DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____	08/03/2012

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

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to follow care plan interventions for 2 of 4 residents (Res. # 138 and Res. #108) by not placing a bed alarm on the bed of Resident #138 and by not padding the side rails of resident # 108 (who had a history of skin tears). Findings include: 1. Resident #138 was admitted on 2-6-12 with the diagnoses of Hypertension, history of Stroke with right sided weakness and personal history of falls. Care Plan dated 2-23-2012, indicated the resident was at risk for falls due to past history. No measures were put into place at that time to prevent falls other than to keep bed in the lowest position and give resident verbal reminders to ask staff for assistance with getting in and out of bed and to educate resident on the use of the call light. An unobserved fall occurred on 3-7-12, without injury. Resident reported to staff he was attempting to transfer self from chair to bed. Resident was able to turn on call light after the fall to ask for assistance. The unobserved fall facility protocol was put into place. This protocol included neurological checks to monitor for	F 282	• A new bed alarm was placed on the bed of resident #138 on 7/27/12 by the Director of Nursing. The side rails were padded for resident #108 on 7/26/12 by the Maintenance Director per the request of the D.O.N. These interventions have remained in place since being corrected. • On 7/26/12, the facility administrative nurses reviewed all QA (incident) reports over the last 90 days to ensure that residents with indications for bed alarms or padded side rail interventions were captured. A list of residents with bed alarms and a list of residents with padded side rails was generated by the D.O.N. on 7/26/12. The administrative nurses then verified that all of these residents had the appropriate interventions in place; this was accomplished by 7/27/12. All residents in the facility continue to have the appropriate bed alarm or padded side rails in place.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sarah Reynolds | TITLE: Administrator | (X6) DATE: 8/22/12

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.

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possible head injury.

A Multidisciplinary Screening Form for a recent fall was completed by a Physical Therapist on 3-8-12 which indicated that the resident was already on the physical therapy caseload. No interventions were recommended at that time.

On 6-29-12, Resident #138 had an unobserved fall while transferring himself from the chair to the bed. No injuries were received by the resident during the fall. The Physician Assistant and the Responsible Party were notified.

A Multidisciplinary Screening Form for a recent fall was completed by physical therapy on 7-4-12 with the following documentation: "No skilled interventions needed at this time."

Observation of Resident at 8:45am on 7-25-12. Resident was lying in bed. No bed alarm was in place.

Observation of Resident at 10:20am on 7-25-12, observed resident #138 sitting up in wheelchair with pad alarm in place.

Per record review, a Fall Risk Assessment was completed on 3-10-12, 5-12-12, and 6-13-12. Each assessment consistently scored the resident greater than a 10, which indicated that the resident was "At risk."

Per record review, an order was obtained on 7-2-12 for a bed pad alarm and a chair pad alarm ordered to remind resident to ask for assistance with transfers and to warn staff if resident was attempting to get up independently. The nurses

- A 100% nursing staff in-service has been initiated by the D.O.N. and/or designee and will be completed by 8/27/12. In-service will be provided to future nursing staff hires as part of orientation. The in-service is specific to bed alarms/fall prevention interventions and padded side rails. The in-service addresses and details the facility's expectations for nursing staff personnel working on the floor in relation to preventing future deficient practice in this area. List(s) of both the current fall prevention intervention log and the residents with padded side rails have been generated and are posted at each nurse's station. These lists are maintained by the D.O.N. and are updated as/when new interventions are indicated or discontinued. Facility nursing staff have continuous access to these lists at each nurses' station as part of the facility's plan to prevent future deficient practice.

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were to check placement and function and document each shift on the Medication Administration Record (MAR).

Observation of Resident #138 at 1:45pm on 7-25-12, Resident was up in chair with pad alarm in place.

Record review of the Medication Administration Record (MAR), indicated that the bed pad alarm and the chair pad alarm were documented on the MAR and the nurses from all shifts had been initialing these alarms were in place and functioning.

Observation of Resident at 3:30pm on 7-25-12, Resident was lying in bed. Alarm was not in place.

Observation of Resident on 7-26-12, Resident was lying in bed, bed alarm was not in place.

