STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345552	A. BUILDING _____ B. WING _____	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

(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
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to (1) label, date and properly store opened bags of cereal, (2) failed to serve food under sanitary conditions by picking up and plating food items with gloved hands for 2 of 3 observations during meals and (3) failed to serve ice in a sanitary manner. 1. An initial tour of the facility was conducted with the Chef on 08/29/11 at 11:30 AM. There was an opened bag of cereal with the top of the bag tied loosely in a knot and sitting on top of other food containers on a rack in the dry storage area. The bag of cereal was not labeled or dated. An observation of dry food storage was made with the Dietary Manager on 8/31/11 at 12:20 PM. Two opened bags of cereal were observed with the top of the bag tied loosely in a knot and lying on top of other containers of food items. The two bags of cereal were not labeled or dated. The Dietary Manager stated that the bags of cereal should have been dated and stored in a sealed	F 371	**A.** Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. **1.** The food/cereal was disposed of immediately and staff was made aware of deficient practice. On 8/30/2011 a Certified Dietary Manager was installed to replace the Chef. On 8/31/2011 the two open bags of cereal found on top of other containers, tied loosely in a knot, not labeled or dated were disposed of. The employees responsible were reprimanded immediately and the staff was educated, full on-spot, in-service was done on 8/31/2011 regarding proper storage dating and labeling of food. On 8/31/2011 a formal staff in-service with all dietary staff was held to reiterate proper storage, dating and labeling of food. **2/3.** A spot In-service was done 8/31/2011 with dietary aides presented by Certified Dietary Manager. Full in-service was completed with kitchen staff concerning safe food handling/cross contamination on 9/1/2011. Full dietary in-service on food safety, infection control, cross contamination, hand-washing and the proper procedure for when to change gloves was done on 9/6, 9/10 and 9/11/2011, and is ongoing. Tongs were supplied to the dietary aides at the next meal service time. Gloves are stocked at each mini kitchen for frequent changing. Random daily checks will be done weekly by Certified Dietary Manager or designee times three months five days out of seven days times three months to include all four communities' mini kitchens.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Rachel Jo. Bennett	Administrator	9-22-11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 1 container. 2. On 08/31/11 at 8:00 AM an observation was made during meal service in the satellite kitchen on the 500/600 hall. Dietary Aide #1 was observed to put on gloves and remove covers from food and place them under the steam table, pick up trays and pick up plates to put in insulated bottoms and open the refrigerator door multiple times to remove cartons of milk and pre-poured glasses of beverages and place on the serving trays. The Dietary Aide was observed to pick up bacon, sausage patties and toast with the same gloved hand and place on the plates to be served to the residents. Dietary Aide #1 stated in an interview on 08/31/11 at 3:00 PM that she usually used tongs to place meat on the plates but forgot to bring tongs from the kitchen. The Dietary Aide stated that it was her usual practice to serve the toast with her gloved hand. When asked if she could have requested staff bring her tongs from the kitchen, the Dietary Aide stated that she did not think of it. On 09/01/11 at 9:27 AM the Dietary Manager stated in an interview that handling food items with gloved hands that have touched other objects in the kitchen was not sanitary. The Dietary Manager stated that the staff should have used tongs to serve the meat and toast. 3. On 08/31/11 at 12:30 PM an observation was made during meal service in the satellite kitchen on the 100/200 hall. Dietary Aide #2 was observed wearing gloves to pick up trays and pick up plates to put in insulated bottoms and open the refrigerator door multiple times to remove	F 371	4. On 8/29/2011, nursing assistant placed an ice scoop flatly into the ice after filling water pitcher, without gloves. Our first course of action was to empty the ice cooler and have it thoroughly cleaned by housekeeping, before having it returned to service. We removed water pitchers from affected residents' rooms and replaced it with a clean pitcher and ice. We reeducated and disciplined certified nursing assistant in on spot in-service. We began full in-service process on days and evening shift on 8/29/2011 for education for infection control and education on use of the scoop holders for the ice chests. On 8/30/2011, third shift nursing assistants and nurses were in-serviced on infection control, the correct way to dispense ice and the correct use of the ice scoop holder. On 8/31/2011, another nursing assistant placed ice scoop flatly in the ice without gloves. We removed water pitchers from affected residents' rooms and replaced it with a clean pitcher and ice. Ice chest was emptied and thoroughly cleaned before having returned it into service. Nursing assistants were reeducated and disciplined in on spot in-service. On 9/1/2011, another in-service was offered to 11-7 shift regarding passing ice, infection control and the use of the ice scoop holder. On 9/1/2011, day shift and 3-11 shift combination of dietary and nursing assistants were in-serviced on infection control, passing of Ice and the use of the ice scoop holder, safe food handling, hand washing, food safety and dry storage, cross contamination. This in-service was repeated on 9/6, 9/10, and 9/11/2011, and is ongoing.	

