| 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 08/13/2025 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SHAIRE NURSING CENTER | 1450 SHAIRE CENTER DRIVE , LENOIR, North Carolina, 28645 |

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| E0000 | Initial Comments<br><br>An unannounced recertification survey was conducted on 08/11/25 through 08/13/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D3175-H1. | E0000 | | |
| F0000 | INITIAL COMMENTS<br><br>A recertification survey was conducted 08/11/25 through 08/13/25. Event ID# 1D3175-H1. | F0000 | | |
| F0584<br>SS = D | Safe/Clean/Comfortable/Homelike Environment<br><br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br><br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br><br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition; | F0584 | This Plan of Correction is submitted to address deficiencies cited under Tag #F584<br><br>This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies.<br><br>On 08/12/25, the wheelchair arm for Resident #18 was immediately replaced at approximately 10:30am. In addition, Resident #18 was assessed for skin concerns by licensed nurse with no skin breakdown, irritation, or redness noted.<br><br>On 08/18/25, a full facility audit of all resident mobility devices (wheelchairs, walkers, and geri-chairs) was completed by the Maintenance and Therapy Departments. There were no identified items in disrepair. Findings were documented and retained for QAPI review.<br><br>All staff were re-educated on 09/02/25 by the Administrator regarding responsibility to report any resident equipment in disrepair immediately to the Maintenance Department. Procedural review of where to find and complete work orders was conducted. Maintenance staff were re-educated on 09/02/25 regarding proactive monitoring of resident mobility devices and other facility equipment. Facility does not utilize agency staffing thereby re-education was not warranted. All newly hired staff receives this education during orientation. Any staff on leave will receive re-education prior to returning to work.<br><br>The Maintenance or Therapy Departments will complete audits of (8) random wheelchairs, geri-chairs, or other | 09/02/2025 |

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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| F0584 SS = D | Continued from page 1<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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).<br><br>Resident #18 was admitted to the facility on 01/22/25.<br><br>Review of weekly skin assessments from 06/07/25 through 08/09/25 revealed Resident #18's skin was intact.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 07/25/25 coded Resident #18 with moderate impairment in cognition and her primary mobility device was a wheelchair.<br><br>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.<br><br>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 | F0584 | Continued from page 1<br>resident mobility devices once per week for a period of 4 weeks, then once every other week for a period of 4 weeks and once monthly for a period of 1 month to verify condition and document findings. The Maintenance Director will compile documentation and report findings to the QAPI Committee for a period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. | |

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| F0584 SS = D | Continued from page 2<br>irritated her skin at times. She added she used the wheelchair frequently and hoped the staff would fix it soon.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F0584 | | |

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| F0584 SS = D | Continued from page 3<br>repair all the times.<br><br>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.<br><br>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. | F0584 | | |
| F0605 SS = D | Right to be Free from Chemical Restraints<br><br>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)<br><br>§483.10(e) Respect and Dignity.<br><br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any . . . chemical restraints<br><br>imposed for purposes of discipline or convenience, and not required to treat the<br><br>resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12 | F0605 | This Plan of Correction is submitted to address deficiencies cited under Tag #F605<br><br>This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies.<br><br>Resident #3's PRN lorazepam order dated 07/05/25 was reviewed by the DON and attending physician on 08/14/25. The PRN lorazepam order was discontinued on 08/15/25, as the resident was already receiving scheduled lorazepam with good effect and had not required PRN doses since 07/05/25. No negative outcome occurred.<br><br>Effective 08/15/25, the Consultant Pharmacist will review all new psychotropic medication orders to ensure compliance with CMS requirements, including mandatory 14-day stop dates. All licensed nursing staff, consultant pharmacist, and medical providers were re-educated on 09/03/25 by the Administrator and DON | 09/05/2025 |

