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 _____	10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DRIVE LENOIR, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		10/16/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/16/2014

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.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to investigate an injury of unknown origin and file a 24 hour and 5 working day report to the North Carolina Health Care Personnel Registry (NCHCPR) for 1 of 1 resident reviewed for an injury of unknown origin (Resident #28). The findings included: Resident #28 was admitted to the facility on 07/01/08 with diagnoses of chronic obstructive pulmonary disease, high blood pressure and dementia. The most recent quarterly Minimum Data Set (MDS) dated 09/12/14 indicated Resident #28 had severely impaired cognition. The MDS further indicated Resident #28 required extensive assistance by staff for bed mobility, transfers and toilet use. Review of the Medication Administration Record (MAR) for 09/2014 revealed Resident #28 received Aspirin 81 milligrams (mg) every day for prevention of blood clots. Review of facility incident reports for 09/01/2014 to 10/02/14 revealed no incident report for Resident 28. Review of nurse's notes dated 09/11/14 at 7:02 AM indicated nurse aide (NA) #1 informed Nurse #2 that Resident #28 had a large bruise covering her right breast. Nurse #2 assessed Resident #28 with no signs or symptoms of injury noted. The note indicated Resident #28 showed no verbal or nonverbal signs of pain at that time. Nurse's note dated 09/11/14 at 12:32 PM indicated Resident #28 received Ultram 50 mg, a medication used to treat pain. Nurse's note dated 09/12/14 at 12:50 PM indicated Resident #28 received Ultram 50mg due to resident being unable to verbalize pain level/pain across upper chest as evidenced by	F 225	This Plan of Correction is submitted to address deficiencies cited under Tag #F225 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On October 15, 2014 resident #28□s skin assessments were reviewed by Director of Nurses to identify unusual bruising. No findings of unusual bruising noted. On October 16, 2014, Director of Nurses did a full body visual examination of resident with no findings of unusual bruising noted. On September 18, 2014, an in-service was conducted by Rehab Coordinator with all nursing staff to review proper procedures of transferring and repositioning patients. On October 15, 2014, nurses□ meeting was held to review facility policy relating to incident report documentation and bruising of un-known origin. All components of the policy including state reporting mandates were reviewed by Incident/Fall Coordinator. Any suspicious incident will be immediately reported to Administrator and/or Director of Nurses for investigation and mandated reporting. All incident reports will be reviewed by Incident/Fall Coordinator for accurate documentation and implementation of facility procedures daily for a period of 12 weeks. Any deviation or omission of facility procedure	

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F 225	Continued From page 2 grimacing when being repositioned. Resident had purple/red areas across upper chest. Nurse ' s note dated 09/13/14 2:00 PM indicated a skin assessment was done and Resident #28 had an extra-large bruise to right chest along the whole breast, with no swelling, had Tylenol with a good effect and was guarding the area. An observation was made on 10/02/14 at 11:50 AM of Resident #28's bruise to her right lower breast and chest revealed bruise to be light green and blue in color covering the entire width of right breast. An interview was conducted on 10/02/14 at 10:06 AM with NA #1. NA #1 stated she started her shift early on 09/11/14 and was getting Resident #28 dressed when she noticed a large bruise covering her right breast to her sternum. NA #1 stated she reported the bruise right away to Nurse #2. NA #1 further stated she had worked with Resident #28 the day before and the bruise was not there. An interview was conducted on 10/02/14 at 11:15 AM with the Director of Nursing (DON). She stated she was aware of Resident #28's bruise and assessed the resident on 09/11/14 and asked the facility Physician Assistant (PA) to assess her the next day. She reported she determined the bruise was caused by staff positioning the resident in her wheelchair. She stated she did not question direct care staff about how or when the bruise occurred. The DON further stated she did not think a 24 hour report should have been filed for this bruise of unknown origin. An interview was conducted on 10/02/14 at 11:30 AM with Nurse #2. She stated she was informed on 09/11/14 by NA #1 that Resident #28 had a large bruise to her right breast. She reported she assessed the resident but did not file an incident report. She further stated she did not question the staff on how the bruise occurred but NA #1 told	F 225	will be immediately corrected by Incident/Fall Coordinator. Random observations of transfers will be made by Rehab Coordinator at least 3 times per week for the next 12 weeks. Any employee not following facility policy relating to incident reporting, will have disciplinary actions taken on an individual basis. The Incident/Fall Coordinator will collaborate documentation and report findings to the Q.A. Committee monthly for a period of three months.	

