STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 07/26/2024 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
					С		
	345483 B. WING			07/	03/2024		
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE			
				450 SHAIRE CENTER DRIVE			
SHAIRE N	URSING CENTER		lι	ENOIR, NC 28645			
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
E 000	Initial Comments		E 000				
F 000	conducted on 07/01/2		F 000				
	investigation survey w 07/01/2024 through 0 #19PK11. The follow investigated NC00211 the 3 complaint allegal deficiency.	7/03/2024. Event ID ing intakes were 1200 and NC00217973. 3 of attions did not result in					
F 637 SS=D	CFR(s): 483.20(b)(2)(i) With determines, or should there has been a sign resident's physical or purpose of this sectio means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplina care plan, or both.) This REQUIREMENT by: Based on record revifacility failed to compl Status Assessment for discharged from hosp	hin 14 days after the facility have determined, that ificant change in the mental condition. (For n, a "significant change" e or improvement in the will not normally resolve attervention by staff or by d disease-related clinical an impact on more than ent's health status, and ary review or revision of the is not met as evidenced ew and staff interviews the ete a Significant Change in r a resident who had been ice care for 1 of 3 residents	F 637	F637 This Plan of Correction is submitted to address deficiencies cited under Tag		7/24/24	
	reviewed for hospice	(Resident #3).		#F637			
ABOBATORY	DIRECTOR'S OR PROVIDER/S	LIPPLIER REPRESENTATIVE'S SIGNATURE		TITI F		(X6) DATE	

(X2) MULTIPLE CONSTRUCTION

Electronically Signed 07/25/2024

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.

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		245492	B. WING		С		
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SHAIRE N	URSING CENTER			1450 SHAIRE CENTER DRIVE			
				LENOIR, NC 28645			
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F 637	Continued From page 1		F 63	7			
	02/13/21 with diagno	nitted to the facility on ses including heart failure		This is to state that we do not cor this recommendation as stated for deficient practice. Upon finding st deficiencies.	r		
	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			On July 8, 2024 a correction to the assessment under Section O-110 completed and submitted removing hospice care as a service received assessments dated March 27, 20 June 24, 2024 consecutively for F#3.) was ng ed for the l24 and		
				On July 8, 2024, a meeting was he facility sontracted Hospice liais nurse, and facility Director of Nurse, and Facility sexpectations for weekly discussion review of all residents receiving here services to include Hospice admit and/or discharges were reviewed must be obtained prior to any respense admitted or discharged from	son and ses and on and dospice ssions . Orders ident m		
				Hospice services was discussed. Complete signed orders must be resident chart within 7 days of the order were discussed and confirm both parties. On July 22, 2024 the MDS Coord was re-educated by the Director of as to the importance of accurately the complete MDS assessment in but not limited to Section O-110. guidelines to determine a signification change were also reviewed. All Massessments will be completed accurately, timely and according	filed on e initial ned by linator of Nurses y coding ncluding RAI ant		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345483 B. WING			C 07/03/2024			
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	00/2024
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SHAIRE N	URSING CENTER			LI	ENOIR, NC 28645		
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F 637	F 637 Continued From page 2		F6	37			
	the nurses and review	v of the resident's chart. The			RAI Manual.		
	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				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		
	_	essment had not been ident #3 was discharged s.			random reviews of MDS assessments 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 wassess and modify the action plan as needed to ensure continued compliance.	ne f	
F 641	Accuracy of Assessm	ents	F 6	641			7/24/24
SS=D	CFR(s): 483.20(g)						
	resident's status. This REQUIREMENT by: Based on record revifacility failed to accura	of Assessments. t accurately reflect the is not met as evidenced ew and staff interviews the ately code the Minimum ssment for 3 of 6 residents			F641 This Plan of Correction is submitted to		

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F 641	Continued From pa	ge 3	F 6	41			
		e, discharge, and falls lent #40, and Resident #50).		address deficiencies cited un #F641	der Tag		
	Findings included:			This is to state that we do not this recommendation as state			
		admitted to the facility on oses including heart failure		deficient practice. Upon findir deficiencies.			
	been admitted to ho noting he had a life months and a diagn	#3's orders revealed he had ospice services on 03/03/21 expectancy of less than 6 osis of heart failure. He was spice services on 08/09/23.		On July 8, 2024 a correction assessment Section O-110 w completed and submitted rem hospice care as a service recassessments dated March 27 June 24, 2024 consecutively #3.	ras noving seived for the 7, 2024 and		
	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.			On July 12, 2024 a correction assessment Section J-1700 v completed and submitted relawith major injury for the 5-day dated June 5, 2024 for Resid	was ating to fall / assessment		
				On July 17, 2024, an inactiva MDS assessment dated April completed and submitted inaprior assessment of un-planner for Resident #50. Un-planner had been selected in error, the warranting inactivation and suplanned discharge assessing Resident #50	5, 2024 was ctivating the ed discharge d discharge hereby, ubmission of		
	An interview conduction 07/03/24 at 12:3 communicated to he discharged from ho 01/08/24. She indictinformation regarding	cted with the MDS Coordinator 5 PM revealed it was not er that Resident #3 had been spice and palliative care on ated she usually got her ng hospice discharges through ew of the resident 's chart.		On July 22, 2024 the MDS Cowas re-educated by the Direct as to the importance of accur the complete MDS assessment but not limited to Section O-1 J-1700 and assessment inact to improper coding of a plann	ctor of Nurses rately coding ent including 10, Section tivation due		

