		ND HUMAN SERVICES		•		14		16		MAPPROVED
		1,000,140	TIOL 5 001	10751107	· · · · · ·				O. 0938-0391	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CON DING		ION			(X3) DATE SI COMPLE	TED
		345552	B. WING	i					02/	C 02/2013
NAME OF PR	ROVIDER OR SUPPLIER		<u> </u>	STREET AD	DRESS	CITY STA	TE 71	P.CODE	1 12	
						GRAY CC				
THE SHA	NNON GRAY REHABILI	FATION & RECOVERY CENTER		JAMES'	TOWN,	NC 272	82			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EAC	H CORRE	ECTIV ENCEI	N OF CORRECT ACTION SHOOT TO THE APPROTECT OF THE APPROTE	ULD BE	(X5) COMPLETION DATE
		/ICES PROVIDED MEET	F 2	81	1. Co	orrectiv	ve a	ction for a	ffected	
SS=B	PROFESSIONAL STANDARDS				re	sident	s wa	s put into	place at	:
	The services provide		;				he survey	-		
	•						•	EXIL	11	
	must meet professional standards of quality.							on 2-2-13.		1. 1.
			!		Ef	fective	at I	that time,	the	11
	•	T is not met as evidenced		:	fa	cility re	equi	red		
	by:	view and document review		•	de	ocumei	ntat	ion of flu s	hots to	· 1
		nsure staff signed off	1		be	e comp	lete	d by the n	urse	
	influenza medication	~				•		stered the		:
	Immunization Record	d immediately after	•					e facility al		
	-	and failed to ensure it was the						-		i
		red the vaccination was the				-		cumentation		1
	-	in the Immunization Record (Resident #1, Resident #2	completed at the time of				of			
	and Resident #5).	(Nosidein #1, Nesidein #2		:	ac	iminist	rati	on.		
	The findings included	i :	ı		2. Tl	ne inte	rver	tions put	into place	a.
				į	on 2	-2-13 fc	or p	reviously a	iffected	
		policy titled Influenza	•		resid	ents w	ıill p	revent fut	ure	
		mber 2007 revealed "For	•	i.				ce as well.		
		e vaccine, the date of per, expiration date, person		ŧ		•		ed a 100%		
		e site of vaccination will be		!		•	•	lents to er		
		esident's/employee medical	į		•					
	record."				•			cumentati		
		1 111 1 1110110 111	:		the o	conclus	ion	of the sur	ey on 2-	
		admitted on 4/19/10 with Alzheimer ' s disease.			2-13	had be	een	completed	l as	
	diagnoses including i	Aizheimer s'uisease.	:		expe	cted.	This	audit was		
	Review of the Quarte	erly Minimum Data Set	[•			2-14-13 an		E
	(MDS) dated 9/13/12	revealed Resident #1 had	!			•		ntified as		
		d was significantly impaired	!							
	in decision making.		i			•		needed to		
į	Review of the facility	document titled Resident	i İ				a flu	ı vaccinati	on since	
!		2012) revealed that it listed		1	that	time.				: {
BODATORY	NIDECTORIS OR DROVINGO	SHODI IED DEDDESENITATIVE'S SIGNATUDE	***************************************	: 		TITIC				(V6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:7ZHM11

Facility ID: 061198

If continuation sheet Page 1 of 11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/12/2013 FORM APPROVED

	VICIO TIENETTA					OMP NO	0. 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				*******	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 02/02/2013	
		345552					
NAME OF PR	OVIDER OR SUPPLIER	1			T ADDRESS, CITY, STATE, ZIP CODE		
THE SHAM	INON GRAY REHABILIT	ATION & RECOVERY CENTER			S SHANNON GRAY COURT MESTOWN, NC 27282	1000 · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	.D BE	(X5) COMPLETION DATE
	season. There were as receiving influenzincluding Resident # Review of the Immur #1 revealed she rece on 9/28/12 and that in Administrative Nurse On 2/1/13 at 2 PM A revealed that in Sept staff (Administrative Nurse #2 [no longer #3 and Administrative vaccines to the facility and no contraindicate format over a 1 - 2 d 9/28/12. She stated spreadsheet prepare and did not consult that the time of administrative Nurse vaccinations were significant on the terministrative Nurse vaccinations on the colinic, came in the fooff the immunization the Nurses who did the She further indicated	and their influenza for the 2012 - 2013 flu 55 residents who were listed a vaccine on 9/28/12 I. Idization Record for Resident sived the influenza vaccine t was signed as given by #4. Idministrative Nurse #1 ember 2012, four nursing Nurse #1, Administrative working at the facility], Nurse the Nurse #3) gave influenza by residents, with consents fons, in a flu clinic type that they worked from a d by Administrative Nurse #2 the resident's medical record fatering the vaccinations. #1 stated that the gened off on the spreadsheet for all the indicative for in the Resident's clinical for Nurse #1 added that for H4, who did not give flay of the immunization flowing day to help by signing for the vaccine administration. It that "technically" correct	F 2	81	3. The Director of Nursing proan in-service for the facility administrative nurses to make these expectations were clear communicated as well as ensithe facility could document completion of training. Note in-service was provided to administrative nurses only as are the only nurses who can provide resident flu shots more forward. Facility floor nurses no longer allowed to provide resident flu shots. These charallow the facility to streamling vaccination administration pand ensure documentation is completely timely and accurate in-service for 100% of eladministrative nurses was completed on 2-13-13. Any future administrative nurses added into an administrative nurse added into an administrative nurse information/in-service as well information/in-service as well.	se sure orly suring e: the sthey oving s are enges ne the rocess s ately. ligible ses who cive role nis same	
	practice would have	t that " technically " correct been for the Nurse giving the It the Resident's medical		:			

