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 ______	C 02/28/2017

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 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if	F 225		3/15/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/17/2017

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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F 225	Continued From page 1 the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to report an allegation of sexual abuse to the North Carolina Health Care Personnel Investigations (HCPI) by a visitor to a resident within the required two (2) hours' time frame for one (1) of three (3) sampled residents that were reviewed for abuse (Resident #1). Findings include: Resident # 1 was admitted to the facility on May 17, 2016 with diagnoses of hypertension, diabetes mellitus (DM), hyperlipidemia,	F 225	The facility was able to successfully complete a 24 hour fax notification to the Health Care Personnel Registry line on 2-20-17. This was after previous unsuccessful fax attempts earlier that same day which resulted in the above citation. Per staff and resident feedback, there were no other active allegations to report at that time that would affect other residents. To prevent future noncompliance with F	

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F 225 Continued From page 2

cerebrovascular accident, non-Alzheimer's dementia and depression.

Resident #1's Minimum Data Set (MDS) dated 12/16/2016 indicated resident's cognition was severely impaired. Resident #1 required extensive assistance with the majority of her activities of daily living (ADL's).

An observation of the video on 2/27/2017 at 12:10 PM with the Director of Nursing (DON), Assistant Administrator (AA) and Maintenance Director (MD) revealed the video was dated 2/20/2017 at 11:16 AM. The video showed Visitor #1 pushing Resident #1, who was seated in her wheelchair, into the break room. As soon as the door shut Visitor #1 leaned over Resident #1 and appeared to be kissing her. Visitor #1's back was partially to the camera but head and right arm movement suggested kissing and fondling of Resident #1. Observed Resident #1 placed her hand on Visitor #1's head numerous times and appeared to be pulling him into her. At 11:19 AM Visitor #1 appeared to say something to Resident #1 and she shook her head. At 11:21 AM Visitor # 1 appeared to reach his right arm over Resident #1 and moved in closer. At 11:22 AM the break room door opened and a staff member entered. Visitor # 1 immediately stood up away from Resident #1 and rolled Resident #1 out of the break room.

An interview with Nurse # 1 on 2/27/2017 at 2:50 PM revealed that she had gone to use the bathroom in lounge on 2/20/2017 at 11:22 AM. Nurse #1 stated she opened the door and almost hit the back of a man who was standing beside the wheelchair of Resident # 1. Nurse #1 stated the man lifted his head up from around Resident

F 225

225 and F 226, the corporate office provided a directed in-service specific to F 225 and F 226. Wording for the in-service was taken directly from F 225, F 226 verbiage and the Code of Federal Regulation (CFR) guidelines. To clarify, the in-service in question specifically reflects the changes to the reporting guidelines which were clarified on 2-10-17 and then later communicated to the facility by the NC DHHS. The in-service also included an updated revision (3-15-17) of the facility policy and procedure specific to reporting guidelines and processes. This in-service was provided to the Administrator, Assistant Administrator, Executive Assistant and Director of Nursing on 3-15-17, documentation was kept regarding the in-service attendees to verify completion. Note: the fax machine which would not supply a fax confirmation proving the unsuccessful timely fax attempt on 2-20-17 has since been corrected. This should prevent any additional occurrences as the facility will only send 24 hour and 5 day reports to the Health Care Personnel Registry from fax machines that produce confirmations which prove reports were sent in or attempted to be sent in timely. If for any reason a fax confirmation is not available, another fax machine will be utilized and all printed/fax generated confirmations will be kept to verify compliance.

The facility created and will utilize a Quality Assurance (QA) Tool, the H.C.P.R. Confirmation Audit Tool, for all future reportable events. This will allow the

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THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	2005 SHANNON GRAY COURT JAMESTOWN, NC 27282

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F 225 Continued From page 3

#1 face and stood up when Nurse #1 entered the room. Nurse #1 stated she did not see him kissing her but he was "acting funny." Nurse # 1 stated she informed Nurse #2 of this incident.

