STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345483	A. BUILDING _____ B. WING _____	C 07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DRIVE LENOIR, NC 28645

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E 000	Initial Comments An unannounced recertification survery was conducted on 07/01/2024 through 07/03/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #19PK11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 07/01/2024 through 07/03/2024. Event ID #19PK11. The following intakes were investigated NC00211200 and NC00217973. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Significant Change in Status Assessment for a resident who had been discharged from hospice care for 1 of 3 residents reviewed for hospice (Resident #3).	F 637	F637 This Plan of Correction is submitted to address deficiencies cited under Tag #F637	7/24/24

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

Electronically Signed | 07/25/2024

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F 637	Continued From page 1 Findings included: Resident #3 was admitted to the facility on 02/13/21 with diagnoses including heart failure and diabetes. Review of Resident #3's orders revealed he had been admitted to hospice services on 03/03/21 noting he had a life expectancy of less than 6 months and a diagnosis of heart failure. He was discharged from hospice services on 08/09/23. A phone interview was conducted with the Hospice Provider on 07/02/24 at 3:15 PM. The Hospice Provider revealed Resident #3 had been admitted to hospice services on 03/03/21 through 08/09/21 then switched to hospice palliative care 08/09/21 which was discontinued on 01/08/24. No facility physician orders, or facility documentation were discovered indicating hospice palliative care services had been ordered or discontinued. Review of Resident #3's Minimum Data Sets (MDS) revealed the most recent comprehensive assessment, a Significant Change in Status Assessment, dated 09/28/23, and followed by three quarterly assessments dated 12/27/23, 03/27/24, and 06/24/24. These assessments were coded for receiving hospice care. An interview conducted with the MDS Coordinator on 07/03/24 at 12:35 PM revealed it was not communicated to her that Resident #3 had been discharged from hospice and palliative care on 01/08/24. She indicated she usually got her information regarding hospice discharges through	F 637	This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On July 8, 2024 a correction to the MDS assessment under Section O-110 was completed and submitted removing hospice care as a service received for the assessments dated March 27, 2024 and June 24, 2024 consecutively for Resident #3. On July 8, 2024, a meeting was held with facility□s contracted Hospice liaison and nurse, and facility Director of Nurses and MDS Coordinator. Facility□s expectations for weekly discussion and review of all residents receiving Hospice services to include Hospice admissions and/or discharges were reviewed. Orders must be obtained prior to any resident being admitted or discharged from Hospice services was discussed. Complete signed orders must be filed on resident chart within 7 days of the initial order were discussed and confirmed by both parties. On July 22, 2024 the MDS Coordinator was re-educated by the Director of Nurses as to the importance of accurately coding the complete MDS assessment including but not limited to Section O-110. RAI guidelines to determine a significant change were also reviewed. All MDS Assessments will be completed accurately, timely and according to the	

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F 637	Continued From page 2 the nurses and review of the resident's chart. The MDS Coordinator stated a significant change in status assessment had been completed in September because Resident #3 had a fall with an injury. The MDS Coordinator indicated a significant change in status assessment should have been completed for Resident #3 when the hospice services ended. An interview conducted with the Administrator and Director of Nursing (DON) on 07/03/24 at 1:30 PM revealed they were not aware Resident #3 had been discharged from hospice and palliative care services. It was further revealed they expected the MDS assessments to be coded accurately and was not aware a significant change in status assessment had not been completed when Resident #3 was discharged from hospice services.	F 637	RAI Manual. On July 23, 2024 a significant change assessment relating to discharge of hospice services was completed and submitted for Resident #3. On July 24, 2024 the MDS Coordinator and Director of Nurses audited and reviewed current residents receiving Hospice services MDS assessments to ensure accuracy of coding in Section O-110 of the MDS. All MDSs were found to be coded accurately. The Director of Nurses will conduct random reviews of MDS assessments on a weekly basis for a period of 4 weeks, then every other week for a period of 4 weeks and monthly for a period of 1 month. The DON will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 6 residents	F 641	F641 This Plan of Correction is submitted to	7/24/24

