### Statement of Deficiencies and Plan of Correction

#### A. Building 01 - The Shannon Gray Rehabilitation & Recovery

**Provider/Supplier/CLIA Identification Number:** 34552

**Date Survey Completed:** 08/11/2016

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#### Name of Provider or Supplier

**The Shannon Gray Rehabilitation & Recovery Center**

**Street Address, City, State, Zip Code:**

2005 Shannon Gray Court
Jamestown, NC 27282

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#### Summary Statement of Deficiencies

Each deficiency must be preceded by full regulatory or LSC identifying information.

**K 029**

**SS=D**

**NFPA 101 Life Safety Code Standard**

Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.

This STANDARD is not met as evidenced by:

- 42 CFR 483.70 (a)

Based on observations, and staff interview on 8/11/2016, at approximately 10:00 AM onward, the following deficiencies were noted:

The facility maintenance and inspection of hazardous areas was non-compliant, specific findings include:

- The laundry department is a one hour protected hazardous area. The one hour rated door to the

The door in question was corrected by the facility Maintenance Director to allow appropriate closure. This was completed on 8/26/16.

All other fire rated doors in the facility were checked again on 8/26/16 by a Maintenance Department employee or by the Assistant Administrator. Any door found to not close accordingly was adjusted/corrected at that time.

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**Laboratory Director’s or Provider/Supplier Representative’s Signature**

Electronically Signed

08/29/2016

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING 01 - THE SHANNON GRAY REHABILITATION & RECOVERY**

**B. WING**

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<table>
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<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<td>clean side of the laundry was dragging on its frame and did not close the door tight in its frame when tested.</td>
<td>The facility adjusted the Administrative Rounds QA tool to incorporate the appropriate closure of doors. This tool is completed a minimum of weekly by an administrative employee/department head. Moving forward, the tool has a space for the administrative employee to check (signifying they have checked all the fire the doors on their rounding assignment for appropriate closure, including not dragging on the door frame). Any door found not closing appropriately will be reported to the Maintenance Department or the Nursing Home Administrator by the administrative employee/department head for correction.</td>
<td>9/6/16</td>
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**K 062**

**NFPA 101 LIFE SAFETY CODE STANDARD SS=E**

Automatic sprinkler systems are continuously maintained in reliable operating condition and are

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**NAME OF PROVIDER OR SUPPLIER**

THE SHANNON GRAY REHABILITATION & RECOVERY CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

2005 SHANNON GRAY COURT
JAMESTOWN, NC 27282

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING**

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**K 062**

**NFPA 101 LIFE SAFETY CODE STANDARD SS=E**

Automatic sprinkler systems are continuously maintained in reliable operating condition and are
K 062 Continued From page 2

inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5
This STANDARD is not met as evidenced by:
42 CFR 483.70 (a)
Based on observations, and documentation
review on 8/11/2016, at approximately 10:00 AM
onward, the following deficiencies were noted:
The facility maintance and inspection of the
sprinkler system was non-compliant, specific
findings include:
The facility did not produce to the surveyor
documentation that the quarterly sprinkler
inspections were conducted during 2016 as
required. Every required sprinkler system shall
be continuously maintained in proper operating
conditions, and requires an inspection every
quarter of a calendar year.
Ref: 2000 NFPA 101 Section 19.7.6; 4.6.12.1;
NFPA 25 2-2; 9.7.5
This deficiency affected all smoke compartments.
Failure to comply with minimum standards as
referenced increases the risk of death or injury
due to fire and/or smoke.

The facility had the sprinkler system
re-inspected, this was completed on
8/22/16.
Moving forward, the sprinkler system will
be inspected (with the results kept on file) quarterly. The next scheduled sprinkler
system inspection will occur by
11/30/2016 with the results documented
accordingly.
The outside company responsible for
quarterly sprinkler inspections will exit with
the facility Administrator, Assistant
Administrator or the Maintenance Director
after each visit, including the results of
that sprinkler inspection. The quarterly
inspections will be kept on file by the
Administrator for future reference.
The facility created a Life Safety QA Team
which includes the Nursing Home
Administrator, Assistant Administrator,
Maintenance Department, Director of
Nursing and the Staff Development
Coordinator. This team will meet monthly
to monitor and ensure compliance with
this plan of correction. They will also
report their efforts to the facility’s
Executive QA Committee, which meets
quarterly. The next scheduled Executive
QA Committee meeting is 10/19/2016.
The facility states full completion and
compliance with this Plan of Correction on
or before 9/6/16.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(K1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345552

THE SHANNON GRAY REHABILITATION & RECOVERY CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
2005 SHANNON GRAY COURT
JAMESTOWN, NC 27282

(K4) ID PREFIX TAG
K 147

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

K 147 SS=D
NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1
This STANDARD is not met as evidenced by:
42 CFR 483.70 (a)

Based on observations, and staff interview on 8/11/2016, at approximately 10:00 AM onward, the following deficiencies were noted:

The facility access to electrical panels was non-compliant, specific findings include:
Access to electrical panels must not be obstructed. There must be at least 36 inches clearance in front of the electrical panels and at least 30 inches clearance to one side of the electrical panel. The electrical panel wall at the following locations did not have the proper clearance to allow for maintenance on the electrical panel circuitry.
1. The staff lounge named "Aunt Bee"
2. The staff lounge named "Pitt Stop"

Ref: 2000 NFPA 101 Section 19.5.1; 9.1.2; NEC 110 Section 26

This deficiency affected one smoke of approximately twelve smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke

The facility Maintenance Director applied a cautionary line on the floor of the areas listed. This solid yellow and black line was applied on 8/12/16 to allow for 36" of clearance in front of the electrical panels in question. Signage was posted in these areas at that time to alert facility staff to maintain the 36" of required electrical door panel clearance.

The facility Maintenance Department and Assistant Administrator inspected all internal electrical panel doors to ensure compliance with 36" door clearance, this was completed on 8/26/16 and all panel doors were found to be in compliance.

Moving forward, the facility will now include this area (adequate electrical panel clearance of 36") with the currently scheduled fire safety in-service which is provided to staff twice each year. This topic will also be covered during orientation for new/future employees. The twice/year in-service will be provided by a Maintenance Department representative and documented accordingly.

The facility created a Life Safety QA Team which includes the Nursing Home Administrator, Assistant Administrator, Maintenance Department, Director of Nursing and the Staff Development Coordinator. This team will meet monthly.
### Statement of Deficiencies and Plan of Correction

#### Provider/Supplier/CLIA Identification Number:

34552

#### Multiple Construction

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

08/11/2016

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**The Shannon Gray Rehabilitation & Recovery Center**

2005 Shannon Gray Court

Jamestown, NC  27282

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**Event ID:** GSJN21

**Facility ID:** 061198

**If continuation sheet:** Page 5 of 5