Interview on 7-26-12 at 11:10am, NA #4 was asked how the NA 's were made aware of any new orders for alarms or other safety devices ordered during their time off from the facility. NA#4 answered that the nurses or other NA 's will pass the information to them during shift report or it is written in the Care Tracker book.

Interview with Nurse #3 on 7-26-12 at 11:20am, the nurse was asked what a bed alarm looked like. Nurse #3 responded that Resident #138 had one on his bed and proceeded to the residents ' room. When the nurse asked the resident to turn over so that she could show the alarm, she realized no alarm was in place on the bed. She immediately obtained a bed alarm and placed it

- The D.O.N. or designee will audit the fall prevention interventions log daily using a printout of the log itself as the QA tool for this area. The person completing the audit will sign the QA tool verifying they have checked and that interventions are in place. This audit will be completed by the D.O.N. or an administrative nurse designee to ensure interventions are in place for the appropriate residents. The charge nurses will continue to check for function and placement of fall prevention interventions each shift and will document their results on the MAR or a separate tool as well.

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under the resident.

2. Record review indicated resident # 108 was admitted to the facility on 04/09/10 with diagnoses of Alzheimer's Disease, B-Complex Deficiency, Unspecified Hemiplegia, and Venous Thrombosis.

Review of the Significant Change Assessment with an Assessment Reference Date (ARD) date of 04/29/2012 indicated the resident had Short and Long-term Memory Problems, and required extensive assistance from staff for bed mobility, transfers.

Review of the Current Care Plan dated 05/09/2012 indicated the resident had a potential for skin breakdown related to limited mobility and a diagnosis of Functional Quadriplegia. The resident was incontinent of bowel and bladder with a goal to maintain intact skin integrity through the next review. The approaches were to observe the resident ' s skin during assistance with daily living care and report changes to the charge nurse.

The Care Plan Update of 6/13/12 read,"Skin Tear on Left Elbow."No new goals were documented. The Care Plan Approaches included: Pad the side rails and assist with repositioning the resident frequently to avoid skin friction rubs.

Nurses Notes of 06/13/2012 at 10:38 PM read, "The resident was found bleeding from the Left elbow with skin tear. Was cleaned with Normal Saline and applied antibiotic ointment and

- The D.O.N. will be the chair of the QA Report Intervention Compliance Action Team which was formed to monitor and track facility performance in this area. The D.O.N. or designee will complete daily audits for ongoing compliance with fall prevention interventions such as bed alarms and with padded side rails. The results of the audits will be evaluated by the D.O.N. and the other members of the administrative team (unit coordinators) weekly x 4 weeks, then monthly, and quarterly thereafter. The D.O.N. will report the efforts of this action team at the next Executive QA Meeting which is currently scheduled for 10/17/2012. The Executive QA Committee will decide the frequency and direction of the QA Report Intervention Compliance Action Team at that time.

- The facility alleges full compliance with F-282 by 8/28/12 as part of the plan of correction.

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covered with telfa. Family to be notified by AM Nurse."

Review of the Accident /Incident Report dated 6/13/12 read, Nursing Assistant found the resident with a skin tear on the Left elbow. Recommended steps to prevent recurrence included: Pad the side rails. The patient was in the bed when this skin tear was found.

The Physician 's orders dated 06/14/2012 and for the month of July read, Cleanse the skin tear to the left elbow with Normal Saline, apply skin prep to peri-wound and steri-strips, and cover with a transparent dressing. Check daily. Change every 3 days and as needed.

Physician 's orders dated: 07/24/2012 read, "Discontinue Treatment to left elbow skin tear, area healed."

Review of the Medication Administration Record (MAR) for the month of July 2012 read, "07/25/11 Pad both bed rails to help prevent Skin Tears. Geri-Sleeves BUE (Bilateral upper extremities) at all times."

The resident was observed in the dining room on 7/25/12 at 9:05 AM being fed by staff a pureed NAS (No Added Salt) diet with orange juice, whole milk, coffee and water. Health shake was observed on the meal tray. The resident was observed with bilateral protective arm coverings applied.

