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 _____	06/06/2019

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 survey was conducted 6/2/19 through 6/6/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #T7IG11.	E 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 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	F 580		6/29/19

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

Electronically Signed | 06/29/2019

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 _____	06/06/2019

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 580	Continued From page 1 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 staff and Resident Representative interviews and medical record review, the facility failed to notify the Resident Representative of a change in condition and subsequent order for a doppler ultrasound for 1 of 1 resident (Resident #76) reviewed for notification of change in condition. Findings included: Resident #76 was admitted to the facility on 7/21/17 with diagnoses that included, in part, dementia. A review of the comprehensive Minimum Data Set (MDS) assessment dated 2/15/19 revealed Resident #76 had impaired memory and severely impaired daily decision making skills.	F 580	F580 The facility nursing staff notified the responsible party (RP) of resident #76 related to the swelling and the ultrasound test order on 6-3-19. A Unit Coordinator (UC) notified the RP of the ultrasound results on the same day they were received by the facility, also on 6-4-19. The facility's administrative nursing staff initiated a notification of change audit of each current resident's Electronic Medical Record (EMR). This audit was initiated to identify anything since 6-1-19 that may have required a notification of change. The initial audit and review was completed to ensure all current residents had recent notifications of change completed and	

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 _____	06/06/2019

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 580	Continued From page 2 A review of the medical record revealed Resident #76's representative was a family member. A review of a nurse's note dated 6/2/19 revealed, "On Sunday, 6/2/19, patient noted to have swelling to left leg from knee to foot. No indications of pain. Patient assisted to bed and leg elevated. On-call provider notified and gave orders to obtain venous doppler ultrasound of left lower extremity ..." On 6/3/19 at 1:44 PM an interview was completed with Family Member #1. She stated she was the person who was notified of any change in condition for Resident #76. Family Member #1 said when she visited Resident #76 on the morning of 6/3/19 she observed someone completing an "ultrasound" of Resident #76's left leg. She stated she immediately went to the nurse's desk and inquired about the test and was told by staff they were unaware of why the test was completed but that Resident #76's leg was swollen over the weekend. Family Member #1 reported that she had not been notified by staff over the weekend that Resident #76's leg was swollen nor that an "ultrasound" was ordered. Family Member #1 further reported she had told the facility in the past that she wanted to be notified prior to any procedures or tests that were completed for Resident #76. On 6/4/19 at 10:40 AM an interview was completed with Nurse #4. She said she was not the nurse on duty when the doppler ultrasound was ordered. She stated Family Member #1 came to her and inquired about the test that was ordered and Nurse #4 told Family Member #1 she wasn't sure why the doppler ultrasound had been ordered but knew Resident #76 had leg pain.	F 580	documented. As of 6-29-19, there are no known notifications of change that have not or were not communicated since 6-1-19. To ensure that future that the deficient practice will not recur, the facility: • Initiated a Notification of Change in-service on 6-26-19 for all current/active nurses (in-service was only for nurses as the nurses are responsible for completing the notification of change). This in-service was initiated by the facility to re-educate the nurses on the expectations for notification of change; the information was pulled from the State Operations Manual (SOM) to ensure thoroughness. This in-service will be provided as part of the facility's orientation/new hire process for all future/new nurses. Any nurse who has not worked or not received the Notification of Change in-service by 7-4-19 will be in-serviced prior to returning to work their next scheduled shift. The facility also added the Notification of Change in-service to our annual nurse in-service calendar to help keep the information current and to repeat for all nurses at a minimum of at least once per calendar year. Copies of the Notification of Change in-service were posted at a location within each nurse's station so nurses can easily reference and utilize the information as a reference. Additionally, the facility expanded utilization of the Electronic Medical Record (EMR) software to facilitate the administrative nurse's ability to print and review the daily nursing notes and physician/MD orders for any	

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 _____	06/06/2019

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 580	Continued From page 3 Nurse #4 said facility protocol was that the resident representative was notified prior to any test or procedure. She further stated Family Member #1 had requested in the past that she be notified prior to any tests or procedures. On 6/5/19 at 2:56 PM an interview was completed with Nurse #5. She said she was the nurse on duty when the doppler ultrasound was ordered. She stated on 6/2/19 a nurse aide notified her that Resident #76's left leg was edematous. Nurse #5 assessed the left leg and said it was swollen, was not hot to the touch and had no redness. Nurse #5 stated she called the on-call provider and received an order for a doppler ultrasound. Nurse #5 said when there was a change in condition staff were supposed to notify the resident representative "right away." She further stated, "If I have to call the on-call provider about a patient then I should be calling the family too." Nurse #5 said at the end of her shift she entered the provider's order into the electronic health record but forgot to call and notify Family Member #1 of the ordered doppler ultrasound. "I forgot to call the family and I should have." Nurse #5 said not calling the resident representative was not proper procedure. On 6/6/19 at 5:08 PM an interview was completed with the Chief Operating Officer (COO). He stated he expected Family Member #1 to have been notified during the shift of the ordered procedure.	F 580	notification of change that could/should be completed by the nursing staff. To prevent reoccurrence of this issue, the facility: • Created and implemented a new process to manually review the Electronic Medical Record (EMR) notes and physician order summary(s) by the administrative nurses. This new Quality Assurance (QA) process allows the administrative nursing team, under the direction of the Director of Nursing (DON), to efficiently review, monitor and assist in completing notification of changes (if necessary or needed). The facility DON will review and present during the weekly Quality Improvement (QI) the findings from the weekly QA notes/working file audits by the administrative nurses. This new process listed above will continue until at least the next annual survey. The results and analysis of notifications of change will also be reported by the DON at the facility's Quarterly Quality Assurance Committee meeting. The next Executive Quarterly Quality QA Committee meeting is scheduled for 7-24-19. All corrective actions referenced in this plan of correction (POC) will be in place by 7-4-19.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the	F 641		6/29/19

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 _____	06/06/2019

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 641	Continued From page 4 resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set assessment in the areas of, skin conditions for 1 of 2 residents (Resident #43) and nutrition status for 1 of 4 (Resident #27) residents reviewed for nutrition and pressure ulcers. The findings included: 1. Resident #27 was admitted to the facility on 6/27/18. Her diagnoses, in part, included dementia and dysphagia. A review of the quarterly Minimum Data Set assessment dated 3/13/19 revealed Resident #27 weighed 191 pounds. A record review revealed a weight of 184 obtained on 3/12/19. An interview with Restorative Aide #1 on 6/5/19 revealed she and the other restorative aide obtain the weights for the facility. She stated she obtains the weights and then puts them into the computer. An interview on 6/5/19 at 2:30 PM with the Minimum Data Set Nurse #2 revealed she enters the weight for the assessment that she finds in the computer. She stated the weight she entered was for February 2019. She stated she didn ' t know there was another weight obtained on 3/12/19 of 184 because it wasn ' t in the computer yet. An interview on 6/6/19 at 3:47 PM with the	F 641	F 641 The inaccurate weight for resident #27 was corrected in the Electronic Medical Record (EMR) prior to the survey and all Minimum Data Set (MDS) assessments and weights for resident #27 since the 3-13-19 quarterly assessment referenced are now correct. Please note, the MDS assessments for resident #27 and resident # 43 were both corrected and resubmitted electronically on 6-28-19. The facility administrative nurses (consisting of the Director of Nursing (DON), Unit Coordinators (UCs), Minimum Data Set (MDS) nurses and a corporate nurse) reviewed all MDS resident assessments submitted since 6-1-19 to ensure that any MDS assessments, 1) Had the most current weight coded for that MDS assessment and 2) That any residents with pressure ulcers or osteomyelitis were coded correctly on the MDS. The audit, completed, 6-28-19, did not reveal outstanding MDS assessments with coding issues for these areas. To prevent future issues, the facility made the following changes: • The internal review by the administrative team of the weights obtained each week has been moved to more closely coincide with the weekly Quality Improvement (QI) meeting.	

