

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345445	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/31/2025
NAME OF PROVIDER OR SUPPLIER Glenaire			STREET ADDRESS, CITY, STATE, ZIP CODE 4000 Glenaire Circle , Cary, North Carolina, 27511	
(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/29/25 through 12/31/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DF17C-H1.	E0000		01/21/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/29/25 through 12/31/25. Event ID# 1DF17C-H1. The following intakes were investigated 889029 and 889030. 5 of the 5 complaint allegations did not result in deficiency.	F0000		01/21/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the	F0609	Corrective Action: Resident #78 was discharged from the facility on February 13, 2025. Due to the resident's discharge status, the facility is unable to retroactively correct the failure to notify law enforcement related to the specific allegation of misappropriation of resident property. Identification of others with the potential to be affected: An audit of facility incidents reports and grievance logs for the past 30 days was conducted by the Administrator and Director of Nursing to verify that allegations of misappropriation of resident property were reported to law enforcement in accordance with regulatory requirements. No additional concerns were identified. Measures put in place or systemic changes to ensure practice does not recur: The facility's Abuse Prohibition Policy was reviewed and reflects that all allegations of misappropriation of resident property are reported immediately to law enforcement when there is a reasonable suspicion of a crime. The review reinforced leadership understanding and supported consistent interpretation and implementing of reporting expectations in accordance with 42 CFR § 483t.12 (c).	01/22/2026

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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F0609 SS = D	<p>Continued from page 1 alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to report an allegation of misappropriation of resident property to law enforcement. This deficient practice affected 1 of 3 residents reviewed for misappropriation (Resident #78).</p> <p>Finding Included:</p> <p>Resident #78 was admitted to the facility on 12/20/2024 with a diagnosis of fracture of unspecified part of the left femur.</p> <p>The facility's 24 hour initial allegation report dated 1/13/2025, completed by the Director of Nursing (DON), documented that Resident #78 told a therapist she was missing \$100 from her wallet. Adult Protective Services (APS) was notified. The DON offered to report the missing money to law enforcement, but Resident #78 declined to make a police report.</p> <p>The facility's investigation report dated 1/13/2025, completed by the DON, documented that law enforcement was not contacted because Resident #78 declined to do so.</p> <p>During an interview on 12/31/2025 at 10:23 a.m., the Social Worker stated she did not report the misappropriation to law enforcement because Resident #78 did not want the incident reported. She confirmed she did report the allegation to APS.</p> <p>During an interview on 12/31/2025 at 10:26 a.m., the DON stated the facility did not contact law enforcement because Resident #78 declined to do so.</p> <p>During an interview on 12/31/2025 at 10:35 a.m., the Administrator stated the facility did not contact law enforcement because Resident #78 declined to make a police report.</p>	F0609	<p>Continued from page 1</p> <p>The Administrator and Director of Nursing were re-educated on the facility's Abuse Prohibition Policy and mandatory reporting requirements by the Tiffany Roberson Vice President of Health Services with emphasis that reporting allegations of misappropriation of resident property to law enforcement when there is a reasonable suspicion of a crime is a facility responsibility.</p> <p>The Director of Nursing provided re-education on the facility's Abuse Prohibition Policy and mandatory reporting requirements to the Interdisciplinary Team to reinforce consistent interpretation and implementation of reporting requirements in accordance with 42 CFR § 483t.12 (c).</p> <p>Ongoing monitoring of corrective actions and new measures:</p> <p>The Administrator and the Director of Nursing will review allegations involving abuse, neglect, exploitation, or misappropriation of resident property to ensure appropriate timely reporting. Monitoring will occur monthly for (3) months. The results of this audit will be brought to and reviewed by the Director of Nursing to the monthly Quality Assurance and Performance Improvement committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performing Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p>	
F0637 SS = A	<p>Comprehensive Assessment After Significant Chg</p> <p>CFR(s): 483.20(b)(2)(ii)</p> <p>§483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or</p>	F0637		01/06/2026

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F0657 SS = E	<p>Care Plan Timing and Revision</p> <p>CFR(s): 483.21(b)(2)(i)-(iii)</p> <p>§483.21(b) Comprehensive Care Plans</p> <p>§483.21(b)(2) A comprehensive care plan must be-</p> <p>(i) Developed within 7 days after completion of the comprehensive assessment.</p>	F0657	<p>Corrective Action:</p> <p>Residents affected were evaluated with an individualized comprehensive assessment. It was determined that bed rails continued to be indicated on 1 of the 4 residents to assist the resident in maintaining or improving functional ability. For that resident (#1), the comprehensive care plan was reviewed and updated to accurately reflect the use of bed rails by the interdisciplinary team.</p>	01/22/2026

