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	08/13/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident and staff, the facility failed to maintain a wheelchair in good repair for 1 of 1 resident reviewed for safe, clean, comfortable and homelike environment (Resident #18). Resident #18 was admitted to the facility on [DATE]. Review of weekly skin assessments from 06/07/25 through 08/09/25 revealed Resident #18's skin was intact. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #18 with moderate impairment in cognition and her primary mobility device was a wheelchair. During an observation conducted on 08/11/25 at 11:30 AM, Resident #18 was seen sitting in her wheelchair next to her bed in her room. The vinyl cover of the left armrest of her wheelchair was in disrepair with multiple torn spots, ripped edges, and cracked lines approximately size of 2. 5 inches by 9 inches. Resident #18 was seen wearing a short-sleeved shirt and her left arm was contacting with the broken armrest during the observation. An interview was conducted with Resident #18 on 08/11/25 at 11:32 AM. She stated that she did not know how long the vinyl cover of the left arm rest had been torn, ripped, and cracked and it bothered her as it irritated her skin at times. She added she used the wheelchair frequently and hoped the staff would fix it soon. During a joint observation conducted on 08/12/25 at 10:36 AM with Nurse #4 and Nurse Aide (NA) #2 in the dining room, the vinyl cover of the left armrest of Resident #18's wheelchair remained in disrepair. Resident #18 was sitting in the wheelchair with her left arm contacting the broken armrest. Nurse #4 assessed Resident #18's left arm immediately and reported that her skin was intact without any redness, rashes or open areas. An interview was conducted on 08/12/25 at 10:41 AM with Nurse #4. She acknowledged that she had provided care for Resident #18 frequently in the past few months, but she did not notice the vinyl cover of the left armrest of Resident #18's wheelchair was broken. She added the broken armrest needed to be fixed immediately to ensure Resident #18's skin integrity. During an interview conducted on 08/12/25 at 10:43 AM, NA #2 stated she noticed the vinyl cover of the left armrest of Resident #18's wheelchair was broken and had reported her findings to the Rehabilitation staff a couple weeks ago. However, she could not recall the name of the rehabilitation staff member. She stated the broken armrest needed to be fixed as soon as possible to avoid skin irritation. An interview was conducted on 08/12/25 at 10:48 AM with the Rehabilitation Director. She stated wheelchair repair was typically handled by the maintenance department. The Rehabilitation Director indicated the department depended on nursing staff to report repair needs for wheelchairs. The Rehabilitation Director explained they would address simple repair issues and notify the maintenance department of complicated repair tasks. She denied she had received any reports related to wheelchair repair from nursing staff in the past couple weeks. An interview was conducted on 08/12/25 at 1:17 PM with the Director of Nursing. She expected the staff to be more attentive to residents' mobility devices when providing care and to report repair needs to the maintenance department in a timely manner. It was her expectation for all the mobility devices to be in good repair all the times. During an interview conducted on 08/12/25 at 1:28 PM, the Maintenance Director acknowledged that the vinyl cover of the left armrest for Resident #18's wheelchair was in disrepair and needed to be fixed immediately. He stated the maintenance department did not perform routine walk throughs in the facility to identify repair needs for wheelchairs. Instead, the maintenance department depended heavily on staff to report repair needs via work order clipboard in each nurse station or verbal notification. He typically checked the work order clipboard at least once daily to ensure all the repair needs were addressed in a timely manner. The Maintenance Director stated he did not know the vinyl cover of the left armrest of Resident #18's wheelchair was broken as he never received any report from the staff. He stated it was important for all the staff to be more attentive to residents' mobility devices and report repair needs as indicated when providing care or performing housekeeping. An interview was conducted with the Administrator on 08/13/25 at 12:06 PM. He expected all the staff, including housekeepers and management staff to be more attentive to residents' repair needs and report the findings to maintenance department in a timely manner. It was his expectation for all the mobility devices including wheelchairs to be in good repair all the times.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, lorazepam (a medication used to relieve anxiety disorder), had a stop date of 14 days for 1 or 5 residents (Resident #3) reviewed for unnecessary medications.Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. The care plan for anxiety disorder initiated on 09/22/24 revealed Resident #3 received antianxiety related to anxiety disorder. The goal was to have decreased episodes of anxiety through the next review date. Interventions included administering medications as ordered by the physician. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #3's with severely impaired cognition and indicated she received antianxiety medications during the assessment period. A review of physician's orders dated 07/05/25 revealed Resident #3 had an order to receive one (1) tablet of lorazepam 0.5 milligrams (mg) by mouth once every 4 hours PRN for anxiety disorder. In addition, Resident #3 also had a scheduled order for lorazepam 0.5 mg 4 times daily initiated on 07/05/25. Both orders were entered into the electronic health records by the Medical Director, and there was no stop date for the PRN lorazepam order. A review of Resident #3's July and August 2025 medication administration records (MARs) revealed the PRN lorazepam order that initiated on 07/05/25 remained an active order. Further review of the MARs revealed Resident #3 had not been administered any doses of the PRN lorazepam. An attempt for a phone interview with the Medical Director on 08/12/25 at 12:48 PM was unsuccessful. He did not return the call. During an interview conducted on 08/12/25 at 1:31 PM, Nurse #4 stated she was aware of Resident #3's PRN lorazepam as it remained an active order. She indicated Resident #3 cried frequently in the past and had an order to receive PRN lorazepam 0.5 mg up to 4 times daily. On average, Resident #3 received the PRN lorazepam 2 to 3 times daily in the past. After the physician initiated the scheduled lorazepam 0.5 mg 4 times daily on 07/05/25, the PRN lorazepam had not been administered so far as Resident #3's behavior was under control. Nurse #4 stated she knew all PRN psychotropic drugs were limited to 14 days. Nurses #4 indicated when she saw the PRN lorazepam order for Resident #3 without a stop date, she thought the rules had been changed. An interview was conducted on 08/13/25 at 11:10 AM with the Director of Nursing (DON). She stated it was her expectation for all the physicians to follow the Centers for Medicare and Medicaid Services (CMS) guidelines to set a stop date of 14 days for PRN psychotropic medications. The DON denied this was a system failure but an isolated oversight by the Medical Director and the Consultant Pharmacist. During an interview conducted with the Administrator on 08/13/25 at 12:06 PM, he stated Resident #3's PRN Lorazepam order should have a stop date of 14 days. It was his expectation for all the physicians to follow CMS guidelines when prescribing PRN psychotropic medications.

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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** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of bladder and bowel, and medications for 2 of 5 residents (Resident #53 and Resident #21) whose MDS were reviewed.The findings included:1.Resident #53 was admitted to the facility on [DATE].A nursing progress note dated 7/20/25 in Resident #53's medical record indicated the nurse discontinued Resident #53's urinary catheter per order without difficulty and without resident complaint.The admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #53 as having an indwelling catheter and was frequently incontinent of urine.An interview with the MDS Coordinator on 8/13/25 at 10:21 AM revealed she should have coded Resident #53's admission MDS as having no indwelling catheter. The MDS Coordinator stated that Resident #53's urinary incontinence status was auto populated based on responses made by the nurse aides and she was frequently incontinent of urine.An interview with the Director of Nursing on 8/13/25 at 2:05 PM revealed the MDS Coordinator should have coded Resident #53's admission MDS accurately. 2.Resident #21 was admitted to the facility on [DATE].The quarterly MDS dated [DATE] coded Resident #21 as taking anticoagulants. An anticoagulant, also known as a blood thinner, is a medication that helps prevent blood clots from forming or growing larger.A review of the Medication Administration Record for Resident #21 for July 2025 indicated she received Apixaban (an anticoagulant) from 7/1/25 to 7/3/25.An interview with the MDS Coordinator on 8/13/25 at 10:17 AM revealed she didn't see that the Apixaban had been discontinued on 7/3/25 for Resident #21. The MDS Coordinator stated she should not have coded Resident #21 as receiving anticoagulants since she did not receive any anticoagulants during the 7-day look back period from 7/25/25.An interview with the Director of Nursing on 8/13/25 at 2:05 PM revealed the MDS Coordinator should have coded Resident #21's quarterly MDS accurately.