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 _____	06/06/2019

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 641	Continued From page 5 Administrator revealed his expectation was for the Minimum Data Set assessment to be coded accurately. 2. Resident #43 was admitted to the facility on 3/23/17 with diagnoses of: diabetes mellitus type 2, polyneuropathy neuropathy, depression, chronic pain and atherosclerosis. A review of the quarterly Minimum Data Set (MDS) assessment dated 3/19/19 revealed Resident #43 was at risk for developing pressure ulcers but did not have a current pressure ulcer. The MDS further reflected Resident #43 had one venous or arterial ulcer and was receiving pressure ulcer care. A record review revealed a wound report indicating a deep tissue injury was identified to Resident #43 ' s left heel on 2/5/19. On 3/19/19, the wound report indicated Resident #43 had a Stage 2 pressure ulcer to her left heel. An observation of wound care to Resident #43 ' s left heel wound was completed on 6/3/19 at 10:04 AM. The wound nurse removed the soiled dressing and the left heel wound was observed to have bone exposed with approximately 50% eschar. There was also slough present in approximately 25% of the wound. Purulent drainage was noted in the wound and on the soiled dressing. There was no odor observed. An interview with MDS Nurse #1 was conducted on 6/6/19 at 1:28 PM. She stated she entered no pressure ulcers on Resident #43 ' s quarterly assessment dated 3/19/19 because Resident #43 went out to the hospital from 3/8/19 - 3/12/19 and was diagnosed with osteomyelitis. She stated that	F 641	Previously, this weekly weight review was held outside of the weekly QI meeting and later in the week after the weekly QI meeting and did not include the Administrator, DON, Unit Coordinators or MDS nurses. The changes will allow the Dietary Manager more time to identify and document any weight gains/losses and to present them to the QI team timelier. A formal process for weight monitoring and interventions was put into place by the corporate team to facilitate timely entry into the Electronic Medical Record (EMR). The Dietary Manager is now responsible for ensuring weights obtained by the Nursing Restorative Team (NRT) have been entered and are available in the EMR. This process was created and in-serviced to the following team members (Administrator, DON, Unit Coordinators, Dietary Manager, Registered Dietician and NRT staff) on 6-20-19. The process changes will ensure the most current resident weights are available in the EMR system within 24 hours for MDS nurses to use the most accurate weight during the look back period of the resident MDS assessment. • Created and provided in-service detailing the guidelines for coding skin breakdown types (osteomyelitis vs. pressure ulcer). This was provided to the MDS nurses/Treatment nurse by a corporate team member who is a nurse. This in-service was completed on 6-21-19. The education/clarification should correct the previously deficient practice as the coding mistake for #43 was directly related to a human error	

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 _____	06/06/2019

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 641	Continued From page 6 would not be a pressure ulcer. An interview was conducted on 6/6/19 at 4:49 PM with the Administrator. He stated his expectation was for MDS assessments to be accurately coded.	F 641	(misunderstanding) of the osteomyelitis vs pressure ulcer coding expectations. Per their feedback, the in-service clarified and resolved that previous issue. To monitor for accuracy and to ensure the solutions are sustained: • The facility now requires the Dietary Manager and the MDS team to attend the weekly QI meeting(s). If they can not attend, a back up familiar with this plan of correction must attend in their absence. During that weekly QI meeting, the MDS nurses will be responsible to discuss any residents who are in a look back window for 1) Current weight accuracy in the EMR and 2) Pressure ulcer coding (if present) accuracy. The QI team will reflect (via an internal QA list from the EMR) their reviews in the weekly QI minutes for those residents in an assessment window; verifying if the information to be submitted is in fact accurate and that any pressure ulcers are coded correctly as well. This practice will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA Committee meeting. The next scheduled meeting of the Executive Quarterly QA Committee is 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans	F 656		6/29/19

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 _____	06/06/2019

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 656	Continued From page 7 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this	F 656		

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 _____	06/06/2019

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 656	Continued From page 8 section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to develop care plans for 1 of 3 sampled residents (Resident #54) reviewed for ADL (activities of daily living) and for 1 of 3 sampled residents (Resident #37) reviewed for dementia care. Findings included: 1. Resident #54 was admitted to the facility on 12/14/17 with diagnoses which included: sepsis, gangrene, acquired absence of left leg above the knee, diabetes mellitus, peripheral vascular disease, and repeated falls. The review of the quarterly minimum data (MDS) set dated 4/16/19 indicated Resident #54 was moderately, cognitively impaired; required extensive assistance with bed mobility, transfers, locomotion, personal hygiene, toileting and dressing; required partial assistance with bathing; and had impairment of his bilate,ral lower extremities. Review of the care plan dated 4/30/19 revealed the extent and type of ADL assistance required for Resident #54 for personal hygiene, bathing and dressing were not included in the care plan. During an interview on 6/3/19 at 4:17 p.m., Resident #54 indicated his ADL care included a nursing assistant setting up a washbasin of water and two washcloths then leaving his room for him to wash himself.	F 656	F656 The care plans for resident #54 and resident #37 were formally corrected on 6-6-19 by the facility MDS nurse as part of the annual survey process. Members of the facility administrative team (Administrator, Director of Nursing (DON), Unit Coordinators (UCs), Minimum Data Set (MDS) nurses, corporate nurse and Social Workers (SW)) reviewed all MDS assessments submitted since 6-1-19 to ensure that all care plans were accurate for 1) ADLs/self-care needs and 2) accurate for Dementia diagnosis if applicable. Our audit, completed, 6-28-19, did not reveal care plan omission issues for either ADL/self- care or Dementia. To prevent future issues, the facility made the following changes: • The MDS nurses will now bring their current/ongoing assessments to the weekly administrative Quality Improvement (QI) meeting for any resident in an active MDS look back window assessment period. During that QI meeting the MDS nurse will review each identified resident with the QI team members to review for ADL deficits. This is done so that care planning can be addressed individually and accurately. This interdisciplinary team approach (that team includes the facility Administrator,	

