STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY		
		345552	B. WING		08/11/2016	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				2005 SHANNON GRAY COURT		
THE SHAN	INON GRAY REHABIL	ITATION & RECOVERY CENTER		JAMESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		
				DEFICIENCY)		
K 000	INITIAL COMMENT	S	K 000			
		(LSC) survey was conducted				
		Federal Register at 42CFR 2000 New Health Care				
	section of the LSC a					
		cility is utilizing speical locking				
	•	conference all deficiencies ed with administration.				
	Stories: One	/ /111)				
	Construction Type V (111) Constructed: 2010					
	Fully Sprinkled - Ye	s				
	At time of survey th					
	Certified Beds: Me	dicare/Medicaid - 150				
	Census - 118					
K 029 SS=D		FETY CODE STANDARD	K 029		9/6/16	
		re protected in accordance shall be enclosed with a one				
		er, with a 3/4 hour fire-rated				
		ws (in accordance with 8.4).				
	•	closing or automatic closing in				
		2.1.8. Hazardous areas are				
		kler system in accordance				
	with 9.7, 18.3.2.1, 1					
		s not met as evidenced by:		The description of a second data		
	42 CFR 483.70 (a)			The door in question was corrected by the facility Maintenance Director to allo		
	Based on observati	ons, and staff interview on		appropriate closure. This was complet		
		ximately 10:00 AM onward,		on 8/26/16.		
	the following deficie					
				All other fire rated doors in the facility		
		nce and inspection of		were checked again on 8/26/16 by a	b	
		as non-compliant, specific		Maintenance Department employee or the Assistant Administrator. Any door	ру	
	findings include:	ment is a one hour protected		found to not close accordingly was		
		ne one hour rated door to the		adjusted/corrected at that time.		
ORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY		
		345552	B. WING		08/11/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2010	
				2005 SHANNON GRAY COURT		
THE SHAP		ATION & RECOVERY CENTER		JAMESTOWN, NC 27282		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO	
K 029	clean side of the laun frame and did not clo when tested. Ref: 2000 NFPA 101 This deficiency affect approximately twelve Failure to comply with	dry was dragging on its ose the door tight in its frame Section 19.3.2.1; 8.4.1; ed one smoke of smoke compartments. n minimum standards as the risk of death or injury	K 029	The facility adjusted the Administrative Rounds QA tool to incorporate the appropriate closure of doors. This too completed a minimum of weekly by an administrative employee/department head. Moving forward, the tool has a space for the administrative employee check (signifying they have checked a the fire the doors on their rounding assignment for appropriate closure, including not dragging on the door fran Any door found not closing appropriate will be reported to the Maintenance Department or the Nursing Home Administrator by the administrative employee/department head for correct The facility created a Life Safety QA T which includes the Nursing Home Administrator, Assistant Administrator Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet mon to ensure compliance with this plan of correction. They will also report their efforts to the facility's Executive QA Committee, which meets quarterly. Th next scheduled Executive QA Commit meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction	l is n to ll me). ely tion. eam , thly ne tee	
K 062	NFPA 101 LIFE SAFE	ETY CODE STANDARD	K 062	or before 9/6/16.	9/6/16	
SS=E	Automatic sprinkler si maintained in reliable	ystems are continuously				

