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 02/12/2016

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 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to remove a large amount of spit out food from the resident's chest before leaving the resident to help in the dining room for 1 of 1 resident reviewed for neglect (Resident #46). The findings included: Resident #46 was admitted to the facility on 10/06/15 with diagnoses of adult failure to thrive and chronic pain. Review of the quarterly Minimum Data Set (MDS) dated 01/06/16 revealed Resident #46 was severely cognitively impaired and was dependent for eating and personal hygiene. An observation made on 02/11/16 at 8:58 AM revealed Resident #46 lying in bed with a large amount of spit out food on a towel across her chest. During an interview conducted with nurse aide (NA) #4 on 02/11/16 at 9:15 AM she revealed she had been feeding Resident #46 her breakfast	F 224	F224 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of corrections constitute the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. How the corrective action will be accomplished for the resident(s) affected. Towel was removed from patient #46. The CNA was called into DON□s office and counselled for her action and suspended pending investigation. 24/5day report completed and submitted to the Health Care Personnel Registry. How corrective action will be	3/11/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2016

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 02/12/2016

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 224	Continued From page 1 when she was called to help in the main dining room. She stated she had laid a towel across Resident #46's chest because she would spit out food. NA #4 stated she left Resident #46 with the soiled towel across her chest to help in the main dining room and planned to return to clean up Resident #46 after she finished in the dining room. NA #4 stated she forgot to return to Resident #46's room to clean her up after she finished in the main dining room. An interview conducted with the Director of Nursing (DON) on 02/11/16 at 9:34 AM revealed it was her expectation that NA #4 should have cleaned Resident #46 up from breakfast before she left to help in the main dining room.	F 224	accomplished for those residents with the potential to be affected by the same practice. Rounds were completed on the patients that were in the building at the time deficient practice was identified to ensure that no other residents were found to be left in a situation that would be neglectful or undignified. Measures in place to ensure practices will not occur. All staff will be in-serviced by DON/SDC on types of Abuse and Dignity which included the below, by March 11, 2016. a) Abuse means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain a patient□s physical, mental, and psychosocial wellbeing. Abuse, includes, but is not limited to: 1) Physical Abuse 2) Verbal Abuse 3) Sexual Abuse (1) Sexual harassment, inappropriate touching. (2) Sexual coercion. (3) Sexual assault or allowing a patient to be sexually abused by another. (4) Inciting any of the above. 4) Psychological/Emotional (Mental) Abuse b) Neglect means a repeated or willful failure to provide timely and consistent services,	

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 02/12/2016

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 224	Continued From page 2	F 224	treatment or care to a patient which are necessary to obtain or maintain the patient□s health, safety or comfort; or a repeated or willful failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental illness, including but not limited to acts that cause, or could case, pain or injury to a patient or the death of a patient; acts that substantially disregard a Center□s duties and obligations to a patient; acts that cause or could significantly or likely be expected to cause, mental or emotional damage to a patient. Examples include but are not limited to: (1) Repeated or willful failure to provide adequate nutrition and fluids. (2) Reckless disregard of precautionary measures to protect the health and safety of the patient. (3) Intentional lack of attention to physical needs including, but not limited to, toileting and bathing, or continued omission in providing daily care and/or failure to address the omission (4) Failure to provide services such as not turning a bedfast patient or leaving a patient in a soiled bed that result in harm to the patient. (5) Failure or refusal to provide a service for the purpose of punishing or	

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 02/12/2016

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 224	Continued From page 3	F 224	disciplining a patient, unless withholding of a service is being used as part of a documented integrated behavioral management program. (6) Willful or reckless disregard of duties to adequately supervise a patient known to wander from the Center without staff knowledge. c. Misappropriation of Personal Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient□s belongings or money without the patient□s consent. Dignity means that in their interaction with residents, staff carries out activities that assist the resident maintain and enhance his/her self-esteem and self-worth, ie. grooming, putting on clothing other than a gown, assisting residents to attend activities of their choosing, labeling clothing in an inconspicuous way, refraining from practices that are demeaning to a resident. This will be taught to all new employees and re-education provided monthly during CNA and Licensed Nurse meetings for three (3) months. Staff will notify Administrator or DON of any suspected abuse or evidence of patient dignity being compromised. How the facility plans to monitor and ensure correction is achieved and sustained. Random audits will be performed by Department Heads that are	

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 02/12/2016

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 224	Continued From page 4	F 224	assigned by Administrator or DON, after meals x 2 weeks Monday Friday, then weekly for two months. DON will report results of monitoring to QA&A committee Monthly x 3 for continued compliance/revision to plan as needed.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to remove a large amount of spit out food from the resident's chest before leaving the resident to help in the dining room for 1 of 1 resident reviewed for dignity and respect (Resident #46). The findings included: Resident #46 was admitted to the facility on 10/06/15 with diagnoses of adult failure to thrive and chronic pain. Review of the quarterly Minimum Data Set (MDS) dated 01/06/16 revealed Resident #46 was severely cognitively impaired and was dependent for eating and personal hygiene. An observation made on 02/11/16 at 8:58 AM revealed Resident #46 lying in bed with a large amount of spit out food on a towel across her	F 241	F241 How the corrective action will be accomplished for the resident(s) affected. Towel was removed from patient #46 The CNA was called into DON s office and counselled for her action and suspended pending investigation. 24/5day report completed and submitted to the Health Care Personnel Registry. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Rounds were completed on the patients that were in the building at the time deficient practice was identified to ensure that no other residents were found to be left in a situation that would be neglectful or undignified.	3/11/16

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 02/12/2016

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 241	Continued From page 5 chest. During an interview conducted with nurse aide (NA) #4 on 02/11/16 at 9:15 AM she revealed she had been feeding Resident #46 her breakfast when she was called to help in the main dining room. She stated she had laid a towel across Resident #46's chest because she would spit out food. NA #4 stated she left Resident #46 with the soiled towel across her chest to help in the main dining room and planned to return to clean up Resident #46 after she finished in the dining room. NA #4 stated she forgot to return to Resident #46's room to clean her up after she finished in the main dining room. An interview conducted with the Director of Nursing (DON) on 02/11/16 at 9:34 AM revealed it was her expectation that NA #4 should have cleaned Resident #46 up from breakfast before she left to help in the main dining room.	F 241	Measures in place to ensure practices will not occur. All staff will be in-serviced by DON/SDC on types of Abuse and Dignity which included the below, by March 11, 2016. a) Abuse means the willful inflection of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, or deprivation by an individual, including caretaker, of goods or services that are necessary to attain or maintain a patient□s physical, mental, and psychosocial wellbeing. Abuse, includes, but is not limited to: 1) Physical Abuse 2) Verbal Abuse 3) Sexual Abuse (1) Sexual harassment, inappropriate touching. (2) Sexual coercion. (3) Sexual assault or allowing a patient to be sexually abused by another. (4) Inciting any of the above. 4) Psychological/Emotional (Mental) Abuse b) Neglect means a repeated or willful failure to provide timely and consistent services, treatment or care to a patient which are necessary to obtain or maintain the patient□s health, safety or comfort; or a repeated or willful failure to provide timely and consistent goods and services necessary to avoid physical harm, mental anguish, or mental	

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 02/12/2016

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 241	Continued From page 6	F 241		

illness,
including but not limited to acts that cause, or could case, pain or injury to a patient or the
death of a patient; acts that substantially disregard a Center□s duties and obligations to a
patient; acts that cause or could significantly or likely be expected to cause, mental or
emotional damage to a patient.
Examples include but are not limited to:
(1) Repeated or willful failure to provide adequate nutrition and fluids.
(2) Reckless disregard of precautionary measures to protect the health and safety
of the patient.
(3) Intentional lack of attention to physical needs including, but not limited to,
toileting and bathing, or continued omission in providing daily care and/or
failure to address the omission
(4) Failure to provide services such as not turning a bedfast patient or leaving a
patient in a soiled bed that result in harm to the patient.
(5) Failure or refusal to provide a service for the purpose of punishing or
disciplining a patient, unless withholding of a service is being used as part of
a documented integrated behavioral management program.
(6) Willful or reckless disregard of duties to adequately supervise a patient
known to wander from the Center

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 02/12/2016

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 241	Continued From page 7	F 241	without staff knowledge. c. Misappropriation of Personal Property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient□s belongings or money without the patient□s consent. Dignity means that in their interaction with residents, staff carries out activities that assist the resident maintain and enhance his/her self-esteem and self-worth, ie. grooming, putting on clothing other than a gown, assisting residents to attend activities of their choosing, labeling clothing in an inconspicuous way, refraining from practices that are demeaning to a resident. This will be taught to all new employees and re-education provided monthly during CNA and Licensed Nurse meetings for three (3) months. Staff will notify Administrator or DON of any suspected abuse or evidence of patient dignity being compromised. How the facility plans to monitor and ensure correction is achieved and sustained. Random audits will be performed by Department Heads that are assigned by Administrator or DON, after meals x 2 weeks Monday □ Friday, then weekly for two months. DON will report results of monitoring to QA&A committee Monthly x 3 for continued compliance/revision to plan as needed.	
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		3/11/16

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 02/12/2016

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 242 SS=D	Continued From page 8 MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to assess and honor the choice for bathing days and frequency for 1 of 3 residents observed for choices. (Resident #129) The findings included: Resident #129 was admitted to the facility with diagnoses which included dementia, diabetes, hypertension, depression, chronic pain, hemiplegia/stroke, muscle weakness, and dysphagia. Resident #129's most recent Minimum Data Set (MDS) dated 12/16/15 assessed him as being cognitively intact. The MDS indicated resident #129 was dependent on staff for bathing with the assistance of one person. On 2/9/16 at 10:09 AM an interview was conducted with Resident #129. Resident #129	F 242	F242 How corrective action will be accomplished for each resident found to have been affected by the deficient practice Resident #129 was offered a shower and preference reviewed with him upon notification to ensure preferences were met. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice All in house Residents were interviewed to find out preference for showers and get up times completed by March 11, 2016 PCC and Care Plan updated and completed by March 11, 2016, by Unit Manager and DON. Measures to be put in place or systemic changes made to ensure practice will not re-occur- Choices will be care planned and notated in Point of Care Tasks for CNA to ensure choices are followed. Nurses and CNAs were in-serviced 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 02/12/2016

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 242	Continued From page 9 stated he would like to have more than two showers per week. He stated sometimes he would like to have three showers per week. He also stated that when he asked to have an extra shower he was told it was not his day. Resident #129 did not remember who told him that. An interview was conducted on 2/10/16 at 10:00 AM with Nursing Assistant (NA) #4. NA #4 stated resident #129 received his showers on Wednesdays and Saturdays. She stated there was a shower book which told what day residents received a shower based on room numbers. NA #4 went on to explain the shower schedule was determined by what room number residents have. NA #4 stated if residents wanted more than two showers per week they would have to ask. NA #4 also stated that the residents were allowed to have extra showers on their non shower days if they ask, and that residents would get extra showers if they have time. NA#4 stated that they would work them in sometime on 1st or 2nd shift. NA #4 was not aware that resident # 129 had asked for an extra shower. On 2/10/16 at 10:30 AM, an interview with NA # 1 revealed that he checked the shower book to see when the residents received showers. Shower days were scheduled by room numbers. NA #1 stated that residents who wanted more than two showers per week would have to ask. He stated that if residents asked to have a shower on their non shower day, they would work them in on 1st or 2nd shifts. NA #1 was not aware that resident #129 had asked for an extra shower.	F 242	Director of Nursing/SDC or designee on making sure resident□s choice of showers and get-up times are honored and put in the CNA task to match resident desire and completed by March 11, 2016. DON, Unit Manager or Designee will complete an audit of new residents admitted to the facility to ensure that their shower preferences and get up times have been acknowledged and scheduled. Any deviations from the preference sheet not being completed will result in re-education/disciplinary action. This audit will be completed daily (Monday-Friday) x4 weeks for new admission, twice a week for 6 new admits if applicable x2 months and monthly 6 admits for 3 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be presented to the QA Committee monthly x6 to ensure continued compliance and revisions to the plan if needed.	