An interview with Nurse #2 on 2/27/ 2017 at 3:13 PM revealed that when she was informed of the incident by Nurse #1 they both went to check on Resident #1, but she was not in her room. Nurse #2 stated that she did see Resident #1 in her wheelchair rolling down the hallway. Nurse #2 stated that the staff told her that Visitor #1 had left the facility and that he would be back at 2:00 PM. Nurse #2 reported this information to the DON.

An interview with the DON and AA on 2/27/2017 at 4:25 PM revealed after reviewing the information they realized that the incident took place in the break room and that there may be a video of the incident. The AA stated that they viewed the video at 1:20 PM to 1:30 PM. AA stated that when they finished viewing the video they determined that there was a concern and they contacted the Administrator who was at their sister facility. The DON stated that Resident #1 was assessed by Nurse #4.

On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017 at 1:15 PM revealed the video system had to be unlocked to assess/watch the interaction with Resident # 1 and Visitor #1. Upon review of the video, the facility was able to view the "event" at approximately 1:40 PM and determined that an investigation needed to be conducted.

On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017 revealed on 2/20/2017 at 2:55 PM the Guilford

F 225

facility to monitor, document and prove timely submission attempts and reporting policy and procedure compliance (with F225 and F226) by documenting specific information step by step for any agency that has been contacted or needs to be contacted due to an allegation. This QA tool will be initiated, completed and kept by the facility administrator for monitoring compliance and internal QA reporting purposes. The monitoring and oversight of this QA function will be directed by the Executive Quarterly QA Committee and will cover any future 24 hour or 5 day report that is sent into the Health Care Personnel Registry during each quarterly look back period. The Administrator will report directly to the Executive Quarterly QA Committee each quarter regarding any reportable events as documented on the HCPR Confirmation Audit QA Tool. The next scheduled Executive Quarterly QA Committee meeting is 4-19-17 and will cover the January-March 2017 period. This plan of correction QA will continue a minimum of 1 year.

The facility alleges full compliance with this plan of correction, effective 3-15-17.

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F 225	Continued From page 4 County Sheriff's Department was notified of the incident. This call was made by the Assistant Administrator. On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017, revealed at 5:02 PM a 24 hour initial report was attempted to be faxed; confirmation of success received at 5:22PM after multiple attempts. On 2/28/2017 at 11:30 AM a review of the 24 hour initial report dated 2/20/2017 revealed that 24hr initial report was received at the HCPI at 5:22 PM from the confirmation sheet attached to the report. During an interview with the Administrator and DON on 2/28/2017 at 12:45 PM the Administrator stated that it was his expectation that a 24 hour report for abuse would be sent in to the state agency as soon as it could be. Administrator also indicated that the facility reported this incident to the Police Department with the two (2) hour time frame. The DON stated that her expectation was the same; the 24 hour report would be sent in as soon as it could be.	F 225		
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226		3/15/17

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F 226	Continued From page 5 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on staff interviews and abuse investigation the facility failed to implement their policy to report an allegation of sexual abuse to the North Carolina Health Care Personnel Investigations (NCHCPI) by a visitor to a resident within the required two (2) hours' time frame for one (1) of three (3) sampled residents that were reviewed for abuse (Resident #1). Findings include: 1. The Facility's Abuse Policy revealed: Each resident of The Shannon Gray has the right to be free from verbal sexual, physical and mental	F 226	The facility was able to successfully complete a 24 hour fax notification to the Health Care Personnel Registry line on 2-20-17. This was after previous unsuccessful fax attempts earlier that same day which resulted in the above citation. There were no issues or noncompliance in staff identification, monitoring or reporting of abuse to administration. This citation/noncompliance is directly associated with the technology failure of not being able to report within 2 hours.	