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| F0605 SS = D | Continued from page 4<br><br>The resident has the right to be free from abuse, neglect, misappropriation of<br><br>resident property, and exploitation as defined in this subpart. This includes but is<br><br>not limited to freedom from corporal punishment, involuntary seclusion and any<br><br>physical or chemical restraint not required to treat the resident's medical<br><br>symptoms.<br><br>§483.12(a) The facility must-. . .<br><br>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints<br><br>imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.<br><br>. . . .<br><br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br><br>(ii) Anti-depressant;<br><br>(iii) Anti-anxiety; and<br><br>(iv) Hypnotic.<br><br>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which | F0605 | Continued from page 4<br>regarding CMS regulations requiring a 14-day stop date for PRN psychotropic medications, including the process for addressing noncompliant orders immediately with the prescribing provider. Facility does not utilize agency staffing thereby re-education was not warranted. All newly hired staff receives this education during orientation. Any staff on leave will receive re-education prior to returning to work.<br><br>On 09/03/25 to 09/05/25, the Consultant Pharmacist, with oversight from the DON, conducted a facility-wide audit of all PRN psychotropic medications to ensure compliance with CMS requirements, including mandatory 14-day stop dates. Any PRN psychotropic orders identified as noncompliant were corrected immediately. All PRN psychotropic orders are in compliance with CMS guidelines.<br><br>The DON or designee and the Consultant Pharmacist will conduct reviews of medication orders for compliance with PRN psychotropic stop-date requirements on all PRN psychotropic orders once per week for a period of 4 weeks, then once every other week for a period of 4 weeks and once monthly for a period of 1 month. The Consultant Pharmacist will continue monthly reviews of all psychotropic medications during routine medication regimen reviews. The DON or designee will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. | |

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| F0605 SS = D | Continued from page 5<br>indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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. | F0605 | | |

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| F0605 SS = D | Continued from page 6<br>Resident #3 was admitted to the facility on 01/02/23 with diagnoses that included anxiety disorder.<br><br>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.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 06/22/25 coded Resident #3's with severely impaired cognition and indicated she received antianxiety medications during the assessment period.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F0605 | | |

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| F0605 SS = D | Continued from page 7<br>she saw the PRN lorazepam order for Resident #3 without a stop date, she thought the rules had been changed.<br><br>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.<br><br>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. | F0605 | | |
| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or | F0641 | This Plan of Correction is submitted to address deficiencies cited under Tag #F641<br><br>This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies.<br><br>Resident #53: The admission MDS was corrected on 08/14/25 to accurately reflect the absence of an indwelling catheter and correct urinary continence status. Resident #21: The quarterly MDS dated 07/25/25 was modified on 08/14/25 to accurately reflect that no anticoagulant was received during the look-back period. Both corrected assessments were re-submitted and accepted by CMS on 08/14/25.<br><br>In addition, on 08/14/25, the Director of Nursing (DON) and MDS Coordinator initiated an audit of all current residents MDS assessments to verify coding accuracy. All MDSs were found to be coded accurately.<br><br>On 08/15/25, the MDS Coordinator was re-educated by the Director of Nurses as to the importance of accurately coding the complete MDS assessment with specific emphasis on Sections H (Bladder/Continence) and N (Medications). RAI guidelines were reviewed. All MDS Assessments will be completed accurately, timely and according to the RAI Manual.<br><br>The DON or designee will conduct (5) random reviews of MDS assessments once per week for a period of 4 weeks, then once every other week for a period of 4 weeks and once monthly for a period of 1 month. The DON or | 08/18/2025 |

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| F0641 SS = D | Continued from page 8<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>The findings included:<br><br>1.Resident #53 was admitted to the facility on 7/16/25.<br><br>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.<br><br>The admission Minimum Data Set (MDS) assessment dated 7/23/25 coded Resident #53 as having an indwelling catheter and was frequently incontinent of urine.<br><br>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.<br><br>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.<br><br>2.Resident #21 was admitted to the facility on 3/19/22.<br><br>The quarterly MDS dated 7/25/25 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.<br><br>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. | F0641 | Continued from page 8<br>designee will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. | |

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| F0641 SS = D | Continued from page 9<br>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.<br><br>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. | F0641 | | |
| F0756 SS = D | Drug Regimen Review, Report Irregular, Act On<br><br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br><br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br><br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen | F0756 | This Plan of Correction is submitted to address deficiencies cited under Tag #F756<br><br>This is to state that we do not concur with this recommendation as stated for deficient practice. Upon finding stated deficiencies.<br><br>Resident #3's PRN lorazepam order dated 07/05/25 was reviewed by the DON and attending physician on 08/14/25. The PRN lorazepam order was discontinued on 08/15/25, as the resident was already receiving scheduled lorazepam with good effect and had not required PRN doses since 07/05/25.<br><br>On 09/03/25, the Consultant Pharmacist was re-educated by the Administrator and DON regarding CMS F605 and F756 requirements, with emphasis on identifying and reporting all irregularities during the monthly Medication Regimen Review (MRR) and ensuring that PRN psychotropic medications have required 14-day stop dates unless renewed by the prescriber.<br><br>On 09/03/25, the Consultant Pharmacist, with oversight from the DON, conducted a facility-wide audit of all PRN psychotropic medications to ensure compliance with CMS requirements, including mandatory 14-day stop dates. No additional residents were found to have active PRN psychotropic orders without stop dates.<br><br>The DON or designee and the Consultant Pharmacist will conduct (5) random reviews of medication orders for compliance with PRN psychotropic stop-date requirements once per week for a period of 4 weeks, then once every other week for a period of 4 weeks and once monthly for a period of 1 month. The DON or designee will review (5) of the Consultant Pharmacist's monthly MRR for completeness and accuracy including pharmacist follow-up recommendations beginning with the September 2025 review once monthly for a period of 3 months. The DON or designee will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a period of three months. The | 09/03/2025 |

