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	06/26/2026

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

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to remove expired medications stored in 1 of 3 medication rooms and 1 of 6 medication carts reviewed for medication storage (Over the Counter (OTC) Medication Storage Room and Medication Cart for 800 hall).The findings included:a. An observation of the Over the Counter Medication Storage Room was conducted on 6/24/2026 at 9:33 AM in the presence of the Supply Coordinator. The observation revealed the following expired medications:-Two bottles of vitamin D-3 10 micrograms (mcg) film-coated tablets (a dietary supplement medication) with an expiration date of 9/2025. Both bottles were opened and observed without labels indicating their opening dates. One bottle contained 65 tablets, and the second bottle contained 34 tablets. The Supply Coordinator confirmed the expiration date by reading aloud the date printed on the bottles and confirmed the bottles were opened and undated.-One tube of triple antibiotic ointment, 0.5 ounce, with an expiration date of 10/2025. The Supply Coordinator confirmed the expiration date by reading aloud the date printed on the box. An interview with the Supply Coordinator was conducted on 6/24/2026 at 9:42 AM. She stated a staff member must have returned the opened Vitamin D bottles to the Over the Counter medication storage room without her knowledge. The Supply Coordinator indicated staff should give her expired over the counter medications so she could properly dispose of them and not place them on the shelf. She explained she typically checked the Over the Counter medication storage room one to two times per week for expired medications and stated the last time she checked the storage room was on 6/17/2026.b. An observation of the medication cart for the 800 hall was conducted on 6/24/2026 at 11:21 AM in the presence of Nurse #2. The observation revealed the following expired medications:-Twenty (20) hydrocodone/acetaminophen 5 milligrams (mg)/325 mg tablets (narcotic pain medication) with an expiration date of 6/1/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the medication card. -Two (2) ondansetron 4 mg tablets (medication used to prevent or treat nausea and vomiting) with an expiration date of 5/27/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the medication card.-Fifteen (15) benzonatate 200 mg capsules (medication used to help stop coughing) with an expiration date of 3/7/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the medication card.-Twenty-nine (29) mycophenolate 500 mg tablets (medication that weakens the immune system to help prevent the body from rejecting a transplanted organ) with an expiration date of 4/24/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the medication card.-Five (5) prednisone 20 mg tablets (medication that reduces inflammation and suppresses the immune system) with an expiration date of 3/31/2026. Nurse #2 confirmed the expiration date by reading aloud the date printed on the medication card. An interview with Nurse #2 was conducted on 6/24/2026 at 11:21 AM. She stated medication carts should be checked for expired medications on an ongoing basis. Nurse #2 revealed she last checked her medication cart approximately two weeks earlier but was informed someone from pharmacy checked the cart on 6/19/2026. Nurse #2 indicated she likely overlooked the medications in the bottom drawer because they were as-needed (PRN) medications. She stated (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotic medications would be sent back to the pharmacy for proper disposal. An interview with the Director of Nursing (DON) was conducted on 6/25/2026 at 11:15 AM. The DON stated staff were educated and instructed to check their medication carts for expired medications prior to use. The DON stated expired medications should not remain in the medication carts but believed many of the expired medications identified were as needed medications that they were overlooked. The DON stated physician orders for medications that were unused for 60 to 90 days should be reassessed to determine whether the medication was still needed by the residents. The DON further stated she was unsure why the two opened bottles of Vitamin D were placed in the medication storage room because they should not have been stored there.