resident to be sent out to the hospital. UM #1 stated to her knowledge the resident was sent out to the hospital for an evaluation. She revealed she was not aware of the resident ever returning to the facility and had no knowledge of any nursing staff refusing the resident to return to the facility or going outside and speaking with EMS. She stated that typically when it comes to resident admissions or discharges, the DON and Administrative staff were notified and they were the only ones that could authorize resident admissions and discharges. An interview conducted with Nurse #1 on 7/30/25 at 3:30 PM revealed she was working at the facility on 4/09/25 from 7:00 AM to 7:00 PM. She stated she did not recall Resident #92 and was not aware of her being sent out to the hospital or not being allowed to return. She revealed she would never tell anyone and was not aware of any other nursing staff that would tell anyone whether a resident was or was not allowed to return to the facility. Nurse #1 stated to her knowledge all	F0627		

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F0627 SS = D	Continued from page 14 decisions regarding resident admissions and discharges were always handled by the DON and the Administrative staff. An interview conducted with Nurse #4 on 7/30/25 at 3:35 PM revealed she was also working at the facility on 4/09/25 from 7:00 AM to 7:00 PM. She stated she could not recall Resident #92 or an incident of her being sent out to the hospital and not being allowed to return. She revealed she denied ever telling anyone and was not aware of any other nursing staff telling anyone whether a resident was or was not allowed to return to the facility. An interview conducted with the Administrator on 7/30/25 at 3:41 PM revealed he was not familiar with Resident #92. He stated he did not recall any incident where EMS had been turned away and a resident was not allowed to return to the facility after a hospital stay. He revealed himself and the DON were the only people at the facility with the authority to refuse to accept a resident back from the hospital. The Administrator stated his DON was out of the facility during that week and he did not recall speaking to anyone about Resident #92 or giving any of his staff the authority to refuse a resident to return to the facility. He revealed Resident #92 should have been allowed to return to their facility regardless of her behaviors until an alternative placement that could better serve her needs could have been arranged.	F0627		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental	F0644		

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F0644 SS = D	Continued from page 15 disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) Level II was completed for two residents with new mental health diagnoses for 2 of 3 residents (Resident #37 and #6) reviewed for PASRR. The findings include: 1. Review of Resident #37's medical record revealed the resident was admitted to the facility on 7/11/17 with a readmission on 7/30/19. PASRR level I was completed on 5/13/17 prior to admission with a recommendation to resubmit paperwork for PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. The electronic medical record revealed Resident #37 was diagnosed with delusional disorder on 7/11/17, impulsive disorder on 3/30/18, mood affective disorder on 3/30/18, and attention-deficit hyperactivity disorder on 7/05/18. No PASRR level II was completed. An interview on 7/30/25 at 1:20 PM with Social Worker (SW) revealed she was responsible for completing PASRR paperwork for residents. She stated she typically completed paperwork for PASRR level II when residents had a limited level II and their paperwork required them to be reviewed every 30 or 60 days, had a change in condition, or received a new mental health diagnosis. SW revealed she was not aware PASRR level II should be completed for residents with mental health diagnosis upon their admission or readmission. SW stated based on Resident #37's mental health diagnosis, a PASRR level II should have been completed. During an interview on 7/30/25 at 3:41 PM with the Administrator revealed PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. He stated based on Resident #37's mental health diagnosis, PASRR level II should have been completed.	F0644		

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F0644 SS = D	Continued from page 16 2. Review of Resident #6's medical record revealed the resident was admitted to the facility on 7/11/25 and PASRR level I was completed 7/08/25 prior to admission to the facility with a recommendation to resubmit paperwork for a PASRR level II if a new mental health diagnosis was suspected or if there was a significant change in the resident's condition. The electronic medical record revealed Resident #6 was diagnosed with psychotic disorder on 7/11/25, anxiety disorder, and major depressive disorder on 7/11/25. No PASRR level II was completed. An interview on 7/30/25 at 1:20 PM with Social Worker (SW) revealed she was responsible for completing PASRR paperwork for residents. She stated she typically completed paperwork for PASRR level II when residents had a limited level II and their paperwork required them to be reviewed every 30 or 60 days, had a change in condition, or received a new mental health diagnosis. SW revealed she was not aware PASRR level II should be completed for residents with mental health diagnosis upon their admission or readmission. SW stated based on Resident #6's mental health diagnosis, a PASRR level II should have been completed. During an interview on 7/30/25 at 3:41 PM with the Administrator revealed PASRR level II should be completed in a timely manner upon the admission or readmission of a resident with a mental health diagnosis and anytime a resident has had a change of condition or received a new mental health diagnosis. He stated based on Resident #6's mental health diagnosis, PASRR level II should have been completed	F0644		
F0679 SS = SQC-H	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by:	F0679		