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F0657 SS = E	<p>Continued from page 3 (ii) Prepared by an interdisciplinary team, that includes but is not limited to--</p> <p>(A) The attending physician.</p> <p>(B) A registered nurse with responsibility for the resident.</p> <p>(C) A nurse aide with responsibility for the resident.</p> <p>(D) A member of food and nutrition services staff.</p> <p>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</p> <p>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</p> <p>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to update the comprehensive care plan to include the use of bed rails. This deficient practice was identified for 4 of 4 residents reviewed for bed rails (Resident #1, Resident #6, Resident #41 and Resident #49).</p> <p>Findings included:</p> <p>a. Resident #1 was admitted to the facility on 7/28/2023.</p> <p>Resident #1's bed rail assessment dated 10/30/25 was signed by Nurse #1 and indicated the resident had a bed rail on the left side of his bed to serve as an enabler and promote independence.</p> <p>Resident #1's significant change in status Minimum Data Set (MDS) assessment dated 10/31/25 revealed the resident was cognitively intact and the bed rail was not used as a restraint. The MDS further revealed Resident #1 had no impairment of upper extremities but</p>	F0657	<p>Continued from page 3</p> <p>Identification of others with the potential to be affected:</p> <p>An audit of residents currently using bed rails was conducted to ensure comprehensive care plans accurately reflect their use, including required assessments, interventions, and monitoring. Any variances identified corrected and comprehensive care plan indicating the use of bed rails as assessed put in place for residents utilizing a bed rail.</p> <p>Measures put in place or systematic changes to ensure practice does not recur:</p> <p>The facility revised its care planning process to require verification that assistive devices, including bed rails, are incorporated into the comprehensive care plan upon initiation, change in condition, or quarterly review. Nursing will ensure bed rail assessments are completed and communicated to the interdisciplinary team for timely care plan updates during the weekly resident at risk meeting.</p> <p>MDS Coordinator educated by the Director of Nursing on ensuring the comprehensive care plan is updated for residents utilizing bed rails to include the use of bed rails as assessed. Education included:</p> <p>Key components of a care plan-</p> <p>resident goals and preferences,</p> <p>measurable objectives with established timeframes,</p> <p>specific interventions, including those that address common causes of multiple issues,</p> <p>additional follow-up and clarification</p> <p>items needing additional monitoring</p> <p>Components of care plans for Bed Rails/Mobility/Transfer/Assist Devices should include:</p> <p>Specific medical symptoms/indications/conditions for use of the bed rail/device and how the intended device will treat condition and what the benefits are and why they outweigh the risk</p>	

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F0657 SS = E	<p>Continued from page 4 did have impairment to both lower extremities. Resident #1 was coded as being independent with rolling left to right in bed and required supervision when moving from lying to sitting on the side of the bed.</p> <p>Review of Resident #1's care plan last reviewed 11/21/25 did not reveal a care plan or intervention addressing the use of bed rails.</p> <p>On 12/29/25 at 10:30 AM Resident #1 was observed sitting in his wheelchair next to his bed. A black metal half-circle bed rail was observed in the raised position on the left side of the bed. During an interview with Resident #1 at the same time, Resident #1 stated he used the bed rail to assist with rolling in bed and sitting up on the side of the bed. Resident #1 was unsure if the bed rail could be lowered and reported he had always had the bed rail.</p> <p>b. Resident #6 was admitted to the facility on 1/4/2024.</p> <p>Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated 11/7/2025 revealed he was severely cognitively impaired, and the bed rail was not used as a restraint. The MDS further revealed Resident #6 had no impairment to both upper extremities but had impairment to both lower extremities. It also showed that Resident #6 required supervision for rolling left and right and required partial/moderate assistance to move from lying in bed to sitting on the side of the bed.</p> <p>Review of Resident #6's bed rail assessment dated 11/23/25 revealed he used a bed rail on the left side of his bed as an enabler and to promote independence.</p> <p>Resident #6's care plan last reviewed on 12/1/25 did not reveal a care plan or intervention addressing the use of bed rails.</p> <p>On 12/29/25 at 10:35 AM Resident #6 was observed sitting in his wheelchair next to his bed. A rectangular bed rail was observed in the raised position on the left side of the bed. During an interview conducted at that time, Resident #6 stated he used the bed rail to help him roll in bed and to assist</p>	F0657	<p>Continued from page 4</p> <p>Any underlying problems causing the medical symptoms/indications/conditions causing use of a device</p> <p>Interventions to mitigate resident specific risks associated with the use of a device, such as, but not limited to:</p> <p>Withdrawal, depression, or reduced social contact</p> <p>Reduced independence, functional capacity, and quality of life</p> <p>Loss of autonomy, dignity, and self-respect</p> <p>Physical injury due to entrapment</p> <p>Education completed on 1/5/2026.</p> <p>Ongoing monitoring of corrective actions and new measures:</p> <p>The Director of Nursing or designee will conduct audits of residents using side rails to ensure the resident's care plans are comprehensive and include the use of bed rails as assessed weekly for x4 weeks and then monthly for x3 months. This audit tool will be reviewed by the Director of Nursing and/or Administrator to ensure compliance.</p> <p>The results of this audit will be brought to and reviewed by the Administrator to the monthly Quality Assurance and Performance Improvement committee meeting. Any issues identified will be addressed immediately by the Director of Nursing and/or Administrator. Any trends or changes needed to the plan will be addressed with the IDT team, Medical Director, and QAPI team and the plan will be updated to ensure continued compliance.</p>	