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F 225	Continued From page 3 her the bruise was not there the day before. A follow up interview was conducted on 10/02/14 at 11:45 AM with NA #1. She stated the NAs never repositioned Resident #28 in her wheelchair by lifting her under her arms. She stated they used a gait belt around her waist or pulled her up by the back of her pants in the wheelchair. An interview was conducted on 10/02/14 at 2:00 PM with the facility PA. He stated he assessed Resident #28 on 09/11/14 for a bruise covering her right breast to the sternum with no underlying hematoma noted. He stated the DON had already assessed the resident and determined the cause of the bruise was from positioning the resident in the wheelchair. The PA stated the bruise could have occurred from pulling the resident up in the wheelchair by her underarms. A follow up interview was conducted on 10/02/14 at 2:15 PM with the DON. She stated that she investigates all possible abuse and had never submitted a 24 hour report or 5 day report to the North Carolina Healthcare Personnel Registry for abuse or an injury of unknown origin. The DON reported she had always determined the cause of the injury and the facility staff were not abusive to the residents. An interview was conducted on 10/02/14 at 2:30 PM with the Administrator. He stated the DON conducts all the abuse investigations and discusses findings with him. He reported if staff were abusive to the residents they would be terminated.	F 225		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a	F 253		10/16/14

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F 253	Continued From page 4 sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain a clean and sanitary environment in two bathrooms on 1 of 3 hallways. The findings included: a. An initial observation of the bathroom for room 317 on 09/30/14 at 10:30 AM revealed brown particles adhered to approximately half of the surface on the inside of the toilet bowl. On 10/01/14 at 2:30 PM the brown particles remained adhered to approximately half of the surface on the inside of the toilet bowl. A subsequent observation on 10/02/14 at 10:01 AM revealed revealed brown particles adhered to approximately half of the surface inside the toilet bowl. An interview was conducted with Housekeeper #1 on 10/02/14 at 11:23 AM during which she confirmed she had completed cleaning the residents' rooms and bathrooms on her side of the hall including room 317. Housekeeper #1 stated they used a disinfectant spray cleaner on the bathroom sink and toilet. She further explained cleaning the toilet included the toilet seat, rim, and the inside of the toilet bowl. During an interview on 10/02/14 at 11:40 AM the Administrator stated the Housekeeping Supervisor was out for the day and agreed to observe the bathroom for room 317. An observation on 10/02/14 at 11:42 AM revealed brown particles adhered to approximately half of	F 253	This Plan of Correction is submitted to address deficiencies cited under Tag #F253 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. On October 2, 2014 at 11:50 a.m. the bathrooms in rooms #313 and #317 were cleaned thoroughly by housekeeping staff. This cleaning included the toilet seat, rim, the inside of the toilet bowl, bottom of toilet where bolted to the floor, and the tank. Immediate inspection was completed by Administrator with all surfaces found to be free of any particles or rust. After meeting with housekeeping staff, housekeepers found to be responsible for this incident were placed on 7 day un-paid suspension. On October 13, 2014 these housekeepers were re-instated and placed on 90 days probation after duties, responsibilities and facility expectations were reviewed. On October 13, 2014, an in-service was conducted by the Administrator and Director of Nurses, with all environmental service employees, in relation to the new housekeeping/laundry service cleaning	

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F 253	Continued From page 5 the surface on the inside of the toilet bowl. The Administrator confirmed the toilet bowl was not clean and stated he would take care of this immediately. b. An initial observation of the bathroom for room 313 on 09/29/14 at 10:36 AM revealed rust colored particles and discoloration at the left side base of the toilet when facing the toilet. The area measured approximately 6 inches long by 1 inch wide and was in the vicinity of the bolt that attached the toilet to the floor. On 09/30/14 at 2:00 PM an observation of the bathroom for room 313 revealed rust colored particles and discoloration at the left side base of the toilet when facing the toilet. The area measured approximately 6 inches long by 1 inch wide and was in the vicinity of the bolt that attached the toilet to the floor. Subsequent observations on 10/01/14 at 9:00 AM and 10/02/14 at 10:00 AM also revealed rust colored particles and discoloration at the left side base of the toilet when facing the toilet. The area measured approximately 6 inches long by 1 inch wide and was in the vicinity of the bolt that attached the toilet to the floor. An interview was conducted with Housekeeper #1 on 10/02/14 at 11:23 AM during which she confirmed she had completed cleaning the residents' rooms and bathrooms on her side of the hall including room 313. Housekeeper #1 stated bathroom floors were mopped daily and she made sure she mopped the base of the toilet and the floor around the base of the toilet well in case a resident had an accident and got urine or stool on the floor. During an interview on 10/02/14 at 11:40 AM the	F 253	checklist schedule and reviewed with all housekeeping staff. A laminated copy was placed on each housekeeping cart as well as placed in the laundry area for quick reference. Housekeepers found to be responsible for the incident will fill out a checklist for each room they are responsible to clean. These checklists will be turned into the Environmental Service Director on a daily basis for the next 90 days. Housekeepers voiced understanding and agreed with compliance. On October 15, 2014, another in-service was held with all environmental service employees. Topics discussed by the Director of Nurses and Staff Development Coordinator were infection control, hand washing, standard precautions, handling and disposal of waste. Environmental Service Director will routinely inspect the cleanliness of each room and common areas once per week for a period of 8 weeks. Any deviation or omission of facility policy will be immediately corrected by Director and disciplinary actions will be addressed with each individual employee. All findings will be documented and reviewed by the Environmental Service Director immediately following observations. The Environmental Service Director will collaborate documentation and report findings to the Q.A. Committee monthly for a period of three months.	