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	345552	A. BUILDING _____ B. WING _____	09/01/2011

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F 371	Continued From page 2 cartons of milk and pre-poured glasses of beverages and place on the serving trays. The Dietary Aide was observed to pick up baked potatoes and rolls with the same gloved hand and place on the plates to be served to the residents. On 09/01/11 at 9:27 AM the Dietary Manager stated in an interview that handling food items with gloved hands that have touched other objects in the kitchen was not sanitary. The Dietary Manager stated that the staff should have used tongs to serve the baked potatoes and the rolls. Dietary Aide #2 stated in an interview on 09/01/11 at 9:38 AM that she should not have handled the baked potatoes and rolls with her gloved hands. The Dietary Aide stated that she forgot to bring tongs to the satellite kitchen. 4. On 8/29/11 at 12:08, NA #1 was observed filling 4 water pitchers with ice for room 303 and 307. NA #1 took the ice scoop and placed it lying flat into the ice after filling each water pitcher. NA #1 was not wearing any gloves. The ice cooler had a plastic ice scoop holder on the side of the ice cooler. During an interview, on 8/29/11 at 12:15 PM, NA #1 stated "did I do something wrong?". NA #1 indicated she had been instructed to place the ice scoop into the holder and not leave on the ice in the cooler. On 8/31/11 at 6:15 am, NA #2 was observed filling 2 water pitchers for room for room 305. NA	F 371	B. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur. 1. Full dietary staff in-services are to be done monthly times three months and every six months thereafter in the Dietary Department by Certified Dietary Manager on proper food storage, dating and labeling of food and upon new employee orientation by Staff Development Coordinator. Daily audit sheets are to be completed by CDM or designee daily for one month and then weekly times two months for assurance of proper storage, dating and labeling of food in the main kitchen. 2/3. Tongs and other utensils will be utilized by dietary staff in mini kitchens at each meal to serve as appropriate. Cook Supervisor will be responsible for assuring appropriate utensils go out on each cart by visual check for each mini kitchen for each meal. Back up tongs are properly stored above the steam line tables in each mini kitchen. A box of gloves will be stored in each mini kitchen. Random daily checks for tongs will be done weekly by Certified Dietary Manager or designee five days out of seven days times three months to include all four communities' mini kitchens. Daily mini kitchen sanitation rounds are in place. We have also added to our new employee orientation an infection control in-service concerning cross contamination called "Sanitation 101". The Certified Dietary Manager will in-service dietary staff on the use of proper utensils and sanitation 101 each month for three months and every six months thereafter. 4. On 9/1/2011, day shift and 3-11 shift	

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F 371	Continued From page 3 #2 placed the ice scoop flat in the ice after filling each pitcher. NA #2 was not wearing any gloves. NA #2 then filled two water pitchers for room 402. NA #2 placed the ice scoop flatly in the ice between each water pitcher. NA #2 was not wearing any gloves. The ice cooler had a plastic ice scoop holder on the side of the ice cooler. At 6:18 am, NA #2 filled one water pitcher with ice. NA #2 laid ice scoop flat into ice cooler. NA #2 was not wearing any gloves. During an interview, on 8/31/11 at 7:00 am, NA #2 stated she had been instructed to place the ice scoop in the holder on cooler after obtaining ice from the cooler. During an interview, on 8/31/11 at 10:30 am, the Director of Nursing stated that ice scoop holders had been purchased and placed on all ice coolers. The ice coolers were filled in the kitchen. Direct care staff had been provided inservice training to place ice scoop into the holder after obtaining ice from the cooler.	F 371	combination of dietary and nursing assistants were in-serviced on infection control, passing of ice and the use of the ice scoop holder, safe food handling, hand washing, food safety and dry storage, cross contamination. This in-service was repeated on 9/6, 9/10, and 9/11/2011, and is ongoing. We have also added to our new employee orientation conducted by the staff development coordinator an infection control in-service concerning cross contamination called "Passing Ice 101". The Staff Development Coordinator will in-service nursing staff once per month for three months and every six months thereafter. Staff Development Coordinator/Infection Control Nurse or designee is to audit the ice carts randomly three times per week, times three months. C. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan musts be implemented and the corrective action evaluated for its effectiveness. The POC is integrated into the quality assurance system of the facility. 1. Audit sheets for labeling, dating and proper storage of food (daily and weekly) will be taken to Quality Assurance meetings monthly for review by the Quality Assurance team to review for effectiveness and increased monitoring, times three months.	