During observations conducted in the resident's room on 7/25/12 at 10 AM, the side rails were observed not padded. The Medication

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Administration Record (MAR) for July 2012, and the Care Plan interventions of 6/13/12 indicated the side rails were to be padded to prevent skin tears.

Observations were conducted in the hallway on 7/25/12 at 11:15 AM. Protective arm coverings were observed applied bilaterally to the resident 's arms. .

A staff interview with Nurse #1 was conducted on 7/25/12 at 11:40 AM regarding the reason the side rails were not padded. The Nurse indicated," I am not sure why the side rail padding was not there."

During observations in resident room on 7/25/12 at 2:39 PM. Resident observed in bed with the side rails up. The side rails were observed not padded. The Medication Administration Record (MAR) for July 2012, and the Care Plan interventions of 6/13/12 indicated the side rails were to be padded to prevent skin tears.

During a follow-up observation conducted on 7/25/12 at 4:20 PM, the resident was observed in bed resting. The side rails were observed up, and not padded. The Medication Administration Record (MAR) for July 2012, and the Care Plan interventions of 6/13/12 indicated the side rails were to be padded to prevent skin tears.

Observations were conducted in the resident 's room on 7/26/12 at 9:00 AM with the Director of Nurses (DON) present during the observation. The side rails were observed up and not padded. The Medication Administration Record (MAR) for July 2012, and the Care Plan interventions of

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F 282	Continued From page 6 6/13/12 indicated the side rails were to be padded to prevent skin tears. A staff interview was conducted on 07/26/12 at 9:30 AM with the DON regarding the expectations concerning the side rails being padded. The DON indicated, "I would expect whoever initiated the need for the padded side rails, should have communicated that to the Maintenance Director, because he is the person who would have implemented the padding on the side rails."	F 282		
F 310 SS=D	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with facility staff, the facility failed to begin restorative therapy as recommended by the Physical Therapist for 1 of 1 sampled resident. (Resident #1). The findings include: Resident #1 was admitted to the facility on 3/2/12 with diagnoses including generalized weakness	F 310	Resident #1 was re-evaluated by the D.O.N. on 7/27/12 for participation in the restorative therapy program and was picked up for restorative modalities including ambulation with a rolling walker with contact guard assistance from staff and active range of motion exercise. This was done after reviewing resident's chart with the therapy director and obtaining consent to participate in the restorative therapy program from the resident and the responsible party. Resident #1 has been participating in the restorative therapy programs 4-5 times each week since restorative therapy was restarted on 7/31/12 and will continue unless documented otherwise. The care plan of resident #1 reflects the restorative therapy in progress and restorative therapy progress is documented on a restorative care plan flow record sheet.	

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F 310	Continued From page 7	F 310	All current residents in the facility were reviewed by the D.O.N. and the restorative nurse by 8/23/12 to ensure that each resident who was indicated for restorative therapy since 5/1/12 has either participated in restorative therapy or has documentation addressing why they are not participating in a restorative program. All residents who were referred from therapy and are still appropriate for restorative programs are participating at this time.	

and deconditioning aggravated during this admission secondary to electrolyte abnormalities and dehydration, mild hyponatremia, cerebral vascular accident (CVA), R (right) side deficits, depression and anxiety.

The Minimum Data Set dated 4/30/12 revealed the resident had no behaviors, she was moderately impaired with her short and long term memory, she required moderate to extensive assist for activities of daily living, and she received pain medication as needed.

Physical Therapy note dated 4/30/12 revealed Resident #1 had 40 visits since evaluation. Initial focus was improving trunk balance, increase in strength and RLE (lower extremity) mobility and improving transfers, shifted emphasis on safe gait with a walker and with the use of an AFO (a brace for foot). Upon discharge from physical therapy, the first shift NAs (nurse aides) were educated and shown how to walk Resident #1 from the bed to the toilet, R AFO donning placing the brace on the resident) and doffing (removing the brace) and the importance of doing this for functional carryover. Restorative training program also was established to help maintain gait and transfer ability at this time for as long as possible. Resident #1 was discharged to nursing restorative care at that time.

