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	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Shannon Gray Rehabilitation & Recovery Center	2005 Shannon Gray Court Jamestown, NC 27282

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility record review, hospital emergency department record review, and Resident, Responsible Party, staff, and Medical Director Interviews, the facility failed to ensure a resident received the medications ordered for her by the physician at discharge from the facility. At the time of discharge on [DATE] medications belonging to another resident were inadvertently provided to Resident #1. On 10/21/25 the Responsible Party looked at the medication packaging and realized the medications were prescribed for another resident and she was taken to the Emergency Department (ED) for evaluation. The ED Provider Note stated Resident #1 had no complaints, but the RP stated she was shaky over the last few days. The ED Provide Note further stated Resident #1 looked good clinically with normal laboratory results and the results of the electrocardiogram completed that day were at her baseline. No treatment or interventions were provided and the ED provider indicated he did not see any evidence of a major medication reaction. Resident #1 was deemed safe for discharge home on [DATE]. The deficient practice occurred for 1 of 3 residents reviewed for discharge from the facility (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE] with rib fractures due to a fall.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact.During an interview by phone with Nurse #2 on 10/30/2025 at 12:25 pm she stated when she came into the facility for her 7:00 pm shift on 10/17/2025 Resident #1's RP came into the facility and took her to the car without notifying the nurse. Nurse #2 stated Nurse #1 asked the RP to come back into the facility so that she could explain the medications and give him Resident #1's medications. She stated she went over the list of medications with the RP and after explaining the medications he signed the medication list. Nurse #2 stated Nurse #1 gave the bag of medications to the RP and gave him one card of narcotic pain medication that was ordered for Resident #1 that she and Nurse #1 had just counted. Nurse #1 was interviewed by phone on 10/30/2025 at 12:21 pm and she stated Resident #1's Responsible Party (RP) came into the facility on [DATE] during the shift change at 7:00 pm and took Resident #1 to the car without telling anyone that they were leaving. Nurse #1 stated Nurse #2 saw the RP leaving with Resident #1 alerted her and she ran out to the parking lot and asked the RP to allow her to go over Resident #1's discharge instructions before he left. Nurse #1 stated the RP came back into the building but was very agitated and was rushing her when she was giving him the medications and the instructions for Resident #1's medications. Nurse #1 stated she did not know how another resident's medications were put into Resident #1's discharge bag. Nurse #1 stated Nurse #2 who was coming in for the 7:00 pm shift counted Resident #1's narcotic pain medication with her and they both signed them out before giving them to the Responsible Party. Nurse #1 stated she was certain Resident #1 received her own narcotic pain medication.During a phone interview with the Responsible Party (RP) on 10/30/2025 at 12:53 pm he stated Resident #1 was sent home with another resident's medications and he had given her the wrong medications for four days before he realized the medication cards had another resident's name. The RP also stated he was given a list of Resident #1's medications and instructions for how to give them but he looked at the medication cards when he gave Resident #1 the medications and did not look at the medication instructions he was given by the facility. The RP stated he called emergency services on the fourth day when she became confused and had jerking motions in her arms, and he realized the medications he gave her belonged to another resident.On 10/31/2025 at 11:06 am Resident #1 was interviewed by phone and stated she did not remember going to the emergency room on [DATE]. She stated her Responsible Party administered her medications to her after she was discharged from the facility and she did not look at the packages containing the medications.Review of the Emergency Department Provider Notes dated 10/21/2025 at 2:51 PM indicated Resident #1 was brought to the emergency department and was seen and evaluated for the chief complaint of a medication problem. It was noted the resident had recently discharged (10/17/21) from a local skilled nursing facility and her Responsible Party (RP) had been giving her the medications provided by the facility. After a few days the RP began to get suspicious because it seemed she was taking a lot more medications than she had previously. When the RP looked medication packaging, he noticed another resident's name on some of the packaging and called poison control and came to the hospital. The Emergency Department Provider Note stated Resident #1 had no complaints, but the RP stated she was shaky over the last few days. The Emergency Department Provide Note further stated Resident #1 looked good clinically with normal laboratory results and the results of the electrocardiogram completed that day were at her baseline. No