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F 641	Continued From page 3 reviewed for hospice, discharge, and falls (Resident #3, Resident #40, and Resident #50). Findings included: 1. Resident #3 was admitted to the facility on 02/13/21 with diagnoses including heart failure and depression. Review of Resident #3's orders revealed he had been admitted to hospice services on 03/03/21 noting he had a life expectancy of less than 6 months and a diagnosis of heart failure. He was discharged from hospice services on 08/09/23. A phone interview was conducted with the Hospice Provider on 07/02/24 at 3:15 PM. The Hospice Provider revealed Resident #3 had been admitted to hospice services on 03/03/21 through 08/09/21 then switched to hospice palliative care 08/09/21 which was discontinued on 01/08/24. No facility physician orders, or facility documentation were discovered indicating hospice palliative care services had been ordered on 08/09/23 or discontinued on 01/08/24. Review of Resident #3's quarterly Minimum Data Sets (MDS) dated 03/27/24, and 06/24/24 revealed the resident was coded for receiving hospice care. An interview conducted with the MDS Coordinator on 07/03/24 at 12:35 PM revealed it was not communicated to her that Resident #3 had been discharged from hospice and palliative care on 01/08/24. She indicated she usually got her information regarding hospice discharges through the nurses and review of the resident ' s chart.	F 641	address deficiencies cited under Tag #F641 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On July 8, 2024 a correction to the MDS assessment Section O-110 was completed and submitted removing hospice care as a service received for the assessments dated March 27, 2024 and June 24, 2024 consecutively for Resident #3. On July 12, 2024 a correction to the MDS assessment Section J-1700 was completed and submitted relating to fall with major injury for the 5-day assessment dated June 5, 2024 for Resident #40. On July 17, 2024, an inactivation to the MDS assessment dated April 5, 2024 was completed and submitted inactivating the prior assessment of un-planned discharge for Resident #50. Un-planned discharge had been selected in error, thereby, warranting inactivation and submission of a planned discharge assessment for Resident #50 On July 22, 2024 the MDS Coordinator was re-educated by the Director of Nurses as to the importance of accurately coding the complete MDS assessment including but not limited to Section O-110, Section J-1700 and assessment inactivation due to improper coding of a planned discharge	

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F 641	Continued From page 4 The MDS Coordinator further revealed Resident #3 should have not been coded for hospice care on the quarterly MDS assessments for 03/27/24 and 06/24/24. An interview conducted with the Administrator and Director of Nursing (DON) on 07/03/24 at 1:30 PM revealed they were not aware Resident #3 had been discharged from hospice and palliative care services. It was further revealed they expected the MDS assessments to be coded accurately. 2. Resident #40 was admitted to the facility on 5/14/24 and readmitted on 5/29/24. Diagnosis included dementia and falls. Review of Resident #40 progress note dated 5/29/24 revealed Resident #40 was readmitted from the hospital on 5/24/24 due to a fall with injury at the facility. Resident #40 readmission diagnosis on 5/29/24 included fracture of neck, not operable, due to fall. Review of 5-day admission Minimum Data Set (MDS) assessment dated 6/05/24 revealed no history of falls or falls with major injury. An interview with the MDS Coordinator on 7/03/24 at 1:18 PM revealed Resident #40 had been readmitted to the facility from the hospital on 5/29/24 due to a fall with major injury. She stated Resident #40 should have been coded on his 5-day admission assessment dated 6/05/24 as having a history of falls and one fall with major injury. She revealed she believed it was just an oversight and human error on her part that she forgot to check the correct boxes under falls.	F 641	as un-planned. RAI guidelines were reviewed. All MDS Assessments will be completed accurately, timely and according to the RAI Manual. On July 24, 2024 the MDS Coordinator and Director of Nurses conducted reviews of current resident MDS assessments to ensure accuracy of coding. All MDSs were found to be coded accurately. The Director of Nurses will conduct random reviews of MDS assessments on a weekly basis for a period of 4 weeks, then every other week for a period of 4 weeks and monthly for a period of 1 month. The DON will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance.	

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F 641	Continued From page 5	F 641		

An interview with the Director of Nursing (DON) on 7/03/24 at 1:31 PM revealed Resident #40 5-day admission MDS dated 6/05/24 should have reflected his previous fall with major injury. She stated MDS assessments should be coded correctly and reflect resident's current orders, changes in conditions, incidents, assessments, and status.

3. Resident # 50 was admitted to the facility on 3/11/24 and was discharged home on 4/05/24.

Review of Resident #50 discharge progress note dated 4/05/24 revealed Resident #50 to discharge home with home health referral completed to evaluate and treat in home and ordered medical equipment received and available at resident home. Resident #50 was wheeled to vehicle and assisted into front seat and her belongings were taken by her husband. Discharge instructions were verbally reviewed in detail with Resident #50 husband, he verbalized understanding, and a written copy was provided. Resident #50 prescriptions were faxed to pharmacy with confirmation received, follow-up appointment made with primary care physician for 4/16/24 at 2:40 PM. Resident #50 had left facility with husband in pleasant mood.

The discharge Minimum Data Set (MDS) assessment dated 4/05/24 indicated under the discharge status, that Resident #50 was an unplanned, return not anticipated discharge to home.

An interview with the MDS Coordinator on 7/03/24 at 1:25 PM revealed Resident #50 was a planned discharge and should have been coded as a planned, return not anticipated, discharge to

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F 641	Continued From page 6 home. She stated she believed it was just an oversight and human error on her part that she forgot to check the correct box under discharge status. An interview with the Director of Nursing on 7/03/24 at 1:40 PM revealed Resident #50 discharge was planned, and she should have been coded on her discharge MDS assessment as a planned discharge to home. She stated MDS assessments should be coded correctly and reflect resident's current orders, changes in condition, admission, and discharge status.	F 641		