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F0657 SS = E	<p>Continued from page 5 with sitting up on the side of the bed. He was unsure whether the bed rail could be lowered and reported that he had always had the bed rail.</p> <p>c. Resident #41 was admitted to the facility on 6/20/2024.</p> <p>Review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated 10/7/25 revealed that the resident was cognitively intact and the bed rails were not used as a restraint. The MDS further revealed Resident #41 had no impairment of upper or lower extremities. Resident #41 was coded as being independent with rolling left to right in bed and required supervision when moving from lying to sitting on the side of the bed.</p> <p>Resident #41's care plan last reviewed 10/21/25 did not reveal a care plan or intervention addressing the use of bed rails.</p> <p>On 12/29/25 at 10:15 AM Resident #41 was observed lying in bed asleep with bilateral rectangular bed rails in the raised position.</p> <p>On 12/30/25 at 11:30 AM, Resident #41 was observed sitting in her chair next to her bed where bilateral bed rails were in the raised position. In an interview at the same time, she stated she used the bed rails to reposition in bed and to assist with moving from lying to sitting on the side of the bed.</p> <p>d. Resident #49 was admitted to the facility on 8/29/25.</p> <p>Review of Resident #49's quarterly Minimum Data Set (MDS) assessment dated 9/4/25 revealed that the resident was cognitively intact and the bed rails were not used as a restraint. The MDS further revealed Resident #49 had no impairment of upper or lower extremities. Resident #49 was coded as needing supervision with rolling left to right in bed and required partial/moderate assistance when moving from lying to sitting on the side of the bed.</p> <p>Review of Resident #49's care plan last reviewed 9/4/25</p>	F0657		

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F0657 SS = E	<p>Continued from page 6 did not reveal a care plan or intervention addressing the use of bed rails.</p> <p>On 12/29/25 at 10:44 AM Resident #49 was observed sitting in her recliner next to her bed. Bilateral black metal half-circle bed rails were observed in the raised position on the bed. During an interview with Resident #49 at the same time, she indicated she used the bed rail to assist with rolling in bed and sitting up on the side of the bed. Resident #49 was unsure if the bed rail could be lowered and reported she had had the bed rails since admission.</p> <p>An interview with Nurse #1 was conducted on 12/30/25 at 8:47 AM. Nurse #1 stated the MDS Nurse was responsible for updating care plans.</p> <p>In an interview with the Director of Nursing (DON) on 12/30/25 at 10:31 AM, she stated the MDS Nurse would have been responsible for updating the comprehensive care plan with bed rail information. She was unaware the care plan did not include bed rail documentation.</p> <p>In an interview with the MDS Nurse on 12/31/25 at 11:17 AM, she stated she was responsible for updating care plans. She was unaware the "grab bars" the facility used were considered bed rails and needed to be care planned.</p> <p>An interview was conducted with the Administrator on 12/30/25 at 10:51 AM He revealed he was unaware the "grab bars" that the facility used were considered bed rails and needed to be care planned.</p>	F0657		
F0700 SS = E	<p>Bedrails</p> <p>CFR(s): 483.25(n)(1)-(4)</p> <p>§483.25(n) Bed Rails.</p> <p>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.</p> <p>§483.25(n)(1) Assess the resident for risk of</p>	F0700	<p>Corrective Action:</p> <p>The Interdisciplinary Team "IDT" and Medical Director conducted an assessment of each resident's diagnosis, functional abilities, care plans and conducted family/resident interviews to identify appropriate alternative options to bed rails/mobility/transfer assist devices.</p> <p>For Resident #1 bed rails removed and a trapeze bar was identified as an appropriate alternative intervention to assist with bed mobility on 1/14/2026. The trapeze bar was not effective for mobility purposes, and it was determined that bed rails continued to be indicated in</p>	01/22/2026

