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 09/02/2022

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/29/22 through 09/02/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # DXAA11.	E 000		
F 000	INITIAL COMMENTS The recertification and complaint investigation survey was conducted from 08/29/22 through 09/02/22. Event ID # DX4A11. The following intakes were investigated NC 000190865 and NC 000189362. . 1 of 5 complaint allegations were substantiated in resulting in deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		9/30/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/25/2022

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 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and staff, Nurse Practitioner, and Physician interviews the facility failed to ensure the Nurse reported a change in condition to the Physician for 1 of 3 residents, Resident #92, reviewed for hospitalization when the resident had an episode of unresponsiveness and a low oxygen saturation.	F 580	F580 On 6/11/22 Resident #92 was observed to be unresponsive. CPR was immediately initiated and 911 was called. EMS arrived at scene and took charge of the CPR and transported resident #92 to hospital where resident expired.	

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F 580	Continued From page 2 Findings included: Resident #92 admitted to the facility on 5/11/2022 with diagnoses of heart disease and respiratory disease. An admission Minimum Data Set (MDS) assessment dated 6/11/2022 indicated Resident #92 was cognitively intact. On 8/31/2022 at 3:02 pm an interview we conducted by phone with Nurse Aide #1, and she stated she was assigned to Resident #92 on the morning of 6/11/2022. She stated the resident was a little confused and while she was assisting her to the bathroom, she passed out in the bathroom. Nurse Aide #1 stated Resident #92's eyes went back in her head, her speech was slurred, and she was not making sense. Nurse Aide #1 stated she called Nurse Aide #2 in to assist her with putting Resident #92 back to bed. She explained after they put her back to bed, raised her legs, she began to come around, she called Nurse #1 into the room, and told her Resident #92 had an episode of unresponsiveness. Nurse Aide #1 stated Nurse #1 put oxygen on Resident #92 and assessed her. A Progress Note dated 6/11/2022 at 10:44 am by Nurse #1 stated she was notified by Nurse Aide #1 that Resident #92 was not feeling well and upon assessment Resident #92's oxygen saturation was 62 to 65%, a normal oxygen saturation level is 95 to 100%. Nurse #1's Progress Note further stated Resident #92 was medicated with a narcotic pain medication for pain and an antihistamine for nausea. The Progress Note stated Resident #92's oxygen saturation level was rechecked and was 90 to	F 580	Beginning on 9/16/22 100% of current facility residents were audited going back two weeks. Progress notes, labs, orders, recorded Vital Signs of Blood Pressure, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated were reviewed. No residents were identified as being deficient by not having a proper notification if indicated. An in-service was initiated by the Director of Nursing for all licensed nursing beginning on 9/16/22 on the importance of proper notification and the location of and how to use our Change of condition tool and the necessity of use whenever a change of condition is suspected. The Director of Nursing, MDS RN nurse and Unit Managers and/or designees will monitor any change of conditions that warranted notification of PCP and/or resident representative in the daily clinical meeting daily 5 x week for 2 weeks, then 1 x week for 4 weeks and then quarterly at Quality Assurance meeting for 3 quarters. Any noted indication of variances will be brought to attention of the Director of Nursing for immediate action. Completion date 9/30/22	

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F 580	Continued From page 3 92% and Resident #92 stated she was feeling better. A telephone interview was conducted with Nurse #1 on 8/31/2022 at 12:52 pm and she stated she was administering medications on her assignment when Nurse Aide #1 notified her Resident #92 needed pain medication and she went to assess Resident #92 and she checked her vital signs. Nurse #1 stated Resident #92's oxygen saturation was 62 to 65% when she checked her vitals and she put oxygen on Resident #92, and she assisted Nurse Aide #1 with getting Resident #92 into the bed. Nurse #1 stated Nurse Aide #1 did not tell her Resident #92 had an unresponsive episode and Resident #92's oxygen saturation went back up to 92% within a few minutes of starting the oxygen. Nurse #1 stated she did not notify the Physician or the Nurse Practitioner of Resident #92's oxygen saturation being 62 to 65%. A phone interview was conducted with the Physician on 9/1/2022 at 10:44 am and he stated Resident #92 came to the facility with diagnosis of cardiomyopathy. The Physician stated Nurse #1 had not reported Resident #92's oxygen saturation had dropped to 62 to 65% and had required oxygen to bring her oxygen saturation up to 92%. The Physician stated since Resident #92's oxygen saturation returned to normal with the oxygen he did not feel the Nurse #1 should have notified him. A telephone interview was conducted with Nurse Practitioner #1 on 9/2/2022 at 6:36 pm and she was not called when Resident #92 had the episode of decreased oxygen saturation. Nurse Practitioner #1 stated she was not present in the	F 580		

