STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345483	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHAIRE NURSING CENTER	1450 SHAIRE CENTER DRIVE , LENOIR, North Carolina, 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
F0000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 7/2/25. Event ID #9LXY11. The following intake was investigated: NC00232139. 3 of the 3 complaint allegations did not result in deficiency.	F0000		
F0607	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.	F0607		

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 reverse for further 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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F0607	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to ensure staff implemented their abuse policy and procedure in the areas of reporting, investigation and protection when nursing staff did not immediately inform the Administrator when a resident reported an allegation of abuse. This failure resulted in a delay in reporting the allegation to the State Agency, local law enforcement and Adult Protective Services (APS) and the facility investigating the allegation for 1 of 3 residents reviewed for abuse (Resident #1). Findings included: The facility's undated policy titled "Abuse, Neglect, Exploitation, or Misappropriation of Property - Reporting and Investigating" revealed in part, all reports of resident abuse including injuries of unknown origin, neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies as required by current regulations and thoroughly investigated by facility management. Findings of all the investigations are documented and reported. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. Immediately is defined as within two hours of an allegation involving abuse or result in serious bodily injury. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions if any are needed for the protection of residents. Resident #1 was admitted to the facility on 6/6/25 and discharged home on 6/27/25. A phone interview on 7/2/25 at 3:10 PM with Nurse Aide (NA) #1 revealed that she worked from 7:00 AM to 11:00 PM on 6/21/25. NA #1 stated that she along with NA #2 were the ones who discovered the bruise on Resident #1's right shoulder during her shower on Saturday 6/21/25 at approximately 11:00 AM. NA #1 stated that she asked Resident #1 what happened. Resident #1 stated that she was hit by a "large black woman" at night.	F0607		

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F0607	Continued from page 2 Resident #1 then stated that she was hit by a lady last week. NA #1 stated that Resident #1 changed her story when NA #1 asked her about the bruise on Resident #1's right shoulder. NA #1 stated that she told Nurse #1 immediately after talking with Resident #1. A phone interview on 7/2/25 at 3:21 PM with NA #2 revealed that she worked from 7:00 AM to 11:00 PM on 6/21/25. NA #2 stated that she and NA #1 were giving Resident #1 a shower and they noticed a bruise on Resident #1's right shoulder. NA #2 asked Resident #1 what had happened. Resident #1 stated that that woman had hit her. She asked Resident #1 what woman? Resident #1 would only say that woman hit her. NA #2 stated that she got Nurse #1 immediately. A phone interview on 7/2/25 at 1:11 PM with Nurse #1 revealed that she worked from 7:00 AM to 7:00 PM on 6/21/25. Nurse #1 stated that Nurse Aide #1 found a bruise on Resident #1's right shoulder during her shower on 6/21/25. Nurse #1 asked Resident #1 what happened. Resident #1 stated that woman hit me. Nurse #1 asked what woman? Resident #1 stated that" black lady at night". Nurse #1 stated that she told the Nurse Supervisor immediately after talking with Resident #1. Nurse #1 stated she could not remember if she told the Administrator or the Director of Nursing (DON). She stated that their policy was to report to their immediate supervisors and the Director of Nursing (DON) and file an immediate report. She stated that she should have reported the allegation to the DON since Resident #1 stated that someone had hit her. A phone interview on 7/2/25 at 1:33 PM with the Nurse Supervisor revealed that she worked from 7:00 AM to 7:00 PM on 6/21/25. She stated that Nurse #1 told her about the bruise on Resident #1's right shoulder. She stated that she spoke with Resident #1 on Saturday (6/21/25) and Resident #1 told her that a lady hit her. The Nurse Supervisor stated that she waited a few hours later and Resident #1 told her it was "that black girl hit me last week". She stated that Resident #1 had habit of changing her story and giving conflicting information during conversations which was why she waited a few hours to ask Resident #1 about the incident a second time. The Nurse Supervisor stated that she told the DON on Saturday 6/21/25 or Sunday 6/22/25 night, but she did not tell her immediately. She stated that she should have told the DON immediately since Resident #1 stated that she had been hit by someone.	F0607		

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F0607	Continued from page 3 A joint interview on 7/2/25 at 4:47 PM with the DON and the Administrator revealed they both expected staff to notify them immediately upon discovery of any abuse allegation. The DON did not recall the Nurse Supervisor telling her about Resident #1's abuse allegation on 6/21/25 or 6/22/25. The DON stated that she would have suspended any suspected staff immediately pending an investigation. The Administrator was notified of the abuse allegation by the surveyor on 7/2/25. The Administrator stated that had he been notified immediately he would have reported the allegation to the state, local law enforcement, and APS within 2 hours. The Administrator stated he would have completed a thorough investigation and provided education to the staff. The DON stated that Nurse #1 and the Nurse Supervisor should have told her about the allegation of abuse immediately.	F0607		