Facility ID: 061198

record, give the vaccination, and then for the

PRINTED: 02/12/2013 **FORM APPROVED** DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WNG 02/02/2013 345552 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2005 SHANNON GRAY COURT THE SHANNON GRAY REHABILITATION & RECOVERY CENTER JAMESTOWN, NC 27282 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETION DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 4. The facility created a QA team, The F 281 F 281 Continued From page 2 Flu Shot Action Team, on 2-13-13 to Nurse who gave it to sign it off on the Immunization Record. both implement a formal plan of correction as well as ensure current On 2/2/13 at 12:13 PM telephone interview with and future compliance. This Administrative Nurse #4 revealed that she was asked to help transcribe the influenza committee consists of the Nursing vaccinations that were given on or around Home Administrator, Director of 9/28/12. She wasn't certain if she came in on Nursing and a current Unit Coordinator the evening most of the vaccinations were given or the following day but stated that at least some with knowledge of the processes of the vaccinations were not signed off in the expected by the facility. The QA team Resident's Immunization Record until the next created the Flu Shot Administration day. She added that she wrote in the date the immunization was actually given, not the date of Tool to allow the facility to monitor signing, and that she did not indicate that her and ensure compliance with F-281, documentation was a late entry. In addition, she said that she signed her name as the Nurse who specifically that flu shots are gave the vaccinations even though at most she documented at the time they are given may have given a few of them but she did not by the nurse who provided the know to whom. She acknowledged that correct practice would be for the Nurse who administered vaccination. the vaccination to sign for it but stated she This spreadsheet tool will be thought there was a 24 hour window to document maintained by the Director of Nursing. vaccinations. The Flu Shot Action Team will meet 2. Resident #2 was admitted on 8/21/12 with weekly x 4 and then monthly x 3 (thru diagnoses including quadriplegia, dysphasia, and the end of the recommended flu depressive disorder. vaccination season, 3-31-13). Review of the Admission Minimum Data Set

cognitively intact.

(MDS) dated 8/28/12 revealed Resident #2 was

Review of the facility document titled Resident

immunization status for the 2012 - 2013 flu

Vaccinations (2011 - 2012) revealed that it listed the facility Residents and their influenza