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 02/12/2016

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 242	Continued From page 10 On 2/10/16 at 10:45 AM, an interview with Nurse #5 revealed that the residents got 2 showers a week based on their room number. If residents wanted a shower that was not on their day, and it was a habit, they may change to a different day. Residents may have extra showers if they ask. Nurse #5 was not aware that resident #129 had asked for extra shower. On 2/10/16 at 11:00 AM interview with the unit manager revealed that upon admission, residents were assigned shower days based on room number. She stated that the admitting nurse told them when their shower days were. If the residents wanted to change shower days they could. The unit manager wasn ' t sure if they were asked how many showers they wanted. On 2/10/16 at 3:00 PM an interview was conducted with the Director of Nursing (DON). The DON stated that the residents received showers by schedule and based on their room numbers on 1st and 2nd shifts. She stated that if residents asked for extra showers they were worked in on 1st and 2nd shifts. She stated that preference for days and frequency of showers should be assessed.	F 242		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		3/11/16

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 02/12/2016

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 248	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, staff interviews and record review, the facility failed to develop and promote an activity program that met the interests of 1 of 6 residents sampled for activities (Resident #121). The findings included: Resident #121 was admitted to the facility on 12/03/15. Her diagnoses included hypertension, diabetes, hyperlipidemia, depression and left hip pain. The admission Minimum Data Set (MDS) dated 12/09/15 coded her as having intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status, being nonambulatory, and needing extensive assistance with locomotion. Under preferences on the MDS, she indicated that books, music, new, participating in favorite activities were very important to her. She further indicated that animals were somewhat important. Activities did not trigger for a comprehensive assessment, however, a care plan was developed on 12/10/15. The care plan addressed the problem that the resident had an alteration of prior leisure routines to continue lifelong interests and preferences due to a recent hospital stay with a need for short term rehabilitation. The goals on the care plan included to attain or maintain her highest practical well being, to enhance her quality of life, community involvement sense of belongs and to use leisure time constructively and consistently with former life style and life roles. The interventions included:	F 248	F 248 How the corrective action will be accomplished for the residents affected: The Activity Director spoke with resident #121 on morning of 2/12/2016 to invite resident to activities of the day. The Activities Director went around to all the residents to invite all residents to activities on 2/12/2016. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: The Activity Director or designee will announce activities for the day and before each activity to remind residents and staff of the activities. The Activity director or designee will post a larger updated activity calendar in each residents room Measures in place to ensure practices will not occur: The Activity Director or designee will check each room weekly times 12 weeks, Monthly x3 months and then quarterly x2 to ensure that activity calendars are present in each resident□s room. The Activity Director will educate all staff to the activity calendar, daily announcements and each staff members responsibility to assist residents to scheduled activities. The Activities Director will educate the weekend receptionist to announce daily activities on Saturday and Sunday. The Administrative Team (Administrator, Discharge Planner, Housekeeping Supervisor, Maintenance	

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 02/12/2016

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 248	Continued From page 12 *to provide an opportunity for decision making, self expression and creative expression; *to provide meaningful involvement and a sense of purpose; *to provide ongoing structured activity program to increase interaction, cooperation, and socialization with peers. On 02/09/16 at 2:35 PM, Resident #121 stated she enjoyed bingo. She stated the activity program in the facility did not meet her interests and she got bored almost daily as she did not have enough to do. Resident #121 stated afternoons did not provide her with anything to do so she usually went back to her room and fell asleep, which she never did at home. Resident #121 also stated that no one came to invite her to the activities and often no one participated in activities and she did not want to go if no one would be there. On 02/10/16 at 11:00 AM, a girl with a portable keyboard was observed going down the hall. She passed Resident #121's door which was closed and proceeded to go down the hall, then stop and play music for a resident sitting by the nursing station. She did not knock or try to offer Resident #121 music. On 02/10/16 at 2:45 PM, Resident #121's door was closed. Upon entering she was noted to be sitting in her room. Her visitor was asleep in a chair and although the television was on she was not facing it. Resident #121 stated that this morning a staff member came to her room and placed a note below the activity calendar which noted changes in the activity program for the day. This note indicted a music group was to play in the dining room at 2:00 PM. Resident #121	F 248	Supervisor, Lifeworks Coach) will perform random weekly audits which consist of checking for activity calendars and invitations to activity programs of 8 residents a week. This audit will be performed 2x a week for four weeks, weekly for 8 weeks, monthly x9 months. All audits will be turned into Administrator to ensure compliance. This will be completed by March 11, 2016 How the facility plans to monitor and ensure correction is achieved and sustained: The Administrator will bring all audits and education to QA&A monthly times 12 months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345457	A. BUILDING _____ B. WING _____	C 02/12/2016

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 248	Continued From page 13	F 248		

stated the staff member asked if she would attend the music activity to which she replied yes and the staff member stated she would be back to get her. The resident stated no one came back to take her to the activity. When asked if she would have gone to the activity, Resident #121 replied yes. Upon leaving the room Nurse Aide #6 was in the hall and agreed to take the resident to the music activity. NA #6 stated she thought she was in therapy. Resident #121 was observed in the music activity at 3:06 PM.

On 02/11/16 at 2:40 PM, bingo was observed in process in the dining room but Resident #121 was not present. On 02/11/16 at 3:09 PM, Resident #121 was observed in her room. She stated at this time she loved bingo but was not invited. She further stated when she ate in the dining room for lunch, she asked a staff member what was going on this afternoon and that staff member replied nothing.

The Activity Director (AD) was interviewed on 02/11/16 at 4:55 PM. She stated she had no activity staff under her and relied on staff to get residents to the activities. She stated Resident #121 had a family member visit almost daily. AD stated she developed resident care plans based on the preferences she obtained during resident interview. She stated that the care plan for Resident #121 was not personalized to her interests. AD recalled talking to her the day the music activity was changed and agreed someone would take her. She stated she relied on help from other staff.

On 02/12/16 at 8:32 AM AD provided the participation record for January for Resident #121. Review of this participation record

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 02/12/2016

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 248	Continued From page 14 revealed 10 entries. Only 1 time out of 10 was Resident #121 noted to be in a group activity of games and puzzles. The other 9 activities were one to one activities either reading or volunteer/guest visits.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272		3/11/16

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 02/12/2016

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 272	Continued From page 15 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to comprehensively assess and analyze triggered areas including residents' strengths, weakness and contributing factors when completing the Minimum Data Set for 2 of 24 sampled residents reviewed for quarterly assessments (Residents #46 and #58). The findings included: 1. Resident #46 was admitted to the facility on 10/06/15 with diagnoses of adult failure to thrive and a stage 4 pressure ulcer. Review of the quarterly Minimum Data Set (MDS) dated 01/06/16 revealed Resident #46 was severely cognitively impaired. The MDS further revealed Resident #46 had one stage 4 pressure ulcer. The pressure ulcer Care Area Assessment (CAA) was dated 10/14/15. The Analysis of Findings stated, "Resident triggered due to needs assist with bed mobility. Staff assists as needed. Does have assist bars on bed. Resident prefers to stay in her room, will get up to geri-chair at times. Is incontinent of bowel and bladder, wears briefs, staff provides peri-care as needed. Treatments	F 272	F272 How corrective action will be accomplished for each resident found to have been affected by the deficient practice - On to February 29, 2016, the MDSC revised resident□s # 46 Pressure Ulcer CAA to analyze the circumstances of her pressure ulcer to adequately assess Resident□s #46 individual strengths, weaknesses, and any associated causes of the pressure ulcer and effects the pressure ulcer has had on Resident # 46. On February 29, 2016, the MDSC revised resident□s # 58 Urinary Incontinence CAA to explain the causes of Resident #58□s incontinence, any history of incontinence, or any analysis of the resident□s abilities and how they impacted her continence. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: By March 11. 2016, all current residents□ most recent comprehensive MDS with an ARD of February 12, 2015 or after were reviewed to determine if the triggered Urinary	

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 02/12/2016

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 272	Continued From page 16 per MD order." The pressure ulcer CAA did not analyze the circumstances of her pressure ulcer to adequately assess Resident #46's individual strengths, weaknesses and any associated causes of the pressure ulcer and effects the pressure ulcer has had on Resident #46. During an interview conducted with the MDS Nurse on 02/12/16 at 2:36 PM she stated the pressure ulcer CAA Analysis of Findings for Resident #46 did not analyze Resident #46's strengths and weaknesses and did not address specific causes and expected outcomes for Resident #46's pressure ulcer. 2. Resident #58 was admitted to the facility on 01/21/16. Her diagnoses included hypertension, Alzheimer's disease, acute kidney failure, atrial fibrillation, anxiety disorder, and gastro-esophageal reflux disease. The admission Minimum Data Set (MDS) dated 01/28/16 coded Resident #58 with moderately impaired cognition (scoring a 9 out of 15 on the Brief Interview for Mental Status), requiring extensive assistance of 2 for toileting and being frequently incontinent of bowel and bladder. The Care Area Assessment (CAA) dated 02/01/16 for incontinence stated Resident #58 triggered due to frequently being incontinent of bladder and staff assisted with toileting and incontinence care as needed. She was noted as receiving therapy to increase level of function.	F 272	Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to urinary incontinence. Also, all current residents with a current pressure ulcer who triggered the Pressure Ulcer CAA were reviewed to ensure the CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to a pressure ulcer. Measures to be put in place or systemic changes made to ensure practice will not re-occur: On 2/29/16, the MDSC Consultant provided education to the MDSC that any Care Area Assessment including Pressure Ulcers or Urinary Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to urinary incontinence or pressure ulcer. The MDS Consultant will audit 5 residents comprehensive MDS who have a current pressure ulcer and triggered the Pressure Ulcer CAA or Urinary Incontinence CAA included documentation of findings with a description of the problem, causes, and contributing factors and risk factors related to a urinary incontinence or pressure ulcer. Any coding issue identified on the audits will be immediately corrected with coaching/discipline as needed to the MDSC. This will be accomplished 1 time a week for 4 weeks, twice a month for 1 month and monthly 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 02/12/2016