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 _____	06/06/2019

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 656	Continued From page 9 During an interview on 6/6/19 at 5:48 p.m., MDS Nurse#2 acknowledged there was no ADL care area/problem included in Resident #54's care plan. She asserted that bed mobility, transfers, and assistance with feeding were included in different areas of the care plan; but due to human error, personal hygiene, bathing, and dressing were not included in Resident #54's care plan. 2. Resident #37 was admitted to the facility on 5/10/18 with diagnoses which included: vascular dementia without behavioral disturbance and major depressive disorder. The review of the significant change minimum data set (MDS) dated 4/2/19 indicated Resident #37 was moderately, cognitively impaired and had a neurological diagnosis of dementia. The care plan dated 4/11/19 did not include the care and interventions required for Resident #37's diagnosis of Dementia. During an observation on 6/6/19 at 9:07 a.m., Resident #37 was in her room in a wheelchair, feeding herself breakfast of mechanical soft consistency. NA#2 (nurse aide) entered room to assist/encourage the resident, but the resident refused to consume more. During an interview on 6/6/19 at 10:20 p.m., NA#2 revealed Resident #37 had been in declining health for several months. She stated that previously required limited assistance with activities of daily living, but currently required total assistance with care. During an interview on 6/6/19 at 2:17 p.m., MDS	F 656	DON, Unit Coordinators, MDS nurses, Dietary Manager, SWs and other team members as needed or designated) will promote better internal communication and a more thorough clinical review thereby preventing care planning omissions. • The MDS nurse will also do a similar review with the QI team (which now includes SW inclusion during the meeting) to make sure Dementia has been care planned where applicable. This interdisciplinary team approach (that team includes the facility Administrator, DON, Unit Coordinators, MDS nurses, Dietary Manager, SWs and other team members as needed or designated) will promote better internal communication and a more thorough clinical review thereby preventing care planning omissions. To monitor for accuracy and ensure that solutions are sustained: • As part of the weekly QI meeting, the MDS nurses will discuss any residents who are in a look back window for 1) ADL/self-care needs and 2) a dementia diagnosis which would require care planning. The QI team will reflect the two areas of review for this portion of the plan of correction for care plan inclusion/accuracy in their weekly minutes. This will be done using internal QA lists for residents in a current MDS assessment window. The process of verifying the information presented at the QI meeting for this area prior to the MDS transmission will promote individualized, thorough, and accurate care plans for	

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 _____	06/06/2019

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 656	Continued From page 10 Nurse#1 revealed the facility's Social Workers were responsible for completing the cognition section of the MDS. During an interview on 6/6/19 at 2:25 p.m., SW#2 (Social Worker) stated that dementia care was not included in the care plan because there was no documentation in the clinical records indicating Resident #37 had the diagnosis of dementia. SW#2 revealed she did not refer to section I (diagnoses section) of the MDS when completing care plans.	F 656	each resident. This new QI process/practice will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA Committee meeting by the facility Director of Nursing or MDS Coordinator. The next scheduled meeting is 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	
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). 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.	F 657		6/29/19

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 _____	06/06/2019

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 657	Continued From page 11 (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 revise care plans to 1) indicate an actual weight loss for 1 of 4 (Resident #87) residents reviewed for nutrition 2) indicate a change in dialysis access sites for 1 of 1 (Resident #48) residents reviewed for dialysis. The findings included: 1. Resident #87 was admitted to the facility on 5/1/19 with diagnoses of, in part, cerebrovascular accident, dysphagia and malnutrition. A review of the admission Minimum Data Set (MDS) assessment dated 5/8/19 revealed Resident #87 weighed 129 pounds. A record review revealed Resident #87 ' s admission weight obtained on 5/2/19 was 133 pounds. On 5/20/19, Resident #87's weight was documented as 126 pounds and on 5/30/19, 124 pounds. A review of the care plan dated 5/13/19 revealed Resident #87 had a problem of "risk for significant weight variances and altered nutrition". The care plan did not reflect Resident #87 ' s weight loss. An interview on 6/6/19 at 1:28 PM with MDS Nurse #1 revealed dietary is responsible for adding the care plans for nutrition but she has been doing them a lot. She stated the interdisciplinary team meets weekly and that is	F 657	F657 The care plan for resident(s) #87 and #48 were corrected updated on 6-6-17 during the annual survey. The facility Dietary Manager, who is responsible for monitoring weight gains/losses, worked with the corporate team and our consultant Registered Dietician to review all current residents to ensure that weight gain/ loss had current care plan updates. This was completed on 6-28-19. A list of residents reviewed was generated from the Electronic Medical Record, printed and audited and then compared to the care plan for each of these residents to ensure care plan interventions were current and accurate. No issues were identified as of 6-28-19. Please note that resident #48 is the only dialysis resident in the facility at this time. There are no other residents to audit for issues cited in this 2567 from our annual survey. To prevent future issues, the facility made the following changes: • The internal review by the administrative team of the weights obtained each week has been moved to more closely coincide with the weekly Quality Improvement (QI) meeting.	

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 _____	06/06/2019

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 657	Continued From page 12 where she would receive weight information from dietary. She stated she did not get this information from dietary and that was why the care plan wasn ' t updated. She stated Resident #87 ' s care plan should have reflected weight loss. An interview on 6/6/19 at 3:47 PM with the Administrator revealed that he expected weight loss to be added to the care plan and interventions to be put into place. 2. Resident #48 was admitted to the facility on 8/22/2016 with diagnoses which included End Stage Renal Disease (ESRD) with hemodialysis three times a week. Review of the most recent quarterly Minimum Data Set (MDS) dated 4/10/19 revealed Resident #48 had moderate cognition impairment and required one-person supervision to extensive assistance with all activities of daily living. The MDS indicated the resident required hemodialysis for ESRD. Review of Resident #48's care plan initiated revised 4/22/19 revealed the resident had End Stage Renal Disease and was at risk for complications due to dialysis. The Care Plan interventions included avoid all pressure on the access site, do not allow blood to be drawn from or take a blood pressure reading on the same arm as the access, and monitor shunt/graft/ fistula for signs and symptoms of infection and adequate circulation. During an interview on 6/6/19 at 11:23 AM with Nurse #6 he stated that he worked with Resident #48 often and that he is able to get himself ready	F 657	Previously, this weekly weight review was held after the weekly QI meeting and did not include the other QI team members such as the Administrator, DON, Unit Coordinators or MDS nurses and designees. This move and the changes listed will allow the Dietary Manager more time to identify and document any weight gains/losses and to also present them to the QI team members for timelier follow up. A formal process for weight monitoring and interventions was put into place by the corporate team to facilitate timely entry into the Electronic Medical Record (EMR). The Dietary Manager is now responsible for ensuring that any suggested interventions for weight loss/gain have been provided to the Unit Coordinators and to the Minimum Data Set (MDS) nurses during the weekly QI meeting. This process was created and in-serviced to the following team members (Administrator, DON, Unit Coordinators, Dietary Manager, Registered Dietician, MDS and Nursing Restorative Team (NRT) on 6-20-19. The process changes will ensure residents have weight gain/loss interventions and care plan updates timelier. • As referenced above, resident #48 is the only resident in the facility at this time on dialysis. For this resident (and future dialysis residents), the facility created and implemented a new process that requires the Unit Coordinators (UCs) to document a minimum of weekly for dialysis residents. As part of this process/required documentation; the dialysis port site	

