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 _____	07/08/2016

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

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F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to include the active diagnoses of depression on the facility ' s comprehensive assessment tool, the Minimum Data Set (MDS), for 1 of 6 sampled residents reviewed for medications and active diagnoses (Resident	F 278	The MDS Assessment for Resident #60 has been re-reviewed; per that review on 7/8/16 a modification of Section I was indicated (for a diagnosis) and entered into the comprehensive assessment. Note: the CAA (Care Area Assessment)	8/5/16

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

Electronically Signed | 08/01/2016

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F 278	Continued From page 1 #60). The findings included: Resident #60 was admitted to the facility on 5/9/13 from a hospital with cumulative diagnoses which included depression. A review of Resident #60 ' s medical record included a Physician Note dated 3/24/16. The Physician Note included a diagnosis of major depressive disorder for this resident. The physician indicated the plan included continuing with sertraline (an antidepressant) to treat Resident #60 and monitoring/evaluating her response to the medication. Resident #60 ' s quarterly Minimum Data Set (MDS) assessment (Section I) dated 5/11/16 did not indicate the resident had an active diagnosis of depression. Section N of the MDS indicated the resident received an antidepressant medication on each of the previous 7 days (7 out of 7 days). An interview was conducted on 7/8/16 at 10:38 AM with MDS Nurse #1. Upon inquiry, MDS Nurse #1 reviewed Sections I and N of the 5/11/16 quarterly MDS completed for Resident #60. During the interview, the nurse acknowledged Section I of Resident #60 ' s MDS did not include depression as an active diagnosis; Section N indicated the resident received an antidepressant medication on each of the 7 days during the look back period. The MDS Nurse #1 reported depression should have been included as an active diagnosis on the 5/11/16 quarterly MDS assessment reviewed for Resident #60.	F 278	and the Care Plan were already correct and did not need a modification. As of 8/1/2016, all current residents had a comprehensive audit of their last full MDS assessment completed by the Administrative nursing team, including the MDS department. The audit results were captured and logged onto a QA Tool, the MDS Diagnosis Audit Tool. Any current resident found to have a diagnosis that needed to be added or removed has been identified and will be corrected (including the need for significant correction if applicable) by 8/5/16. To prevent future deficient practice, the facility: Completed a 100% in-service with the MDS department specific to Section I of the RAI Manual. Any future changes in the MDS department staff will receive this same in-service. The MDS specific in-service will be repeated annually. The facility created a Quality Assurance Team, the MDS Assessment QA Team, with the purpose of directing, reviewing and reporting the MDS department Section I assessment accuracy. The MDS Assessment QA Team collaborated to create the MDS Diagnosis Audit QA Tool to help the facility check for diagnosis entry accuracy and to log our monitoring efforts. To monitor performance of future MDS assessment accuracy, the facility: Formed the MDS Assessment QA Team to both direct and monitor the efforts of	

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F 278	Continued From page 2 An interview was conducted on 7/8/16 at 3:00 PM with the facility ' s Director of Nursing (DON). Upon review of Resident #60 ' s medical record and MDS assessment, the DON reported depression should have been included as an active diagnosis for this resident.	F 278	MDS QA Audits. This team has already started meeting and will continue to meet at a minimum of weekly x 8, monthly x 4 and quarterly thereafter unless otherwise noted in the Executive Quarterly QA Committee notes. The MDS Assessment QA Team consists of the NHA (chair), DON, MDS Department Nurses and a Unit Coordinator. The MDS Assessment QA Team chair will report their efforts and quarterly results to the Executive Quarterly QA Committee and will be tasked to address any trends or issues that are identified. The facility's Executive Quarterly QA Committee last met on 7/27/2016 to review proposed MDS Assessment QA Team actions and is scheduled to meet again on 10/19/2016. The facility will utilize the newly created QA tool, the MDS Diagnosis Audit Tool as a way of both monitoring and reporting to the Executive QA Committee. The facility alleges full compliance with this plan of correction by 8/5/2016.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to be free of a medication error rate greater than 5% as	F 332	The employee in question with deficient practice was addressed during the survey. The appropriate strength of the OTC	8/5/16