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and resident interviews, the facility failed to provide a resident with dignity and respect when Nurse Aide (NA) #1 confronted Resident #77 about reporting her and making false accusations to management. Resident #77 stated this made her feel fearful and treated unfairly. The facility also failed to provide dignity and respect to Resident #35 when NA #2 spoke smack and not very nice to the resident. Resident #35 stated this made him feel frustrated. This occurred for 2 of 4 residents reviewed for dignity (Resident #77 and Resident #35). The findings included:Resident #77 was admitted to the facility on [DATE] with diagnoses of lumbar spina bifida without hydrocephalus (a birth defect where the bones in the lower back do not fully close leaving a gap without fluid on the brain). The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #77 was cognitively intact and required partial/moderate assistance with bathing and was dependent on toileting. There were no behaviors documented on the MDS. Resident #77 was interviewed on 06/23/2026 at 2:20pm. Resident #77 explained that NA #1 had previously (Resident #77 was unable to provide a time frame) confronted her about speaking with the Unit Coordinator about NA #1 not spending time with her and speaking harshly. Resident #77 stated NA #1 told her she was making false accusations and did not appreciate her talking to the Unit Coordinator. Resident #77 stated she didn't want people to be mean to her and stated it was not fair. Resident #77 stated she felt fearful and was treated unfairly. NA #1 was interviewed on 06/24/2026 at 9:39am. NA #1 stated Resident #77 would tell her other staff were rude or speaking harshly to her. The NA indicated she told Resident #77 to speak with upper management. NA #1 stated Resident #77 had made false accusations against her such as saying she had scratched the resident but was unable to provide a time frame of when this occurred. NA #1 explained after Resident #77 spoke with upper management; she went back to Resident #77 and confronted her. NA #1 was unable to say when this occurred. NA #1 stated she wanted to clarify what the problem was and let Resident #77 know she didn't appreciate being reported. An interview with Nurse #1 occurred on 06/24/2026 at 11:21am. Nurse #1 confirmed she had been routinely assigned to Resident #77 during the 7:00am to 3:00pm shift. Nurse #1 stated she didn't know anyone who spoke harshly to Resident #77. Nurse #1 stated Resident #77 had not told her about any incidents with NA #1. Unit Coordinator #1 was interviewed on 06/24/2026 at 11:47am and revealed Resident #77 had come to her with concerns regarding NA #1 (Unit Coordinator #1 could not provide a time frame). Unit Coordinator #1 stated Resident #77 reported NA #1 just wanted to change her and was not taking time with her and was speaking harshly. Unit Coordinator #1 stated she felt NA #1 was direct but not harsh. Unit Coordinator #1 indicated she explained to Resident #77 that NA #1 had a lot of other residents to care for and gave the same amount of time to each resident but if a resident needed more time, then more time would be provided. Unit Coordinator #1 further stated she spoke with NA #1 regarding Resident #77's concerns related to not spending enough time with her and being harsh. The Unit Coordinator stated NA #1 voiced being shocked that Resident #77 had expressed these concerns. Unit Coordinator #1 recalled she spoke with NA #1 but did not have any written notes and did not recall when the meeting occurred. Unit Coordinator #1 indicated she did not feel the event warranted a formal written document and she did not provide any formal instructions to NA #1. Unit Manager #1 stated she hope that staff would not confront Residents with concerns brought to management related to staff. She also stated she did not report the conversation with NA #1 to the Director of Nursing (DON) or Administrator, and she was unaware NA #1 had returned to Resident #77 to confront her on the discussion of the meeting. An interview was conducted with the DON and Administrator on 06/24/2026 at 12:44pm. Both the Administrator and DON indicated they were not aware of Resident #77's encounter with NA #1 until the interview. The DON stated the perspective of the resident was the reality. The Administrator explained that staff were trained on the abuse policy, which included (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intimidation, yearly. He also stated he needed to speak further with Resident #77. The DON stated after meeting with NA #1, she noted NA # 1 had a lack of knowledge, experience and cultural awareness related to resident care and NA #1 needed further training and education. The Administrator stated NA #1 should not have spoken to Resident #77 about her meeting with Unit Coordinator #1. The Administrator stated if the Unit Coordinator had known about the conflict, he would have expected to be notified. The DON stated Unit Coordinator #1 had told her that during her meeting with NA #1 the Unit Coordinator informed NA #1 not to approach Resident #77 about their conversation. 