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| F0756 SS = D | Continued from page 10<br>review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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).<br><br>Resident #3 was admitted to the facility on 01/02/23 with diagnoses that included anxiety disorder.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 06/22/25 coded Resident #3's with severely impaired cognition and indicated she received antianxiety medication during the assessment period.<br><br>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.<br><br>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.<br><br>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.<br><br>During a phone interview conducted on 08/12/25 at 10:57 | F0756 | Continued from page 10<br>QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. | |

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| F0756 SS = D | Continued from page 11<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. | F0756 | | |
| F0880 SS = D | Infection Prevention & Control<br><br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control | F0880 | This Plan of Correction is submitted to address deficiencies cited under Tag #F880<br><br>This is to state that we do not concur with this | 08/19/2025 |

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| F0880 SS = D | Continued from page 12<br><br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br><br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br><br>(i) A system of surveillance designed to identify possible communicable diseases or<br><br>infections before they can spread to other persons in the facility;<br><br>(ii) When and to whom possible incidents of communicable disease or infections should be reported;<br><br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br><br>(iv)When and how isolation should be used for a resident; including but not limited to:<br><br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br><br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br><br>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will | F0880 | Continued from page 12<br>recommendation as stated for deficient practice. Upon finding stated deficiencies.<br><br>Resident #8 was immediately placed on Enhanced Barrier Precautions (EBP) on 08/13/25.<br><br>Proper EBP signage was posted outside their room. Personal protective equipment (PPE) including gowns and gloves was stocked outside resident room.<br><br>Nurse #1 and Nurse Aide #1 were immediately re-educated on the requirement to don gowns and gloves for wound care under EBP; the facility's infection control policy on EBP for clarity to include EBP definition; application and indication of use; PPE requirements and examples of high-contact resident care activities by the Infection Preventionist (IP) on 08/12/25. Nurse #2 and Nurse #3 were re-educated on the facility's infection control policy on EBP for clarity to include EBP definition; application and indication of use; PPE requirements and examples of high-contact resident care activities on 08/13/25.<br><br>On 08/18/25, the IP reviewed all residents with open wounds, indwelling medical devices and other risk factors requiring EBP. In addition, wound care treatment orders were audited by the IP to confirm that EBP was applied where indicated. All residents with open wounds, indwelling devices, or who otherwise meeting criteria for EBP were found to have appropriate signage and PPE supplies for every applicable room.<br><br>All licensed nurses, CNAs, rehabilitation staff, and environmental service staff were re-educated by the IP on EBP, gown/glove use, and signage requirements. Training also included CMS guidance, policy review, and case-based scenarios (e.g., wound care) concluding on 08/19/25. New staff will receive EBP training during orientation. Facility does not utilize agency staffing thereby re-education was not warranted. Any staff on leave will receive re-education prior to returning to work.<br><br>The IP will conduct (5) random audits of wound care procedure and EBP protocol once per week for a period of 4 weeks, then once every other week for a period of 4 weeks and once monthly for a period of 1 month to ensure staff compliance. The IP will compile documentation and report findings to the Quality Assurance and Performance Improvement Committee for a | |

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| F0880 SS = D | Continued from page 13<br>transmit the disease; and<br><br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br><br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br><br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>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.<br><br>The findings included:<br><br>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 (muti-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). | F0880 | Continued from page 13<br>period of three months. The QAPI Committee will assess and modify the action plan as needed to ensure continued compliance. | |

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| F0880 SS = D | Continued from page 14<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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 | F0880 | | |

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| F0880 SS = D | Continued from page 15<br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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. | F0880 | | |