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	04/03/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46725 Based on staff interviews and record reviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of active diagnoses and urinary catheter for 2 of 20 residents reviewed for MDS accuracy (Residents #39 and #100). The findings included: 1. Resident #39 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder. A record review indicated Resident #39 had an active diagnosis of Post-Traumatic Stress Disorder (PTSD) since 8/8/23. The annual Minimum Data Set (MDS) assessment dated [DATE] did not indicate Resident #39 had an active diagnosis of PTSD in the Psychiatric/Mood Disorder section An interview was conducted on 4/3/25 at 10:25 AM with Minimum Data Set (MDS) Nurse #1. She stated it was an oversight that she did not code an active diagnosis of PTSD in the Psychiatric/Mood Disorder section of Resident #39's annual MDS assessment dated [DATE]. An interview was conducted on 03/06/25 at 10:50 AM with the Administrator. He stated she expected the MDS assessments to be coded accurately. 41579 2. Resident #100 was admitted to the facility on [DATE] with diagnoses which included urinary retention. Resident #100's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #100 was cognitively intact and was frequently incontinent with bladder and was not coded to have an indwelling urinary catheter. A review of Resident #100's care plan 10/30/24 revealed Resident #100 had an indwelling urinary catheter. (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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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 3:11 PM an interview was conducted with Nurse #1, and she indicated she was assigned to Resident #100 while he was in the facility. Nurse #1 reported Resident #100 had an indwelling catheter for urinary retention. An interview was conducted on 04/03/25 at 11:33 AM with the Minimum Data Set (MDS) Nurse #1. The MDS Nurse #1 indicated the indwelling catheter should have been coded on the MDS. She stated, I did care plan it. An interview was conducted on 04/03/25 at 1:20 PM with the Administrator and he indicated it was his expectation the MDS assessments to be coded accurately.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38129 Based on record review and staff, Wound Care Physician, and lab vendor interviews, the facility failed to notify the Wound Care Physician of a positive wound culture lab result when it was reported to the facility which delayed initiating antibiotics for 3 days. This deficient practice affected 1 of 2 sampled residents (Resident #53). Findings included: Resident #53 was admitted to the facility on [DATE] with the diagnosis of dementia. The annual Minimum Data Set, dated dated dated [DATE] for Resident #53 documented she had an intact cognition, a diagnosis of one stage 3 pressure ulcer, and the pressure ulcer stage 3 was reported not present on admission or reentry. The resident was frequently incontinent of bladder and always incontinent of bowel. The care plan dated 3/20/25 for Resident #53 had interventions for pressure reduction, nutrition supplementation for wound healing, and pressure ulcer wound care. The resident was at risk of developing pressure ulcers. Resident #53 had a Wound Care Physician progress note dated 2/10/25 which documented the progress of her pressure ulcer wound. The wound was not progressing and suspected to be infected. A deep swab technique was performed on the stage 3 pressure wound of the right buttock completed on 2/10/25 and order provided for culture. Resident #53's physician ordered a wound culture for stage 3 right buttock pressure ulcer on 2/10/25 that was initiated by the Wound Care Nurse. Resident #53's pressure ulcer wound culture lab result dated 2/14/25 documented the specimen was picked up on 2/11/25 and the final result was completed on 2/14/25. The report was sent to the facility directly into the resident's electronic medical record (EMR) on 2/14/25 and was positive for bacteria organism proteus mirabilis. The culture report had printing dates of 2/14/25 and 2/17/25 on the copy in Resident #53's EMR. On 4/3/25 at 12:44 pm an interview was conducted with Nurse #2. Nurse #2 stated she was assigned to Resident #53 on day shift on 2/14/25. She was not aware of the lab result reported on 2/14/25 for Resident #53. She stated the process for lab results was a paper copy of the lab was provided to staff at the nurses' station by the Director of Nursing (DON). The result would then be reported to the ordering provider. Nurse #2 stated she was not aware that the lab was directly reported into the resident's individual EMR. The EMR type had changed on 12/2024, and the process had changed from paper to directly placed into the EMR. The lab could be reviewed in the lab portal if it was known a lab result had been reported. Nurse #2 stated she was not informed that the resident had a lab result received on 2/14/25 and there was no EMR notification. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 10:33 am an observation was done of Resident #53's final lab culture report dated 2/14/25 with Nurse #2. The report had two dates for being printed, 2/14/25 and 2/17/25 on the form. Nurse #2 commented that the report was printed from the internet vendor site showing the two dates and then scanned into the resident's EMR on 2/17/25. On 4/2/25 at 10:33 am an interview was conducted with the Wound Care Nurse. The Wound Care Nurse stated she was absent on Friday, 2/14/25 and returned on Monday 2/17/25. The wound culture result was reported to the Wound Care Physician on 2/17/25 when he was at the facility to see the residents, and the physician ordered antibiotics. The Wound Care Nurse stated she expected the nurse assigned Resident #53 on 2/14/25 to address the lab results reported that day. The Wound Care Nurse was aware the result was posted to the Resident #53's EMR, but thought the result was printed and provided to the staff nurse assigned on 2/14/25. The Wound Care Nurse stated printing a copy of lab results and providing it to assigned nursing staff was the process. The Wound Care Nurse stated she printed her own lab results and thought nursing staff printed their resident assignment lab result(s). The Wound Care Nurse was absent on 2/14/25 and she printed her own copy on 2/17/25. Resident #53's Wound Care Physician progress note dated 2/17/25 documented the wound was exacerbated due to infection, there was a moderate amount of serous drainage (light red liquid), and 100% of granulation tissue. A deep swab technique of stage 3 pressure wound of the right buttock demonstrates proteus mirabilis on 2/10/25. The wound care order remained unchanged, and the antibiotic Invanz 1 gram for 10 days was ordered. Resident #53 had an order dated 2/17/25 for Ivanz (antibiotic) 1 gram intramuscular for 10 days. On 04/02/25 at 10:46 am an interview was conducted with the lab vendor. She stated the wound culture for Resident #53 was posted in the resident's EMR