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F0679 SS = SQC-H	Continued from page 17 Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 4 residents reviewed for activities (Resident #31, #44, #78, and #80). During interview, Resident #44 cried when speaking about his inability to enjoy his retirement because he was not able to do things outside such as eating at a restaurant, going to a baseball game, going out to see Christmas lights, socializing, going into a store and being able to touch items and shop for himself. Other residents expressed not being able to leave the facility made them feel “like a dog”, unimportant, sad, and they missed getting out with the group to shop, attend community activities, and socialize. The findings included: A review of the July 2025 activity calendar revealed scheduled activities for inside of the facility during the week and on the weekends. There were no activities scheduled outside of the facility. Observation on 7/28/25 at 9:00 AM revealed the facility was located within a business and residential area that was within driving distance to numerous local and commercial shops, grocery stores, local and commercial coffee shops, fast food, and sit-down restaurants. a. Resident #31 was admitted to the facility on 12/24/24. An admission Minimum Data Set (MDS) dated 12/30/24 indicated Resident #31 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #31 was cognitively intact. An interview conducted with Resident #31 on 7/29/25 at 1:30 PM during the Resident Council meeting revealed there had not been a scheduled group activity outside of the facility since his admission in December 2024. He stated he believed they might have discussed scheduled activities outside of the facility maybe once during their Resident Council meeting and it was said	F0679		

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F0679 SS = SQC-H	Continued from page 18 that residents have families that take them out and the facility does not have a van. He stated in his opinion group activities outside of the facility were important to the residents that they were able to go and participate because it allowed them socialization with the group and outside world, helped with their health, made them feel normal and that they weren't just stuck in a facility. Resident #31 stated not being able to leave the facility and participate in group activities outside the facility had sometimes made him feel "like a dog", that he was unimportant, and had lost some of his own independence. He revealed personally being able to go shopping, go out to ball games and community activities, and socializing with other people outside of the facility was very important to him and would make him feel more human and like he was still important. b. Resident #44 was admitted to the facility on 11/27/24. An admission Minimum Data Set (MDS) dated 12/02/24 indicated Resident #44 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #44 was cognitively intact. An interview was conducted with Resident #44 on 7/29/25 at 1:30 PM during the Resident Council meeting revealed he had been at the facility since November 2024 and there had not been a scheduled group activity outside of the facility since his admission. He stated he had been told by staff and other residents that they were not able to go out to activities outside the facility because they didn't have a van at the facility. Resident #44 began crying and stated he was sorry for crying but that he was retired and was not able to enjoy his retirement and that going out to eat at a restaurant, going to a baseball game, going out to see Christmas lights, socializing, going into a store and being able to touch items and shop for your own personal belongings made you feel independent and normal. He stated he felt that not being able to do those things since his admission made him sad, miss his home life more, like he was not able to enjoy his retirement, become more reliant on staff and not as social as he used to be. Resident #44 revealed he would just like the opportunity to enjoy those things again.	F0679		

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F0679 SS = SQC-H	Continued from page 19 c. Resident #78 was admitted to the facility on 5/03/25. An Admission Minimum Data Set (MDS) dated 5/09/25 indicated Resident #78 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #78 was cognitively intact. An interview conducted with Resident #78 on 7/29/25 at 1:30 PM during the Resident Council meeting revealed that since she had been admitted to the facility there had been no scheduled activities outside of the facility. She revealed not having scheduled activities outside of the facility made her feel sad, depressed, and like she was missing out on the world. Resident #78 stated she would like the opportunity to go shopping for herself or to eat at a restaurant and socialize with other people. d. Resident #80 was admitted to the facility on 11/02/20. An Annual Minimum Data Set (MDS) dated 4/20/25 indicated Resident #80 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #80 was cognitively intact. An interview conducted with Resident #80 on 7/29/25 at 1:30 PM during Resident Council meeting revealed that since she had been to the facility there had been no scheduled activities outside of the facility. She stated she participated in a monthly Resident Council meeting and they had discussed with the Activities Director about scheduling activities outside of the facility. She revealed they were always told that it was not possible because the facility was not able to provide transportation due to not having a facility van. Resident #80 stated not having the opportunity to participate in activities outside of the facility made her feel sad, unimportant, and like she was losing her independence. She revealed that she felt it was important for residents to have scheduled activities outside of the facility because not all of the residents at the facility had family that could take them out or shop for them. She also revealed having	F0679		