If continuation sheet Page 2 of 5

	-	ID HUMAN SERVICES				FOR	D: 04/12/20 [,] M APPROVE <u>O. 0938-039</u>
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY			(X3) DATE SURVEY COMPLETED	
		345552	B. WING			08	/11/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	,	
				20	005 SHANNON GRAY COURT		
THE SHAP	NON GRAT REHABILIT	ATION & RECOVERY CENTER		J	AMESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE
K 062	Continued From page	2	K	062			
	inspected and tested 4.6.12, NFPA 13, NFP	periodically. 18.7.6, 19.7.6, PA 25, 9.7.5		002			
	 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 			The facility had the sprinkler system re-inspected, this was completed on 8/22/16. Moving forward, the sprinkler system of be inspected (with the results kept on quarterly. The next scheduled sprinkle system inspection will occur by 11/30/2016 with the results documente accordingly. The outside company responsible for quarterly sprinkler inspections will exit the facility Administrator, Assistant Administrator or the Maintenance Dire after each visit, including the results of that sprinkler inspection. The quarterl inspections will be kept on file by the Administrator for future reference. The facility created a Life Safety QA To which includes the Nursing Home Administrator, Assistant Administrator	file) er ed with ctor f y eam		
	due to fire and/or smo	oke.			Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet mon to monitor and ensure compliance with this plan of correction. They will also report their efforts to the facility's Executive QA Committee, which meet quarterly. The next scheduled Execut QA Committee meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction or before 9/6/16.	s ive	

Event ID: GSJN21

Facility ID: 061198

If continuation sheet Page 3 of 5

-		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/12/20 FORM APPROVE OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345552				(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY		
		B. WING		08/11/2016		
NAME OF PROVIDER O	R SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE		
				2005 SHANNON GRAY COURT		
THE SHANNON GR		ATION & RECOVERY CENTER		JAMESTOWN, NC 27282		
	ACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO	
	01 LIFE SAFI	ETY CODE STANDARD	K 14	7	9/6/16	
accorda (NFPA S This ST 42 CFF Based o 8/11/20 the follo The faci non-com Access obstruct clearand least 30 electrica following clearand electrica 1. The 2. The Ref: 200 110 Sec This def approxin Failure f	nce with Nati b) 18.9.1, 19 ANDARD is in a 483.70 (a) on observation 16, at approxi- wing deficien lity access to apliant, speci- to electrical p- ed. There mu- ce in front of t- inches cleara- al panel. The g locations di- ce to allow for al panel circui- staff lounge m- staff lounge m- b) NFPA 101- tion 26- iciency affect nately twelve- to comply with	not met as evidenced by: ns, and staff interview on mately 10:00 AM onward, cies were noted: a electrical panels was fic findings include: anels must not be ust be at least 36 inches he electrical panels and at ance to one side of the electrical panel wall at the d not have the proper r maintenance on the try. amed "Aunt Bee" amed "Pitt Stop" Section 19.5.1; 9.1.2; NEC red one smoke of smoke compartments. n minimum standards as the risk of death or injury		The facility Maintenance Director a cautionary line on the floor of the listed. This solid yellow and black was applied on 8/12/16 to allow fo clearance in front of the electrical in question. Signage was posted areas at that time to alert facility st maintain the 36" of required electri- panel clearance. The facility Maintenance Departme Assistant Administrator inspected a internal electrical panel doors to en- compliance with 36" door clearance was completed on 8/26/16 and all doors were found to be in complian Moving forward, the facility will nov- include this area (adequate electri- panel clearance of 36") with the cu- scheduled fire safety in-service wh provided to staff twice each year. topic will also be covered during orientation for new/future employe twice/year in-service will be provid Maintenance Department represer and documented accordingly. The facility created a Life Safety C which includes the Nursing Home	e areas line r 36" of banels in these aff to cal door ent and all nsure e, this panel nce. v cal urrently ich is This es. The ed by a ntative	

Event ID: GSJN21

Facility ID: 061198

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/12/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		DRRECTION IDENTIFICATION NUMBER: A.		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY			SURVEY LETED
		345552	B. WING			08/	11/2016
	ROVIDER OR SUPPLIER	ATION & RECOVERY CENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 105 SHANNON GRAY COURT AMESTOWN, NC 27282		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
K 147	Continued From page	e 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 Executi QA Committee meeting is 10/19/2016. The facility states full completion and compliance with this Plan of Correction or before 9/6/16.	s ive	
	7(02-99) Previous Versions Obs	alete Event ID: GS.			ility ID: 061198		et Page 5 of 5

Facility ID: 061198

If continuation sheet Page 5 of 5