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F0700 SS = E	<p>Continued from page 7 entrapment from bed rails prior to installation.</p> <p>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.</p> <p>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.</p> <p>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record reviews, staff and resident interviews the facility failed to complete a bed rail assessment for one resident (Resident #49), failed to document consent for the use of bed rails for two residents (Resident #49 and Resident #6), failed to assess entrapment risk or document attempts for alternatives to bed rails prior to installing or using bed rails for four residents (Resident #1, Resident #6, Resident #41 and Resident #49). This deficient practice occurred for 4 of 4 residents reviewed for side rails (Resident #1, Resident #6, Resident #41 and Resident #49).</p> <p>Findings included:</p> <p>1. Resident #1 was admitted to the facility on 7/28/2023 with diagnoses that included congestive heart failure and below the knee leg amputation.</p> <p>Resident #1's significant change Minimum Data Set (MDS) assessment dated 10/31/25 revealed the resident was cognitively intact and bed rails were not used as a restraint. The MDS further revealed Resident #1 had no impairment of upper extremities but did have impairment on both lower extremities. Resident #1 was coded as being independent with rolling left to right in bed and required supervision when moving from lying to sitting on the side of the bed.</p> <p>Resident #1's care plan last reviewed 11/21/25 did not include a care plan addressing the use of bed rails.</p>	F0700	<p>Continued from page 7 maintaining or improving functional ability. Education provided and informed consent obtained from the resident or the resident representative for the use of bed rails, entrapment risk assessment completed, bed rail assessment completed, and individualized care plan for the use of bed rails in place.</p> <p>After the assessments were completed on Residents #6, #41, and #49, the residents and responsible parties were educated on both the risks and benefits of the devices. It was decided to remove the devices.</p> <p>Identification of others with the potential to be affected:</p> <p>The NHA conducted a review of all resident's beds to ensure that every device attached to a bed was accounted for.</p> <p>All residents with bed rails or mobility/transfer assist devices that attach to a bed have the potential to be affected.</p> <p>All residents with bed rails or mobility/transfer assist devices that attach to the bed were assessed by the Interdisciplinary Team "IDT" Team. Each assessment included:</p> <p>Alternative options attempted and implemented if successful.</p> <p>An entrapment risk assessment.</p> <p>Consultation with the IDT and physician.</p> <p>For the 3 residents where alternatives to mobility/transfer assist devices failed:</p> <p>The "Resident Assessment for Bed Rail/Mobility/Transfer Assist Device" was completed.</p> <p>The residents and/or the residents' representatives were presented the potential risks and benefits of the devices and consent was obtained for the use of the devices.</p> <p>The IDT developed an individualized care plan for the use of the devices with the resident and/or resident representative and physician.</p>	

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F0700 SS = E	<p>Continued from page 8 Additionally, Resident #1's bed rail assessment dated 10/30/25, signed by Nurse #1, did not include documentation of alternatives considered prior to implementing bed rails. The bed rail assessment did not include an assessment for risk of entrapment.</p> <p>On 12/29/25 at 10:30 AM Resident #1 was observed sitting in his wheelchair next to his bed. A black metal half-circle bed rail was observed in the raised position on the left side of the bed. During an interview with Resident #1 at the same time, Resident #1 stated he used the bed rail to assist with rolling in bed and sitting up on the side of the bed. Resident #1 was unsure if the bed rail could be lowered and reported he had always had the bed rail.</p> <p>An interview with Nurse #1 was conducted on 12/30/25 at 8:47 AM. Nurse #1 stated the therapy department completed the bed rail assessment and it was then signed by a Registered Nurse (RN) indicating consent had been obtained from the resident or their Responsible Party (RP). She further explained she would notify maintenance to install bed rails on the bed after receiving the assessment from therapy recommending use. Nurse #1 indicated therapy probably did the entrapment risk evaluation as the nursing department did not complete this task.</p> <p>In an interview with the Therapy Manager on 12/30/25 at 9:07 AM, she stated that she had never heard of completing a bed rail risk assessment. She further explained that therapy had attempted alternatives to bed rails before recommending use; however, she noted that this information would have been scattered throughout therapy notes and would have been difficult to locate without reviewing every note from each visit. The Therapy Manager reported that she sometimes completed risk versus benefit education and obtained consent for the use of bed rails, while other times nursing would complete this step. She confirmed that an RN needed to sign the bed rail assessment after consent was obtained.</p> <p>In an interview with the Director of Nursing (DON) on 12/30/25 at 10:31 AM, she stated the therapy department was responsible for completing the bed rail assessment which was then signed by an RN. She further stated therapy should have completed a bed rail entrapment risk evaluation. The DON believed therapy attempted alternatives to bed rails before recommending use but</p>	F0700	<p>Continued from page 8</p> <p>Physician ordered the device.</p> <p>Maintenance team members completed the Bed Safety System Data Collection Tool to ensure the bed rails or mobility/transfer assist devices were installed according to manufacturer's instructions.</p> <p>Measures put in place or systematic changes to ensure practice does not recur:</p> <p>Glenaire reviewed the Bed Rail/Bed Safety policy. (See Attached)</p> <p>Glenaire reviewed and revised the Consent for Bed Rails/Mobility/Transfer Assist Devices. (See attached) The form will be completed and obtained from resident and/or responsible party when appropriate.</p> <p>Glenaire reviewed and revised Resident Assessment for Bed Rail/Mobility/Transfer Assist Devices. (See Attached) Following the installation of resident bed rails/mobility/transfer/assist devices, reoccurring bed rail assessments will be completed quarterly or with a significant change.</p> <p>Glenaire reviewed and revised the Bed Safety System Data Collection Tool. (See attached)</p> <p>The NHA, DON and maintenance staff were educated on the Bed Safety System Data Collection Tool utilizing the Bionix – Bed System Measurement Device #B4000. This training has been added to orientation and onboarding for newly hired maintenance staff. Education completed by 1/20/2026.</p> <p>All licensed nursing staff and the IDT educated on the revised policies, procedures and forms including alternative interventions to attempt prior to the installation of bed rails, risk and benefit analysis, prevention of entrapment, and other safety risks. This training has been added to orientation and onboarding for newly licensed nursing staff. Education completed by 1/22/2026. Licensed nurses that have not completed this education will complete prior to the beginning of their next shift.</p>	