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 272	Continued From page 17 There was no other information to explain the causes of Resident #58's incontinence, any history of incontinence, or any analysis of the resident's abilities and how they impacted her continence. Interview with MDS nurse on 02/11/16 at 3:38 PM revealed she did not complete this MDS and the other MDS nurse was on vacation this date. MDS nurse was unable to explain any details about Resdient #58's incontinence and stated the incontinent CAA did not include an analysis of findings to direct the plan of care. MDS nurse was only able to say she had 2 continent episodes during the look back period but could not determine the circumstances of those events, i.e. if she requested to use the toilet or if staff just took her on rounds.	F 272	four months. The results of the audit will be reviewed by the MDSC consultant. Results of the audits and reviews to be submitted to Administrator for compliance. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Audits will be presented to QA&A for compliance and/or revision monthly for a period 6 months.	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided	F 279		3/11/16

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 02/12/2016

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 279	Continued From page 18 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to include resident specific interventions and/or measurable goals on the care plans of 6 of 12 sampled residents. Fall care plans for Residents #58 and #144 did not include specific planned interventions and activity care plans did not have measurable goals and/or or specific goals for Residents #1, #91, #121, #144 and #210. The findings included: 1. Resident #58 was admitted to the facility on 01/21/16. Her diagnoses included hypertension, Alzheimer's disease, acute kidney failure, atrial fibrillation, anxiety disorder, and gastro-esophageal reflux disease. The falls risk assessment dated 01/21/16 stated Resdient #58 tried to climb out of bed alone unsafely and was chair bound. The device assessment dated 01/21/16 noted assist bars on the bed were needed to assist with bed mobility. The admission Minimum Data Set (MDS) dated 01/28/16 coded her with moderately impaired cognition, requiring extensive assistance with bed mobility and transfers, and having one fall since admission. The care plan developed on 01/28/16 and revised on 02/01/16 identified the risk for falls related to	F 279	F279 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Specific measurable goals were added to care plan for Resident #58 and #144 for falls and residents #1, #91, #121, #144 and #210 for activity care plans. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ The Director of Nursing/Unit Manager or designee will audit all current residents for falls from 2/12/2016 and Activity Director will audit all in house residents for measurable goals by 3/11/2016 and updated appropriately. Measures to be put in place or systemic changes made to ensure practice will not Re-occur - All new admissions and readmissions will be reviewed for patient specific goals for falls and activities. The Director of Nursing/Unit Manager or designee will review the care-plan goals and interventions on new falls and Minimum Data Set Specialist or Director of Nursing will audit all care plans to ensure Goals and Interventions are	

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 02/12/2016

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 279	Continued From page 19 unsteady gait and an actual fall. The care plan interventions included to re-locate to a a high visible area. The care plan noted nothing related to chair alarms, bed alarms or floor mats. Resident #58 was observed with a bed alarm and floor mat in place during observations while she was in bed on 02/10/16 at 11:11 AM, on 02/10/16 at 2:33 PM after being assisted to bed, on 02/11/16 at 2:54 PM. The resident also had chair alarm in place when observed sitting in her wheelchair on 02/10/16 at 1:18 PM, on 02/10/16 at 2:31 PM and on 02/11/16 at 8:25 AM. On 02/11/16 at 1:19 PM the Director of Nursing stated that any nurse can add interventions to the care plan as they deem appropriate. Each fall was reviewed at morning meeting and care plans were reviewed to ensure they were updated with interventions. She further stated that she was unable to determine when the chair alarm, bed alarm and mat was added, but stated these devices were appropriate and should be on the care plan. 2. Resident #144 was admitted to the facility on 01/15/16 with diagnoses including acute kidney failure, muscle weakness, hypothyroidism, cognitive communication deficit and Alzheimer's disease. The fall risk assessment dated 01/15/16 noted Resident #144 tried to stand and walk alone, transferred unsafely and tried to climb out of bed alone unsafely. The device assessment dated 01/15/16 stated he was to have a bed alarm, chair alarm, assist bars, low bed with mats in order to protect him in the event of a fall and to alert staff of unsafe behaviors.	F 279	specific for activities during the completion of Comprehensive Assessment weekly x 8 weeks, twice a month x 4 month, and monthly x 6 on 5 residents if applicable. Any recommendations by families/resident during Comprehensive Care Plan meeting will be added to care plan. Reviewed with Activities Director and DON patient specific goals and interventions by Corporate Nurse Consultant. Corporate Nurse Consultant and Data Analyst Verification Specialist reviewed audit requirements with MDS. Audits to the Administrator for validation of completion. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur - The results of these audits will be reviewed during the Monthly QA meeting for a period of 12 months for review for compliance and revision as needed.	

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 02/12/2016

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 279	Continued From page 20	F 279		

The admission Minimum Data Set (MDS) dated 01/22/16 coded Resident #144 with severely impaired cognitive skills, requiring limited assistance with bed mobility, and extensive assistance with transfers, toileting, and hygiene. He was coded as having had a fall in the month prior to admission but no falls since admission to the facility.

The Care Area Assessment (CAA) dated 01/25/16 related to falls stated that per the discharge summary, Resident #144 had a reported fall on 12/19/15 but he had no falls since being admitted to this facility. He had personal alarms in place due to poor safety awareness, he required extensive assistance with transfers and limited assistance with ambulation due to poor turning technique and verbal cueing needed for safety.

Physician orders included a bed alarm added on 01/25/16. Physician orders did not include a chair alarm, low bed or floor mats as indicated in the 01/15/16 device assessment.

The care plan created on 02/05/16 addressed the problem Resident #144 had an actual fall (on 01/29/16) with no injury due to communication and comprehension. The goal was for the resident to resume usual activities without further incident through next review of 04/16/16. Interventions included bed alarm in place for safety awareness, continue intervention on the at-risk plan, keep environment well lit during day, monitor changes in behaviors, promote hydration, provide ambulation assistance, re-direct/provide diversional activity and re-locate to high visibility area. There was no interventions included for 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 02/12/2016

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 279	Continued From page 21	F 279		

chair alarm, mats on the floor or low bed as indicated in the 01/15/16 device assessment.

Resident #144 was observed in a wheelchair with a chair alarm in place on 02/09/16 at 1:14 PM, 02/10/16 at 9:14 AM and at 10:54 AM, on 02/11/16 at 11:38 AM, and on 02/12/16 at 9:00 AM.

Resident #144 was observed in a low bed, with a pressure alarm in place and without any floor mats in place or visible in the room on 02/09/16 at 10:20 AM as he rested on his back with his right leg hanging off the bed; on 02/10/16 at 11:43 AM; on 02/10/16 at 1:13 PM after tray had been removed; on 02/10/16 at 2:25 PM; on 02/11/16 at 8:30 AM; and on 02/11/16 at 9:48 AM as he was a little sideways in bed and scooted down in bed.

Interview with the unit manager on 02/12/16 at 11:45 AM revealed the nurse aides would know the individual care needs of a resident via the kardex in the kiosk. A copy of this revealed intervention under safety was encourage resident to use bell to call for assistance and under monitors was a bed alarm in place for safety awareness. There was no directive for fall mats.

Interview with the Director of Nursing (DON) on 02/12/16 at 1:37 PM revealed any nurse can update care plans with interventions. All falls were reviewed in morning meeting and at weekly fall meetings. At that time the care plan should be reviewed to ensure planned interventions were included on the care plan. The DON stated Resident #144 should have chair alarm, bed alarm and fall mats in place and these should be on the care plan.

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 02/12/2016

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 279	Continued From page 22	F 279		

Interview with Nurse Aide #6 on 02/12/16 at 2:03 PM revealed she knew what to do for residents based on directions from nursing staff and the kiosk information.

3. Resident #144 was admitted to the facility on 01/15/16 with diagnoses including acute kidney failure, muscle weakness, hypothyroidism, cognitive communication deficit and Alzheimer's disease.

The admission Minimum Data Set (MDS) dated 01/22/16 coded Resident #144 with severely impaired cognitive skills and having preferences related to books and newspapers, animals, keeping up with the news, being with groups of people, doing favorite activities and religious activities being very important to him.

The activity care plan developed 01/19/16 identified the problem of alteration of prior leisure routines to continue life-long interests and preferences due to recent hospital stay and need for short term rehab. The goals were:
*attain or maintain the highest practicable well being;
*enhance quality of life, community involvement, and sense of belonging; and
*use leisure time constructively and consistently with former life style and life roles.

Interview with the Activity Director (AD) on 02/12/16 at 9:33 AM revealed she determined residents' preferences when she interviewed them when she completed the admission MDS. She stated the computer system allowed her to pick goals and individualize the interventions. The AD was unable to explain how the goals listed were measurable, just stating 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 02/12/2016

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 279	Continued From page 23	F 279		

would participate to the best of their ability. She could not explain how she would measure if the goals were being met. She stated she used to have goals that were measurable just as participating in activities three times a week until the facility went to the new computer system. She stated she had found out that her corporate supervisor could add goals that were measurable from which she could choose the appropriate goal.

4. Resident #121 was admitted to the facility on 12/03/15. Her diagnoses included hypertension, diabetes, hyperlipidemia, depression and left hip pain.

The admission Minimum Data Set (MDS) dated 12/09/15 coded her as having intact cognition, scoring a 14 out of 15 on the Brief Interview for Mental Status, being nonambulatory, and needing extensive assistance with locomotion. Under preferences on the MDS, she indicated that books, music, new, participating in favorite activities were very important to her. She further indicated that animals were somewhat important.

A care plan was developed on 12/10/15 for activities. The care plan addressed the problem that the resident had an alteration of prior leisure routines to continue lifelong interests and preferences due to a recent hospital stay with a need for short term rehabilitation. The goals on the care plan included:
*to attain or maintain her highest practical well being;
*to enhance her quality of life, community involvement, sense of belonging; and
*to use leisure time constructively and consistently with former life style and life roles.

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 02/12/2016

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 279	Continued From page 24	F 279		

The interventions included:
*to provide an opportunity for decision making, self expression and creative expression;
*to provide meaningful involvement and a sense of purpose;
*to provide ongoing structured activity program to increase interaction, cooperation, and socialization with peers.