season. There were 55 residents who were listed

Information, activity and updates from

this QA team will be reported to the

scheduled meeting, 4-17-13. The QA

Executive QA Committee by the

Director of Nursing at the next

team will resume activity prior to

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SUI COMPLET		
		345552	B. WING		i i	C 02/02/2013	
	OVIDER OR SUPPLIER	LITATION & RECOVERY CENTER	200	ET ADDRESS, CITY, STATE, ZIP COD 15 SHANNON GRAY COURT MESTOWN, NC 27282	E		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 281	Review of the Imm #2 revealed her in off as given on 9/2 although on the ald date given was lis On 2/1/13 at 2 PM revealed that in Se staff (Administrative Nurse #2 [no long #3 and Administrative vaccines to the far and no contraindic format over a 1 - 2 9/28/12. She stat spreadsheet prep and did not consu at the time of adm Administrative Nu vaccinations were once they were gi administration site immediately signe record. Administr Administrative Nu vaccinations on th clinic, came in the off the immunizati the Nurses who d She further indica practice would ha vaccination to cor record, give the ve	nza vaccine on 9/28/12 t #2. nunization Record for Resident fluenza vaccination was signed 26/ by Administrative Nurse #4 pove noted facility document the	F 281	September 2013 when scheduled to resume fluction control of the per facility infection control of the QA notes/minutes. 5. The facility states fur compliance with F-281 effective 2-15-13.	u vaccinations introl guidelines. in in place d or reflected in		
	Nurse who gave i Immunization Rec		; ; ;			1	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	W	c	
		345552	B. WNG		02/02/2013	
	OVIDER OR SUPPLIER	BILITATION & RECOVERY CENTER	2005	TADDRESS, CITY, STATE, ZIP CODE S SHANNON GRAY COURT MESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES HENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION	
F 281	Continued From	page 4	F 281			
	Administrative No asked to help trai vaccinations that 9/28/12. She was the evening most or the following dof the vaccination Resident's Immeday. She added immunization was signing, and that documentation was aid that she sign gave the vaccina may have given a know to whom. Spractice would be the vaccination to	its PM telephone interview with curse #4 revealed that she was inscribe the influenza were given on or around isn't certain if she came in on the of the vaccinations were given lay but stated that at least some inside were not signed off in the unization Record until the next that she wrote in the date the sactually given, not the date of she did not indicate that her was a late entry. In addition, she ned her name as the Nurse who attons even though at most she are few of them but she did not she acknowledged that correct in the for the Nurse who administered to sign for it but stated she is a 24 hour window to document.				
	3. Resident #5 w diagnoses includ chronic heart faile Review of the Sig Set (MDS)dated was cognitively in Review of the fac Vaccinations (20 the facility Reside immunization sta season. There w	gnificant Change Minimum Data 8/29/12 revealed the resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
	CORRECTION	IDENTIFICATION NUMBER:	` '			COMPLETED		
			A. BUIL	DING:	LANCE TO LAN	С		
		345552	B. WING	S		02	02/2013	
NAME OF PR	OVIDER OR SUPPLIER		<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP CODE			
WILLE OFF	MON ODAY DENAME	TATION & DECOVEDY CENTED			SHANNON GRAY COURT			
THE SHAN	INUN GRAY REHABILI	TATION & RECOVERY CENTER		JAME	ESTOWN, NC 27282			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
			1	i	was considered the second seco			
F 281	Continued From pag	je 5	F2	281				
	including Resident#	‡ 5.					:	
							!	
		nization Record for Resident					!	
		eived the influenza vaccine						
		it was signed as given by		t :			:	
	Administrative Nurse	e #4.	i				:	
			•					
		Administrative Nurse #1	1	:				
		tember 2012, four nursing		:				
		Nurse #1, Administrative		:				
		working at the facility], Nurse						
		/e Nurse #3) gave influenza						
		ity residents, with consents						
		tions, in a flu clinic type	1	:				
		day period, on or around					:	
	enroadehaat granar	i that they worked from a					i	
	spreadsneet prepare	ed by Administrative Nurse #2 the resident 's medical record						
		istering the vaccinations.	į.	:			1	
	Administrative Nurse							
		igned off on the spreadsheet					:	
	once they were give	•						
		and lot number, but were not	i					
		off in the Resident 's clinical					į.	
		ive Nurse #1 added that	į	!			:	
		e #4, who did not give	i					