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F 641 Continued From page 4		F 6	641			
3 should have not be n the quarterly MDS	en coded for hospice care			as un-planned. RAI guidelines were reviewed. All MDS Assessments will b completed accurately, timely and according to the RAI Manual.	e	
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				and Director of Nurses conducted revie 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 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 wassess and modify the action plan as	ews oon ne f	
TO A TOTAL ON SECOND SANT SANT SANT	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LESTING CENTER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LESTING CENTER) Ontinued From page the MDS Coordinator 3 should have not be in the quarterly MDS and 06/24/24. In interview conducter irector of Nursing (DM revealed they were ad been discharged are services. It was for expected the MDS associated to the MDS associated the MDS) associated the MDS associated to the MDS associated the MDS associated to the MDS associated to the MDS associated the MDS associated to the MDS associated the MD	ASSESSMENT STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 4 the MDS Coordinator further revealed Resident 3 should have not been coded for hospice care in the quarterly MDS assessments for 03/27/24 and 06/24/24. In interview conducted with the Administrator and irrector of Nursing (DON) on 07/03/24 at 1:30 M revealed they were not aware Resident #3 and been discharged from hospice and palliative are services. It was further revealed they expected the MDS assessments to be coded courately. Resident #40 was admitted to the facility on 1/14/24 and readmitted on 5/29/24. Diagnosis cluded dementia and falls. Review of Resident #40 progress note dated 1/29/24 revealed Resident #40 was readmitted on the hospital on 5/24/24 due to a fall with jury at the facility. Resident #40 readmission lagnosis on 5/29/24 included fracture of neck, of operable, due to fall. Review of 5-day admission Minimum Data Set MDS) assessment dated 6/05/24 revealed no istory of falls or falls with major injury. In interview with the MDS Coordinator on 1/03/24 at 1:18 PM revealed Resident #40 had been readmitted to the facility from the hospital in 5/29/24 due to a fall with major injury. She	IDENTIFICATION NUMBER: 345483 B. 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She ated Resident #40 should have been coded on is 5-day admission assessment dated 6/05/24 is and one fall with major ijury. She revealed she believed it was just an versight and human error on her part that she	A BUILDING 345483 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1450 SHAIRE CENTER DRIVE SUMMARY STATEMENT OF DEPICIENCIES SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 4 he MDS Coordinator further revealed Resident 3 should have not been coded for hospice care in the quarterly MDS assessments for 03/27/24 and 06/24/24. In interview conducted with the Administrator and irector of Nursing (DON) on 07/03/24 at 1:30 M revealed they were not aware Resident #3 and been discharged from hospice and palliative are services. It was further revealed they early services and the discharged from hospice and palliative are services. 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WING STREET ADDRESS, CITY, STATE, 2IP CODE 1450 SHARE CENTER DIVENCE SING CENTER SIMMARY STATEMENT OF DEFICIENCIES (EACH OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Ontinued From page 4 The MDS Coordinator further revealed Resident 3 should have not been coded for hospice care the quarterly MDS assessments for 03/27/24 and 06/224/24. In interview conducted with the Administrator and irrector of Nursing (DON) on 07/03/24 at 1:30 The revealed frew were not aware Resident #3 and been discharged from hospice and palliative are services. It was admitted to the facility on 14/124 and readmitted on 5/29/24. Diagnosis cluded dementia and falls. Personal of the process of the pr

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345483	B. WING _			C 07/03/2024	
NAME OF PROVIDER OR SUPPLIER SHAIRE NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1450 SHAIRE CENTER DRIVE LENOIR, NC 28645		01700/2024	
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F 641	on 7/03/24 at 1:31 F 5-day admission ME reflected his previou stated MDS assess correctly and reflect changes in condition and status. 3. Resident # 50 wa 3/11/24 and was dis Review of Resident dated 4/05/24 revea discharge home with completed to evalua ordered medical equavailable at resident wheeled to vehicle and her belongings Discharge instruction detail with Resident understanding, and Resident #50 prescripharmacy with confiappointment made w 4/16/24 at 2:40 PM. with husband in please to reflect the property of the discharge Minim	e Director of Nursing (DON) M revealed Resident #40 DS dated 6/05/24 should have see fall with major injury. She ments should be coded resident's current orders, as, incidents, assessments, as admitted to the facility on charged home on 4/05/24. #50 discharge progress note led Resident #50 to an home health referral the and treat in home and dipment received and home. Resident #50 was and assisted into front seat were taken by her husband. The swere verbally reviewed in #50 husband, he verbalized as written copy was provided. The injuries were faxed to remation received, follow-up with primary care physician for Resident #50 had left facility asant mood.	F	DEFICIENCY)			
	discharge status, the unplanned, return no home.	/05/24 indicated under the at Resident #50 was an ot anticipated discharge to e MDS Coordinator on					
	7/03/24 at 1:25 PM planned discharge a	revealed Resident #50 was a and should have been coded not anticipated, discharge to					

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F 641	oversight and human forgot to check the costatus. An interview with the 7/03/24 at 1:40 PM redischarge was planned been coded on her dias a planned discharassessments should reflect resident's curr	e believed it was just an error on her part that she orrect box under discharge Director of Nursing on	F 6	41		