The Activity Director (AD) was interviewed on 02/11/16 at 4:55 PM. She stated Resident #121 had a family member visit almost daily. She also stated she determined residents' preferences when she interviewed them when she completed the admission MDS. She stated the computer system allowed her to pick goals and individualize the interventions. The AD was unable to explain how the goals listed were measurable, just stating the resident would participate to the best of their ability. She stated that the care plan for Resident #121 was not personalized to her interests which she normally listed preferences under interventions. On follow up interview on 02/12/16 at 8:32 AM, the AD stated that she used to have goals that were measurable just as participating in activities three times a week until the facility went to the new computer system and that she had found out that her corporate supervisor could add goals that were measurable from which she could choose the appropriate goal.

5. Resident #210 was admitted to the facility on 01/21/16 with diagnoses including acute cystitis, bone marrow disease and hypercalcemia.

The admission Minimum Data Set dated 01/28/16 coded her with intact cognition, with interests of music, animals and being with groups of people being very important to 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 02/12/2016

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 279	Continued From page 25	F 279		

An activity care plan was developed on 02/02/16 with identified the problem of alteration of prior leisure routines to continue life long interests and preferences due to recent hospitalization and need for short term rehab. The goals included:
*attain or maintain the highest practical well being
*enhance quality of life,community involvement and sense of belonging;
*use leisure time constructively and consistently with former life style and life roles.

Interview with the Activity Director (AD) on 02/11/16 at 4:55 PM revealed she determined residents' preferences when she interviewed them when she completed the admission MDS. She stated the computer system allowed her to pick goals and individualize the interventions. The AD was unable to explain how the goals listed were measurable, just stating the resident would participate to the best of their ability. On follow up interview on 02/12/16 at 8:32 AM, the AD stated that she used to have goals that were measurable just as participating in activities three times a week until the facility went to the new computer system and that she had found out that her corporate supervisor could add goals that were measurable from which she could choose the appropriate goal.

6. Resident #1 was admitted to the facility on 11/22/05.

Review of the annual Minimum Data Set (MDS) dated 09/08/15 revealed Resident #1 cognition was moderately impaired. The annual MDS indicated Resident #1 was interviewed regarding

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 02/12/2016

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 279	Continued From page 26	F 279		

her activity preferences and stated listening to music she liked, doing things with groups of people, participating in favorite activities, and participating in religious services or practices were very important to her.

Review of an activity annual review completed by the Activity Director (AD) on 09/08/15 revealed Resident #1 was alert and oriented to self, staff, and family. The AD noted Resident #1 was involved in cavities daily including socials, musicals, and religious programs. The activity annual review further revealed Resident #1 loved to sing daily and listened to television with her roommate.

Review of the activity care plan developed on 04/01/14 revealed Resident #1 had an alteration of prior leisure routines to continue life-long interests and preferences due to total care patient with all activities of daily living. The goal was for Resident #1 to attain or maintain the highest practical well being. Interventions included: provide accommodations related to total care for all activities of daily living (ADL), provide an opportunity for decision making, self expression, creative expression, provide meaningful involvement and sense of purpose, and provide ongoing structured activity program to increase interaction, cooperation, and socialization with peers.

An interview was conducted with the Activity Director (AD) on 02/12/16 at 8:28 AM. The AD stated she determined residents' activity preferences when she interviewed them for their MDS assessments. The AD reviewed Resident #1's activity care plan during the interview and confirmed the care plan did not have measurable

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 02/12/2016

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 279	Continued From page 27	F 279		

goals or resident specific interventions. The interview further revealed the facility went to an electronic medical record three years ago and she had been utilizing the care plans available in this computer system since that time.

7. Resident #91 was admitted to the facility on 01/09/14 with diagnoses of hypertension, anxiety and depression.

Review of the annual Minimum Data Set dated 12/01/15 revealed Resident #91 was severely cognitively impaired with preferences related to listening to music, participating in favorite activities and participating in religious activities or practices.

Review of the activity care plan dated 12/15/16 revealed Resident #91 had an alteration of prior leisure routines to continue life-long interests and preferences due to total care patient with activities of daily living (ADL). The goal was for Resident #91 to attain or maintain the highest practical well-being. Interventions included providing accommodations related to total care for all ADL, provide an opportunity for decision making, self-expression, creative expression, provide meaningful involvement and sense of purpose and provide ongoing structured activity program to increase interaction, cooperation and socialization with peers.

An interview was conducted with the Activity Director (AD) on 02/12/16 at 8:28 AM. The AD stated she determined residents' activity preferences when she interviewed them for their MDS assessments. The AD reviewed Resident #91's activity care plan during the interview and confirmed the care plan did not have measurable

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 02/12/2016

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 279	Continued From page 28 goals or resident specific interventions. The interview further revealed the facility went to an electronic medical record three years ago and she had been utilizing the care plans available in this computer system since that time.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the nutritional plan of care with the intervention of a magic cup supplement for 1 of 5 residents reviewed for nutrition (Resident #58).	F 280	F280 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: Care plan was updated for resident #58 on 3/3/16 to reflect	3/11/16

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 02/12/2016

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 280	Continued From page 29 The findings included: Resident #58 was admitted to the facility on 01/21/16. Her diagnoses included hypertension, Alzheimer's disease, acute kidney failure, atrial fibrillation, anxiety disorder, and gastro-esophageal reflux disease. The computer's Weight Record, Resident #58 weighed 127.4 pounds on 01/21/16. The admission Minimum Data Set (MDS) dated 01/28/16 coded Resident #58 with moderately impaired cognition (scoring a 9 out of 15 on the Brief Interview for Mental Status). She required extensive assistance for eating. She received a mechanical diet and therapeutic diet. She weighed 127 pounds. The nutrition Care Area Assessment (CAA) dated 01/29/16 indicated she was on a heart healthy pureed diet, was consuming 25 to 75 percent of her meals and had Boost (a nutritional supplement) ordered three times a day. The CAA stated the Boost would be changed to Ensure Plus (a nutritional supplement) which was more readily available in the facility. A nutrition note dated 01/29/16 at 10:21 AM noted the Boost supplement was going to be changed to Ensure Plus as it was more readily available. Another nutrition note dated 01/29/16 at 10:50 AM stated the resident was also receiving magic cups twice daily for weight maintenance. A care plan was developed on 01/28/16 and revised on 01/29/16 for the problem of Resident #58 being at risk for weight fluctuation related to recent hospitalization, recent admission to the	F 280	supplement intervention. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice : A review of nutrition related care plans for all patients receiving supplements was completed 3/4/16 Corporate Dieticians and care plans were updated to indicate supplement intervention as needed. Measures to be put in place or systemic changes made to ensure practice will not Re-occur: Dietary Manager is responsible for updating care plans and was in-serviced on how to and importance of updating care plans to reflect current interventions. Current in-houses nurses educated on Dietary Communication slips to assist with tray accuracy. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: A nutritional care plan audit will be completed once a week for 4 week then once month x 2 months by Corporate Dietitian and results reported to Administrator to ensure care plans are kept up to date to reflect current interventions. After initial audit period, care plans will be audited quarterly x 6 months to ensure 100% accuracy, then thereafter as needed as part of routine corporate oversight visits. The results of the audits will be presented to QA monthly for a period of 6 months to ensure continued compliance and revision if needed.	

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 02/12/2016

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 280	Continued From page 30	F 280		

center and fluctuating intake. The goal was "Will avoid significant weight change through next review" with a target date of 05/01/16. Interventions included to provide diet as ordered, monitor intake and record each meal, offer substitute when intake is less than 50 percent and weekly weights. The magic cup and Ensure were not specified on the care plan as interventions.

Observations of Resident #58's meal trays revealed no magic cup was included on her meal tray on 02/10/16 at 12:45 PM while in the dining room. On 2/11/16 at 8:25 AM and on 02/11/16 at 1:17 PM while eating in her room there was no magic cup served on her tray.

On 02/11/16 at 12:22 PM Nurse #2 stated that if there was an order for a supplement, a communication slip would be sent to the dietary department. Nursing was responsible for providing and documenting liquid supplements, i.e. Ensure and the kitchen was responsible for sending magic cups out on the resident's tray. A follow up interview with Nurse #2 on 02/11/16 at 2:50 PM revealed she did not provide magic cups and it was not located on the Medication Administration Record as being provided by nursing. Nurse #2 reviewed the physician order and stated that the RD noted as an addition to the diet order that Resident #53 should get a magic cup with lunch and dinner meals which started on 01/29/16.

On 02/11/16 at 3:55 PM RD was interviewed. RD stated interventions to address weight concerns identified during weight committee meetings were added to the meal ticket, usually by himself and the supplement portion of the diet order in 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 02/12/2016

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 280	Continued From page 31 computer. RD further stated that the supplements and magic cup would not necessarily be added to the care plan due to being a physician's order. Interview with the Director of Nursing on 02/11/16 at 4:16 PM revealed she expected supplements such as magic cups and Ensure to be added as interventions on the care plan.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and family and staff interviews the facility failed to follow the care plan for 1 of 23 reviewed resident care plans (Resident #91). The findings included: Resident #91 was admitted to the facility on 01/09/14 with diagnoses of anemia, hypertension, anxiety and depression. Review of the annual Minimum Data Set (MDS) dated 12/01/15 revealed Resident #91 was severely cognitively impaired and required extensive assistance with bed mobility, transfers, toileting and personal hygiene. Review of the care plan dated 12/08/15 revealed	F 282	F282 How corrective action will be accomplished for each resident found to have been affected by the deficient practice □ Resident #91 was offered a shower and preference reviewed with him upon notification to ensure preferences were met. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice □ All in house Residents were interviewed to find out preference for showers and get-up time were completed by March 11, 2016 PCC and Care Plan updated and completed by March 11, 2016, by Unit Manager and DON. Measures to be put in place or systemic	3/11/16

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 02/12/2016

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 282	Continued From page 32 Resident #91 had an activity of daily living (ADL) self-care performance deficit related to generalized muscle weakness, cognitive impairment and impaired vision. The goal was patient's basic care needs will be maintained through next review. The interventions included AM routine: allow resident to choose her time of arising and routine care for AM. Observations made of Resident #91 revealed the following: · 02/09/16 at 9:40 AM - observed Resident #91 sitting in her wheelchair, slumped over with her eyes closed at the nurse's desk. · 02/10/16 at 8:30 AM - observed Resident #91 sitting in her wheelchair with her eyes closed at the nurse's desk. · 02/11/16 at 9:00 AM - observed Resident #91 sitting in her wheelchair at the nurse's desk with her eyes closed. During an interview with Resident #91's Responsible Party (RP) on 02/09/16 at 12:14 PM she stated she had asked the facility numerous times not wake Resident #91 up early because she hated to get up early. She stated staff explained to her they had to get Resident #91 out of bed early because they had a lot of residents to get up and ready for breakfast. An interview conducted with nurse aide (NA) #5 on 02/11/16 at 11:44 AM revealed the 11:00 PM to 7:00 AM shift NAs get Resident #91 up around 6:00 to 6:30 AM every morning. She stated she was not aware Resident #91's care plan stated to allow Resident #91 to choose her time of arising and routine care for AM because it was not on her kardex, a list of resident specific interventions for NAs to follow for resident care.	F 282	changes made to ensure practice will not re-occur- Choices will be care planned and notated in Point of Care Tasks for CNA to ensure choices are followed. Nurses and CNA□s were in-serviced by Director of Nursing/SDC or designee on making sure resident□s choice of showers and get-up times are honored and put in the CNA task to match resident desire and completed by March 11, 2016. DON, Unit Manager or Designee will complete an audit of new residents admitted to the facility to ensure that their shower preferences and get up times have been acknowledged and scheduled. Any deviations from the preference sheet not being completed will result in re-education/disciplinary action. This audit will be completed daily (Monday-Friday) x4 weeks for new admission, twice a week for 6 new admits if applicable x2 months and monthly 6 admits for 3 months. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur- All audits will be presented to the QA Committee monthly x6 to ensure continued compliance and revisions to the plan if needed.	