Care Plan updated 5/11/12 did not include and interventions for range of motion.

Physician orders dated 7/1/12 to 7/31/12 revealed Resident #1 required a R AFO to correct foot drop due to late effects of CVA for improved safety and independent transfers and ambulation.

The facility now has an accurate and current restorative case load log for all residents receiving restorative therapy. Any resident who needs to be added or discontinued from the restorative program will not be done without the D.O.N. or restorative nurse's review/approval. All future therapy department referrals for a restorative program will be delivered from the therapy department directly to the D.O.N. or restorative nurse as well to prevent future deficient practice. The therapy department will also maintain a Restorative Therapy Referral Log of all of their referrals to the nursing department and this log will be audited at the weekly restorative meeting by the DO.N. and/or restorative nurse to further ensure each resident was evaluated timely for a restorative program. The D.O.N. or restorative nurse will maintain the QA tool (referred to as the Restorative Therapy Case Log) to help prevent future deficient practice as it will allow the facility to track entry/exit from the restorative program.

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F 310	Continued From page 8 The resident also required a soft kit interface for skin integrity to wear with the AFO. The schedule was to be determined, once the device arrived, per doctor 's order.. Interview on 7/25/12 at 10:10 AM with the restorative scheduler revealed that the Resident went to Hospice and they discontinued the ROM (Range of Motion). Interview on 7/25/12 at 10:35 AM with the restorative aide revealed that the resident had ROM and it was discontinued. She had hyperextended fingers on the R hand. She did well in therapy and then they discontinued it.. Interview on 7/25/23 at 10:50 PM with the Physical Therapist revealed that the Resident had physical therapy until she reached her maximum potential and then was placed on restorative. Interview on 7/25/12 at 11:00 AM with the restorative supervisor revealed that on 4/27/12 the resident was referred to restorative for ROM and the ambulation program. At some point it was believed she was going to Hospice. A miscommunication happened and no one communicated the there was no hospice and they could resume restorative therapy. No one ever wrote an order to discontinue the restorative therapy. Restorative therapy was never started. The months of May, June, July, the restorative aides were throwing the documentation sheets away. Interview on 7//25/12 with the nurse supervisor at 2:00 PM revealed that the resident was able to walk, at the present time, with assistance and	F 310	The facility has implemented the Restorative Therapy Case Management Action Team effective 8-15-12. This team consists of the D.O.N., the restorative nurse, and the restorative aides. The Restorative Therapy Case Management Action Team will meet weekly to review the previously mentioned Restorative Therapy Case Log and the Restorative Therapy Referral Log to manage restorative referrals and discontinuations. The Restorative Therapy Case Log will be updated weekly as a result of this meeting. Changes (additions or discontinuations) for restorative therapy residents will be reported to the MDS department by the Restorative Therapy Case Management Action Team to facilitate appropriate care plan updates as well. The Restorative Therapy Case Management Action Team will report the summary of their weekly meetings/activities to the Executive QA Committee which meets quarterly. The next Executive QA Committee is currently scheduled for 10/17/2012. The facility alleges full compliance with F-310 by 8/28/12 as part of the plan of correction.	

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F 310	Continued From page 9 walker but not very far, about 6 to 7 feet. Interview with the physical therapy tech on 7/25/12 at 2:05 PM revealed that the resident was able to ambulate 65 feet at the time she was discharged from physical therapy (4/30/12), with someone placing their hand (hand on guard) to her back. Interview on 7/26/12 at 8:00 AM with the DON (Director of Nursing) revealed that his expectation was the resident should have been transferred to restorative therapy once the resident did not receive hospice.	F 310		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	Resident #138 had a potassium level drawn on 7/26/12 per MD order on 7/25/12. The laboratory result for this resident was returned on 7/26/12 with a normal value of 3.6. The results were reported on 7/26/12 by the charge nurse to the Physician Assistant who ordered the potassium level check and no new orders were given to change or discontinue the medication. The next scheduled CMP/potassium check for this resident is scheduled for 9/20/12. The results of that laboratory result will be reported to the PA/MD who will decide the course of treatment.	

