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 REHABILITATION & RECOVERY** B. WING _____	**08/11/2016**

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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K 000	INITIAL COMMENTS A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. The facility is utilizing speical locking systems In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type V (111) Constructed: 2010 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 150 Census - 118	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1. This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, and staff interview on 8/11/2016, at approximately 10:00 AM onward, the following deficiencies were noted: The facility maintance and inspection of hazardous areas was non-compliant, specific findings include: The laundry department is a one hour protected hazardous area. The one hour rated door to the	K 029	The door in question was corrected by the facility Maintenance Director to allow appropriate closure. This was completed on 8/26/16. All other fire rated doors in the facility were checked again on 8/26/16 by a Maintenance Department employee or by the Assistant Administrator. Any door found to not close accordingly was adjusted/corrected at that time.	9/6/16

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

Electronically Signed | 08/29/2016

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K 029	Continued From page 1 clean side of the laundry was dragging on its frame and did not close the door tight in its frame when tested. Ref: 2000 NFPA 101 Section 19.3.2.1; 8.4.1; This deficiency affected one smoke of approximately twelve smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke	K 029	The facility adjusted the Administrative Rounds QA tool to incorporate the appropriate closure of doors. This tool is completed a minimum of weekly by an administrative employee/department head. Moving forward, the tool has a space for the administrative employee to check (signifying they have checked all the fire the doors on their rounding assignment for appropriate closure, including not dragging on the door frame). Any door found not closing appropriately will be reported to the Maintenance Department or the Nursing Home Administrator by the administrative employee/department head for correction. The facility created a Life Safety QA Team which includes the Nursing Home Administrator, Assistant Administrator, Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet monthly to ensure compliance with this plan of correction. They will also report their efforts to the facility's Executive QA Committee, which meets quarterly. The next scheduled Executive QA Committee meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction on or before 9/6/16.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler systems are continuously maintained in reliable operating condition and are	K 062		9/6/16

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K 062	Continued From page 2 inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, and documentation review on 8/11/2016, at approximately 10:00 AM onward, the following deficiencies were noted: The facility maintance and inspection of the sprinkler system was non-compliant, specific findings include: The facility did not produce to the surveyor documentation that the quarterly sprinkler inspections were conducted during 2016 as required. Every required sprinkler system shall be continuously maintained in proper operating conditions, and requires an inspection every quarter of a calendar year. Ref: 2000 NFPA 101 Section 19.7.6; 4.6.12.1; NFPA 25 2-2; 9.7.5 This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	The facility had the sprinkler system re-inspected, this was completed on 8/22/16. Moving forward, the sprinkler system will be inspected (with the results kept on file) quarterly. The next scheduled sprinkler system inspection will occur by 11/30/2016 with the results documented accordingly. The outside company responsible for quarterly sprinkler inspections will exit with the facility Administrator, Assistant Administrator or the Maintenance Director after each visit, including the results of that sprinkler inspection. The quarterly inspections will be kept on file by the Administrator for future reference. The facility created a Life Safety QA Team which includes the Nursing Home Administrator, Assistant Administrator, Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet monthly to monitor and ensure compliance with this plan of correction. They will also report their efforts to the facility's Executive QA Committee, which meets quarterly. The next scheduled Executive QA Committee meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction on or before 9/6/16.	

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K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, and staff interview on 8/11/2016, at approximately 10:00 AM onward, the following deficiencies were noted: The facility access to electrical panels was non-compliant, specific findings include: Access to electrical panels must not be obstructed. There must be at least 36 inches clearance in front of the electrical panels and at least 30 inches clearance to one side of the electrical panel. The electrical panel wall at the following locations did not have the proper clearance to allow for maintenance on the electrical panel circuitry. 1. The staff lounge named "Aunt Bee" 2. The staff lounge named "Pitt Stop" Ref: 2000 NFPA 101 Section 19.5.1; 9.1.2; NEC 110 Section 26 This deficiency affected one smoke of approximately twelve smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke	K 147	The facility Maintenance Director applied a cautionary line on the floor of the areas listed. This solid yellow and black line was applied on 8/12/16 to allow for 36" of clearance in front of the electrical panels in question. Signage was posted in these areas at that time to alert facility staff to maintain the 36" of required electrical door panel clearance. The facility Maintenance Department and Assistant Administrator inspected all internal electrical panel doors to ensure compliance with 36" door clearance, this was completed on 8/26/16 and all panel doors were found to be in compliance. Moving forward, the facility will now include this area (adequate electrical panel clearance of 36") with the currently scheduled fire safety in-service which is provided to staff twice each year. This topic will also be covered during orientation for new/future employees. The twice/year in-service will be provided by a Maintenance Department representative and documented accordingly. The facility created a Life Safety QA Team which includes the Nursing Home Administrator, Assistant Administrator, Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet monthly	9/6/16

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K 147	Continued From page 4	K 147	to monitor and ensure compliance with this plan of correction. They will also report their efforts to the facility's Executive QA Committee, which meets quarterly. The next scheduled Executive QA Committee meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction on or before 9/6/16.	