2. Resident #35 was admitted to the facility on [DATE] with diagnoses of stroke. The quarterly MDS dated [DATE] revealed Resident #35 was cognitively intact and had no rejection of care. Resident #35 was interviewed on 06/22/2026 at 12:51pm. Resident #35 explained that NA #2 was talking smack (verbally mocking, criticizing, or belittling someone) and not very nice. Resident #35 was unable to provide specific details as to what NA #2 said. Resident #35 stated NA #2 had never said a nice word to him, and he had never reported the situation. NA #2 was interviewed via phone call on 06/24/2026 at 3:55pm. NA #2 said she worked 3rd shift (11:00pm to 7:00am) and was familiar with Resident #35. NA #2 stated most residents thought she was a man when she spoke and that her voice carried, and she was told she had a stern voice. NA #2 stated she told Resident #35 she was there to help him to help himself. NA #2 stated that when Resident #35 got upset with her checking on him, she told him, If you could use the bathroom I wouldn't have to keep coming in here. NA #2 also stated she felt the resident needed to be encouraged to do things on his own and that's why he got upset with her. Interview with Nurse #1 occurred on 06/24/2026 at 11:21am. Nurse #1 stated she had not been assigned to Resident #35 often but was assigned to him today (06/24/2026). Nurse #1 stated she never heard anyone not speaking kindly to Resident #35 and the resident had never reported anyone not speaking nicely to him. NA# 1 was interviewed on 06/24/2026 at 9:39am. NA #1 stated she hadn't heard anyone not speaking kindly to Resident #35. A follow up interview occurred with Resident #35 on 06/25/2026 at 9:08am and Resident #35 stated NA #2 didn't upset him when she made the comment that he needed to get up and use the bathroom. Resident #35 indicated he understood what NA #2 was telling him about using the bathroom, but stated NA #2 communicated the message in a rough manner. Resident #35 also stated NA #2 may have meant to say it to hurt him, but it didn't hurt him. Resident #35 stated he and NA #2 had never gotten along from day one and NA #2 had never expressed a kind word to Resident #35. The Resident discussed trying not to bite back at NA #2, but she kept poking at me. Resident #35 expressed feeling frustrated at times when NA #2 did not convey any kind words to him. The Director of Nursing (DON) and Administrator were interviewed on 06/24/2026 at 12:44pm. The DON indicated she was not aware of Resident #35's encounter with NA #2. She stated the perspective of the resident was reality. The Administrator stated staff were trained in intimidation and stated he needed to speak further with Resident #35.

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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. Based on observation, staff and Physician interviews, and record review, the facility failed to implement their infection control policy and procedure, when a Nurse Aide (NA) failed to perform hand hygiene after the completion of catheter care for Resident #36 who was on Enhanced Barrier Precautions (EBP) for an indwelling catheter. This deficiency occurred for 1 of 4 staff members reviewed for infection control practices (NA #4). The findings included:A review of the facility's policy and procedure titled Infection Control in Long Term Care (LTC) Policy dated April 2026 read in part:Use a piece of personal protective equipment one-time-then throw it away.Change gloves when they are soiled, and when moving from a contaminated to clean area of the body.A review of facility's Infection Prevention and Control Program (IPCP) dated April 2024 read in part: The hand hygiene procedures were to be followed by staff involved in direct resident contactReview of the Hand Hygiene Policy (no date), staff were required to execute hand hygiene when the following tasks are performed:After handling items potentially contaminated with blood, body fluids, secretions, or excretionsBefore and after removing glovesAn observation of urinary catheter care by Nurse Aide #4 for Resident #36 was made on 06/24/2026 at 8:52 AM. While Resident #36 was lying in a flat position NA #4 was observed performing indwelling catheter care. NA #4 gathered a wash basin, warm water, and washcloths. NA #4 was wearing gloves to both hands and a gown. NA #4 held and stabilized the indwelling urinary catheter tubing at the point where it exited the perineal (genital) area with her left hand while cleaning the exposed catheter line with her right hand using a washcloth, soap and water. When catheter care was completed, NA #4 assisted Resident #36 to turn on her right side and re-attached her brief. NA #4 positioned Resident #36 for comfort, pulled her linens up, fluffed and repositioned her pillow and placed her pillow behind her head. NA #4 re-adjusted the bed. NA #4 did not remove her gloves and perform hand hygiene after performing urinary catheter care before touching Resident #36 or Resident #36's personal items. NA #4 then picked up the wash basin and washcloths and went to the bathroom to empty the