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This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to obtain lab work for a resident with an order to have potassium monitored (Resident #138.) There was no documented medical diagnosis or diuretics indicating the necessity for this medication This was evidenced by review of one of 10 residents for Unnecessary Medications.

Findings Include:

Resident #138 was admitted on 2-6-12 with diagnoses of Hypertension, history of Stroke and a history of falls.

Record review indicated a Consultant Pharmacist Review done on 3-13-12 with recommendations to the physician to consider discontinuing potassium 10 milliequivalents (mEq = a unit of measure for dose) that the resident was taking every day and to redraw a potassium level two weeks after discontinuation. The resident was not taking any diuretics and the last potassium lab result was normal at 3.8 on 2-9-11.

Record review showed that on 3-21-12, the Physician agreed to the recommendation with the following order written on the consultant work sheet, " Will follow and maintain potassium results. Check potassium every 2 weeks times three. "

The D.O.N. and administrative nursing team completed and audit of the pharmacy consultant reports created since March 2012 to ensure that all laboratory orders generated as a result of the pharmacy consultant reports have been drawn per MD order/pharmacy recommendation. All current residents have laboratory results as indicated by the MD in response to the pharmacy consultant report.

To prevent future deficient practice, the completed pharmacy consultant reports will not be filed to the resident chart each month until they have been reviewed by an administrative nurse to ensure that signed MD orders specific to that pharmacy consultant report have been transcribed to either the specific resident's chart or to the laboratory computer. The administrative nurse reviewing the signed pharmacy consultant report will initial on the newly created QA tool (Pharmacy Consultant Report Laboratory Monitoring Log) verifying the orders have been transcribed correctly and have not been omitted. The facility will continue to monitor the pink slips which are generated as a carbon copy of the MD order and have made modifications to the monitoring tool which will allow the facility to focus specifically on future/pending laboratory orders.

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 _____	08/03/2012

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 329	Continued From page 11 Record review indicated the nurse wrote a telephone order and documented the order on the MAR on 3-22-12. Lab results obtained on that same date show the potassium level remained at 3.8 as indicated by the pharmacist. Record review determined that the potassium lab order was carried over to the following month MAR with the next due date marked as 4-5-12. The lab was not drawn and the MAR indicates the resident continued to receive the medication. Interview with the Director of Nursing (DON) on 7-25-12 at 11:00am indicated that these labs had been missed and were not available. The DON indicated that during the most recent QA&A meeting, 7-18-12, the members had identified that orders for labs were being missed and had developed a system where the key QA&A staff were monitoring all orders to assure none were being missed. This resident had not been checked at the time of the record review. Record review of the MAR on indicated that the resident was still receiving the potassium 10 mEq every day. Physician Assistant interview on 7-25-12 at 2:30pm indicated she was unsure why resident was on the potassium but would write an order to recommend a potassium level be drawn on the next lab date and ask the physician to do further follow up with this resident.	F 329	The Pharmacy Consultant Report Laboratory Monitoring Log will be maintained by the D.O.N. and the results of this ongoing audit tool will be shared with the facility's pharmacy consultant and the medical director each month. The D.O.N. will also report the ongoing monitoring results from the Pharmacy Consultant Report Laboratory Monitoring Log to the Executive QA Committee which meets quarterly. The next scheduled meeting is 10/17/2012. The facility alleges full compliance with F-329 by 8/28/12 as part of the plan of correction.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431	The expired medications were removed from the central supply medication room on 7/26/12 by the central supply clerk during an audit by the D.O.N and the central supply clerk.	

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 _____	08/03/2012

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

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F 431	Continued From page 12 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview with facility staff, the facility failed to remove expired medications from the central supply room for 1 of 1 central supply room..	F 431	The facility re-checked the central supply medication room on 7/27/12 in addition to the medications that were stored in the medication carts on the hallways and there were no other expired medications that could have reached the residents. To prevent future deficient practice, the facility will continue the central supply medication room audits which were initiated on 7/26/12. The facility will utilize a QA tool, the Med Room Inspection Report, to document their efforts and to prevent future deficient practice. Medications that are expiring in the upcoming month (example = September's expiring medications will be removed during the August audit) will be removed from the central supply medication room as they are identified. These medications, if applicable, will be listed on the QA Tool. The facility already utilized an outside pharmacy representative to check the medications which are stored in the medication carts on the hallway and this practice will continue as it did prevent deficient practice in the area of expired medication storage.	

