

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(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 Shaire Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1450 Shaire Center Drive Lenoir, NC 28645	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).</p> <p>Findings included:</p> <p>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.</p> <p>Resident #1 was admitted to the facility on [DATE] and discharged home on 6/27/25.</p> <p>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. 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.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p>		