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 02/12/2016

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 282	Continued From page 33 An interview conducted with NA #3 on 02/12/16 at 2:46 PM revealed the 11:00 PM to 7:00 AM NAs always had Resident #91 out of bed and dressed when she came in at 7:00 AM to begin her shift. She stated she was not aware Resident #91's care plan stated to allow her to choose her time of arising in the AM because it was not on her kardex. During an interview conducted with the Director of Nursing (DON) on 02/12/16 at 4:30 PM she revealed she was not aware Resident #91's RP had made requests for Resident #91 not be gotten out of bed early. She also stated she was not aware Resident #91's care plan stated to allow Resident #91 to choose her time of arising and routine care in the AM. The DON stated it was her expectation that the care plan be followed for Resident #91.	F 282		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews the facility failed to provide nail care to 3 of 6 dependent residents reviewed for activities of daily living (Residents #80, #176, and #212).	F 312	F312 How the corrective action will be accomplished for those residents affected: Resident #80, #176, and #212 were provided nail and foot care. How the corrective action will be	3/11/16

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 02/12/2016

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 312	Continued From page 34 The findings included: 1. Resident #80 was readmitted on 01/22/15 with diagnoses including diabetes mellitus, arthritis, and cerebrovascular accident (CVA). Review of an annual Minimum Data Set (MDS) 09/11/15 revealed Resident #80's cognition was intact and she was able to make her needs known. The annual MDS noted Resident #80 required extensive assistance with personal hygiene and had an upper extremity impairment on one side that interfered with daily functioning. The annual MDS further revealed Resident #80 did not reject evaluation or care. Review of the Care Area Assessment (CAA) Summary for Activities of Daily Living (ADL) dated 09/11/15 revealed Resident #80 had resided at the facility since March 2012 and required extensive assistance with bed mobility, transfers, toilet use, locomotion, and dressing due to muscle weakness. Review of a care plan revised on 12/08/15 revealed Resident #80 had an ADL self-care performance deficit related to CVA and muscle weakness. Interventions included to assist Resident #80 with personal hygiene and grooming as needed. Observations of Resident #80's fingernails during the resident interview conducted on 02/09/16 at 9:45 AM revealed brown debris was noted under all 10 fingernails. Resident #80 stated if she could get an orange stick she would try to clean under her fingernails herself. Review of a document titled "Shower/Skin	F 312	accomplished for those residents with the potential to be affected by the same practice: The DON and SDC educated all Nurses and Certified Nursing Assistants on finger nail and toe trimming and care. Residents in-house were examined by DON and Unit Manager to ensure no other residents needed attention to their nails. Measure in place to ensure practices will not occur: SDC to educate all new hires on performing nail care and foot care twice a week on Sundays and Wednesdays and bath and shower days as needed. The Certified Nursing Assistants will perform finger nail and toe nail clipping and cleaning twice a week on patients that are not diabetic on Sundays and Wednesdays. Diabetic patients will be examined and nail care (clipped and cleaned) provided by the Licensed staff on Sundays and Wednesdays, all patients that cannot be safely trimmed will be referred to the Podiatrist. Currently CNA□s are documenting finger and toenail care on an audit tool indicating the task has been completed and licensed nurses are verifying completion and signing the audit tool for accountability. Unit Manager will verify task has been completed on 8 random residents weekly for period of 16 weeks and then monthly for 6 months. Audits will be turned into Administrator to ensure completion. The Unit Manager will audit weekly times eight weeks then monthly thereafter. How the facility plans to monitor and ensure correction is achieved and sustained: The Administrator will bring	

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 02/12/2016

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 312	Continued From page 35 Inspection Record" dated 02/09/16 revealed Nurse Aide (NA) #2 had given Resident #80 a bed bath and indicated nail care had been completed. Observations of Resident #80's fingernails on 02/10/16 at 9:13 AM revealed brown debris was noted under all 10 fingernails. An interview with NA #1 on 02/10/16 at 11:06 AM revealed he checked residents' fingernails daily while providing care and cleaned and trimmed their nails as needed. Observations of Resident #80's fingernails on 02/11/16 at 11:22 AM revealed brown debris was noted under all 10 fingernails. Resident #80 stated she had a good bed bath earlier but still needed her fingernails cleaned. Observations of Resident #80's fingernails on 02/12/16 at 9:52 AM revealed brown debris was noted under the nail of her index, middle, and ring finger on her right hand. Brown debris was also noted under her thumb and pinky fingernail on her left hand. Resident #80 pointed at an orange stick on her overbed table and stated a staff member had brought her the orange stick yesterday and she had been working on her fingernails. An interview was conducted with NA #2 on 02/12/16 at 1:03 PM. During the interview NA #2 stated she usually cleaned and trimmed residents' fingernails on shower days. NA #2 confirmed she had given Resident #80 a bed bath on 02/09/16 because Resident #80 preferred bed baths to showers. NA #2 further stated she did not notice if there was debris under Resident	F 312	audits to QA&A monthly for 12 months to review for compliance and revision as needed.	

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 02/12/2016

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 312	Continued From page 36	F 312		

#80's fingernails during the bed bath because Resident #80 had washed her own hands.

An interview with NA #3 on 02/12/16 at 2:35 PM NA #3 revealed she had given Resident #80 a full bed bath earlier that day but Resident #80 did not want anything done to her fingernails because her fingers were sensitive at times.

During an interview on 02/12/16 at 2:35 PM Resident #80 stated she did not refuse to have her fingernails cleaned that morning. Resident #80 further stated an NA told her that morning she was going to soak Resident #80's fingernails in soap and water but had not come back to do this.

An interview with the Director of Nursing (DON) on 02/12/16 at 3:21 PM revealed she expected NAs to check residents' fingernails daily and clean and trim as needed. The DON further stated she would not expect Resident #80 to clean her own fingernails.

2. Resident #212 was admitted to the facility on 12/31/15 with diagnoses of atrial fibrillation, muscle weakness and difficulty walking.

Review of the admission Minimum Data Set dated 01/07/16 revealed Resident #212 was cognitively intact and required extensive assistance with personal hygiene and bathing.

Review of the care plan dated 01/08/16 revealed Resident #212 had an activity of daily living self-care deficit related to fatigue. The goal was for Resident #212 to maintain his current level of function through the next review date. Interventions included assistance as needed with

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 02/12/2016

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 312	Continued From page 37	F 312		

dressing, eating, toileting, personal hygiene and oral care.

Observations of Resident #212 fingernails revealed the following:
· 02/09/16 at 9:16 AM - Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/10/16 at 1:19 PM - Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/11/16 AT 9:47 AM - Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.
· 02/12/16 at 8:58 AM - Fingernails on both hands were approximately ¼ inch long with brown debris under all fingernails.

During an interview 02/09/16 at 9:16 AM Resident #212 stated staff gave him a bed bath every morning but they had not cleaned or trimmed his fingernails since he had been admitted to the facility. He stated he did not like his fingernails to be dirty and they were too long.

An interview with nurse aide (NA) #1 on 02/12/16 at 9:35 AM revealed nail care was provided during showers and as needed.

An interview conducted with the Unit Manager on 02/12/16 at 9:39 AM revealed she expected nail care to be provided during showers and as needed. The Unit Manager was accompanied to Resident #212's room on 02/12/16 at 9:40 AM to observe resident fingernails and confirmed fingernails should have been cleaned and trimmed.

During an interview conducted on 02/12/16 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 02/12/2016

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 312	Continued From page 38	F 312		

4:13 PM the Director of Nursing stated it was her expectation for nail care to be performed with showers and as needed.

3. Resident #176 was admitted to the facility on 01/20/16 with diagnoses of hip fracture and non-Alzheimer's dementia.

Review of the admission Minimum Data Set (MDS) dated 01/20/16 revealed Resident #176 was moderately cognitively impaired and required extensive assistance with personal hygiene and bathing.

Review of the care plan dated 01/26/16 revealed Resident #176 had an activity of daily living (ADL) self-care performance deficit. The goal was for Resident #176 to have increased independence with ADL and return home by the next review. Interventions included assist as needed with bathing and showering, assist as needed with personal hygiene.

Observations made on 02/09/16 at 9:35 AM revealed Resident #176's toenails on both feet to be jagged and approximately a ¼ inch long.

An interview conducted with Resident #176 on 02/09/16 at 9:36 AM revealed she received a bath twice a week but staff had never offered to trim her toenails. Resident #176 stated her toenails were too long and it hurt to put her tennis shoes on at times. She stated she would like her toenails to be trimmed.

An interview with nurse aide (NA) #1 on 02/12/16 at 9:35 AM revealed nail care was provided during showers and as needed.