		day of the immunization	!				:	
		ollowing day to help by signing	•	-			!	
		ns in the medical record for	:	į				
		the vaccine administration.		!				
		d that "technically" correct		1				
	practice would have	been for the Nurse giving the					1	
		ult the Resident 's medical		i			!	
	record, give the vac	cination, and then for the						
	Nurse who gave it to	o sign it off on the	•					
	Immunization Reco		:				!	
	· :			i			:	
	On 2/2/13 at 12:13	PM telephone interview with	:					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING B. WING			C C	
		345552	D. VVIIV	·		02	/02/2013
	OVIDER OR SUPPLIER	TATION & RECOVERY CENTER		2005 SH/	DRESS, CITY, STATE, ZIP CODE ANNON GRAY COURT TOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa Administrative Nurs asked to help trans- vaccinations that we 9/28/12. She wasn the evening most of or the following day of the vaccinations Resident's Immun- day. She added the immunization was signing, and that she documentation was said that she signed gave the vaccination may have given a fe know to whom. Sh practice would be fe the vaccination to se thought there was a vaccinations. 483.25(i) DRUG RE UNNECESSARY D	ge 6 e #4 revealed that she was cribe the influenza ere given on or around ' t certain if she came in on fithe vaccinations were given but stated that at least some were not signed off in the ization Record until the next at she wrote in the date the actually given, not the date of the did not indicate that her a late entry. In addition, she did her name as the Nurse who are even though at most she ew of them but she did not e acknowledged that correct for the Nurse who administered ign for it but stated she a 24 hour window to document	F	281		ed resident stration of 2-12-12. n 12-12-12	
	drug when used in duplicate therapy); without adequate mindications for its usadverse consequer should be reduced combinations of the Based on a compreresident, the facility who have not used given these drugs to	excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of aces which indicate the dose or discontinued; or any	Communication of the communica		2. The facility has since completed a 100% a current residents to that administration vaccine occurred on resident per facility expectation. This au completed on 2-14-additional issues no	ensure ensure of the flu ace per adit was	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
· · ·			ļ				С	
		345552	B. WIN	G		02	/02/2013	
	OVIDER OR SUPPLIER	ITATION & RECOVERY CENTER		2005	FADDRESS, CITY, STATE, ZIP CODE SHANNON GRAY COURT IESTOWN, NC 27282			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X6) COMPLETION DATE	
F 329	Continued From page 7		F 329		3. To prevent future deficie	nt		
	as diagnosed and documented in the clinical				practice, the Director of			
		nts who use antipsychotic ual dose reductions, and			Nursing provided an in-serv		:	
:	drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.				for the facility administrative	/e	:	
					nurses on 2-13-13 to make		:	
				i	sure the expectations of the	e	:	
					facility were clearly	2		
				:	communicated and			
			:		understood. This in-service	:	:	
	This REQUIREME	:	:	was given to 100% of the				
	by:	by: Based on staff interview and document review, he facility failed to ensure 1 of 3 residents			administrative nurses who			
					participate in the flu			
	received no more t	han one dose of influenza		:	vaccination process for			
	:	2012 - 2013 influenza season	•		residents. The in-service			
	(Resident #2).			:	details that floor nurses are			
	The findings includ	led:			longer allowed to administ	er		
	A	- sine Information Statement	:	:	flu vaccinations; only the		:	
		accine Information Statement Vaccine Inactivated dated	:	·	administrative nurses who			
	7/2/12 the risks fro	m inactivated influenza vaccine	1		have been trained and		:	
	include the following			i	designated by the Director	of.		
		or swelling where the shot was ; sore, red, or itchy eyes;	;	:	Nursing can now provide the		·	
		s, headache, itching and	i i		vaccinations. The in-service	was		
	fatigue.		1		completed on 2-13-13. Any	future	•	
	Resident #2 was a	dmitted on 8/21/12 with		:	administrative nurses who a	are		
	diagnoses includin	g quadriplegia, dysphasia, and	:		added into an administrativ	e role		
	depressive disorde	er,	:		or position will be provided	this		
	Review of the Adm	nission Minimum Data Set			same information/in-service	e as		
	(MDS) dated 8/28/	12 revealed Resident #2 was			well.			
	cognitively intact. Under "Did the resident received influenza vaccine in this facility for this		ŧ .					