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F 226	Continued From page 6 abuse, corpal punishment and involuntary seclusion. Resident abuse is not accepted at The Shannon Gray and every effort shall be made to prevent resident abuse. Resident should not be subject to abuse by anyone, including but not limited to facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members, resident representative or legal guardians' friends or other individuals. It is the policy of the Shannon Gray that anyone reporting abuse or neglect will not suffer any repercussions or mal-treatment of any kind. All allegations of abuse or neglect can be reported to nurses, the social work department, department heads or any administrative staff. All allegation will be investigated and death with accordingly. Resident to Resident altercations. Visitor to Resident Abuse: individual who visit the facility and are abusive or mistreat resident will be asked to leave and appropriate agency will be notified. Abuse definition s are many Verbal, sexual, physical mental and involuntary seclusion, neglect, misappropriation of resident property. The facility most do the following: employees will be trained, staff assist with preventing abuse, identifying events via incident reports all allegation of staff abuse, neglect or misappropriation of resident property will be investigated within 24 hrs.' of the facility 's knowledge of such an occurrence. In the event of a suspicion of a crime, the facility will report to the appropriate authorities within 2 hours, to protect the resident, from the accused person, All staff allegation are to be report to the State Agency board of Nursing.	F 226	Per staff and resident feedback, there were no other active allegations to report at that time that would affect other residents. To prevent future noncompliance with F 225 and F 226, the corporate office provided a directed in-service specific to F 225 and F 226. Wording for the in-service was taken directly from F 225, F 226 verbiage and the Code of Federal Regulation (CFR) guidelines. To clarify, the in-service in question specifically reflects the changes to the reporting guidelines which were clarified on 2-10-17 and then later communicated to the facility by the NC DHHS. The in-service also included an updated revision (3-15-17) of the facility policy and procedure specific to reporting guidelines and processes. This in-service was provided to the Administrator, Assistant Administrator, Executive Assistant and Director of Nursing on 3-15-17, documentation was kept regarding the in-service attendees to verify completion. Note: the fax machine which would not supply a fax confirmation proving the unsuccessful timely fax attempt on 2-20-17 has since been corrected. This should prevent any additional occurrences as the facility will only send 24 hour and 5 day reports to the Health Care Personnel Registry from fax machines that produce confirmations which prove reports were sent in or attempted to be sent in timely. If for any reason a fax confirmation is not available, another fax machine will be utilized and all printed/fax generated confirmations will be	

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Continued From page 7

All allegation will be reported to the proper authorities within a reasonable time frame per state and federal regulation. THE TIME PERIOD TO REPORT AN INCIDENT OF 'SERIOUS BODILY INJURY OR (ABUSE) IS 2 HOURS. All other incident of suspected abuse will be reported within 24 hours. A completed investigation and written report will be sent to the proper authorities within five working days if an initial 24 hour report is necessary.

Resident # 1 was admitted to the facility on May 17, 2016 with diagnoses of hypertension, diabetes mellitus (DM), hyperlipidemia, cerebrovascular accident, non-Alzheimer's dementia and depression.

Resident #1's Minimum Data Set (MDS) dated 12/16/2016 indicated resident's cognition was severely impaired. Resident #1 required extensive assistance with the majority of her activities of daily living (ADL's).

An observation of the video on 2/27/2017 at 12:10 PM with the Director of Nursing (DON), Assistant Administrator (AA) and Maintenance Director (MD) revealed the video was dated 2/20/2017 at 11:16 AM. The video showed Visitor #1 pushing Resident #1, who was seated in her wheelchair, into the break room. As soon as the door shut Visitor #1 leaned over Resident #1 and appeared to be kissing her. Visitor #1's back was partially to the camera but head and right arm movement suggested kissing and fondling of Resident #1. Observed Resident #1 placed her hand on Visitor #1's head numerous times and appeared to be pulling him into her. At 11:19 AM Visitor #1 appeared to say something to Resident #1 and

F 226

kept to verify compliance.