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F 580	Continued From page 4 building when Resident #92 had the decreased oxygen saturation, but the oxygen saturation had come up to within normal limits after Resident #92 received oxygen per the standing orders. Nurse Practitioner #1 stated she did not know if she would have ordered anything differently since she was not present when Resident #92's oxygen saturation was low. During an interview with the Administrator on 9/1/2022 at 1:24 pm he stated he felt the nursing staff had handled Resident #92's care appropriately but had not reported the change in condition to the Nurse Practitioner or Physician. The Administrator stated he was not a clinician and was not sure if Nurse #1 should have notified the Nurse Practitioner or Physician of the decreased oxygen saturation since she had administered oxygen and the oxygen saturation had returned to normal.	F 580		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		9/30/22

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F 657	Continued From page 5 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure 1 of 1 residents, Resident #73, reviewed for care planning was given an opportunity for the resident or resident representative to participate in development and revision of their care plan. Findings included: Resident #73 admitted to the facility on 5/5/2021 with diagnoses of stroke and diabetes. A quarterly Minimum Data Set (MDS) assessment dated 7/28/2022 indicated Resident #73 was severely cognitively impaired. Review of the Care Plan Team Meeting Sign-in sheets for Resident #73 revealed her last Care Plan Team Meeting was 1/20/2022. During an interview with the Family Member on 8/29/2022 at 2:01 pm she stated she had not been invited to a care plan meeting since 1/2022. An interview was conducted with the Social	F 657	F657 On 9/15/22 Resident #73 expired of natural causes. Family at bedside. Beginning on 9/16/22 100% of current facility residents were audited going back 90 days to 6/16/22 to ensure all residents and/or their resident representatives either participated in or were offered the opportunity for an interdisciplinary care plan meeting. Residents that were identified that had not been offered an opportunity for an interdisciplinary care plan meeting were contacted and offered an opportunity to schedule a meeting at their earliest convenience. Written notification will be sent by the social worker or designee, to the resident and/or resident representative no later than 20 days prior to the scheduled comprehensive and quarterly review assessments inviting to participate in a	

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F 657	Continued From page 6 Worker on 8/31/2022 at 11:12 am and she stated she had missed scheduling the past two quarterly Care Plan Team Meetings with Resident #73 and her Family Member. The Social Worker stated when the calendar for the Minimum Data Set (MDS) assessments changed it changed the Care Plan schedule and caused her to miss sending out the Care Plan Team Meeting invitations. The Administrator was interviewed on 9/1/2022 at 1:34 pm and stated the Social Worker should have followed the rules and regulations regarding scheduling of Resident #73's Care Plan Team Meetings.	F 657	interdisciplinary care plan meeting for the development of the resident care plan. One week prior to date of care plan a phone call will be attempted by social worker or designee, to resident and/or resident's representative who have not previously responded to the written meeting invitation, inviting them to participate in the interdisciplinary meeting. The administrator and social work or designee, will monitor Assessment Reference Dates of all residents and schedule interdisciplinary care plan meetings and invitations 5 x week for 2 weeks, then 1 x week for 4 weeks in a daily meeting and then quarterly in the Quality Assurance meeting for 3 quarters. Any noted indication of variances be immediately addressed. Completion date 9/30/22	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and physician interviews the facility failed to ensure 1	F 684	F 684	9/30/22