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F0700 SS = E	<p>Continued from page 9 did not know where that information could be found.</p> <p>An interview was conducted with the Administrator on 12/30/25 at 10:51 AM. The Administrator stated residents work with therapy to determine if the resident could benefit from the use of bed rails and that an entrapment risk evaluation was completed at that time. He was unaware entrapment risk evaluations had not been completed for residents who had bed rails. The Administrator did not know alternatives to bed rails needed to be documented. He revealed he was unaware the "grab bars" that the facility used were considered bed rails.</p> <p>2. Resident #6 was admitted to the facility on 1/4/2024 with a diagnosis of heart failure.</p> <p>Resident #6's quarterly Minimum Data Set (MDS) assessment dated 11/7/2025 revealed he was severely cognitively impaired and bed rails were not used as a restraint. The MDS further revealed Resident #6 had no impairment to both upper extremities but had impairment to both lower extremities. It also showed that Resident #6 required supervision for rolling left and right and required partial/moderate assistance to move from lying in bed to sitting on the side of the bed.</p> <p>Resident #6's bed rail assessment dated 11/23/25 did not include documentation regarding the use of alternatives to bed rails prior to implementation, nor did it contain a Registered Nurse (RN) signature indicating that risk versus benefit education had been completed and consent received from the resident or his Responsible Party (RP). The bed rail assessment did not include an assessment for risk of entrapment.</p> <p>Resident #6's care plan last reviewed on 12/1/25 did not reveal documentation regarding the use of bed rails.</p> <p>On 12/29/25 at 10:35 AM Resident #6 was observed sitting in his wheelchair next to his bed. A rectangular bed rail was observed in the raised position on the left side of the bed. During an interview conducted at that time, Resident #6 stated he used the bed rail to help him roll in bed and to assist with sitting up on the side of the bed. He was unsure whether the bed rail could be lowered and reported that</p>	F0700	<p>Continued from page 9</p> <p>The IDT will review any residents with bed rails/devices at the weekly resident at risk meeting. They will review any changes to the resident, their risks, benefits and devices. Any changes to the plan of care will be noted in the residents care plan or if significant, an updated Resident Assessment for Bed Rail/Mobility/Transfer Assist Device will be completed.</p> <p>Ongoing monitoring of corrective actions and new measures:</p> <p>The Director of Nursing and/or designee will audit of all resident's beds to ensure that every device attached to a bed is accounted for. Each device will be reviewed to ensure that appropriate documentation is present. This includes the attached assessment, consent, tool and plan of care. The audit will take place weekly x4 weeks, and then monthly x3 months.</p> <p>Maintenance staff will complete quarterly inspections using the Bed Safety System Data Collection Tool on all devices. Any issues identified will be immediately addressed and corrected along with immediate re-education of staff upon discovery. This quarterly inspection will continue, as long as, there are any devices installed on beds.</p> <p>Results of these audits will be presented in the monthly Quality Assessment Performance Improvement Committee Meeting. Any trends or changes needed to the plan will be addressed with the IDT team, Medical Director, and QAPI team and the plan will be updated to ensure continued compliance.</p>	