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 _____	06/06/2019

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 657	Continued From page 13 for his dialysis treatments on Mondays, Wednesdays, and Fridays. When asked where the resident's access site was located, Nurse #6 stated that he didn't know. When asked what type of access site the resident had, the nurse stated he wasn't sure. When asked if he assessed the site he stated no, but that the resident would be able to tell him if there was any problems with it. Review of the Medication Administration Records and the Treatment Administration Records for Resident #48 for the months of May and June 2019 revealed no entry for assessing or checking the dialysis access sites. There was no documentation in the electronic medical records/nursing notes/assessments for dialysis access sites. During an interview with the MDS Nurse #1 on 6/6/19 at 3:30 PM she stated that the care plan should have been updated each time the resident's dialysis access changed. She also stated that the care plan should have reflected the use of the left chest permacath for dialysis after it was placed in June 2018. During an interview with the COO on 6/6/19 at 3:21 PM he stated that it was his expectation that staff assessed and monitored Resident #48's dialysis appropriately.	F 657	should be assessed and documented (location and function of the site). This will be completed by the Unit Coordinator to ensure assessment, accuracy and thorough documentation. This new process and expectations listed were provided by a corporate team member to the Administrator, DON, and Unit Coordinators on 6-20-19. To monitor for accuracy and make sure solutions are sustained: • The Dietary Manager will bring all weights obtained in the last week/since the last QI weekly meeting; these will be reviewed individually by the team during the current weekly QI meeting. Any resident triggering for weight loss/gain with a new intervention will be reviewed at that time. The Dietary Manager will keep a record of all the residents reviewed during the weekly meeting specific to this plan of correction (POC). This interdisciplinary team QI meeting will promote and ensure that care plan updates are made timely as MDS nurses will also be in attendance during the weekly QI meeting. This practice will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA meeting. The next scheduled meeting is 7-24-19. • During the weekly QI meeting, the DON will review the Electronic Medical Record (EMR) for any dialysis resident in the facility to ensure the resident has a current weekly note/assessment of dialysis site function and location. The	

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 _____	06/06/2019

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 657	Continued From page 14	F 657	DON will reflect this audit for compliance in the weekly QI meeting notes. This practice will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA meeting. The next scheduled meeting is 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, the facility failed to promote healing of an existing pressure ulcer by not offloading the left heel and failed to complete the weekly wound report to include measurements for 1 of 2 residents (Resident # 43) reviewed for pressure ulcers.	F 686	F686 At the time the issue with resident #43 was identified, the facility put the specified offloading intervention back into place. The offloading intervention usage for resident #43 continues and remains in place at the time of this submission.	6/29/19

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 _____	06/06/2019

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 686	Continued From page 15 The findings included: Resident #43 was admitted to the facility on 3/23/18. Her diagnoses included: diabetes mellitus type 2, polyneuropathy, congestive heart failure and atherosclerosis. A review of a quarterly Minimum Data Set assessment dated 3/19/19 revealed Resident #43 was at risk for developing pressure ulcers. Resident #43 required extensive assistance to total dependence for her activities of daily living. A review of the care plan updated on 5/30/19 revealed a problem for left heel pressure ulcer with an intervention to float heels. A review of Resident #43 ' s physician orders for June 2019 revealed an order to float heels at all time dated 5/2/19. An observation on 6/4/19 at 3:42 PM revealed Resident #43 lying in bed with her left heel resting on two pillows under her lower leg. Her heel was not offloaded. An observation on 6/5/19 at 8:25 AM revealed Resident #43 lying in bed. Two pillows were observed under the left lower leg and the left foot was resting on the pillow with the heel not offloaded. An interview on 6/5/19 at 8:40 AM with Nursing Assistant (NA) #1 was conducted. NA#1 revealed the way she knows what the residents need for their care is by looking at the care plan. NA#1 stated she knew Resident #43 ' s heels had to be floated. She acknowledged the way Resident #43 had her heel resting on the pillow was not the	F 686	An administrative nurse (Unit Coordinator (UC)) audited the offloading, skin protection interventions which should be in place for all current residents. The information was transferred into a newly created audit/tracking QA tool (The Skin Prevention Intervention Tracking Log). This QA tool reflects all current residents who should have offloading or skin prevention/healing interventions in place (this does not include treatments as those are already reflected on the Treatment Administration Record (TAR)). This list was completed by the Unit Coordinator on 6-24-19 and is specific to each current resident and includes the type of skin intervention/offloading they should have in place. Note: all current residents were verified to have correct offloading/skin interventions in place as of 6-24-19. To prevent future issues, the facility made the following changes: • The newly created QA Skin Prevention Intervention Track Log/Tool and the usage of the tool was provided to all nursing staff members via a Skin Prevention Intervention Log in-service which was initiated on 6-26-19. This in-service was provided by the facility DON and UCs to re-educate the nursing staff on the skin prevention intervention/offloading expectations in addition to educating them on the new QA tool. Education given to staff on the QA tool includes how the Administrative	

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 _____	06/06/2019

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 686	Continued From page 16 proper way to float the heel. NA #1 stated she had not been in Resident #43 ' s room yet so had not checked to see if her heels were floated. She stated she didn ' t make a round when she arrived on shift. An interview on 6/5/19 at 9:10 AM with Unit Coordinator #1 revealed the nursing assistants are familiar with the residents and information for each resident is kept in the care plan book. She stated she expected the nursing assistants to complete a round on their assigned residents when they arrived on shift in the morning to ensure assistive devices and pressure reducing interventions are in place. A review of a wound report revealed a deep tissue injury was identified on Resident #43 ' s left heel on 2/5/19. There were no measurements documented on the wound report. Further review of the wound report revealed measurements were not documented for the weeks of 4/2/19 and 5/28/19. An interview on 6/6/19 at 1:20 PM with the wound nurse revealed she completed the weekly wound report and measurements were a part of the report. She stated Resident #43 developed a deep tissue injury to her left heel that was identified on 2/5/19. She stated she didn ' t measure the area then because it wasn ' t open. She stated the area had opened the next week. She stated the wound care physician saw Resdient #43 when he visited the facility every two weeks and he also measured the wounds. The wound nurse stated she had been doing the report and the measurements, she just didn ' t always plug the measurements into the report. The measurements for the weeks of 4/2/19 and 5/28/19 were not available to the surveyor.	F 686	nursing team will monitor residents; make updates to the log with changes or new interventions, where the information will be posted for staff to reference and how the nursing staff can communicate with administrative nurses any issues (including noncompliance by residents). This QA tool usage in-service will be provided as part of the facility's orientation/new hire process for all future/new nursing staff members. Any nursing staff member who has not worked or not received the Skin Prevention Intervention Tracking Log in-service by 7-4-19 will be in-serviced prior to returning to work their next scheduled shift. • The facility has established a back up to the Unit Coordinator who is responsible for populating the weekly skin measurement information. An additional administrative nurse is now in place and has been trained who can complete the required documentation each week in the event the primary Unit Coordinator/Treatment nurse is not available. The primary Unit Coordinator/Treatment nurse was out of the facility on an extended leave at the time of the issue in question and was the reason for the omission cited in the 2567. To monitor for accuracy and to ensure solutions are sustained, the facility will: • Use the Skin Prevention Intervention Tracking QA Log to monitor compliance. Weekly random audits for compliance/usage of Skin Prevention Interventions will be completed by the Unit	