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 02/12/2016

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 312	Continued From page 39 An interview conducted with the Unit Manager on 02/12/16 at 9:39 AM revealed she expected nail care to be provided during showers/baths and as needed. The Unit Manager was accompanied to Resident #176's room on 02/12/16 at 9:50 AM to observe resident toenails and confirmed they should have been and trimmed. During an interview conducted on 02/12/16 at 4:13 PM the Director of Nursing stated it was her expectation for nail care to be performed with showers and as needed.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide planned interventions for 1 of 5 sampled residents with histories of falls (Resident #144). The findings included: Resident #144 was admitted to the facility on 01/15/16 with diagnoses including acute kidney failure, muscle weakness, hypothyroidism, cognitive communication deficit and Alzheimer's disease.	F 323	F323 How corrective action will be accomplished for each resident found to have been affected by the deficient practice –Resident #144 fall intervention, care-planned and verified in place and on Kardex. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice – The Director of	3/11/16

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 02/12/2016

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 323	Continued From page 40 The fall risk assessment dated 01/15/16 noted Resident #144 tried to stand and walk alone, transferred unsafely and tried to climb out of bed alone unsafely. The device assessment dated 01/15/16 stated he was to have a bed alarm, chair alarm, assist bars, low bed with mats in order to protect him in the event of a fall and to alert staff of unsafe behaviors. The admission Minimum Data Set (MDS) dated 01/22/16 coded Resident #144 with severely impaired cognitive skills, requiring limited assistance with bed mobility, and extensive assistance with transfers, toileting, and hygiene. He was coded as having had a fall in the month prior to admission but no falls since admission to the facility. The Care Area Assessment (CAA) dated 01/25/16 related to falls stated that per the discharge summary, Resident #144 had a reported fall on 12/19/15 but he had no falls since being admitted to this facility. He had personal alarms in place due to poor safety awareness, he required extensive assistance with transfers and limited assistance with ambulation due to poor turning technique and verbal cueing needed for safety. Physician orders included a bed alarm added on 01/25/16. Physician orders did not include a chair alarm, low bed or floor mats as indicated in the 01/15/16 device assessment. Review of progress notes revealed on 01/29/16 at 2:36 PM, Resident #144 was found sitting on the	F 323	Nursing/Unit Manager or designee will audit all current residents to determine that fall interventions are implemented appropriately by 3/11/2016 Measures to be put in place or systemic changes made to ensure practice will not re-occur - Staff Nurses in-serviced on adding interventions to care plan, by 3/11/2016, by SDC/DON. SDC will educate all new staff on care planning interventions and updating device assessment after falls. A fall risk assessment and device assessment will be completed on all new admissions and readmissions. The DON/Unit Manager or designee will review for completion and revisions as needed weekly times 6 weeks then monthly thereafter to ensure interventions are in place.. Daily Monday through Friday DON and Unit Manager will review incident reports to ensure that interventions are appropriate, device assessment completed and interventions put on care plan and implemented. The Director of Nursing/Unit Manager or designee will audit resident records of 5 residents who experience a fall or residents with no fall that have interventions on care plan to ensure interventions are care planned, device assessment completed and device is implemented and intervention is in place for resident - daily (Monday – Friday) x 2 weeks, weekly x 2 weeks, twice a month x 1 month, and monthly x 3. Audits will be completed and turned in to Administrator to ensure compliance.	

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 02/12/2016

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 323	Continued From page 41 floor beside his wheelchair. Review of the incident report revealed no indication that an alarm was in place or sounding. The Post Fall Assessment dated 01/29/16 noted education was provided on using call light. Interview with Nurse #2 on 02/11/16 at 2:04 PM revealed she recalled the alarm was not sounding when she responded to Resident #144 being on the floor on 01/29/16. She stated that either therapy or the family had left the resident without attaching the alarm to him. There was no indication that re-education was provided to therapy or family. The care plan created on 02/05/16 addressed the problem Resident #144 had an actual fall with no injury due to communication and comprehension. The goal was for the resident to resume usual activities without further incident through next review of 04/16/16. Interventions included bed alarm in place for safety awareness, continue intervention on the at-risk plan, keep environment well lit during day, monitor changes in behaviors, promote hydration, provide ambulation assistance, re-direct/provide diversional activity and re-locate to high visibility area. There was no interventions included for a chair alarm, mats on the floor or low bed as indicated in the 01/15/16 device assessment. An incident report dated 02/09/16 at 9:30 PM revealed Resident #144 was found on the floor. The resident stated he was trying to see some people which was why he got out of bed. The report indicated a "fall" alarm was in use but did not address the presence of a floor mat. Interview with Nurse #3 on 01/12/16 at 2:30 PM via phone revealed Nurse #3 recalled the alarm was sounding but she could not recall seeing a floor mat when she responded to this fall.	F 323	How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur- The results of these audits will be reviewed in Monthly QA X 12 months for review for continued compliance and revision as needed.	

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 02/12/2016

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 323	Continued From page 42 Resident #144 was observed in bed without any floor mats in place or visible in the room on 02/09/16 at 10:20 AM as he rested on his back with his right leg hanging off the bed; on 02/10/16 at 11:43 AM; on 02/10/16 at 1:13 PM after tray had been removed; on 02/10/16 at 2:25 PM; on 02/11/16 at 8:30 AM; and on 02/11/16 at 9:48 AM as he was a little sideways in bed and scooted down in bed. Interview with the unit manager on 02/12/16 at 11:45 AM revealed the nurse aides would know the individual care needs of a resident via the kardex in the kiosk. A copy of this revealed intervention under safety was encourage resident to use bell to call for assistance and under monitors was a bed alarm in place for safety awareness. There was no directive for fall mats. Interview with the Director of Nursing (DON) on 02/12/16 at 1:37 PM revealed any nurse can update care plans with interventions. Each fall was reviewed in morning meetings to ensure interventions were in place and at weekly meeting the falls are reviewed again to ensure interventions are care planned and in place. Regarding the 01/29/16 fall, DON stated there was not enough information on the incident report and she gave it back to the nurse today for more information such as alarm usage. The DON stated Resident #144 should have chair alarm, bed alarm and fall mats in place and these should be on the care plan. She further stated the fall on 02/09/16 had not been reviewed in the weekly meeting yet.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		3/11/16

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 02/12/2016

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 325	Continued From page 43 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide a supplement (magic cup) which was planned to help prevent weight loss to 1 of 5 sampled residents reviewed for weight loss (Resident #58). The findings included: Resident #58 was admitted to the facility on 01/21/16. Her diagnoses included hypertension, Alzheimer's disease, acute kidney failure, atrial fibrillation, anxiety disorder, and gastro-esophageal reflux disease. The computer's Weight Record, Resident #58 weighed 127.4 pounds on 01/21/16. The admission Minimum Data Set (MDS) dated 01/28/16 coded Resident #58 with moderately impaired cognition (scoring a 9 out of 15 on the Brief Interview for Mental Status). She required extensive assistance for eating. She received a	F 325	F325 How corrective action will be accomplished for each resident found to have been affected by the deficient practice - Menu Management profile for Resident #58 was updated on 2/11/16 to correctly reflect supplements given at meal time. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice - A review of menu management profiles for all patients receiving supplements was completed 3/3/16 to ensure supplements are correctly indicated on all menu tickets. Measures to be put in place or systemic changes made to ensure practice will not re-occur - Dietary staff was in-serviced on 3/4/16 regarding importance of reading menu tickets and providing food/supplement items indicated on meal trays.	

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 02/12/2016

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 325	Continued From page 44 mechanical diet and therapeutic diet. She weighed 127 pounds. The nutrition Care Area Assessment (CAA) dated 01/29/16 indicated she was on a heart healthy pureed diet, was consuming 25 to 75 percent of her meals and had Boost (a nutritional supplement) ordered three times a day. The CAA stated the Boost would be changed to Ensure Plus (a nutritional supplement) which was more readily available in the facility. A nutrition note dated 01/29/16 at 10:21 AM noted the Boost supplement was going to be changed to Ensure Plus as it was more readily available. Another nutrition note dated 01/29/16 at 10:50 AM stated the resident was also receiving magic cups twice daily for weight maintenance. A care plan was developed on 01/28/16 and revised on 01/29/16 for the problem of Resident #58 being at risk for weight fluctuation related to recent hospitalization, recent admission to the center and fluctuating intake. The goal was "Will avoid significant weight change through next review" with a target date of 05/01/16. Interventions included to provide diet as ordered, monitor intake and record each meal, offer substitute when intake is less than 50 percent and weekly weights. The computer's Weight Record, Resident #58 weighed 117.4 pounds on 02/04/16. A physician's progress note dated 02/08/16 noted Resident #58 had significant weight loss since admission and Registered Dietician (RD) was to evaluate. A nursing fax communication dated 02/08/16 noted the Registered Dietician (RD) was	F 325	How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur - A nutritional supplement audit will be completed once a week for 4 week then once month x 2 months by Corporate Dietitian or Designee and results reported to Administrator. After initial audit period, patients receiving supplements will be audited quarterly x 6 months to ensure 100% accuracy, then thereafter as needed as part of routine corporate oversight visits. The results of the audits will be presented to QA monthly for a period of 6 months to ensure continued compliance and revision if needed.	

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 02/12/2016

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 325	Continued From page 45	F 325		

to evaluate due to resident's weight of 117.4 pounds with significant weight loss since admission. The note indicated the resident was currently on Ensure three times a day and magic cup twice a day.

Observations of Resident #58's meal trays revealed no magic cup was included on her meal tray on 02/10/16 at 12:45 PM while in the dining room. On 2/11/16 at 8:25 AM and on 02/11/16 at 1:17 PM while eating in her room there was no magic cup served on her tray.

On 02/11/16 at 12:22 PM Nurse #2 stated that if there was an order for a supplement, a communication slip would be sent to the dietary department. Nursing was responsible for providing and documenting liquid supplements, i.e. Ensure and the kitchen was responsible for sending magic cups out on the resident's tray. A follow up interview with Nurse #2 on 02/11/16 at 2:50 PM revealed she did not provide magic cups and it was not located on the Medication Administration Record as being provided by nursing. Nurse #2 reviewed the physician order and stated that the RD noted as an addition to the diet order that Resident #53 should get a magic cup with lunch and dinner meals which started on 01/29/16.

On 02/11/16 at 3:55 PM RD was interviewed. RD stated interventions to address weight concerns identified during weight committee meetings were added to the meal ticket, usually by himself and the supplement portion of the diet order in the computer. RD reviewed the diets in the computer and noted magic cups were ordered via the computer on 01/26/16. However, on 02/03/16 the computer booted Resident #53 out of the system

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 02/12/2016

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 325	Continued From page 46 and then within a few minutes added her back into the system. This was done automatically but RD could not figure out why. When the computer booted her off the system, it appeared the magic cup was dropped from the tray card system therefore, she had not been receiving the magic cup since 02/03/16 as it was not on the tray card to alert dietary staff to include it on her meal trays twice a day. Review of the tray card at this time revealed no magic cup was listed to be placed on her tray twice a day. On 02/12/16 at 111:56 AM the Dietary Manager stated that magic cups would be sent from the kitchen on the trays per the diet list and tray cards. Resident #58's diet per the diet list provided by the facility did not include any supplements including the magic cup.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		3/11/16