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F 253	Continued From page 6 Administrator stated the Housekeeping Supervisor was out for the day and agreed to observe the bathroom for room 313. An observation on 10/02/14 at 11:41 AM revealed rust colored particles and discoloration at the left side base of the toilet when facing the toilet. The area measured approximately 6 inches long by 1 inch wide and was in the vicinity of the bolt that attached the toilet to the floor. The Administrator wiped the area with his hand and removed a 2 inch area of the rust colored particles. The Administer confirmed the base of the toilet was not clean and stated he would take care of this immediately.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assess a resident for constipation and administer physician's standing orders for constipation for 1 of 5 residents reviewed for constipation (Resident #28). The findings included: Resident #28 was admitted to the facility on 07/01/08 with diagnoses of chronic obstructive pulmonary disease, high blood pressure and dementia. The most recent quarterly Minimum	F 309	This Plan of Correction is submitted to address deficiencies cited under Tag #F309 This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies. Resident #28□s BM report has been	10/16/14

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F 309	Continued From page 7 Data Set (MDS) dated 09/12/14 indicated Resident #28 had severely impaired cognition. The MDS further indicated Resident #28 required extensive assistance by staff for transfers and toilet use. Review of the care plan for incontinence of bowel and bladder dated 09/16/14 revealed Resident #28 was incontinent of bowel and bladder. Review of Shaire Nursing Center Standing Orders read in part for constipation: 1. Check for bowel sounds and impaction 2. Miralax 17gm in 8oz of fluid by mouth everyday 3. Milk of Magnesia (MOM) 30cc by mouth x3 doses at bedtime as needed 4. Dulcolax suppository 1 x2 days as needed 5. Fleets enema x1 and if no results, give soap suds enema x1. Review of the Medication Administration Record for 09/2014 revealed Resident #28 received docusate sodium 2 teaspoons daily to prevent constipation. The MAR further revealed Resident #28 received MOM 30cc on 09/13/14 due to no BM for 6 days. A review of Resident #28's bowel record for 09/2014 revealed no bowel movement (BM) from 09/06/14 thru 09/12/14 (7 days). An extra-large BM was documented on 09/13/14. An interview was conducted on 10/01/14 at 2:06 PM with Nurse #1. She stated the 11:00 PM to 7:00 AM shift nurses print the BM report daily and review it for resident's not having a BM for 3 days. She stated if a resident did not have a BM in 3 days the standing orders for constipation should be implemented. She reported the 3rd shift nurse begin the standing order protocol but if they did not have time they reported off to the oncoming nurse to begin standing orders for constipation. Nurse #1 stated it was not reported to her that	F 309	reviewed daily from October 2, 2014 thru October 15, 2014 by MDS Coordinator. Findings include resident□s bowels moved no less than every three days. New order was obtained for Dulcolax Suppository one per rectum at bedtime on Tuesdays and Fridays if no BM noted. On October 15, 2014, nurses□ meeting was held to review BM protocol. Third shift nurses will run a BM report sheet on a daily basis. If a resident is noted to have not had a bowel movement for 3 consecutive days, standing orders will be initiated by hall nurses. Daily BM report sheets will be reviewed by Director of Nurses for accurate documentation and implementation of facility protocol and standing orders on Monday, Wednesday, and Fridays for the next 12 weeks. Any deviation or omission of facility protocol will be immediately corrected by Director of Nurses with implementation of standing orders. Any nurse not following facility BM protocol, will have disciplinary actions taken on an individual basis. All nurses voiced understanding and agreed with compliance. The Director of Nurses will collaborate documentation and report findings to the Q.A. Committee monthly for a period of three months.	

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F 309	Continued From page 8 Resident #28 had not had a BM for 3 days on 09/08/14 and was also not aware the pattern of constipation continued until 09/13/14. Nurse #1 stated after reviewing Resident #28's MAR and nurses notes the resident did not receive medication for constipation until the 8th day of no BM. She further stated she did not know how Resident #28 was overlooked for no BM for 7 days. An interview was conducted on 10/01/14 at 3:00 PM with the Director of Nursing (DON). She reported the facility protocol for BMs indicated if no BM after 3 days begin the physician's standing order protocol. The DON stated it was her expectation for the 11:00 PM to 7:00 AM nurses to review the BM record and implement interventions for constipation as per standing orders and report to the oncoming nurse.	F 309		