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 _____	06/06/2019

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 686	Continued From page 17 An interview on 6/6/19 at 3:47 with the Director of Nursing revealed she wasn ' t aware the measurements weren ' t being added to the wound report. She stated the wound care physician came in every two weeks and measured Resident #43 ' s wound then. She stated she expected Resident #43 ' s heels to be floated per the physician ' s orders.	F 686	Coordinators and brought to the weekly Quality Improvement (QI) meeting. Any issues discovered during the audits will be corrected and addressed at the time of the audits by the Unit Coordinators. The weekly QI tools/audits will be reviewed for compliance by the DON and reflected in the QI meeting minutes each week. This practice of auditing and reviewing will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA Committee meeting. The next scheduled meeting is 7-24-19. • The Unit Coordinator who is responsible for weekly documentation of skin measurements will bring the measurements to the weekly QI meeting. If the Unit Coordinator is unavailable, the back up (also an administrative nurse) will provide this information to the QI team which includes the Administrator, DON, UCs, MDS nurses, and other administrative team members as needed. After auditing the log to ensure no weekly wound measurements have been left out, the DON will reflect in the QI minutes for that week. This practice of auditing and reviewing will continue until at least the next annual survey. This information will also be provided to the Executive Quarterly QA Committee meeting. The next scheduled meeting is 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	

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 _____	06/06/2019

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 692	Continued From page 18	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and staff and nurse practitioner interviews, the facility failed to complete a nutritional assessment and failed to address a weight loss for 1 of 4 (Resident #87) reviewed for nutrition. The findings included: Resident #87 was admitted to the facility on 5/1/19 with diagnoses, in part, of dysphagia and malnutrition. A review of an admission Minimum Data Set	F 692	F692 The nutritional assessment for resident #87 weight loss was completed by the Dietary Manager on 6-10-19. The Dietary manager and a corporate representative (nurse) reviewed the weights of all current residents. Any resident identified to have weight loss (or gain) was addressed at that time if not already addressed. As of 6-28-19, there	6/29/19

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 _____	06/06/2019

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 692	Continued From page 19 assessment dated 5/8/19 for Resident #87 revealed intact cognition. Resident #87 required supervision with meals and was on a mechanically altered diet. Her weight was 129 pounds. A review of the care plan dated 5/13/19 revealed a problem of risk for significant weight variances and altered nutrition. The goal was for Resident #87 to not have significant weight variances through the next review. Interventions included: dietitian referral as indicated. A record review revealed Resident #87 ' s weight documented on 5/2/19 as 133 pounds. On 5/20/19, Resident #87 ' s weight was 126 pounds and on 6/3/19, Resident #87 ' s weight was documented as 126 pounds, indicating a greater than 5% weight loss in 30 days. An interview was conducted on 6/5/19 with Restorative Aide (RA) #1. RA #1 stated she collects the weights with the other restorative aide. She is responsible for the daily, weekly and monthly weights. She stated all new admissions are weighed weekly for 4 weeks. A medical record review did not indicate a nutritional assessment had been done since Resident #87 ' s admission date of 5/1/19. There were also no notes under the nutrition tab in the electronic health record. A review of the physician ' s orders for June 2019 revealed Resident #87 was on a pureed diet with thin liquids. There were no orders for a nutritional supplement. An observation on 6/4/19 of Resident #87 eating	F 692	are no residents with weight loss or gain that have not been identified and addressed with a nutritional assessment/note. Any future resident's triggering for weight loss/gain will be identified via the documentation listed below in this list plan of correction. To prevent future weight related issues cited in this 2567, the facility made the following changes: • The internal review by the administrative team of the weights obtained each week has been moved to more closely coincide with the weekly Quality Improvement (QI) meeting. Previously, this weekly weight review was completed outside of the weekly QI meeting and later in the week after the weekly QI meeting and that meeting did not include the Administrator, Director of Nursing (DON), Unit Coordinators or Minimum Data Set (MDS) nurses. The changes will allow the Dietary Manager more time to identify and document any weight gains/losses and to present them to the QI team timelier. A formal process for weight monitoring and interventions was put into place by the corporate team to facilitate timely entry into the Electronic Medical Record (EMR). The Dietary Manager is now responsible for ensuring weights obtained by the Nursing Restorative Team (NRT) have been entered and are available in the EMR. The Dietary Manager is also responsible for bringing the list of residents to the weekly QI meeting who have triggered for	

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 _____	06/06/2019

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 692	Continued From page 20 lunch revealed minimal intake of lunch. An interview was conducted on 6/6/19 at 11:27 AM with the Dietary Manager. She revealed she was not in the building and did not have access to Resident #87 ' s information. She recalled completing a nutritional assessment on Resident #87 but stated she completed it on paper. She could not recall if Resident #87 had experienced weight loss. The nutritional assessment was not available by the time the survey team exited the building. A record review revealed the nurse practitioner (NP #1) saw Resident #87 on 5/23/19. The progress note from that visit did not include Resident #87 ' s weight of 126 pounds that was obtained on 5/20/19 and weight loss was not mentioned in the progress note. An interview was conducted on 6/5/19 at 2:36 PM with the nurse practitioner (NP #1) that provided care to Resident #87. NP #1 stated she was aware of Resident #87 ' s weight loss; she gets notified by the nurses by a sheet they use. She stated she also follows the new admissions. NP #1 stated Resident #87 had some edema and she ordered Lasix (a diuretic) to draw off some of the fluid. However, a review of the electronic health record revealed the Lasix was not ordered until 5/31/19, after the weight loss had already occurred on 5/20/19.	F 692	weight loss in the Electronic Medical Record (EMR). This process allows the facility to ensure we have an interdisciplinary formal review of anyone who has triggered for weight loss/gain since the previous weekly meeting and/or new admissions. To monitor for future issues and to make sure solutions are sustained the facility: • Now requires this portion of the weekly QI meeting to include at least the Administrator, DON, Unit Coordinator(s), MDS nurse Dietary representative and a Nurse Restorative Team (NRT) team member who participates in weights/weight input into the EMR. This expanded interdisciplinary QI team will audit the weekly weights completed to ensure that resident weights were obtained, entered timely, weight notes are present (including gain/loss if applicable), weight related assessments are current and any interventions (including snacks or supplements) are entered in the EMR as well. To complete the internal QI review, the MDS nurses who are also a part and present in this meeting will be able to update the resident care plans in real time based on the information discussed, documented and verified in the weekly QI meeting. This monitoring/auditing/updating will be reflected in the weekly QI meeting notes by the DON or designee taking notes for that week's meeting. The Dietary Manager will be responsible for bringing this information to the Executive Quarterly	

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 _____	06/06/2019

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 692	Continued From page 21	F 692	QA meeting as well. The next scheduled Executive Quarterly QA Committee meeting is scheduled for 7-24-19. The processes and monitors mentioned in this Plan of Correction (POC) will continue until at least the next annual survey. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to 1) follow physician order by ensuring respiratory equipment was in place on admission and failed to provide education to staff for non-invasive mechanical ventilation equipment for 1 of 1 resident (Resident #251) reviewed for bilevel positive airway (bi-pap or non-invasive mechanical ventilation) machine use 2) label and date oxygen tubing and the humidification water bottle as ordered by the physician (MD) for 2 of 3 residents (Resident # 53 and Resident #14) reviewed for oxygen therapy.	F 695	F695 The bi-pap equipment for resident #251 was delivered to the facility and in place as of 5-30-19, prior to the annual survey. All oxygen tubing and humidifier bottles were corrected and verified to be dated and labeled as of 6-6-19. Additional staff nurse education has since been initiated since the annual survey and will be referenced below.	6/29/19