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F 684	Continued From page 7 of 3 residents (Resident #92), reviewed for discharge from the facility, was not provided monitoring after she experienced a low oxygen saturation, received a narcotic analgesic, and antianxiety medication. Furthermore the facility failed to have a licensed nurse assess a resident after a fall before moving her in the dialysis center parking lot. This was evident of 1 of 3 (Resident #1) residents who were reviewed for accidents. Findings included: 1. Resident #92 admitted to the facility on 5/11/2022 with diagnoses of heart disease and respiratory disease. An admission Minimum Data Set (MDS) assessment dated 6/11/2022 indicated Resident #92 was cognitively intact. On 8/31/2022 at 3:02 pm an interview we conducted by phone with Nurse Aide #1, and she stated she was assigned to Resident #92 on the morning of 6/11/2022. She stated the resident was a little confused and while she was assisting her to the bathroom, she passed out in the bathroom. Nurse Aide #1 stated Resident #92's eyes went back in her head, her speech was slurred, and she was not making sense. Nurse Aide #1 stated she called Nurse Aide #2 in to assist her with putting Resident #92 back to bed. She explained after they put her back to bed, raised her legs, she began to come around, she called Nurse #1 into the room, and told her Resident #92 had an episode of unresponsiveness. Nurse Aide #1 stated Nurse #1 put oxygen on Resident #92 and assessed her. Review of Resident #92's Medication Administration Record for 6/11/2022 she was	F 684	On 6/11/22 Resident #92 was observed to be unresponsive. CPR was immediately initiated and 911 was called. EMS arrived at scene and took charge of the CPR and transported resident #92 to hospital where resident expired. On 10/22/21 Resident #1 was assessed for pain and injury upon return to facility from dialysis due to fall in transport by the facility assigned nurse. No apparent injures were noted. Pain was assessed at 3 out of 10 and PRN acetaminophen was administered. Beginning on 9/16/22 100% of current facility residents were audited going back two weeks. Progress notes, labs, orders, recorded Vital Signs of Blood Pressure, pulse, respiratory rate, temperature, pulse ox, and/or finger stick glucose if indicated were reviewed. No residents were identified as being deficient by not having a proper monitoring. Beginning on 9/16/22 100% of all resident falls since April 1st 2022 of both in-facility and transported residents were audited to ensure that they were properly assessed. No deficient practices were identified. An in-service was initiated by the Director of Nursing for all transportation staff and in-facility staff on 9/16/22 on the importance ensuring proper assessments are instituted on change of condition and falls and are documented as appropriate. The Director of Nursing, MDS RN nurse,	

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F 684	Continued From page 8 administered Oxycodone 10 milligrams, a narcotic analgesic, at 10:35 am and hydroxyzine 10 milligrams for anxiety at 10:59 am. A review of the electronic medical record revealed Nurse #1 had documented an oxygen saturation of 92% on 6/11/2022 at 9:21 pm. There were no other oxygen saturation levels documented for 6/11/2022. A Progress Note dated 6/11/2022 at 10:44 am by Nurse #1 stated she was notified by Nurse Aide #1 that Resident #92 was not feeling well and upon assessment Resident #92's oxygen saturation was 62 to 65%, a normal oxygen saturation level is 95 to 100%. Nurse #1's Progress Note further stated Resident #92 was alert and oriented, and complaining of gas pain, and was medicated with a narcotic pain medication for pain and an antihistamine for nausea. The Progress Note stated Resident #92's oxygen saturation level was rechecked, after she was placed on oxygen, and was 90 to 92% and Resident #92 stated she was feeling better; and monitoring was put into place. A telephone interview was conducted with Nurse #1 on 8/31/2022 at 12:52 pm and she stated she was administering medications on her assignment when Nurse Aide #1 notified her Resident #92 needed pain medication and she went to assess Resident #92 and she checked her vital signs. Nurse #1 stated Resident #92's oxygen saturation was 62 to 65% when she checked her vitals and she put oxygen on Resident #92, and she assisted Nurse Aide #1 with getting Resident #92 into the bed. Nurse #1 stated Nurse Aide #1 did not tell her Resident #92 had an unresponsive episode and Resident #92's oxygen saturation went back up to 92% within a few minutes of starting the oxygen. Nurse #1	F 684	Unit Managers and/or designee will monitor any change of condition and incidents in the daily clinical meeting daily 5 x week for 2 weeks, then 1 x week for 4 weeks and then quarterly at Quality Assurance meeting for 3 quarters. Any noted indication of variances will be brought to attention of the Director of Nursing for immediate action. Completion date 9/30/22	