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews with staff and the Consultant Pharmacist, the Consultant Pharmacist failed to identify a drug irregularity and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Residents #3). Resident #3 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #3's with severely impaired cognition and indicated she received antianxiety medication during the assessment period. A review of physician orders dated 07/05/25 revealed Resident #3 had an order to receive one (1) tablet of lorazepam 0.5 milligrams (mg) by mouth once every 4 hours as needed (PRN) for anxiety disorder. In addition, Resident #3 also had a scheduled order of lorazepam 0.5 mg 4 times daily initiated on 07/05/25. Both orders were entered into the electronic health records by the Medical Director, and there was no stop date for the PRN lorazepam order. A review of Resident #3's July and August 2025 medication administration records (MARs) revealed the PRN lorazepam order that initiated on 07/05/25 remained an active order. Further review of the MARs revealed Resident #3 had not been administered any doses of the PRN lorazepam. A review of Resident #3's medical record revealed the Consultant Pharmacist had conducted a monthly Medication Regimen Review (MRR) on 08/03/25. Further review of Resident #3's August 2025 MMR revealed no recommendations related to the PRN lorazepam order without a stop date had been made by the Consultant Pharmacist to the facility after completing the MRR on 08/03/25. During a phone interview conducted on 08/12/25 at 10:57 AM, the Consultant Pharmacist confirmed he had completed the monthly MRR for Resident #3 on 08/03/25 but he did not recommend the Medical Director to have a stop date for the PRN lorazepam order. He recalled identifying the PRN lorazepam order that originated on 07/05/25 without a stop date but he could not explain why he did not make a recommendation to the physician. He stated he was familiar with the Centers for Medicare and Medicaid Services (CMS) guidelines and indicated the PRN lorazepam order should have a stop date. He attributed the incident to his oversight. An attempt for a phone interview with the Medical Director on 08/12/25 at 12:48 PM was unsuccessful. He did not return the call. During an interview conducted on 08/12/25 at 1:31 PM, Nurse #4 stated she was aware of Resident #3's PRN lorazepam as it remained an active order. She indicated Resident #3 cried frequently in the past and had an order to receive PRN lorazepam 0.5 mg up to 4 times daily. On average, Resident #3 received the PRN lorazepam 2 to 3 times daily in the past. After the physician initiated the scheduled lorazepam 0.5 mg 4 times daily on 07/05/25, the PRN lorazepam had not been administered so far as Resident #3's behavior was under control. During an interview conducted on 08/13/25 at 11:10 AM, the Director of Nursing (DON) stated she expected the Consultant Pharmacist to identify irregularities related to Resident #3's PRN lorazepam when performing monthly MRRs and report the findings to the facility in a timely manner. The DON further stated it was her expectation that the Consultant Pharmacist followed the CMS guidelines when conducting MRRs. An interview was conducted with the Administrator on 08/13/25 at 12:06 PM. He stated Resident #3's physician order for PRN Lorazepam should have a stop date of 14 days. It was his expectation for the Consultant Pharmacist to identify irregularities when performing monthly MRRs and report the findings to the facility in a timely manner.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility failed to follow their infection control policies and procedures for Enhanced Barrier Precautions when 3 of 6 staff members (Nurse #2, Nurse #1 and Nurse Aide #1) reviewed for infection control practices failed to wear a gown while performing and assisting with wound care.The findings included: A review of the facility’s undated infection control policy entitled, “Enhanced Barrier Precautions,” indicated enhanced barrier precautions apply when a resident is NOT known to be infected or colonized with any MDRO ([NAME]-drug resistant organism), has a wound or indwelling medical devices, and does not have secretions or excretions that are unable to be covered or contained. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room). Examples of high-contact resident care activities requiring the use of gown and gloves for enhanced barrier precautions (EBP) include dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing linens, prolonged, high-contact with items in the resident’s room, with resident’s equipment, or with resident’s clothing or skin, device care or use and wound care (any skin opening requiring a dressing). 