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F0700 SS = E	<p>Continued from page 10 he had always had the bed rail.</p> <p>During an interview with Nurse #1 on 12/30/25 at 8:47 AM she stated the therapy department completed the bedrail assessment and that an RN should have signed it to indicate risk versus benefit education had been completed and consent obtained. Nurse #1 was unsure why Resident #6's bed rail assessment was not signed by herself or another RN. She further explained that she would notify maintenance to install bed rails after receiving an assessment from therapy recommending use. Nurse #1 indicated therapy probably did the entrapment risk evaluation, as the nursing department did not.</p> <p>In an interview with the Therapy Manager on 12/30/25 at 9:07 AM, she stated she had never heard of completing a bed rail risk assessment. She explained that therapy attempted alternatives to bed rails before recommending use; however, she noted that this information would have been scattered throughout therapy notes and would have been difficult to locate without reviewing every note from each visit. The Therapy Manager reported that she sometimes completed risk versus benefit education and obtained consent for the use of bed rails, while other times nursing would complete this step. She confirmed that an RN needed to sign the bed rail assessment after consent was obtained.</p> <p>In an interview with the Director of Nursing (DON) on 12/30/25 at 10:31 AM, she stated the therapy department was responsible for completing the bed rail assessment which was then signed by an RN to indicate risk versus benefit education was completed and consent obtained. She further stated therapy should have completed an entrapment risk evaluation. The DON believed therapy attempted alternatives to bed rails before recommending use but did not know where to find that information.</p> <p>An interview was conducted with the Administrator on 12/30/25 at 10:51 AM. The Administrator stated residents work with therapy to determine whether they could benefit from the use of bed rails and that an entrapment risk evaluation was completed at that time. He was unaware entrapment risk evaluations had not been completed for residents who had bed rails. The Administrator indicated he did not know alternatives to bed rails needed to be documented. He also reported he was unaware the "grab bars" that the facility used were considered bed rails. The Administrator believed that nursing obtained consent for the implementation of bed</p>	F0700		

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F0700 SS = E	<p>Continued from page 11 rails after they were recommended by therapy.</p> <p>3. Resident #41 was admitted to the facility on 6/20/2024 with a diagnosis of chronic respiratory failure.</p> <p>Resident #41's quarterly Minimum Data Set (MDS) assessment dated 10/7/25 revealed that the resident was cognitively intact and bed rails were not used as a restraint. The MDS further revealed Resident #41 had no impairment of upper or lower extremities. Resident #41 was coded as being independent with rolling left to right in bed and required supervision when moving from lying to sitting on the side of the bed.</p> <p>Resident #41's care plan last reviewed 10/21/25 did not reveal documentation addressing the use of bed rails.</p> <p>Resident #41's bed rail assessment dated 10/29/25 and signed by Nurse #1 did not reveal documentation regarding the use of alternatives to bed rails prior to implementation. The bed rail assessment did not include an assessment for risk of entrapment.</p> <p>On 12/29/25 at 10:15 AM Resident #41 was observed lying in bed asleep with bilateral rectangular bed rails in the raised position.</p> <p>On 12/30/25 at 11:30 AM, Resident #41 was observed sitting in her chair next to her bed where bilateral bed rails were in the raised position.</p> <p>An interview with Nurse #1 was conducted on 12/30/25 at 8:47 AM. Nurse #1 stated the therapy department had completed the bed rail assessment, which was then signed by a Registered Nurse (RN). She further explained she would notify maintenance to install bed rails after receiving the assessment from therapy recommending use. Nurse #1 indicated therapy probably did the entrapment risk evaluation as the nursing department did not.</p> <p>In an interview with the Therapy Manager on 12/30/25 at 9:07 AM, she stated she had never heard of completing a bed rail risk assessment. She further explained that therapy had attempted alternatives to bed rails before</p>	F0700		