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 _____	06/06/2019

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 695	Continued From page 22 Findings included: 1. Resident #251 was admitted to the facility from the hospital on 5/29/19 with diagnoses that included metabolic encephalopathy, chronic respiratory failure with hypercapnia, and chronic obstructive pulmonary disease (COPD), asthma, and oxygen use via nasal cannula. The resident's cognition was intact. Resident #251's care plan initiated on 5/31/19 revealed a care plan in place for breathing patterns related to use of Bi-pap with interventions to apply as ordered and assure mask fits correctly related to need for continuous oxygen, asthma, and chronic respiratory failure. Review of physician's orders revealed a written order placed Resident #251 on 5/29/19 for bi-pap to be worn every night and during naps with settings of 22/8 with FiO2 at 40% and a medium mask. This order was faxed to the facility medical supply company on 5/29/19 at 4:08 PM. The equipment was delivered to the facility on 5/30/19, time unknown. An observation and interview with Resident #251 on 6/2/19 at 11:52 AM revealed the resident was alert and oriented. She stated that she was admitted on 5/29/19 but did not receive her bi-pap equipment until 5/30/19 in the afternoon. She stated that she had reported to nursing staff that after wearing the bi-pap on the night of 5/30/19, she felt that the mask did not fit correctly. She was told by nursing staff that they did not deal with the bi-pap machine or equipment. During an interview with Unit Coordinator #1 on 6/2/19 at 12:010 PM when asked about Resident	F 695	All other residents in the facility with a bi-pap/c-pap were checked by the Director of Nursing (DON) to ensure their bi-pap/c-pap equipment was in place. 100% of residents identified had the necessary equipment in place and functioning as expected. All residents with oxygen concentrators in their room were reviewed on 6-7-19 and verified to have currently dated and labeled oxygen tubing and humidifier packs with their concentrators. To prevent future issues: • The facility, working with the corporate team, created a new process for ensuring bi-pap/c-pap equipment would be delivered on the day of admission. This was done in coordination with the current medical equipment supplier who provides and services the bi-pap/c-pap equipment. Residents who cannot have bi-pap/c-pap at the facility by 8PM on the day of admission will no longer be admitted until the prescribed equipment is delivered. To make the process more efficient, the facility collaborated with the medical equipment supplier to make sure notification was sent to them as soon as possible, following notification to the facility from the hospital of the discharging resident's settings on their b-pap/c-pap. Note: as the facility does not program or re-program the machine settings, the providing medical equipment supplier must know the prescribed settings from	

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 _____	06/06/2019

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 695	Continued From page 23 #251's bi-pap equipment she stated that the company delivered it the day after her admission. When asked if the resident's mask was not fitting correctly, what would she do, she stated that the medical supply company handles all of that and that once it is set-up in the room, nurses really don't mess with the machine. During an interview with the COO on 6/4/19 he stated that Resident #251 was given a size medium mask on 5/30/19 on admission, however different manufacturers' sizes vary. He stated a new mask was ordered and the resident was happy with how it fit. Record review revealed a note by the COO from 6/6/19 at 5:39 AM that stated Resident #251 had inquired about her bi-pap settings and wondered if they were too high. During an interview with Nurse #7 on 6/6/19 at 1:40 PM she stated that she did not know what the settings were for the bi-pap and did not know how to find out. She stated that she had only worked in the facility for a short time but that an outside company came in to set-up the bi-pap machine. When asked if she was educated on the equipment after set-up, she stated no and that she did not have anything to do with the machines once they were set up. When asked if she was educated on how to check the settings or on what different emergency alarms on the machine meant, she stated no. During an interview with Nurse #6 on 6/6/19 at 2:10 PM he stated that he did not have any residents with bi-pap machines in his assignment at that time. When asked if he was educated on respiratory equipment after set-up, he stated no.	F 695	the discharging hospital/entity. An in-service from a corporate team member was initiated and completed on 6-27-19 with all members of the facility team who participate in the admission process, including the Administrator, DON, Unit Coordinators, Social Workers, Admission Coordinator, Minimum Data Set (MDS) nurses and clinical support QA nurses. If the positions listed above change, the facility Administrator is responsible for covering this information with the new employee in that role to ensure continued compliance. • The facility initiated a Bi-Pap/C-Pap/O2 in-service for all current/active nurses (in-service was only for nurses as the nurses are the only employees the facility allows to verify settings). This in-service was initiated by the facility to ensure nurses know the facility expectations of what the nurses can/cannot do on the machines, how to verify the prescribed settings on the machines, what the different machine alarms can mean and what to do in response to the alarms. The in-service also reviewed the facility's expectation for ongoing changing, dating, labeling of oxygen tubing and humidifier packs. Note, this in-service will be provided as part of the facility's orientation/new hire process for all future/new nurses. Any nurse who has not worked or not received the Bi-Pap/C-Pap/O2 in-service by 7-4-19 will be in-serviced prior to returning to work their next scheduled shift. The facility also added the Bi-Pap/C-Pap/O2 in-service to our annual nurse in-service	

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 _____	06/06/2019

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 695	Continued From page 24 When asked if he was educated on how to check the settings or on what different emergency alarms on the machine meant, he stated no. During an observation and interview with the ADON on 6/6/19 at 2:30 PM she observed the bi-pap equipment with this surveyor to determine what the settings were for Resident #251. The ADON was unable to determine the settings and was also unable to tell this surveyor when and how often the equipment is checked and/or cleaned. When asked if orders were placed to change the settings on the bi-pap machine, would she know how to do it, she stated no. During an interview with Unit Coordinator #1 on 6/6/19 at 4:20 PM when asked if she was educated on the equipment after set-up, she stated no and that she did not have anything to do with the machines once they were set up. When asked if she was educated on how to check the settings or on what different emergency alarms on the machine meant, she stated no. When asked if orders were placed to change the settings on the bi-pap machine, would she know how to do it, she stated no. A policy related to bi-pap equipment was requested on 6/6/19 and no policy was obtained. During an interview with the COO on 6/6/19 at 4:32 PM he stated that it was his expectation that staff knew how to verify bi-pap settings were correct and followed as ordered by the physician. He stated that he expected staff to know how to respond if a problem should arise with the machine. 2. Resident #53 was admitted to the facility on	F 695	calendar to help keep the information current and to repeat for all nurses at a minimum of at least once per calendar year. Copies of the Bi-Pap/C-pap/O2 “how to” information in the in-service were posted at a location within each nurse’s station so nurses can easily reference and utilize the information if needed. To monitor and ensure solutions are sustained the facility: • Now requires the DON or a Unit Coordinator designee to bring a current list of any resident on a bi-pap/c-pap machine to the weekly Quality Improvement (QI) meeting. At that QI meeting, the QA Log of bi-Pap/c-Pap residents (a newly created document to track and monitor resident’s with a bi-pap/c-pap) will be reviewed by the QI team members present (which for this portion of the QI meeting includes the Administrator, DON, Unit Coordinators (UCs), MDS nurses and other team members as needed) to ensure a bi-pap/c-pap machine was delivered on the date of admission, that prescribed settings have been verified by a nurse and are correct, that MD orders for specific machine settings are referenced within the Electronic Medical Record (EMR) and that the resident care plan reflects these areas as well. A list of all current residents with MD orders for oxygen will also be passed out during the QI meeting by the DON or the UCs. Upon completion of the QI meeting, the UCs will take the	