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F 332	Continued From page 3 evidenced by 2 medication errors out of 32 opportunities, resulting in a medication error rate of 6.2% for 2 of 9 residents (Resident #55 and Resident #229) observed during medication pass. The findings included: 1) On 7/6/16 at 8:39 AM, Medication Aide #1 was observed as she pulled an eye drop medication from the medication cart for administration to Resident #55. The medication pulled from the cart was cyclopentolate 1% ophthalmic solution (an anticholinergic medication indicated for treatment of excessive dilatation of the pupil of the eye). The nurse was observed as she administered one drop of the cyclopentolate 1% solution into each eye for Resident #55. A review of Resident #55 ' s physician ' s medication orders included a current order for cyclopentolate 1% eye drops to be instilled as one drop into the right eye twice daily. An interview was conducted with Medication Aide #1 on 7/6/16 at 2:45 PM. Upon request, the Medication Aide reviewed the Medication Administration Record (MAR) for Resident #55. The resident ' s MAR indicated the cyclopentolate 1% eye drops were to be instilled as one drop into the right eye only. When the Medication Aide read this, she stated, "I put it in both of his eyes." The Medication Aide acknowledged the eye drops should have been administered only in his right eye. An interview was conducted with the facility ' s Director of Nursing (DON) on 7/7/16 at 4:44 PM. Upon discussion of the medication error, the DON stated her expectation was to utilize the 3	F 332	medication was corrected during the survey as well. No other deficient practices or other residents were identified during the survey. The facility initiated a 100% in-service for active nurses and medication aides who participate in medication administration. The facility also completed a review of all current medication orders to ensure that medication strengths were consistent with MD orders as reflected on the MAR (Medication Administration Record). This was completed on 8/1/2016. To prevent future deficient practice, the facility: Created a QA Team, The Medication Administration QA Team, on 7/25/2012 with the purpose of both educating nurses and medication aides, monitoring performance and preventing medication errors. Specific interventions include: A 100% in-service on medication administration will be provided to the appropriate nursing staff; this in-service will be directed by the Administrative Nursing Team. The facility will also provide a test of basic medication administration knowledge for all appropriate staff. Any future/new nursing staff who are hired that will be providing medications will receive the same in-service and test during their orientation process. The facility will also provide a Pharmacist directed medication error prevention in-service 2x a year to appropriate nurses and medication aides. The first	

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F 332	Continued From page 4 check system which required the medication to be checked: 1) When pulling it out of the med cart; 2) When putting it in the medication cup; and 3) Before administration to the patient. The DON also indicated she also expected nursing staff to follow the 5 rights of medication administration when doing the medication pass (the right patient, the right drug, the right dose, the right route, and the right time) to reduce the risk of medication errors. 2) On 7/6/16 at 8:53 AM, Medication Aide #1 was observed as she prepared medications for administration to Resident #229. The medications included one tablet from a floor stock bottle containing a combination of 500 milligrams (mg) calcium and 200 International Units (IU) Vitamin D. The medication aide was observed as she administered the calcium/Vitamin D tablet to Resident #229. A review of Resident #229 ' s physician ' s medication orders included a current order for 500 mg calcium carbonate with 600 IU of Vitamin D to be given as one tablet by mouth twice a day. An interview was conducted on 7/6/16 at 2:45 PM with Medication Aide #1. Upon request, the medication aide reviewed the Medication Administration Record (MAR) for Resident #229. The MAR revealed the physician ' s order was written for a combination product containing 500 mg calcium with 600 IU Vitamin D. The medication aide pulled the medication she had given Resident #229 from among the stock medications stored on the med cart. A review of the labeling for the medication given revealed it contained a combination of 500 mg calcium with 200 IU Vitamin D. After reviewing the content of	F 332	Pharmacist led in-service is scheduled to occur on 8/2/16. Any future nursing employees providing medications will receive this same Pharmacist led medication error prevention in-service during their orientation. To monitor performance of medication administration, the facility will: Continue the Medication Administration QA Team meetings weekly x 4, monthly x 12 and quarterly thereafter unless otherwise noted in the Executive QA Committee notes. This QA team consists of the NHA, DON (chair), Unit Coordinators and Staff Development Coordinator. The Medication Administration QA Team chair will report their efforts and results to the Executive Quarterly QA Committee and will be tasked to address any trends or issues that are identified. The facility's Executive Quarterly QA Committee last met on 7/27/2016 to review proposed Medication Administration QA Team actions and is scheduled to meet again on 10/19/2016. The facility alleges full compliance with this plan of correction by 8/5/2016. Note, any employee who has not been in-serviced by an Administrative nurse and tested as well will not be allowed to work until those interventions have been completed. To facilitate continuity of care, those employees will have necessary interventions completed before or during their next scheduled date/shift of medication pass administration.	