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F0700 SS = E	<p>Continued from page 12 recommending use; however, she noted that this information would have been scattered throughout therapy notes and would have been difficult to locate without reviewing every note from each visit. The Therapy Manager reported that she sometimes completed risk versus benefit education and obtained consent for the use of bed rails, while other times nursing would complete this step. She confirmed that an RN needed to sign the bed rail assessment after consent was obtained.</p> <p>In an interview with the Director of Nursing (DON) on 12/30/25 at 10:31 AM, she stated the therapy department was responsible for completing the bed rail assessment which was then signed by an RN. She further stated therapy should have completed an entrapment risk evaluation. The DON believed therapy attempted alternatives to bed rails before recommending use but did not know where that information could be found.</p> <p>An interview was conducted with the Administrator on 12/30/25 at 10:51 AM. The Administrator stated residents work with therapy to determine if the resident could benefit from the use of bed rails and that an entrapment risk evaluation was completed at that time. He was unaware entrapment risk evaluations had not been completed for residents who had bed rails. The Administrator indicated he did not know alternatives to bed rails needed to be documented. He revealed he was unaware the "grab bars" that the facility used were considered bed rails.</p> <p>4. Resident #49 was admitted to the facility on 8/29/25 with a diagnosis of anxiety disorder.</p> <p>Resident #49's quarterly Minimum Data Set (MDS) assessment dated 9/4/25 revealed that the resident was cognitively intact and bed rails were not used as a restraint. The MDS further revealed Resident #49 had no impairment of upper or lower extremities. Resident #49 was coded as needing supervision with rolling left to right in bed and required partial/moderate assistance when moving from lying to sitting on the side of the bed.</p> <p>Resident #49's care plan last reviewed 9/4/25 did not reveal a care plan addressing the use of bed rails.</p>	F0700		

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F0700 SS = E	<p>Continued from page 13 Resident #49's medical record did not reveal documentation that included a bed rail assessment, a consent for the use of bed rails or entrapment risk evaluation prior to the use of bed rails.</p> <p>On 12/29/25 at 10:44 AM Resident #49 was observed sitting in her recliner next to her bed. Bilateral black metal half-circle bed rails were observed in the raised position on the bed. During an interview with Resident #49 at the same time, she indicated she used the bed rail to assist with rolling in bed and sitting up on the side of the bed. Resident #49 was unsure if the bed rail could be lowered and reported she had had bed rails since admission.</p> <p>An interview with Nurse #1 was conducted on 12/30/25 at 8:47 AM. Nurse #1 stated the therapy department completed the bedrail assessment after which she or another Registered Nurse (RN) signed it. She further explained she would notify maintenance to install bed rails on the bed after receiving the therapy assessment recommending use. Nurse #1 indicated that therapy probably completed entrapment risk evaluation as the nursing department did not perform this task. She was unaware Resident #49 did not have a bed rail assessment that also included the signed consent for the use of bed rails and was unsure how it was missed.</p> <p>In an interview with the Therapy Manager on 12/30/25 at 9:07 AM, she stated she had never heard of completing a bed rail risk assessment. She further explained that therapy attempted alternatives to bed rails before recommending use; however, that information would have been scattered within therapy notes and was not readily available. The Therapy Manager believed Resident #49 had not been assessed for bed rails as she had moved to skilled nursing from the assisted living section and the bed rails may have already been on the bed.</p> <p>In an interview with the Director of Nursing (DON) on 12/30/25 at 10:31 AM, she stated the therapy department had been responsible for completing the bed rail assessment which was then signed by an RN indicating consent was obtained. She further stated therapy should have completed an entrapment risk evaluation. The DON believed therapy attempted alternatives to bed rails before recommending use but did not know where that information could be found. She also stated that Resident #49 had not been assessed for the use of bed rails as the resident had moved directly to skilled</p>	F0700		

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F0700 SS = E	Continued from page 14 care from the assisted living section. The DON acknowledged that the facility needed to develop a process to address this situation in the future. In an interview with the Administrator on 12/30/25 at 10:51 AM, he stated residents work with therapy to determine whether they could benefit from the use of bed rails and that an entrapment risk evaluation was completed at that time. He was unaware entrapment risk evaluations had not been completed for residents that had bed rails. The Administrator did not know alternatives to bed rails needed to be documented. He revealed he was unaware the "grab bars" that the facility used were considered bed rails. The Administrator acknowledged the need to implement a process ensuring that residents transitioning from assisted living to skilled nursing, such as Resident #49, receive a bed rail assessment, an entrapment risk evaluation, and obtain consent prior to the use of bed rails.	F0700		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza	F0883	Resident #4 received the pneumococcal vaccine on December 31, 2025, and the influenza vaccine on January 20, 2026. Vaccination orders were verified by the nurse practitioner. Documentation in the medical record was updated to accurately reflect vaccine administration. The resident and responsible party were notified of the vaccinations. Identification of others with the potential to be affected: The facility conducted a review of residents with signed consent forms to receive influenza and pneumococcal vaccines. Any variances identified during this verification were corrected at the time of review, including administration of vaccine. No further issues related to the cited concern were identified. Measures put in place or systemic changes to ensure practice does not recur: The facility refined the vaccination workflow to ensure clear communication and visibility of vaccination consent and follow through. During the admission process, the admissions coordinator is responsible for obtaining vaccine consent and ensuring the signed consent is included with the admission documentation provided to the licensed nurse. The licensed nurse reviews the consent, confirms vaccination orders are in place by communicating with the nurse practitioner, and administers the vaccine as ordered. Nurse leadership/mentor will monitor compliance and verify	01/22/2026