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F0679 SS = SQC-H	Continued from page 20 scheduled activities outside of the facility allowed residents to feel normal and to be able to shop and purchase their own items, maintain their independence, and to be able to socialize with the real world. An interview conducted with the Activity Director on 7/30/25 at 12:11 PM revealed she had been working as the Activity Director at the facility for the past 5 years and part of her responsibilities were scheduling and implementing resident activities for each month. She stated since she began working at the facility as the Activity Director, she had not scheduled any resident group activities outside of the facility due to the facility not having their own van and residents having families that could take them out when they wanted to go. She revealed to her knowledge; the facility had never had a van and had always relied on contract transport for resident appointments only. The Activity Director stated she believed she had discussed scheduled activities outside of the facility maybe once over the past year and the residents she spoke with stated they had family that could take them out. She revealed she had been doing some personal shopping for residents so they could continue to receive their preferences but understood that this was not the same as the residents being able to leave the facility and shop for themselves, eat a meal together at a restaurant, participate in community activities, or watch a movie outside of the facility. She stated she felt like activities outside of the facility for those residents who could participate were important for their overall mental and physical well-being and allowed them some independence. An interview conducted with the Administrator on 7/30/25 at 3:41 PM revealed he was unaware of residents wanting to participate in activities outside of the facility over the past year. He stated he would investigate the issue and see what alternative transportation methods were available that could be used to assist the residents being able to participate in activities outside of the facility.	F0679		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and	F0695		

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(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
F0695 SS = D	Continued from page 21 tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to post cautionary signage outside of resident room that indicated the use of oxygen for 1 of 8 residents reviewed for respiratory care (Resident #95). Findings included: Resident #95 was admitted on 07/21/25 with diagnoses that included chronic obstructive pulmonary disease (COPD), and chronic respiratory failure with hypoxia (low oxygen levels). A review of Resident #95's care plan created on 07/21/25 revealed a plan for oxygen therapy to relieve hypoxia due to COPD. The stated goal was that Resident #95 would be free from respiratory complications. Interventions included oxygen via nasal cannula as ordered, monitor for signs of respiratory distress and notify provider if indicated, and administer medications as ordered. Resident #95's physician orders revealed an order dated 07/22/25 for oxygen via nasal cannula as needed for shortness of breath at 2 liters per minute. Resident #95's admission Minimum Data Set (MDS) dated 07/27/25 revealed that Resident #95 was cognitively intact, dependent on staff for all activities of daily living, and coded for COPD, respiratory failure, and oxygen use. An observation of Resident #95 in her room on 07/27/25 at 12:13 PM revealed oxygen concentrator in use via nasal cannula at 2 liters per minute. No cautionary oxygen in use signage was noted outside of Resident #95's room indicating oxygen in use. A second observation of Resident #95 in her room on 07/28/25 at 9:28 AM revealed the oxygen concentrator in use via nasal cannula at 2 liters per minute. No cautionary oxygen in use signage outside of Resident #95's room indicating oxygen in use. A third observation of Resident #95 in her room on 07/28/25 at 3:40 PM revealed the oxygen concentrator in use via nasal cannula at 2 liters per minute. No	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345457	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2025

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F0695 SS = D	Continued from page 22 cautionary oxygen in use signage outside of Resident #95's room indicating oxygen in use. Nurse #1's interview on 07/28/25 at 3:48 PM revealed Resident #95 received oxygen continuously. Nurse #1 stated that she did not know who was responsible for applying the oxygen in use cautionary signs to resident rooms. Nurse #1 indicated that she had not noticed that Resident #95 did not have an oxygen sign on door. An interview conducted with the Director of Nursing (DON) on 07/29/25 at 3:05 PM revealed the DON placed the concentrator into room and applied oxygen to Resident #95, but cautionary signage was overlooked. The DON indicated oxygen in use cautionary signage should be posted outside the doors of all residents' rooms that used oxygen.	F0695		