Event ID:7ZHM11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345552	B. WING			02/	C 02/2013
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER:	•	2005	ADDRESS, CITY, STATE, ZIP CODE SHANNON GRAY COURT ESTOWN, NC 27282			
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 329	Continued From nag	ne 8	F	329			
, old	• -		•		The facility removed	t all flu	
				:			
		or receiving the vaccine has			vaccine vials from t	neir	I
				:	previous place of st	orage in	:
	Review of the Resid		:	the refrigerators in	the	š	
					medication rooms		İ
	dose of influenza va	ccine in the Left Deltoid that	ï				!
	day.				The flu vaccine vials	:	:
	Devilers of the Origin	orly MDS dated 11/15/12	:		stored in a locked re	etrigerator;	1
	revealed Resident #2 was cognitively intact.			:	only the Administra	itor and	8
revealed Resident Under " Did the re- vaccine in this facil		:		Director of Nursing	have		
	vaccine in this facilit	y for this years influenza	:		access to the flu va		
					This was done at the		
			1	-			
					suggestion of the ne	•	
Review of the Resident dated 12/12/12 revedues of influenza va	Colle III the Felt Deltoid that			created QA team, Th		:	
	· uay.			-	Action Team. This te	am also	· 1
	Interview with Admir	histrative Nurse #1 on 2/1/13	•		appointed the Direct	or of	!
				:	Nursing as the prima	rv nerson	
·		•		i	responsible for moni		1
						O.	y
				:	tracking and directing	-	
			:		efforts of the admini	strative	
	-	-			nurses who provide f	lu shots.	
	in internation record	a to bo give			These interventions v	were	
	Telephone interview	with Administrative Nurse #1		:			
	on 2/7/13 at 12:01 F	M revealed that the influenza			implemented to bett		
		for Resident #2 was dated	:		and streamline the fl		\$
	•	uring the admission process).	•	:	process as well as pre	vent	
		eptember 2012, Resident #2		:	duplication of service	s for the	•
		influenza vaccine for the za season and that at that	:		residents.	· -	:
		opment Coordinator, who no	:	!			
	longer works at the		:				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-			OWR M	<i>).</i> 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE LDING	E CONSTRUCTION	(X3) DATE SU COMPLE	rED
			B. WING				С
		345552	3. 11	· · · · · · · ·		02/0	2/2013
NAME OF PR	OVIDER OR SUPPLIER			1	ET ADDRESS, CITY, STATE, ZIP CODE		
THE SHAN	INON GRAY REHABI	LITATION & RECOVERY CENTER		ı	5 SHANNON GRAY COURT		
				JAI	MESTOWN, NC 27282	······································	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 329	Continued From page	age 9	' . F	329	4. The facility created a C	QA .	:
. 020	-	all the residents names on it			team, The Flu Shot Action	n	•
	•	and vaccination status.			Team, on 2-13-13 to botl		
		se #1 indicated that on			implement a formal plan		
:	12/12/12 she observed that Resident #2 had a signed consent for influenza vaccine but the spreadsheet did not indicate that the resident had been given the vaccine. Administrative Nurse #1 also said she wrote the influenza vaccination			!	correction as well as ens		;
•					current and future comp		:
				:	•		
				1	This committee consists		
		because of this and	1	1	Nursing Home Administr		<u>:</u>
		t she did not check the nization Record before writing	1		Director of Nursing and a		:
		ng the floor nurse (Nurse #2) to	•		current Unit Coordinator	with	:
	give the immuniza	tion, like she should have. She			knowledge of the proces	ses	
	added that Nurse #2 called her immediately upon				expected by the facility.	The	
		t she had given Resident #2 a			QA team created a new		
	second influenza v	vaccination.			The Flu Shot Monitoring		: !
	Telephone intervie	w with Nurse #2 on 2/7/13 at			to allow the facility to re		
	3:22 PM revealed	that on 12/12/12 Nurse #1			· · · · · · · · · · · · · · · · · · ·		•
		a vaccination order for Resident	: :		compliant with F-329. The state of the state		
		at because Nurse #1 was an rse whom Nurse #2 trusted,		:	Shot Monitoring Log will		
		is a busy evening, she gave the			maintained by the Direct		:
	influenza vaccinat	ion to Resident #2 without	:	į	Nursing and will be used	to	
		unization Record first. Nurse	•		ensure the facility tracks	the	
	#2 said she then v	vent to sign the influenza	:		flu vaccination status of	the	1
	vaccination as give	en and discovered she had just se. She acknowledged that it		!	current residents who ar	'e ;	:
		ce to check the Medication,	!	i	eligible to receive a flu		<u> </u>
	Treatment or Imm	unization record before giving a	i	1	vaccination.		
		nent or immunization and that	1	į	The log will prevent duplication	n of flu	
		one this and not relied written order. She said that	İ	!			\$ 1 2
		written order. She said that strative Nurse #1 immediately	:		shot administration by tracking		
	after realizing that	a second influenza vaccination			shot status of all current resid		į Į
	had just been give	en and that Resident#2 ' s vital		:	have consented to the flu shot		
		monitored following the			residents are vaccinated, the I		
	incident with no ac	averse outcomes.	i		be updated to reflect their up	dated	!

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
						c l
		345552	B. WNG		02/0	2/2013
	IDER OR SUPPLIER ON GRAY REHAB	LITATION & RECOVERY CENTER	5	STREET ADDRESS, CHY, STATE, ZIP CODE 2005 SHANNON GRAY COURT JAMESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				vaccination status. The ifrom this log will be reposed shot Action Team at each The QA team will meet withen monthly x 3 (thru the recommended flu vaccing 3-31-13). Information, a updates from this QA tear reported to the Executive Committee by the Direct at the next scheduled med 4-17-13. The team will resume act to September 2013 where facility is scheduled to revaccinations per facility control guidelines. This will remain in place unless otherwise noted or reflet QA notes/minutes.	h meeting. weekly x 4 and he end of the nation season, nctivity and am will be te QA tor of Nursing teeting, ctivity prior n the esume flu infection QA team	
				5. The facility states full compliance with F-329, effective 2-15-13.		