2/3. Audit sheets for back up tongs, tongs in use, gloves, safe food handling and sanitation will be taken to Quality Assurance meetings monthly for review by the Quality Assurance team to review for effectiveness and increased monitoring times three months.

4. Audit sheets for proper infection control with ice passing and scoop storage will be taken to Quality Assurance meetings monthly for review by the quality assurance team to review for effectiveness and increased monitoring times three months.

D. Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

1. Date of alleged compliance is 9/6/2011.
2. **2/3.** Date of alleged compliance is 9/6/2011.
3. **4.** Date of alleged compliance is 9/6/2011.

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	345552	A. BUILDING 01 - THE SHANNON GRAY REI B. WING _____	10/06/2011

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 10/6/2011 at approximately 10:00 AM onward the following was noted. 1) The corridor door to the Storage Chart closet on 400 Hall did not latch. The strike plate was taped over preventing the door from latching. 42 CFR 483.70	K 029	The tape covering the strike plate was removed immediately in front of the surveyor, Roger Fortman. Staff members were informed that the strike plate must be free of obstruction and remain operational at all times. All corridor and storage room doors were inspected throughout the facility. The Maintenance Director and/or his assistant will make monthly rounds to examine all corridor doors and their strike plates throughout the facility to ensure all doors close, latch and seal tightly, and that no obstructions exist. Daily less detailed rounds will be done as well. It is our routine to do complete rounds of the facility each work day during the work week. The Maintenance Director will utilize the "2011 Life Safety Plan of Correction Audit Tool" that has been developed to log all findings and corrective actions if necessary. This report will be reviewed in the quarterly Quality Assurance (QA) meetings through the end of the current calendar year. Staff inservice will be held, which will include this issue as part of the agenda.	10/6/2011 10/7/2011 10/28/11 10/28/11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 18.2.8 This STANDARD is not met as evidenced by: Based on observation on Thursday 10/6/2011 at approximately 10:00 AM onward the following was noted. 1) The walk-in refrigeration units in the Kitchen did not have illumination provided on the inside at all time in order for an individual to exit the room. 42 CFR 483.70	K 045	The canister light, the existing safety light bulb, was replaced to allow it to remain on at all times in order for individual to exit the room in both the walk-in freezer and refrigerator. All other interior lights in both the walk-in freezer and the Refrigerator were inspected and no problems found. The Maintenance Director and/or his assistant will make monthly rounds to examine all interior lights in the walk-in coolers to ensure they both have suitable lights to allow an individual to exit the cooler The Maintenance Director will utilize the "2011 Life Safety Plan of Correction Audit Tool developed to log all findings and corrective actions, if necessary. This report will be reviewed in the quarterly Quality Assurance (AQ) Meeting through the end of the current calendar year. A dietary staff inservice will be held including this issue as part of the agenda.	10/11/11 10/11/11 10/28/11 10/28/11 11/8/11, 12/11/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

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

Sarah Bennett | Administrator | 10/20/2011

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K 147	Continued From page 1 Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Thursday 10/6/2011 at approximately 10:00 AM onward the following was noted. 1) In resident rooms 505, 306, 311, 211, 112 and 111 it was observed that items were found to be stored on the overhead bed light. 42 CFR 483.70	K 147	All items stored on over the bed lights were removed. Staff members were informed that no items may be Stored on over the bed lights. All over the bed lights were inspected throughout the Facility and all items were removed. Only six Locations were found with improper storage, but all items were removed. The Maintenance Director will utilize the "2011 Life Safety Plan of Correction Audit Tool developed to log All findings and corrective actions if necessary. This Report will be reviewed in the quarterly Quality Assurance (QA) Meeting through the end of the current Calendar year 2012.	10/6/2011 10/7/2011 11/8,12/2011,