basin. NA #4 removed her gloves while in the bathroom and performed hand hygiene before leaving Resident #36's room. In an interview with NA #4 06/24/2026 at 9:15 AM she verbalized that she should have changed her gloves after catheter care before touching the resident. NA #4 was unsure of her last urinary catheter care training. NA #4 stated her last education training was in a group setting, although she could not remember when. NA #4 stated she recently received a handout related to catheter care. An interview on 06/25/2026 at 12:43 PM with Unit Coordinator #2 who also served as a backup as an infection preventionist nurse, revealed that proper indwelling catheter care procedure included removal of contaminated gloves immediately after completing catheter care and before touching Resident #36 or Resident #36's personal items. Unit Coordinator #2 stated NA #4 should have removed her gloves, performed hand hygiene then put on clean gloves. She stated the nurse aide should have removed her dirty gloves after providing catheter care. She stated Indwelling Catheter Care Education training was completed upon hire and in yearly checkoffs.In an interview with the Director of Nursing (DON) on 06/26/2026 at 10:30 AM it was revealed the situation did not constitute uncleanliness. She stated that it was not inappropriate for the nurse aide to touch or engage with Resident #36 without performing hand hygiene after catheter care. The DON also stated that it was acceptable for the nurse aide to touch Resident #36's personal items without removing her gloves or performing hand hygiene after completing catheter care.In an interview on 06/25/2026 at 4:10 PM the Physician stated that touching Resident #36's personal belongings or pillow after performing indwelling catheter care without first removing contaminated gloves was not consistent with appropriate infection control standards. The Physician continued to state that the risk of harm was considered low, and NA #4 should have removed their gloves and applied new clean gloves before touching the resident or the residents' personal items.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of Resident Council meeting minutes, resident and staff interviews, the facility failed to implement an effective process to resolve and communicate the facility's efforts to address repeated concerns by residents related to lack of weekend housekeeping and unlabeled/missing clothing items, for 2 of 5 months of Resident Council meetings (May 2026 and June 2026).The findings included:The Resident Council meeting minutes were reviewed for May 2026. Under the heading Housekeeping/Laundry, the minutes noted residents' concerns of needing more frequent housekeeping visits on the weekend and multiple unlabeled/missing clothing items.The Resident Council meeting minutes were reviewed for June 2026. Under the heading Housekeeping/Laundry, the minutes had no follow up notated. The minutes noted residents' concerns of needing more housekeeping on the weekend for trash removal and multiple unlabeled/missing clothing items.Resident Council was held on 06/24/2026 at 2:00pm. During the Resident Council meeting, the Residents voiced concern that their grievances were not being addressed (Resident #20, #6, #26, #32, #39, #42, #10, #55, #77, #87, #94, #95). The Resident Council President stated housekeeping and laundry have been a continued concern for the past two months without any resolution.An interview occurred with the Resident Council President on 06/25/2026 at 12:35pm. The Resident Council President discussed not seeing housekeeping on the weekends. She also stated when the facility provided laundry services Resident clothes were not being returned. The Resident Council President stated Residents would have to obtain clothes from the donation area.An interview with the Activities Director occurred on 06/25/2026 at 11:32am. The Activities Director discussed grievances within the Resident Council meeting. She stated that her process for grievances voiced during Resident Council was, she would ask a staff member to join the meeting to handle the grievance immediately or she would verbally inform the Administrator, Director of Nursing (DON), or the Social Worker about Resident Council grievances. The Activities Director stated she did not follow up on the grievances but expected the Administrator, DON, or Social Worker to follow up and inform her of the outcome so she could follow up during the next Resident Council.During an interview with the DON on 06/26/2026 at 10:57am, the DON stated she was unaware that there was a process for grievances related to Resident Council.The Administrator was interviewed on 06/26/2026 at 10:33am. The Administrator discussed Residents being able to voice individual concerns at any time. The Administrator was unable to explain how grievances from Resident Council were being addressed.