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F0883 SS = D	<p>Continued from page 15 immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-</p> <p>(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review, and staff, resident and Nurse Practitioner interviews, the facility failed to provide pneumococcal and influenza vaccinations to a resident with a signed consent form to receive the vaccinations. This deficient practice was identified for 1 of 5 residents reviewed for vaccinations (Resident #4).</p> <p>Findings included:</p> <p>Resident #4 was admitted to the facility on 11/20/25.</p> <p>Resident #4's comprehensive Minimum Data Set (MDS) assessment dated 11/26/25 indicated moderate cognitive impairment. The assessment also showed that the influenza and pneumococcal vaccines had not been offered.</p>	F0883	<p>Continued from page 15 completion and accuracy of vaccination administration and documentation through routine clinical reviews and oversight.</p> <p>Admission Coordinator and Nurse Practitioner educated by the Director of Nursing on the revised vaccine consent workflow as detailed above on 1/22/2026.</p> <p>Licensed nurses were re-educated on ensuring timely vaccine administration following receipt of signed consent. Education to be completed by 1/22/2026. Licensed nurses that have not completed this education will complete prior to the beginning of their next shift. Orientation and onboarding for newly hired licensed nursing staff reviewed ensuring training listed above with no changes necessary.</p> <p>Ongoing monitoring of corrective actions and new measures:</p> <p>The Director of Nursing or designee will verify vaccination status for residents with signed consent during routine admission for the next three months. The results of this audit will be brought to and reviewed by the Director of Nursing to the monthly Quality Assurance and Performance Improvement committee meeting. Any issues or trends identified will be addressed by the Quality Assurance Performing Improvement Committee as they arise, and the plan will be revised to ensure continued compliance.</p>	

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F0883 SS = D	<p>Continued from page 16</p> <p>Resident #4's medical record revealed no documentation of vaccination administration or any signed consent forms indicating acceptance or refusal of the pneumococcal or influenza vaccinations.</p> <p>On 12/30/25 at 9:30 AM the Infection Preventionist (IP) presented a pneumococcal and influenza vaccination consent form signed by Resident #4 on 11/21/25 stating he consented to receiving the vaccinations.</p> <p>An interview with Resident #4 was conducted on 12/31/25 at 10:15 AM. He recalled signing the vaccination consent form upon admission and confirmed he wanted to receive pneumococcal and influenza vaccinations.</p> <p>In an interview with the IP on 12/31/25 at 8:58 AM, she stated she was not involved in obtaining consents, administering, or tracking resident vaccinations. She explained that the Nurse Practitioner (NP) maintained a list of residents who received vaccinations during the twice-yearly clinics and provided that list to the IP for recordkeeping. The IP was unsure how or when residents admitted between vaccination clinics were offered or administered vaccinations.</p> <p>In an interview with the Director of Nursing (DON) on 12/31/25 at 9:00 AM, she stated Resident #4 did not receive pneumococcal and influenza vaccinations due to a breakdown in communication. She acknowledged there was no established process for ensuring residents admitted between clinics received vaccinations if desired. The DON indicated the Admissions Coordinator obtained the consents upon admission but was unsure what occurred after that step.</p> <p>In an interview with the Admissions Coordinator on 12/31/25 at 9:07 AM, she reported obtaining signed vaccination consents from residents or their Responsible Party (RP) at admission and uploading them into the medical record. The NP then reviewed records for consents. However, the Admissions Coordinator admitted she did not notify the NP or nursing staff when a consent was signed and was unsure why Resident #4's consent was missing from his medical record.</p> <p>In an interview with the NP on 12/31/25 at 9:13 AM, she</p>	F0883		

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F0883 SS = D	<p>Continued from page 17 stated nursing staff typically obtained consents prior to the twice-yearly vaccination clinics and provided them to her so she could prepare a list of residents scheduled for vaccinations. For residents admitted between clinics, the Admissions Coordinator obtained consent and sometimes notified her by text, but not consistently. The NP acknowledged the facility lacked a system to ensure residents admitted between clinics received vaccinations when they consented.</p> <p>On 12/31/25 at 9:20 AM an interview was conducted with the Administrator. The Administrator stated that the Admissions Coordinator notified the IP or the DON when a vaccination consent form was signed upon admission and nursing coordinated with the NP to administer the vaccinations.</p>	F0883		