1. An observation of wound care on Resident #8 was conducted on 8/12/25 at 1:42 PM with Nurse #2. Nurse #2 was observed performing hand hygiene using hand sanitizer, donned gloves, and removed the dressing from Resident #8’s pressure ulcer to the right buttock. She removed her gloves, applied hand sanitizer to both hands and donned new gloves. She sprayed the wound with wound cleanser, wiped it with dry gauze, removed her gloves and performed hand hygiene using hand sanitizer. She donned new gloves, applied Silvadene cream to the wound and covered it with a foam dressing. She removed her gloves and performed hand hygiene using hand sanitizer. There was no signage for EBP or personal protective equipment outside of Resident #2’s door. An interview with Nurse #2 on 8/12/25 at 1:50 PM revealed Resident #8’s dressing change was scheduled for the evening shift, and it was normally done by the evening shift nurse. Nurse #2 stated she thought the ordered treatment for Resident #8 was just for protection and that the wound was not open which was why she didn’t put on a gown prior to doing the wound care. Nurse #2 stated Resident #8 probably should have been placed on EBP because of her open stage 2 pressure ulcer to the right buttock. An interview with Nurse #3 on 8/12/25 at 3:32 PM revealed she had been doing Resident #8’s treatment on the evening shift since she observed an open pressure ulcer to her right buttock sometime in July 2025. Nurse #3 stated that she was not aware that she had to place Resident #8 on EBP, and that she thought EBP was just for residents with medical devices or active infections. Nurse #3 stated she had never been told by the facility’s Infection Preventionist that EBP was required for residents with open wounds. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Infection Preventionist (IP) on 8/13/25 at 3:27 PM revealed she was not aware of Resident #8’s pressure ulcer being open. The IP stated she knew Resident #8 used to have a treatment to her buttocks for protection only. The IP stated that Nurse #3 should have initiated EBP for Resident #8 after she identified Resident #8’s pressure ulcer to her right buttock. The IP stated that Nurse #3 received education on EBP, and she was not sure why Nurse #3 was confused except that she might not have understood the education on EBP. The IP further stated that Nurse #2 received education on EBP and should have worn a gown and gloves while providing wound care to Resident #8. An interview with the Director of Nursing (DON) on 8/13/25 at 2:05 PM revealed she was not sure how EBP got missed for Resident #8. The DON stated Resident #8 should have been placed on EBP as soon as her pressure ulcer was identified, and that the nurses should follow EBP and wear a gown and gloves when providing wound care to Resident #8. 2. An observation of wound care on 08/12/25 at 3:10 PM on Resident #50 was conducted with Nurse #1 and Nurse Aide (NA) #1 assisting. Nurse #1 and NA #1 were observed performing hand hygiene, donned gloves, and while NA #1 held the resident over on her side, Nurse #1 removed the dressing from Resident #50’s pressure area to the sacrum. He removed his gloves, washed his hands with soap and water and donned clean gloves. Nurse #1 cleansed the wound with normal saline soaked gauze and dried with another gauze. He doffed his gloves, sanitized his hands and donned new gloves and applied calcium alginate, and covered the wound with foam dressing. Nurse #1 and NA #1 removed their gloves, sanitized their hands, Nurse #1 gathered his supplies and NA #1 gathered the trash and they both left the room. An interview on 08/12/25 at 3:30 PM with NA #1 revealed her understanding of Enhanced Barrier Precautions (EBP) was that she only had to wear a gown while providing incontinence care to Resident #50. An interview on 08/12/25 at 3:40 PM with Nurse #1 revealed he should have worn a gown to perform Resident #50’s wound care. Nurse #1 stated he was in a hurry to get it done and just forgot to put the gown on but said he knew that he was supposed to wear a gown into Resident #50’s room to perform her wound care. An interview on 08/13/25 at 3:20 PM with the Infection Preventionist (IP) revealed Nurse #1 and NA #1 had received education on EBP, and she was not sure why they had not worn a gown in the room because the sign was on the wall beside her door and the bin filled with personal protective equipment (PPE) right outside her door. The IP stated Nurse #1 and NA #1 should have worn a gown while performing wound care to Resident #50. An interview on 08/13/25 at 2:05 PM with the Director of Nursing (DON) revealed she was not sure why Nurse #1 and NA #1 had not worn a gown into Resident #50’s room to do her wound care since she was on EBP. The DON stated the signage was on the wall beside her door and personal protective equipment (PPE) was in a bin right outside her door and there was no excuse for them not wearing a gown while providing wound care to Resident #50.