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 _____	06/06/2019

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 695	Continued From page 25 9/26/17 with diagnoses that included, in part, chronic obstructive pulmonary disease (COPD) and asthma. A review of the quarterly MDS assessment dated 4/12/19 revealed Resident #53 was cognitively intact. She received oxygen therapy. A review of care plans updated 4/25/19 revealed a care plan for, "Continuous oxygen via nasal cannula." A review of a MD order dated 1/9/19 revealed, "Change/replace oxygen tubing and humidifier and clean filter per facility policy, every Monday on night shift (7 PM-7 AM). Date and initial both tubing and humidifier after replacing." On 6/3/19 at 9:14 AM an observation was made of Resident #53 with oxygen in use. An observation of the oxygen concentrator and tubing revealed neither the tubing nor the humidification bottle was labeled or dated. An interview was completed with Resident #53. She stated the staff changed out the oxygen tubing but was unsure how often the tubing or humidification bottle was changed. On 6/4/19 at 1:39 PM an observation was made of Resident #53 with oxygen in use. An observation of the oxygen concentrator and tubing revealed neither the tubing nor the humidification bottle was labeled or dated. On 6/5/19 at 1:28 PM an observation of the oxygen concentrator revealed neither the tubing nor the humidification bottle was labeled or dated. On 6/4/19 at 4:12 PM an interview was completed	F 695	list of oxygen residents and manually inspect (go to the resident's room) to verify that oxygen tubing and humidifier packs are currently labeled and dated (this will occur same day, upon completion of the QI meeting). This Quality Assurance (QA) tool and weekly Quality Improvement (QI) meeting audit/review, in addition to the staff education provided and manual verification of oxygen dating/labeling, will allow the facility to monitor and prevent previous bi-pap/c-pap/O2 issues. The facility DON will review the weekly QA notes/working file audits presented at the weekly QI meeting by the administrative nurses to ensure compliance can be asserted in the QI meeting minutes. This process listed above will continue until at least the next annual survey. The audits/results will be reported by the DON at the facility's Executive Quarterly Quality Assurance Committee meeting. The next Executive Quarterly Quality QA Committee meeting is scheduled for 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	

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 _____	06/06/2019

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 695	Continued From page 26	F 695		

with Nurse #3 who worked with Resident #53 on night shift. He reported whenever he observed the humidifier was low, he changed the humidification bottle and oxygen tubing. He stated he typically had not dated the tubing or humidification bottle after he changed them out and said he was not sure if he was supposed to date or initial the tubing or humidification bottle.

On 6/5/19 at 1:32 PM an interview was completed with the Director of Nursing (DON). She stated the oxygen tubing and humidification bottle should have been labeled and dated as per MD order and was unsure why it had not been done.

3. Resident #14 was admitted to the facility 7/16/18 with diagnoses of, in part, anorexia and protein calorie malnutrition.

A review of a quarterly Minimum Data Set assessment dated 2/21/19 revealed Resident #14 used oxygen.

A review of the physician ' s orders for June 2019 revealed oxygen at 2 liters per minute via nasal cannula. Another order read: replace oxygen tubing and humidifier bottle and clean filter every Monday night; date and time tubing after replacing.

An observation on 6/2/19 at 11:10 AM revealed Resident #14 receiving oxygen at 2 liters per minute via nasal cannula. There was not a date and time observed on the oxygen tubing or the humidifier bottle to indicate when it had been changed.

An observation on 6/4/19 at 10:27 AM revealed

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 _____	06/06/2019

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 695	Continued From page 27 no date and time on the oxygen tubing and humidifier bottle to indicate when it had been changed. A review of the Treatment Administration Record for June 2019 indicated the oxygen tubing and humidifier had been changed on 6/3/19 during the 7pm to 7 am shift. An attempt to interview Nurse #1 who worked the night shift on 6/5/19 at 9:26 AM was unsuccessful. A voicemail message was left for Nurse #1 to call surveyor back. A second attempt to interview Nurse #1 on 6/5/19 at 1:31 PM was also unsuccessful. An interview on 6/5/19 at 1:53 PM with the Director of Nursing revealed the policy is for the oxygen tubing and humidifier bottles to be changed weekly. She stated if the order stated to date and time the oxygen tubing and humidifier bottles, the nurses should be doing that. She did not know why it was not being done.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, observations and facility staff and resident interviews, the facility failed to monitor a dialysis resident's access/shunt site,	F 698	F698 Resident #78 had information referencing	6/29/19

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 _____	06/06/2019

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 698	Continued From page 28 failed to provide nursing assessments for a resident after dialysis treatments, and failed to provide ongoing communication documentation with the hemodialysis center for 1 of 1 resident reviewed for dialysis (Resident #48). Findings included: Record review revealed Resident #48 was admitted to the facility on 8/22/2016 with diagnoses which included End Stage Renal Disease with Hemodialysis three times a week. Review of the most recent quarterly Minimum Data Set (MDS) dated 4/10/19 revealed Resident #48 had moderate cognition impairment and required one-person supervision to extensive assistance with all activities of daily living. The MDS indicated the resident required hemodialysis for End Stage Renal Disease. Review of Resident #48's care plan initiated revised 4/22/19 revealed the resident had End Stage Renal Disease and was at risk for complications due to dialysis. The Care Plan interventions included avoid all pressure on the access site, do not allow blood to be drawn from or take a blood pressure reading on the same arm as the access, and monitor shunt/graft/ fistula for signs and symptoms of infection and adequate circulation. During an interview on 6/6/19 at 11:23 AM with Nurse #6 he stated that he worked with Resident #48 often and that he is able to get himself ready for his dialysis treatments on Mondays, Wednesdays, and Fridays. When asked where the resident's access site was located, Nurse #6 stated that he didn't know. When asked what	F 698	site location, assessment and care plan inclusion updated during the annual survey; this was completed by 6-6-19. The facility can now demonstrate communication with the dialysis center as part of weekly visits as well. Resident #78 is currently the only resident in the facility on dialysis as of this plan of correction submission. No other residents would have been included or impacted and could not be reviewed at this time. Current and future dialysis residents will be maintained using the processes listed below in this Plan of Correction (POC). To ensure that future that the deficient practice will not recur, the facility created new processes that: • Now require the facility administrative nurses (Director of Nursing (DON), Unit Coordinators (UCs) or other administrative or corporate nurse to enter a weekly note for any resident who receives dialysis services. This intervention will ensure there is a current dialysis related assessment/note of the access site location and function. The team members listed above will also update the care plan team (Minimum Data Set (MDS) nurses can complete the actual care plan update and/or modifications with changes). The team members listed above have been in-serviced by a corporate nurse and are aware of their roles in ensuring compliance.	

