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	06/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belaire Health Care Center	2065 Lyon Street Gastonia, NC 28052

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Resident Representative, and Home Health Nurse interviews, the facility failed to include discharge instructions for a daily surgical wound dressing change for 1 of 3 sampled residents with wound care (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] and was discharged home on 5/18/25. Review of Resident #1's consultation records revealed an orthopedic consultation dated 5/16/25 with an order for daily dry dressing change to right hip. Resident #1's discharge Minimum Data Set assessment dated [DATE] revealed she was independent for decision making. Review of Resident #1's facility discharge instructions dated 5/18/25 for home care revealed no daily surgical wound dressing instructions. An interview on 6/24/25 at 9:56 AM with Resident #1's Representative revealed Resident #1 did not receive surgical wound care instructions when the resident was discharged from the facility on 05/18/25 until seen by Home Health on 05/21/25. An interview on 6/24/25 at 11:01 AM with the Director of Nursing (DON) revealed that Resident #1 had been transported to an outside orthopedic follow-up appointment on 5/15/25. The DON stated it was an oversight, and she had not entered the order for the resident to have daily dry dressing change to her right hip. An interview on 6/24/25 at 1:11 PM with Nurse #2 revealed she had discharged Resident #1 on 5/18/25. She stated she was not aware of the order for daily dressing change to right hip and had not told the resident or resident representative about the surgical dressing changes. An interview on 6/24/25 at 1:30 PM with the Home Health Nurse revealed she had seen and assessed Resident #1 on 5/21/25 in her home. She stated there were no instructions for the surgical wound dressing changes on the facility referral orders. She stated she had changed the right hip surgical dressing on 5/21/25 and there were no signs or symptoms of infection. She stated the wound had slight drainage and the staples were intact.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, and orthopedic office Practice Manager interviews, the facility failed to provide care for a surgical wound as ordered by the consultant orthopedic physician for a daily surgical dressing for 1 of 3 sampled residents with wound care (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE]. Hospital Discharge summary dated [DATE] revealed Resident #1 had diagnoses which included closed fracture of neck of right femur with routine healing. No surgical wound care instructions were noted on the hospital discharge summary. Review of facility orders revealed Resident #1 had a physician's order dated 5/08/25 to monitor the surgical dressing to right hip every shift and report any signs or symptoms of infection to physician every day and night shift for surgical wound care. Review of Resident #1's consultation records revealed an orthopedic consultation dated 5/16/25 with an order for daily dry dressing change to right hip. Review of facility orders revealed no order for daily dry dressing change to right hip. Review of the Treatment Administration Record (TAR) dated May 2025 revealed no record of a daily dry dressing for Resident #1. Resident #1's discharge Minimum Data Set assessment dated [DATE] revealed she was independent for decision making. An interview on 6/24/25 at 11:01 AM with the Director of Nursing (DON) revealed that Resident #1 had been transported to an outside orthopedic follow-up appointment on 5/15/25. She stated the consultation note was dated incorrectly and the resident had been seen on 5/15/25 instead of 5/16/25. She also stated she had been filling in as the unit manager on 5/15/25 and had been responsible for reviewing the orthopedic note and ensuring the orders were entered into the resident's electronic health record. The DON stated it was an oversight, and she had not entered the order for the resident to have daily dry dressing change to her right hip. An interview on 6/24/25 at 12:39 PM with Nurse #1 revealed she had been on duty and assigned to Resident #1 on 5/15/25 when she went for her orthopedic surgical follow up visit. She stated that she could not recall if she had received Resident #1's consultation paperwork when she returned to the facility. She stated she did not know why the surgical dressing change order was not entered in the resident's electronic health record. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 6/24/25 at 1:11 PM with Nurse #2 revealed she had worked on 5/17/25 and been assigned to Resident #1. She was unaware of any orders for surgical wound dressing to be changed and had not changed the dressing. She also worked on 5/18/25 and had provided discharge instructions for Resident #1 on 5/18/25. She stated she was not aware of the order for daily dressing change to right hip and had not changed the dressing prior to discharge and had not told Resident #1 or Resident Representative about the daily dry dressing. An interview on 6/24/25 at 2:06 PM with the orthopedic office Practice Manager revealed it was normal practice for the surgical dressing to stay in place until the 1st post operative visit. He also stated that the surgeon noted no signs or symptoms of wound infection on her 5/15/25 visit. An interview on 6/24/25 at 2:21 PM with the Administrator revealed the facility staff should transcribe and follow physician's orders.