The facility created and will utilize a Quality Assurance (QA) Tool, the H.C.P.R. Confirmation Audit Tool, for all future reportable events. This will allow the facility to monitor, document and prove timely submission attempts and reporting policy and procedure compliance (with F225 and F226) by documenting specific information step by step for any agency that has been contacted or needs to be contacted due to an allegation. This QA tool will be initiated, completed and kept by the facility administrator for monitoring compliance and internal QA reporting purposes. The monitoring and oversight of this QA function will be directed by the Executive Quarterly QA Committee and will cover any future 24 hour or 5 day report that is sent into the Health Care Personnel Registry during each quarterly look back period. The Administrator will report directly to the Executive Quarterly QA Committee each quarter regarding any reportable events as documented on the HCPR Confirmation Audit QA Tool. The next scheduled Executive Quarterly QA Committee meeting is 4-19-17 and will cover the January-March 2017 period. This plan of correction QA will continue a minimum of 1 year.

The facility alleges full compliance with this plan of correction, effective 3-15-17.

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F 226	Continued From page 8 she shook her head. At 11:21 AM Visitor # 1 appeared to reach his right arm over Resident #1 and moved in closer. At 11:22 AM the break room door opened and a staff member entered. Visitor # 1 immediately stood up away from Resident #1 and rolled Resident #1 out of the break room. An interview with Nurse # 1 on 2/27/2017 at 2:50 PM revealed that she had gone to use the bathroom in lounge on 2/20/2017 at 11:22 AM. Nurse #1 stated she opened the door and almost hit the back of a man who was standing beside the wheelchair of Resident # 1. Nurse #1 stated the man lifted his head up from around Resident #1 face and stood up when Nurse #1 entered the room. Nurse #1 stated she did not see him kissing her but he was "acting funny." Nurse # 1 stated she informed Nurse #2 of this incident. An interview with Nurse #2 on 2/27/ 2017 at 3:13 PM revealed that when she was informed of the incident by Nurse #1 they both went to check on Resident #1, but she was not in her room. Nurse #2 stated that she did see Resident #1 in her wheelchair rolling down the hallway. Nurse #2 stated that the staff told her that Visitor #1 had left the facility and that he would be back at 2:00 PM. Nurse #2 reported this information to the DON. An interview with the DON and AA on 2/27/2017 at 4:25 PM revealed after reviewing the information they realized that the incident took place in the break room and that there may be a video of the incident. The AA stated that they viewed the video at 1:20 PM to 1:30 PM. AA stated that when they finished viewing the video they determined that there was a concern and they contacted the Administrator who was at their	F 226		

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F 226	Continued From page 9 sister facility. The DON stated that Resident #1 was assessed by Nurse #4. On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017 at 1:15 PM revealed the video system had to be unlocked to assess/watch the interaction with Resident # 1 and Visitor #1. Upon review of the video, the facility was able to view the "event" at approximately 1:40 PM and determined that an investigation needed to be conducted. On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017 revealed on 2/20/2017 at 2:55 PM the Guilford County Sheriff's Department was notified of the incident. This call was made by the Assistant Administrator. On 2/27/2017 at 1:30 PM a review of a form called "Initial timeline of Events dated 2/20/2017, revealed at 5:02 PM a 24 hour initial report was attempted to be faxed; confirmation of success received at 5:22PM after multiple attempts. On 2/28/2017 at 11:30 AM a review of the 24 hour initial report dated 2/20/2017 revealed that 24hr initial report was received at the HCPI at 5:22 PM from the confirmation sheet attached to the report. During an interview with the Administrator and DON on 2/28/2017 at 12:45 PM the Administrator stated that it was his expectation that a 24 hour report for abuse would be sent in to the state agency as soon as it could be. Administrator also indicated that the facility reported this incident to the Police Department with the two (2) hour time frame. The DON stated that her expectation was	F 226		

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THE SHANNON GRAY REHABILITATION & RECOVERY CENTER	**2005 SHANNON GRAY COURT** **JAMESTOWN, NC 27282**

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F 226	Continued From page 10 the same; the 24 hour report would be sent in as soon as it could be.	F 226		