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F 332	Continued From page 5 the medication given, the medication aide stated, "We don't have it." A review of the calcium/Vitamin D products stocked on the medication cart revealed a combination product containing 500 mg calcium with 600 IU Vitamin D was not stored on the cart at the time of the observation. An interview was conducted with the facility ' s Director of Nursing (DON) on 7/7/16 at 4:44 PM. Upon discussion of the medication error observed, the DON stated her expectation was to utilize the 3 check system which required the medication to be: 1) Checked when pulling it out of the med cart; 2) Checked when putting it in the medication cup; and 3) Checked before administration to the patient. The DON also indicated she also expected nursing staff to follow the 5 rights of medication administration when doing the medication pass (the right patient, the right drug, the right dose, the right route, and the right time) to reduce the risk of medication errors.	F 332		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356		8/5/16

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F 356	Continued From page 6 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to include all of the required information on the daily nurse staffing postings for 60 of the past 60 days; and, failed to post the daily nurse staffing information at the beginning of the shift on 1 of 4 days of the recertification survey. The findings included: An observation made on 7/5/16 at 11:00 AM revealed the daily nurse staffing information dated 7/5/16 was posted in a glass display case in the front hallway. The facility name was not written on the form used for the staff posting. Additional observations made on 7/6/16 at 10:00 AM and 7/7/16 at 4:00 PM revealed the daily nurse staffing information had been posted for	F 356	The Daily Nurse Staffing Hours Sheet(s) were updated during the survey to include the missing fields/information. The Scheduling Coordinator and the back-up staff responsible for posting/updating the Daily Nurse Staffing Hour Sheets were in-serviced by the NHA during the annual survey process. In-service was specific to staff posting requirements. The facility DON will directly oversee and monitor the facility's Scheduling Coordinator regarding posting and routine updating of Daily Nurse Staffing Hours. These sheets will continue to be kept and stored per our current practices.	

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F 356	Continued From page 7 each of the corresponding dates in the glass display case in the front hallway. The facility name was not written on the forms used for the staff posting. An observation made on 7/8/16 at 8:35 AM revealed daily nurse staffing information posted in a glass display case across from the nursing station was dated 7/7/16. The staff posting included staffing through 7/8/16 at 7:00 AM. An observation made on 7/8/16 at 9:15 AM revealed the 7/8/16 nurse staffing information had been updated and included all three shifts for 7/8/16. An interview was conducted on 7/8/16 at 9:24 AM with the facility ' s Scheduling Coordinator. During this interview, the Scheduling Coordinator reported that she herself was responsible to post the daily staffing information for all 3 shifts when she came into work at 8:30 AM each weekday, Monday through Friday. The Scheduling Coordinator stated she typically had the staffing information posted by 9:00 AM. She also reported the daily posting reflected information on the nursing staff scheduled for the day, beginning with the first shift at 7:00 AM. Upon inquiry, the Scheduling Coordinator reported the Weekend Supervisor was responsible to be sure the postings were completed on Saturdays and Sundays. A review of the previous 60 days of postings for nurse staffing information was completed on 7/8/216 at 9:30 AM. None of the postings reviewed included the facility name. An interview was conducted on 7/8/16 at 10:06 AM with the facility ' s Administrator. Upon inquiry, the Administrator stated he would want to	F 356	The DON will report indefinitely, but for a minimum of 1 year at the facility's current weekly Nurse QI meeting with any concerns or issues with the posting of facility Daily Nurse Staffing Hours. The facility alleges full compliance with this plan of correction by 8/5/2016.	

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F 356	Continued From page 8 see the name of the facility on the daily postings for nurse staffing information. He also reported the facility had initiated a change in their procedures to ensure this information was posted at the beginning of the first shift each day.	F 356		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to serve food under sanitary conditions as staff failed to maintain foods for service at safe temperatures in 1 of 4 dining rooms and staff failed to change contaminated gloves prior to touching and serving bread products in 1 of 4 dining rooms. 1. On 7/7/2016 at 4:45 pm Dietary Aide #1 was observed assessing food temperatures for the dinner service. She assessed the temperature of the sliced pork roast to be 113.2 degrees Fahrenheit. The thermometer was observed to be shallowly inserted in the top of the meat slice. She then continued to check the temperatures of the other foods. When all foods had been checked, she cleaned her thermometer and began setting up trays and plates for food	F 371	As referenced in the 2567, the meat in question was re-heated to the appropriate temperature on 7/7/2016 prior to serving. Any known problems were corrected during the survey process. Also, during the survey the employee in question who did not appropriately change gloves was counseled by the Dietary Manager. To prevent future issues, the dietary department has: 1. Initiated a 100% in-service for all dietary staff on the appropriate food temperature ranges and correctly taking food temperatures (and the appropriate actions if necessary to correct). Initiated another 100% in-service for all dietary	8/5/16

