STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345445	A. Building B. Wing	12/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenaire	4000 Glenaire Circle Cary, NC 27511

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).Finding Included:Resident #78 was admitted to the facility on [DATE] with a diagnosis of fracture of unspecified part of the left femur.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.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.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.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.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.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). Findings included: a. Resident #1 was admitted to the facility on [DATE]. Resident #1's bed rail assessment dated [DATE] 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. Resident #1's significant change in status Minimum Data Set (MDS) assessment dated [DATE] 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 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. 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. 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. b. Resident #6 was admitted to the facility on [DATE]. Review of Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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. Review of Resident #6's bed rail assessment dated [DATE] revealed he used a bed rail on the left side of his bed as an enabler and to promote independence. 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. 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 he had always had the bed rail. c. Resident #41 was admitted to the facility on [DATE]. Review of Resident #41's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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. Resident #41's care plan last reviewed 10/21/25 did not reveal a care plan or intervention addressing the use of bed rails. 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. 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. d. Resident #49 was admitted to the facility on [DATE]. Review of Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact and the bed rails were not used as a restraint. The MDS further revealed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Review of Resident #49's care plan last reviewed 9/4/25 did not reveal a care plan or intervention addressing the use of bed rails. 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. 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. 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. 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. 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.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).Findings included: 1. Resident #1 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure and below the knee leg amputation. Resident #1's significant change Minimum Data Set (MDS) assessment dated [DATE] 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. Resident #1's care plan last reviewed 11/21/25 did not include a care plan addressing the use of bed rails. Additionally, Resident #1's bed rail assessment dated [DATE], 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. 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. 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. 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. 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 did not know where that information could be found. 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 (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 2. Resident #6 was admitted to the facility on [DATE] with a diagnosis of heart failure. Resident #6's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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. Resident #6's bed rail assessment dated [DATE] 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. Resident #6's care plan last reviewed on 12/1/25 did not reveal documentation regarding the use of bed rails. 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 he had always had the bed rail. 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. 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. 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. 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 rails after they were recommended by therapy. 3. Resident #41 was admitted to the facility on [DATE] with a diagnosis of chronic respiratory failure. Resident #41's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Resident #41's care plan last reviewed 10/21/25 did not reveal documentation addressing the use of bed rails. Resident #41's bed rail assessment dated [DATE] 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. 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. 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. 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. 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 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. 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. 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. 4. Resident #49 was admitted to the facility on [DATE] with a diagnosis of anxiety disorder. Resident #49's quarterly Minimum Data Set (MDS) assessment dated [DATE] 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. Resident #49's care plan last reviewed 9/4/25 did not reveal a care plan addressing the use of bed rails. 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. 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. An interview with Nurse #1 was conducted on 12/30/25 at 8:47 AM. Nurse #1 stated the (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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. 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 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.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).Findings included: Resident #4 was admitted to the facility on [DATE]. Resident #4's comprehensive Minimum Data Set (MDS) assessment dated [DATE] indicated moderate cognitive impairment. The assessment also showed that the influenza and pneumococcal vaccines had not been offered. 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. 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. 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. 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. 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. 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. In an interview with the NP on 12/31/25 at 9:13 AM, she 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. 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.