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F 684	Continued From page 9 stated she did not notify the Physician or Nurse Practitioner of Resident #92's oxygen saturation and did not recheck Resident #92's oxygen saturation after it had increased to 92% when she assessed her. During an interview with the Administrator on 9/1/2022 at 1:24 pm he stated he felt the nursing staff had handled Resident #92's care appropriately but had failed to document that she had monitored Resident #92 after the episode of decreased oxygen saturation and unresponsiveness. 2. Resident #1 was admitted to the facility on 09/28/21 with diagnoses that included hypertension, end-stage renal disease, hyperlipemia, seizure disorder, malnutrition, asthma, dependence on supplemental oxygen and dysphagia. Review of Quarterly Minimum Data Set (MDS) dated 10/15/21 revealed Resident #1 was assessed as being cognitively intact and required extensive assistance with one-person physical assist with bed mobility, transfer, walk in corridor, dressing, toilet use and bathing. Further review of the MDS revealed Resident #1 had no history of falls before admission to the facility. A review of Resident #1's care plan dated 10/18/21 revealed Resident was able to ambulate in room with a rollator independently, however, gait was somewhat unsteady. Intervention included Resident was encouraged to ask for assistance with transfers and ambulation. Review of incident report was done and indicated Resident #1 had a fall at the dialysis center and	F 684		

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F 684	Continued From page 10	F 684		

returned. No documentation of Resident being assessed by a nurse at the dialysis center.

An interview was conducted with family member on 08/31/22 at 11:00 am. Family member indicated that Resident #1 had a fall after her dialysis treatment in October 2021. Family member indicated Resident was not assessed after the fall at the dialysis center.

During an interview with Transportation staff member on 08/31/22 at 12:45pm, it was indicated he had written a statement in October 2021 after the incident with Resident #1. He indicated Resident #1 had fell on her hands and knees and he assisted her back to the wheelchair because resident was persistent about getting back in the wheelchair and stated to him, she did not need help getting up. He also indicated he did not seek help from the dialysis center and transported Resident #1 back to the facility and informed the nurse and the nursing aide at the facility.

Attempted to contact the Nurse Aide who was assigned to Resident #1 on 10/22/21 and was unsuccessful.

Attempted to contact the Nurse who completed the incident report on 10/22/21 and was unsuccessful.

During a second interview with family member on 08/31/22 at 4:40 pm, it was indicated, she was informed by Resident #1 she had a fall at the dialysis center and that staff had not assessed her after the fall. Family member indicated she visited the facility that afternoon and she informed the Nurse on duty, and at that was when the

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F 684	Continued From page 11 Nurse assessed her mother. An interview was conducted with Resident #1 on 09/01/22 at 10:00 am and it was indicated she had not informed the Transportation staff member that she did not need help after the fall. She indicated the Transportation staff member assisted her back into the wheelchair and took her back to the facility and dropped her off in her room. Resident #1 indicated the Nurse did not assess her until her family member came to the facility and informed the Nurse of the fall. During an interview on 09/01/22 at 10:40 am the Director of Nursing stated it was her expectation that staff would call the facility immediately and report an incident. She indicated staff were not to move a resident after a fall until a Nurse assessed the resident. During an interview on 09/01/22 at 11:05 am with the Administrator, it was indicated he expected employees to follow the rules and regulations of the State of North Carolina and the Board of Nursing. Findings included: 2. Resident #1 was admitted to the facility on 09/28/21 with diagnoses that included hypertension, end-stage renal disease, seizure	F 684		

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 09/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 12 disorder, dependence on supplemental oxygen and dysphagia. Review of Quarterly Minimum Data Set (MDS) dated 10/15/21 revealed Resident #1 was assessed as being cognitively intact and required extensive assistance with one-person physical assist with bed mobility, transfer, walk in corridor, dressing, toilet use and bathing. Further review of the MDS revealed Resident #1 had no history of falls before admission to the facility. During an interview with Transportation staff member on 08/31/22 at 12:45pm, it was indicated he had written a statement in October 2021 after the incident with Resident #1. He indicated Resident #1 had fell on her hands and knees and he assisted her back to the wheelchair because resident was persistent about getting back in the wheelchair and stated to him, she did not need help getting up. He also indicated he did not seek help from the dialysis center and transported Resident #1 back to the facility and informed the nurse and the nursing aide at the facility. An interview was conducted with Resident #1 on 09/01/22 at 10:00 am and it was indicated she had not informed the Transportation staff member that she did not need help after the fall. She indicated the Transportation staff member assisted her back into the wheelchair and took her back to the facility and dropped her off in her room. Resident #1 indicated the Nurse did not assess her until her family member came to the facility and informed the Nurse of the fall. During an interview on 09/01/22 at 10:40 am the	F 684		

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 684	Continued From page 13 Director of Nursing stated it was her expectation that staff would call the facility immediately and report an incident. She indicated staff were not to move a resident after a fall until a Nurse assessed the resident.	F 684		