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 02/12/2016

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 329	Continued From page 47 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and pharmacist interviews the facility failed to document monitoring for potential adverse side effects of an antipsychotic medication for 1 of 5 sampled residents reviewed for unnecessary medications (Resident #58). The findings included: Resident #58 was admitted on 01/2/16 with diagnoses including Alzheimer's disease and anxiety disorder. Review of the admission Minimum Data Set (MDS) dated 01/28/16 revealed Resident #58's cognition was moderately impaired. The admission MDS noted Resident #58 had received an antipsychotic medication daily and an antianxiety medication one day during the last 7 days. Review of the Care Area Assessment (CAA) Summary for Psychotropic Drug Use dated 01/28/16 revealed the area triggered due to receiving an antipsychotic medication (Seroquel) and an antianxiety medication (Xanax) per the physician's order for insomnia and anxiety. The CAA Summary noted psychotropic drug use	F 329	F329 How the corrective action will be accomplished for the residents affected: The Director of Nursing initiated behavior monitoring for resident #58. How the corrective action will bae accomplished for those residents with the potential to be affected by the same practice: The Unit Manager, Director of Nursing will audit all residents on anti-psychotic medications to ensure behavior monitoring is updated and entered if appropriate. Measures in place to ensure practices will not occur: Licensed nurses were in-serviced by SDC/DON on putting behavior monitoring in PCC in the MAR when an antipsychotic medication is utilized. For an antipsychotic medication monitoring needs to be placed in PCC in the MAR to Monitor for Behavior, Side Effect Monitoring also needs to be implemented. The Unit Manger will review all new admissions for antipsychotic medications to ensure behavior monitoring is on the MAR. The Unit Manager will perform an audit weekly to ensure behavior monitoring is in place	

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 02/12/2016

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 329	Continued From page 48 would be combined with Resident #58's fall care plan to monitor for signs and symptoms of adverse reactions. Review of medical record revealed physician's admission orders dated 01/21/16 which included an order for Seroquel 25 mg (milligrams) by mouth at bedtime for insomnia. On 01/25/16 an order was written to decrease the dosage of the Seroquel to 12.5 mg at bedtime for insomnia. Further review of the medical record including nurse's notes, assessments, and Medication Administration Records (MARs) from 01/26/16 through 02/12/16 revealed no documentation of monitoring Resident #58 for adverse side effects or movement disorder due to the administration of antipsychotic medications. Review of a pharmacy communication dated 01/29/16 revealed the Pharmacist recommended the Seroquel be discontinued if it was prescribed solely for insomnia. The Nurse Practitioner documented on the communication form that a gradual dose reduction was started on 01/25/16. Continued review of the medical record revealed the physician discontinued the Seroquel on 02/10/16. An interview with Director of Nursing (DON) on 02/12/16 at 9:38 AM revealed when a resident was admitted with or ordered an antipsychotic medication she or the unit managers entered the monitoring for these medications on the residents' electronic MAR. The DON explained the nurses were required to document on the electronic MAR every shift whether or not they observed any adverse side effects and document in their	F 329	for residents receiving antipsychotic medications weekly times three months then monthly thereafter for a period of 9 months. The audits will be given to the Administrator to ensure compliance. How facility will monitor corrective action(s) to ensure deficient practice will not Re-occur: The results of the audits will be presented to QA monthly for a period of 12 months to ensure continued compliance and revision if needed.	

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 02/12/2016

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 329	Continued From page 49 nursing progress notes as needed. During an interview on 02/12/16 at 3:54 PM the Pharmacist stated the facility documented monitoring for adverse side effects of antipsychotic medications on the MAR and he typically reviewed residents' MARs for monitoring of antipsychotic medication when he completed his monthly review. A follow up interview was conducted with the DON on 02/12/16 at 4:11 PM. During the interview the DON accessed Resident #58's January and February 2016 MARs and confirmed there was no documentation of monitoring for adverse side effects from antipsychotic medications. The DON stated the documentation block on residents' MARs was how nurses were alerted to monitor for and document for side effects of antipsychotic medications. The DON stated they had missed entering the antipsychotic medication monitoring on Resident #58's MAR on admission but could not explain how this occurred.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law).	F 356		3/11/16

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 02/12/2016

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 356	Continued From page 50 - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to post nurse staffing data daily for all shifts and failed to maintain the data for a minimum of 18 months. The findings included: Upon entry to the facility on 02/08/16 at 6:05 PM, the nurse staffing data was observed located at the front entrance. The form included the name of the facility, no date and did not include any data for second or third shifts. Upon exiting the facility on 02/08/16 at 8:45 PM, the form had been changed with the date but no facility name and second shift information had been added. On 02/09/16 at 8:15 AM the nurse staffing data	F 356	F356 How corrective action will be accomplished for each resident found to have been affected by the deficient practice: No residents affected by deficient practice. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: DON and SDC were educated by regional nurse consultant on posting nurse staffing and retention of 18 month□s worth of summary sheets on 3/4/2016. Measures to be put in place or systemic	

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 02/12/2016

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 356	Continued From page 51 form from 02/08/16 at 8:45 PM was observed still posted with no third shift data. On 02/10/16 at 8:23 AM the nurse staffing data form dated 02/09/16 was observed still posted, however, third shift information was never added. During observation on 02/11/16 at 8:15 AM there was no nurse staffing data posted for the day. Interview with the Director of Nursing (DON) on 02/11/16 at 4:22 PM revealed she had been having the Staff Development Coordinator (SDC) post the daily nurse staffing data and maintain the copies of them. The DON stated she filled the information out for first shift, usually after the morning meeting when the census was verified. She expected second and third shift to fill the information out when they came on duty. She stated she realized this was not being completed. The DON stated she thought this was because of a lack in consistency and education. On 02/11/16 at 4:28 PM the SDC stated during interview that since she came to work at this facility, she cleaned up the office and has been keeping the nurse staffing data. On 02/11/16 at 5:15 PM, the nurse staffing data that had been posted was provided since the last survey. What was provided was as follows: *April 2015 consisted of only 04/14/15; *May 2015 consisted of only 05/21/15 and did not include information for 3rd shift; *June 2015 consisted of only 6 days and 4 of those days did not include data for all three shifts; *July 2015 consisted of 17 days and 7 of those days did not include data for all three shifts; *August 2015 consisted of 13 days and 6 of those	F 356	changes made to ensure practice will not re-occur: DON/SDC education licensed nurses on each shift on daily staffing sheet. The 11-7 shift will update sheet daily at 0700. The 3-11 shift will update staffing sheet at the beginning of the shift. 11-7 will complete for the day. Administrator and/or DON will conduct audit of daily nurse staffing summary for completeness daily Monday - Friday and make changes based on call-outs and staffing adjustments, for 4 weeks then every other week for 4 weeks and monthly x4. The completed sheets will be filed in a binder tabbed January through December and filed in chronological order from oldest to newest. This binder is to be maintained in the DON□s office. Audits are to be filed in the survey book by the Administrator. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at monthly Quality Assurance meeting for a period of 6 months for compliance and revision if needed.	

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 02/12/2016

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 356	Continued From page 52 days did not include data for all three shifts; *September 2015 consisted of 10 days and 5 of those days did not include data for all three shifts; *October 2015 consisted of 8 days and 4 of those days did not include data for all three shifts; *November 2015 consisted of 11 days with 8 of those days had missing data for 2nd and 3rd shifts; *December 2015 consisted of 9 days and 6 of those days had missing data for 2nd and 3rd shifts; and *January 2016 consisted of 16 days with 6 of those days missing shift data.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain food items and the environment in a condition that promoted food safety in 2 of 2 nourishment rooms. The findings included: 1. The nourishment room on the south unit was observed on 02/08/16 at 6:45 PM as follows:	F 371	F371 Failure to Properly Store/Prepare/Serve in a Sanitary Manner How the corrective action will be accomplished for the resident(s) affected: On 2/11/16, the ice scoop and holder from both nourishment rooms were immediately washed and sanitized. Food items stored in an unacceptable manner	3/11/16

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 02/12/2016

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 371	Continued From page 53 a. An ice scoop was located in a blue holder attached to the side of the ice machine. Observations of the blue holder revealed there was slimy water with dark residue in the bottom of the holder which could be removed with a paper towel. b. The freezer had a Styrofoam container uncovered, unlabeled with frozen orange ice cream looking material inside. c. A plastic container with soup was located in the refrigerator and labeled with a resident's name and dated 01/24/16. d. The two drawers in the cabinet in this room had coffee like grounds spilled in each drawer. e. The portable ice chest located in this room had ice inside and the scoop rested directly on top of the ice. On 02/08/16 at 7:28 PM, the Director of Nursing was shown the findings in this nourishment room. She removed the ice scoops and the holder. She stated that housekeeping staff were responsible for general cleaning of the room and that dietary staff were responsible for the refrigerator cleanliness. She further stated that residents and or families have to be asked before disposing of food brought in for them. The ice scoops and holder were taken to the kitchen for cleaning on the way to show the Director of Nursing the other nourishment room. Dietary Aide/Cook stated at this time the ice scoops and holders were washed about every other day. On 02/09/16 at 9:30 AM housekeeper #1 stated during interview that housekeeping staff was responsible for wiping all surfaces in the nourishment room and wiping out the microwaves. Housekeeping did not clean or inspect the inside of the refrigerator, cabinets or	F 371	were removed and discarded, and storage areas including pantry drawers and cupboards were cleaned and sanitized. How corrective action will be accomplished for those residents with the potential to be affected by the same practice: An interdisciplinary department head meeting was held on 3/4/16 to establish a system of responsibility for cleaning and maintenance of the unit pantries including ice scoops and holders, refrigerator storage, and dry storage maintenance and cleaning/sanitizing, these areas were reviewed with Maintenance, Dietary Manager, Housekeeping Director by Director of Nursing, by Corporate Nurse Consultant and Corporate Dietician. Measures in place to ensure practices will not occur: Corporate Nurse Consultant and Corporate Dietician educated Maintenance Director, Housekeeping Director, Dietary Manager and DON on Department specific cleaning duties. Audits of unit pantries will be completed once a week for 4 weeks then once month x 11 months by Maintenance, Dietary Manager, Housekeeping Director and results reported to Administrator. The Administrator or Dietician/Nurse Consultant (if they are in the building) can do in place of Administrator at his request, will then take the completed audits and visualize the pantries and ice chest to ensure cleanliness once a week for 4 weeks then once month x 11 months. Completed audits will be given to the Administrator to ensure compliance. How the facility plans to monitor 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 02/12/2016

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 371	Continued From page 54 ice machines. She further stated she cleaned the nourishment room each morning and rechecked it before leaving for the day in the afternoon. Interview with Nurse Aide #7 on 02/11/16 at 9:55 AM revealed nurse aides checked milk expiration dates before serving but were not responsible for general cleaning of the refrigerators. The Dietary Manager was interviewed on 02/11/16 at 10:01 AM regarding the nourishment rooms. She stated dietary stocks items and nursing passes them. Family foods should be labeled by nursing with names ad dates. If staff observed resident foods out of date we either ask the resident if we can throw it away or alert nursing so that they can follow up with families. She further stated that the ice scoops and holders come to the kitchen about every other day to be run through the dish machine, however, she did not believe there was a set schedule for them to be washed. Interview with the south unit manager on 02/11/16 at 10:29 revealed ice scoops should be hanging in the holder or in a plastic bag when used with the portable ice chests. She further stated scoops should be sent to the kitchen for cleaning during third shift daily. She stated the ice holders should be housekeeping's responsibility. She further stated the resident's personal food items were good for 3 days and nursing should handle the outdated food items. The unit manager also stated med pass supplements should be dated when opened and were good for 72 hours. Housekeeper # 2 was interviewed on 02/11/16 at 10:51 AM and stated housekeeping wiped the outside of the refrigerator, inside of the	F 371	ensure correction is achieved and sustained. The results of the audits will be presented to QA monthly for a period of 12 months to ensure continued compliance and revision if needed.	

