

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/23/2026
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G118	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/17/2026
NAME OF PROVIDER OR SUPPLIER SHANNONBROOK HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 914 WEST FIRST STREET NEWTON, NC 28658		
(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	
W 000	INITIAL COMMENTS	W 000			
W 153	<p>A complaint survey was completed on 2/17/26 for intake #NC00235679. The allegation was unsubstantiated but a deficiency was cited relative to the allegation.</p> <p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on the facility documentation reviews and interview, the facility failed to ensure an abuse investigation was reported timely to external officials in accordance with state laws for client #1. The finding is:</p> <p>Review of internal investigation summary on 2/17/26 revealed an allegation of client abuse reported on 1/18/26. Further review of internal investigation summary revealed the investigation began on 1/18/26 and completed on 1/21/26. Continued review of the investigation summary revealed that on 1/18/26 "client #1 returned home from a therapeutic leave on Sunday at 12:50pm. Resident was noted to have blood on night gown when she came to the med room to take her PM medication. The resident was assisted to clean up and change. Staff noted blood in resident's underwear and blood on the wipes used to clean the resident."</p> <p>Subsequent review of the internal investigation revealed no report of incident from the facility to</p>	W 153			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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W 153	Continued From page 1 the Division of Health Service Regulation (DHSR). Interview on 2/17/26 with the facility administrator revealed that the she sent an email but could not locate it.	W 153			