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 _____	08/03/2012

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 431	Continued From page 13 The findings include: Observations during the medication storage of the central supply room on 7/26/12 at 9:30 AM audit revealed the following medications out of date but remained on the shelf with the medications that were to be used by facility staff. The out of date medications included: 2 bottles Children 's Tylenol, two bottles expired 2/12; 2 bottles Citrate of Magnesia, one bottle expired 8/10 and one bottle expired 7/11; 1 Bottle of Natural vegetable bulk forming laxative and dietary fiber supplement, expired 2/12. Interview with the Central Supply Manager on 7/26/12 at 9:30 AM revealed, "I thought I was on top of it. I thought I knew what I had. I rotate them just out of habit."	F 431	The central supply clerk and an administrative nurse will review the central supply medication room each month and detail their efforts on the QA tool known as the Med Room Inspection Report. The results of this monitoring tool will be reported to the D.O.N. and will be monitored, evaluated and tracked each month. The information obtained from the audits of the central supply medication room audit tool on the Med Room Inspection Report QA tool will be reported by the D.O.N. to the Executive QA Committee which meets quarterly. The next scheduled meeting is 10/17/2012. These monthly audits will continue indefinitely, unless otherwise indicated and noted in the Executive QA Committee meeting minutes, with a minimum of 6 months of completed audits. The facility alleges full compliance with F-431 by 8/28/12 as part of the plan of correction.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345552	A. BUILDING 01 - THE SHANNON GRAY REI B. WING	09/05/2012

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
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the New Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	A. Maintenance Director found a loose belt on a Supply Air Fan. He adjusted the tension on the Supply Air Fan belt. When correct tension was applied, make up air was adequate and kitchen doors closed properly. All roof mounted fan units were inspected throughout the facility. The Maintenance Director and/or his assistant will make monthly rounds to examine all roof mounted fan units. At that time he will also check negative pressure in the kitchen assuring all 3 doors close and latch in their frame.	10/01/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: By observation on 9/5/12 at approximately noon the following Heating, Ventilating, and Air Conditioning (HVAC) system was non-compliant, specific findings include; A. The negative pressure due to the kitchen range hood would not allow the three (3) doors to the kitchen to close and latch in their frame. B. HVAC switch at Highlands area nurses station did not shut down the unit when tested.	K 067	The Maintenance Director will utilize the "2012 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) meeting through the end of the current calendar year. B. Maintenance Director found the HVAC switch wired incorrectly. The HVAC shutdown was wired parallel and needed to be wired in series. Correct wiring and HVAC switches are in working order. All HVAC switches were inspected throughout the facility. The Maintenance Director and/or his assistant will make monthly rounds to check all HVAC switches in the facility. The Maintenance Director will utilize the "2012 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) meeting through the end of the current calendar year.	10/01/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jack Bennett — TITLE: Administrator — (X6) DATE: 9/20/12

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.

DRW

The Shannon Gray
Sarah Bennett Administrator Rehabilitation & Recovery Center 336-307-4729

2012 LIFE SAFETY PLAN OF CORRECTION AUDIT TOOL

The purpose of this audit tool is to serve as a written account of the continued efforts of the Shannon Gray personnel to correct deficiencies and to maintain compliance regarding the Life Safety Survey conducted by Della Wooten, Building System Engineer, on September 5, 2012.

A. All roof mounted fans units were inspected for loose belts and negative pressure checked in the kitchen assuring all three (3) doors close and latch in their frame properly.

Date of inspection : _____

Person conducting the inspection: _____
Notes about the inspection (include any correction made):

_____

_____

_____

B. All HVAC switches will be checked monthly to assure working properly.

Date of inspection : _____

Person conducting the inspection: _____
Notes about the inspection (include any correction made):

_____

_____

_____