when the final report was completed 2/14/25 at 9:48 am. All labs for facilities that use the connected EMR were automatically posted to their EMR including on the weekends. The labs were placed in the residents' EMR electronically. If the lab was critical the facility was called as well. Resident #53's would culture result was not considered critical. She further stated that this facility was connected directly to the lab to receive reports into the residents' EMR. On 4/2/25 at 11:10 am the DON reviewed Resident #53's wound culture result and was interviewed. The DON stated she was not aware the lab would come directly to the EMR but was expecting a fax. There was no notification in the EMR that a lab result was posted. The DON stated she kept a written logbook of all labs to follow, and Resident #53's wound culture was not recorded in her logbook (the DON opened her logbook and reviewed). The DON stated she kept track of all labs in her book and if known she would have addressed the lab. The DON commented that this EMR type was new to the facility as of 12/2024. A review of the lab culture result revealed it was a final report on 2/14/25 at 9:48 am and was printed at the facility on 2/14/25 and 2/17/25 and scanned into the Resident #53's EMR. The DON further stated she was keeping a logbook of submitted labs and printing a copy of the result from the vendor site instead of accessing the result from the residents' EMR. (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 12:09 pm an interview was conducted with the Wound Care Physician. The Wound Care Physician stated he completed a wound culture swab of Resident #53's right buttock pressure ulcer on 2/10/25 and he was not informed of the culture report until 2/17/25. The Wound Care Physician indicated the wound culture result should have been reported to me on 2/14/25 when it was received, and he would have ordered the antibiotic on 2/14/25. He commented that the Wound Care Nurse was usually prompt in reporting culture results. The Wound Care Physician further commented that he was available 24/7 by phone, especially for wound culture reports. The delayed start of the antibiotic had not caused the resident harm, and her wound was now improving.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 38129 Based on record review, observation and interviews of the staff and wound care physician, the facility failed to follow their infection control policy for hand hygiene and glove use when the Wound Care Nurse did not perform hygiene and don new gloves after the dirty portion of the pressure ulcer dressing change and before beginning the clean portion of the dressing change (Resident #53). This deficient practice occurred for 1 of 2 staff observed for infection control practices. Findings included: The infection control policy last updated on 10/22/24 documented, in part, 1. Hand hygiene d. Wash hands after removing gloves. 2. Gloves e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a dirty site to a clean one). g. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident and wash hands immediately to avoid transfer of microorganisms to other residents or environments. On 04/02/25 at 10:35 am an observation of Resident #53's pressure ulcer wound care to her right buttock by the wound care nurse was done. The wound care nurse washed her hands and donned gloves. She placed all her supplies on a clean surface next to the resident's bed. The wound care nurse removed the wound dressing. The right buttock stage 3 pressure ulcer was approximately 2 centimeters (cm) around and 1 cm deep with a small amount of serous (light red) drainage present and there were no signs or symptoms of infection. She cleansed the pressure ulcer with normal saline and applied skin prep around the pressure ulcer. The wound care nurse used the same gloves and had not performed hand hygiene before she placed the silver alginate (medicated gauze) into the ulcer wound bed and then placed the dressing over the wound. There was no use of hand sanitizer or change of gloves in-between removing the dirty dressing, cleansing the wound and placement of the treatment and dressing. The wound care nurse was interviewed. The wound care nurse stated she only changed gloves during wound care when the resident had more than one wound. She would change gloves between each wound. If there was only one wound, she would use the same gloves. The wound care nurse commented she wore the same gloves and had not stopped for hand hygiene and re-glove in between the dirty dressing and placing the treatment and clean dressing because Resident #53 had one wound. On 04/02/25 at 12:09 pm an interview was conducted with the wound care physician. The wound care physician stated he remembered Resident #53. The wound care physician stated that the expected use of infection control during wound care would have been to use hand hygiene and don gloves and remove the old/soiled dressing and cleanse as required and then use hand hygiene and change to clean gloves before having placed the treatment and a clean dressing. This would be the same for each wound a resident would have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/25 at 4:40 pm an interview was conducted with the Administrator. The deficient practice by the wound care nurse when she failed to perform hand hygiene and change gloves after she removed the dirty pressure ulcer dressing, cleansed the wound and then placed the treatment calcium alginate and sterile dressing was discussed. The Administrator stated he thought that use of the same gloves was appropriate when there was only one wound on the resident. The facility owner was requested to attend the interview. The owner stated if the old dressing was not soiled and there was only 1 wound, it was not necessary to change gloves in-between removing the dirty dressing and cleansing and then placing the treatment and clean dressing. The owner stated the wound care nurse was certified/trained and he thought this process was what she learned. The owner stated he would provide information from SPICE (Statewide Program for Infection Control and Epidemiology) to corroborate the use of the same gloves for dirty dressing/cleanse and clean dressing and would get back to me tomorrow (4/2/25). On 4/2/25 at 10:15 am an interview was conducted with the Administrator. He stated the facility had nothing to add from SPICE or any other information regarding infection control and the use of hand hygiene and gloves during wound care. Hand hygiene and change of gloves would need to be performed during wound care. On 04/03/25 at 11:28 am an interview was conducted with the Director of Nursing (DON). The DON stated the wound care nurse was confused that not changing dirty gloves before starting the clean process for wound care was not part of the SPICE recommendations. The DON informed the wound care nurse that hand hygiene and changing gloves was required during wound care after removing the soiled dressing and cleaning and then handling clean treatment and dressing for each wound.