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F 371	Continued From page 9 service. As she began to reach for the food, this surveyor asked her to recheck the pork and to insert the thermometer deeper in to the meat. She did recheck the meat temperature and found it to be 131.2 degrees Fahrenheit. She did not remove the meat from the service line. When asked what she should do with the meat, she replied, " Send it back to the kitchen. " At this time she removed the pork and sent it back to the kitchen. A pan of pork roast was returned and the temperature was assessed to be 165 degrees Fahrenheit. She then began the meal service. On 7/8/2016 at 2:45 pm the Chef was interviewed. He indicated that he expected his staff to send food less than 140 degrees Fahrenheit back to the kitchen. He explained that the dietary aide was new and that this was the first time she had assessed a food temperature that was too low. He indicated that she realized what she had done wrong. On 7/8/2016 at 5:06 pm Dietary Aide #1 was interviewed. She explained that this was her first time identifying a low food temperature on the food service line. She indicated that she is aware that she should stop and send the food back to the kitchen immediately. 2. On 7/5/2016 at 12:15 pm Dietary Aide #2 was observed to serve bread during lunch using her gloved hand. She was also observed touching the coffee dispenser, ice machine lid, basket of condiments and the refrigerator door with the same gloved hand and then returned to serve bread without changing her gloves. On 7/8/2016 at 12:05 pm Dietary Aide #2 was interviewed. She indicated that she knew that	F 371	staff members on proper serving procedures. Future new dietary hires will be in-serviced as part of orientation. 2. Required a return demonstration to the Dietary Manager or Executive Chef from current serving staff demonstrating that they could: a. Correctly check food temperature(s) b. Correctly follow food service procedures 3. Revised the temperature QA monitoring log to promote documentation and food safety. The facility created a new QA team, the Food Preparation QA Team, to provide the above in-services, revise the temperature monitoring QA log and oversight for return demonstrations. This QA team will meet weekly x 8, monthly x 4 and quarterly thereafter to monitor and promote compliance. Members of this QA team include the NHA, DON, Dietary Manager (chair) and Executive Chef. Additional members can be added to the team per the discretion of the chair for the purpose of ensuring compliance. The Food Preparation QA Team will report directly to the Executive Quarterly QA Committee, the next scheduled quarterly meeting is 10/19/2016. The facility alleges full compliance with this plan of correction by 8/5/2016.	

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F 371	Continued From page 10 she should have used utensils to serve the bread, but that she did not have tongs so she used her gloved hand. She also explained that when using gloves, she should change the gloves after touching other surfaces. On 7/8/2016 at 2:45 pm the Chef was interviewed. He explained that he expected staff to use utensils when serving food and not their hands. He indicated that if they are using gloved hands, they should change their gloves when touching other kitchen surfaces. He also indicated that the dietary aide knew what she had done wrong.	F 371		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		8/5/16

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F 520	Continued From page 11 Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the facility staff, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee in September of 2015 in order to achieve and sustain compliance. This was for one recited deficiency which was originally cited in August 2015 on a recertification survey and again on the current recertification survey. The deficiency was in the area of Accuracy of Assessment. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F278: Accuracy of Assessment. Based on record review and staff interviews, the facility failed to include the active diagnoses of depression on the facility ' s comprehensive assessment tool, the Minimum Data Set (MDS), for 1 of 6 sampled residents reviewed for medications and active diagnoses. During the recertification survey of 8/27/15, the facility was cited for F278 for failing to identify on admission the placement of an indwelling catheter for a resident; and, for failing to accurately assess a resident ' s Preadmission	F 520	The facility's current Plan of Correction was reviewed and approved by a corporate representative prior to submission into the ePOC application on 8/1/16. The additional oversight and direction from a corporate representative was specific to the Plan of Correction that was submitted to the Executive Quarterly QA Committee, this will be ongoing. Ongoing compliance with each component of this and any future accepted Plan of Correction will be monitored by a corporate representative and then reported at future Executive Quarterly QA meetings (as specified in the Plan of Correction). To help ensure future compliance in this area, the facility will have at least 1 corporate representative at all Executive Quarterly QA meetings. The next scheduled Executive Quarterly QA meeting is scheduled for 10/19/2016. The facility alleges full compliance with this plan of correction by 8/1/2016.	

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 _____	07/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 520	Continued From page 12 Screening and Resident Review status upon readmission to the facility. On the current recertification survey, the facility was re-cited for failing to identify and assess depression as an active diagnosis for a resident treated with a psychotropic medication. An interview was conducted with the Administrator on 7/8/16 at 4:55 PM. During the interview, the Administrator stated he was relatively new in his role as Administrator as of November, 2015, and was not in this position at the time of the facility ' s last recertification. While the Administrator reported he was not involved in QAA activities directly resulting from the previous recertification of August, 2015, he was able to identify a related quality initiative the QAA Committee had developed. The Administrator reported on 3/19/16, a quality initiative was undertaken to increase the accuracy of the facility ' s case mix and Resource Utilization Groups (RUGs). He noted this initiative placed an emphasis on the accurate completion of MDS assessments.	F 520		