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	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shaire Nursing Center	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)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews the facility failed to complete a Significant Change in Status Assessment for a resident who had been discharged from hospice care for 1 of 3 residents reviewed for hospice (Resident #3). Findings included: Resident #3 was admitted to the facility on [DATE] with diagnoses including heart failure and diabetes. 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 the nurses and review of the resident's chart. The 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. (continued on next page)

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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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 change in status assessment had not been completed when Resident #3 was discharged from hospice services.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 3 of 6 residents reviewed for hospice, discharge, and falls (Resident #3, Resident #40, and Resident #50). Findings included: 1. Resident #3 was admitted to the facility on [DATE] with diagnoses including heart failure and depression. 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 on 08/09/23 or discontinued on 01/08/24. Review of Resident #3's quarterly Minimum Data Sets (MDS) dated [DATE], and 06/24/24 revealed the resident was 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 the nurses and review of the resident ' s chart. The MDS Coordinator further revealed Resident #3 should have not been coded for hospice care on the quarterly MDS assessments for 03/27/24 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. 45380 2. Resident #40 was admitted to the facility on [DATE] and readmitted on [DATE]. 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 [DATE] revealed no history of falls or falls with major injury. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 his 5-day admission assessment dated [DATE] as having a history of falls and one fall with major injury. She revealed she believed it was just an oversight and human error on her part that she forgot to check the correct boxes under falls. An interview with the Director of Nursing (DON) on 7/03/24 at 1:31 PM revealed Resident #40 5-day admission MDS dated [DATE] should have reflected his previous fall with major injury. She stated MDS assessments should be coded correctly and reflect resident's current orders, changes in conditions, incidents, assessments, and status. 3. Resident # 50 was admitted to the facility on [DATE] and was discharged home on 4/05/24. Review of Resident #50 discharge progress note dated 4/05/24 revealed Resident #50 to discharge home with home health referral completed to evaluate and treat in home and ordered medical equipment received and available at resident home. Resident #50 was wheeled to vehicle and assisted into front seat and her belongings were taken by her husband. Discharge instructions were verbally reviewed in detail with Resident #50 husband, he verbalized understanding, and a written copy was provided. Resident #50 prescriptions were faxed to pharmacy with confirmation received, follow-up appointment made with primary care physician for 4/16/24 at 2:40 PM. Resident #50 had left facility with husband in pleasant mood. The discharge Minimum Data Set (MDS) assessment dated [DATE] indicated under the discharge status, that Resident #50 was an unplanned, return not anticipated discharge to home. An interview with the MDS Coordinator on 7/03/24 at 1:25 PM revealed Resident #50 was a planned discharge and should have been coded as a planned, return not anticipated, discharge to home. She stated she believed it was just an oversight and human error on her part that she forgot to check the correct box under discharge status. An interview with the Director of Nursing on 7/03/24 at 1:40 PM revealed Resident #50 discharge was planned, and she should have been coded on her discharge MDS assessment as a planned discharge to home. She stated MDS assessments should be coded correctly and reflect resident's current orders, changes in condition, admission, and discharge status.