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 02/12/2016

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 371	Continued From page 55	F 371		

microwave and countertops. She did not do anything with the ice scoops.

2. The nourishment room on the north unit was observed on 02/08/16 at 7:00 PM as follows:
a. An ice scoop was located sitting on the counter of the nourishment room. The blue holder attached to the side of the ice machine was observed with slimy water with dark residue in the bottom which was easily removed with a paper towel.
b. The microwave had dried food splattered on the ceiling inside the microwave and brown residue in the bottom that could be removed with a paper towel.
c. The freezer contained an open box of ice cream with a resident's name and dated 11/18 that had at lease a quarter inch of ice crystals covering the remainder of the ice cream.
d. There was one box of opened med pass (supplement) that was undated.
e. A Styrofoam plate with a chicken sandwich and meat balls covered in foil with a resident's name and no date in the refrigerator.
f. A Styrofoam bowl of chicken strips that appeared dried covered in foil with a resident's name and no date in the refrigerator.
g. A Styrofoam bowl with salad covered in foil with a resident's name and no date in the refrigerator.
h. 13 cartons of Nutren 1.5 (a calorie dense liquid drink) with an expiration date of 03/18/15 in the refrigerator. The box contained a label with a name and address on the outside.
i. The two drawers in this nourishment room counter had crumbs inside and one drawer contained a grilled cheese sandwich in a wax bag with no name or date.
j. The portable ice chest in this room contained ice and the scoop was observed directly lying 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 02/12/2016

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 371	Continued From page 56	F 371		

top of the ice inside the ice chest.

Interview on 02/08/16 at 7:10 PM with the nurses (#4 and #5) revealed they did not believe any resident was currently receiving Nutren supplements. The box was handed to the Director of Nursing at this time.

On 02/08/16 at 7:40 PM the Director of Nursing threw out the med pass and cheese sandwich and removed the ice scoops and holders from the room.

On 02/09/16 at 9:30 AM housekeeper #1 stated during interview that housekeeping staff was responsible for wiping all surfaces in the nourishment room and wiping out the microwaves. Housekeeping did not clean or inspect the inside of the refrigerator, cabinets or ice machines. She further stated she cleaned the nourishment room each morning and rechecked it before leaving for the day in the afternoon.

On 02/11/16 at 9:04 AM observation of the microwave in the South unit revealed dried food matter on the ceiling inside the microwave. Interview with housekeeper #1 at first stated it could not be cleaned because it was baked on. When the surveyor scrapped the food off with a fingernail, housekeeper #1 stated it could be cleaned.

Interview with Nurse Aide #7 on 02/11/16 at 9:55 AM revealed nurse aides checked milk expiration dates before serving but were not responsible for general cleaning of the refrigerators.

The Dietary Manager was interviewed on 02/11/16 at 10:01 AM regarding the nourishment

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 02/12/2016

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 371	Continued From page 57 rooms. She stated dietary stocks items and nursing passes them. Family foods should be labeled by nursing with names ad dates. If staff observed resident foods out of date we either ask the resident if we can throw it away or alert nursing so that they can follow up with families. She further stated that the ice scoops and holders come to the kitchen about every other day to be run through the dish machine, however, she did not believe there was a set schedule for them to be washed. Interview with the south unit manager on 02/11/16 at 10:29 revealed ice scoops should be hanging in the holder or in a plastic bag when used with the portable ice chests. She further stated scoops should be sent to the kitchen for cleaning during third shift daily. She stated the ice holders should be housekeeping's responsibility. She further stated the resident's personal food items were good for 3 days and nursing should handle the outdated food items. The unit manager also stated med pass supplements should be dated when opened and were good for 72 hours. Housekeeper # 2 was interviewed on 02/11/16 at 10:51 AM and stated housekeeping wiped the outside of the refrigerator, inside of the microwave and countertops. She did not do anything with the ice scoops.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		3/11/16

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 02/12/2016

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 441	Continued From page 58 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility policy, and staff interviews the facility failed to disinfect a blood glucose meter per facility policy after use during 1 of 6 medication administration observations (Resident #150).	F 441	F441 How the corrective action will be accomplished for the resident(s) affected. Nurses were immediately in-serviced 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 02/12/2016

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 441	Continued From page 59 The findings included: Review of a facility policy titled "Patient Care Equipment" dated 02/01/15 stated blood glucose meters were to be cleaned in accordance with manufacturer's recommendations. Review of the manufacturer's recommendations for disinfection on the germicidal disposable wipe label revealed instructions to use enough wipes for the treated surface to remain visibly wet for 2 minutes. During a medication administration observation beginning on 02/10/16 at 4:36 PM Nurse #1 was accompanied to Resident #150's room and was observed checking her blood glucose level using a blood glucose meter. At 4:39 PM Nurse #1 returned to the medication cart and was observed wiping the surface of the blood glucose meter with a germicidal disposable wipe for approximately 10 seconds. Nurse #1 then placed the blood glucose meter in a clear plastic cup on the medication cart. At 4:40 PM Nurse #1 observed the surface of the blood glucose meter and confirmed all surfaces of the meter were dry. An interview with Nurse #1 on 02/10/16 at 4:52 PM revealed he had been instructed to disinfect blood glucose meters by wiping down the surface well with a germicidal disposable wipe and let the meter sit for 10 minutes. Nurse #1 reviewed the label on the germicidal disposable wipes and stated he had never verified the blood glucose meters surface remained wet for 2 minutes when he disinfected them after use. During an interview on 02/10/16 at 4:57 PM the	F 441	the use of PDI Super Sani Cloth wipes to disinfect glucometers on 2/11/2016. Any nurses not in-serviced will not be allowed work until in-service is obtained from SDC. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Nurses were in-serviced on the disinfection process using PDI Super Sani Cloth wipes, wiping the machine and discarding first wipe and using a second wipe and allowing the 2 minutes of contact with wipe and then allowed to air dry. Any nurses not in-serviced will not be allowed work until in-service is obtained from SDC. The following is the information that was presented: Using PDI Super Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters. Steps for disinfecting Blood Glucose Meters: 1. Use one wipe to clean meter- discard 2. Use a second wipe and wrap the meter in it. 3. Place wrapped meter in cup, let stand for 2 minutes 4. Remove wrapped meter from cup, discard wipe, place meter On wash cloth to air dry. While this meter is being disinfected utilize your second Blood Glucose Meter. Measures in place to ensure practices will not occur. During orientation all nurses will receive education in regards to disinfection of glucometer using PDI	

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 02/12/2016

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 441	Continued From page 60 Director of Nursing (DON) stated nurses were expected to disinfect the blood glucose meters by wiping them down with a germicidal disposable wipe and letting the meter air dry for 2 minutes. Then wipe the meter a second time with another germicidal disposable wipe and air dry. An interview with the Staff Development Coordinator (SDC) on 02/10/16 at 5:00 PM revealed she expected nurses to disinfect blood glucose meters by wiping them clean with a germicidal disposable wipe and cover with a paper towel and allow to dry for 2 minutes. The SDC stated she had not reviewed manufacturer's recommendations for disinfecting on the label of the germicidal wipes used by the facility. During a follow up interview on 02/10/16 at 5:20 PM the SDC stated she had been employed by the facility for 3 months and they had used a different product at her previous facility for disinfecting. The SDC further stated she reviewed the policy for cleaning and disinfecting patient care equipment when she oriented new nurses but did not teach the procedure step by step. The interview further revealed that new nurses were paired with an experienced nurse for a 5 day orientation on the hall and the SDC assumed they would receive instructions for disinfecting blood glucose meters during that time.	F 441	Super Sani Cloth wipes, wiping surfaces and wrapping in a second cloth for 2 minutes and then allowed to air dry. Using PDI Super Sani-Cloth Germicidal Disposable Wipes to disinfect the Blood Glucose Meters. Steps for disinfecting Blood Glucose Meters: 1. Use one wipe to clean meter- discard 2. Use a second wipe and wrap the meter in it. 3. Place wrapped meter in cup, let stand for 2 minutes 4. Remove wrapped meter from cup, discard wipe, place meter on wash cloth to air dry. While this meter is being disinfected utilize your second Blood Glucose Meter. How the facility plans to monitor and ensure correction is achieved and sustained. SDC/Infection Control Nurse/Unit Manager or DON to do weekly observations on 5 residents a week for x12 weeks, to observe for correct disinfection, then monthly x3 months. This documented information will be shared with the QA/QI committee and revisions to practice made if needed to ensure compliance.	
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of	F 520		3/11/16

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 02/12/2016

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 520	Continued From page 61 nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor those interventions that the committee put into place in April 2015. This was for one recited deficiency which was originally cited in April 2015 on the recertification/complaint survey and on the current recertification/complaint survey. The deficiency was in the area of nutritional/therapeutic diet. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assessment and Assurance Program.	F 520	F520 How the corrective action will be accomplished for the resident(s) affected. The Magic Cup was added to the tray card by the Regional Dietician at the time of discovery. How corrective action will be accomplished for those residents with the potential to be affected by the same practice. Individual actions denoted on said area for citation F-325. Measures in place to ensure practices will not re-occur. Nurses re-in-serviced 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 02/12/2016

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 520	Continued From page 62 The findings included: This tag is cross referred to: F325 Nutritional/Therapeutic diet. Based on observations, record review, and staff interviews, the facility failed to provide a supplement (magic cup) which was planned to help prevent weight loss to 1 of 5 sampled residents reviewed for weight loss (Resident #58). During an interview on 02/12/16 at 4:55 PM the Administrator stated the Quality Assessment and Assurance Committee currently met on a quarterly basis with their meetings focusing on clinical indicators not being met. He stated they continued to discuss previously cited issues but had not monitored as closely as they had for the plan of correction. He stated they focused on specific issues at each meeting and would be taking all problems related to citations found during the current recertification survey to monthly Quality Assessment and Assurance Committee meetings.	F 520	verifying all communication on re-admits is forwarded to dietary to ensure that additional supplements are added to the tray ticket. Dietary staff in-serviced on tray card accuracy and ensuring what is on the ticket is present How the facility plans to monitor and ensure correction is achieved and sustained. The Results of audit will be reported during weekly QA specifically to discuss F Tag 325 for further analysis and revision if needed x8 weeks and every other week for a period of 2 months and monthly for a period of 8 months.	