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 _____	06/06/2019

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 698	Continued From page 29 type of access site the resident had, the nurse stated he wasn't sure. When asked if he assessed the site he stated no, but that the resident would be able to tell him if there was any problems with it. When asked about communication documentation with dialysis, he stated that he was told by someone (couldn't remember who) to stop sending documentation sheets with each visit and that if there were any changes with Resident #48, a call would be placed to the facility and documentation would be sent from the dialysis center. He stated that there were no communication sheets available for the last couple of months or longer. During an interview with the ADON and the DON on 6/6/19 at 12:45 PM, they were unable to determine the kind or location of Resident #48's dialysis access. During an observation of Resident #48 on 6/6/19 at 12:50 PM this surveyor and the ADON assessed the resident and found a right fistula, a left arm fistula, and a tunneled central venous dialysis catheter (permacath) to his left chest. The resident stated that dialysis had been using the permacath for a while and stated the right and left arm fistulas were no longer working. The ADON stated that she did not know he had a permacath. Review of the Medication Administration Records and the Treatment Administration Records for Resident #48 for the months of May and June 2019 revealed no entry for assessing or checking the dialysis access sites. There was no documentation in the electronic medical records/nursing notes/assessments for dialysis	F 698	• The facility now provides a manual form to the dialysis center for communication purposes. The transport driver from the facility will ensure the communication form has been delivered and that more importantly the dialysis center sends the communication form back completed. The transport driver will provide the completed communication form to a team member in the bullet listed above. The transport driver(s) have been in-serviced and are aware of their role in ensuring compliance. • In-serviced all current nurses on what to do if changes occur in the dialysis port site function in between assessments by the administrative nursing team or the weekly dialysis visits. This was done to improve communication and to reduce the likelihood of issues in between assessments and visits. Note, this in-service will be provided as part of the facility's orientation/new hire process for all future/new nurses. Any nurse who has not worked or not received the Dialysis Management in-service by 7-4-19 will be in-serviced prior to returning to work their next scheduled shift. The facility also added the Dialysis Management in-service to our annual nurse in-service calendar to help keep the information current and to repeat for all nurses at a minimum of at least once per calendar year. To monitor for compliance and ensure solutions are sustained the facility: • Now requires the DON, Unit	

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 _____	06/06/2019

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 698	Continued From page 30 access sites. During an interview with the COO on 6/6/19 at 3:21 PM he stated that it was his expectation that staff assessed and monitored Resident #48's dialysis appropriately. He also stated that he expected on-going communication with the dialysis center about changes in the resident's condition or access sites.	F 698	Coordinator or designee to bring a current list of any dialysis resident to the weekly Quality Improvement (QI) meeting. At that meeting, the dialysis residents will be reviewed on a QA tool (a newly created QA document to track and monitor dialysis residents) by the team members present which include the Administrator, DON, Unit Coordinators, MDS nurses and other team members as needed, to ensure any dialysis resident has a current weekly assessment of site location, port function, that dialysis communications have been returned (and followed up if applicable) and that care plans are current for each dialysis resident. This QA tool, newly implemented processes listed above, and the staff education provided will allow the facility to monitor and prevent the previous dialysis issue. The facility DON will review the weekly QA notes/working file audits presented at the weekly QI meeting by the administrative nurses to ensure compliance can be asserted. This process listed above will continue until at least the next annual survey. The audits/results will be reported by the DON at the facility's Executive Quarterly Quality Assurance Committee meeting. The next scheduled Executive Quarterly Quality QA Committee meeting is scheduled for 7-24-19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	
F 761	Label/Store Drugs and Biologicals	F 761		6/29/19

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 _____	06/06/2019

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 761 SS=D	Continued From page 31 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly label medications available for use in 1 of 3 medication carts observed. The findings included: An observation on 6/6/19 at 5:04 PM of the 700 hall medication cart revealed one Trelegy inhaler that had no label to indicate who the medication	F 761	F761 The two medications, identified as not labeled on 6-6-19 during the annual survey, on the medication cart were removed by a Unit Coordinator nurse on 6-6-19.	

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 _____	06/06/2019

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 761	Continued From page 32 belonged to or instructions for use. The observation also revealed a tube of Santyl ointment (a chemical debriding agent for pressure ulcers) in the bottom drawer of the 700 hall medication cart that had no residents name or instructions for use. An interview on 6/6/19 at 5:04 PM with Nurse #2 revealed the trelegy inhaler belonged to one of the residents on her hall and she had not put the residents name on it yet. An interview on 6/6/19 at 5:22 PM with the Director of Nursing revealed the pharmacy does a monthly medication cart audit that was last done on Monday, 6/3/19. The Director of Nursing stated nurses should be checking the carts as medication passes are done. She stated she expected all medications to be labeled with residents name and instructions for use.	F 761	The Unit Coordinators (UCs) completed a 100% review of the medications carts in use and found no other medications that were unlabeled. This was completed 6-7-19. To ensure that future that the deficient practice will not recur, the facility: • In-serviced the current nurses and medication aides on the facility expectations for medication labeling. This in-service is specific to labeling medications and what to do if unlabeled medications are found in a medication cart. This intervention was done to prompt and facilitate timely removal by nurses of unlabeled medications (should a medication become unlabeled in addition to making sure that new medications added to the cart are labeled as well). Note, this in-service will be provided as part of the facility's orientation/new hire process for all future/new nurses. Any nurse who has not worked or not received the Medication Labeling in-service by 7-4-19 will be in-serviced prior to returning to work their next scheduled shift. The facility also added the Medication Labeling in-service to our annual nurse in-service calendar to help keep the information current and to repeat for all nurses at a minimum of at least once per calendar year. • Now requires members of the administrative nursing team (including the Director of Nursing (DON), Unit Coordinators, nurse designees and/or corporate nurse) to audit each medication	

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 _____	06/06/2019

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 761	Continued From page 33	F 761		

cart at least weekly. The unannounced random audits will be documented on a newly created Quality Assurance (QA) Tool to ensure that nurses and medication aides are adhering to the medication labeling information provided to them via in-service. Any unlabeled medication found to be an issue will be corrected at that time, addressed for causation and presented at the weekly Quality Improvement (QI) Meeting for tracking.

To monitor compliance and ensure solutions are sustained the facility:

- Now requires the Director of Nursing or a Unit Coordinator designee to bring the weekly medication cart QA audits to the weekly QI meeting. Team members present for this portion of the QI meeting review include the Administrator, DON, Unit Coordinators, and other corporate or facility team members. This QA tool review, newly implemented processes listed above, and the staff education provided will allow the facility to monitor and prevent the previous medication labeling issue. The facility DON will review the weekly QA audits and working file audits presented at the weekly QI meeting by the administrative nurses to ensure compliance can be asserted. This process listed above will continue until at least the next annual survey. The audits/results will be reported by the DON at the facility's Executive Quarterly Quality Assurance Committee meeting. The next Executive Quarterly Quality Assurance Committee meeting is scheduled for 7-24-

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 _____	06/06/2019

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 761	Continued From page 34	F 761	19. All corrective actions referenced in this Plan of correction (POC) will be in place by 7-4-19.	