A. BUILDING ________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING ________________________

B. WING _____________________________

(X3) DATE SURVEY COMPLETED

C 02/06/2020

NAME OF PROVIDER OR SUPPLIER

SHAIRE NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1450 SHAIRE CENTER DRIVE
LENOR, NC  28645

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

E 000 Initial Comments

An unannounced Recertification survey was conducted on 02/03/2020 through 02/06/2020. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 7U4T11.

F 000 INITIAL COMMENTS

The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).

E 000

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

Electronically Signed

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/21/2020

TITLE

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.