STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING _____ B. WING _____	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON REHABILITATION CENTER	509 WEST GANNON AVENUE ZEBULON, NC 27597

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 6/24/24 through 6/27/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #GTF911.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/24/24 through 6/27/24. Event ID# GTF911. The following intakes were investigated NC00214043, NC00209782, NC00216198, NC00216614,and NC00217188. 11 of the 11 complaint allegations did not result in deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident and staff interviews the facility failed to complete a self-administration of medication assessment and care plan self-administration of medication before leaving medication at the bedside for 1 of 5 residents (Resident #5) reviewed for unnecessary medication. Findings included: Resident #5 was admitted to the facility on 3/25/24 with a diagnosis of chronic obstructive pulmonary disease.	F 554	Resident #5 was observed self administering albuterol 90 microgram inhaler safely on 6/24/24 and A Self-Administration evaluation was completed by Director of Nursing/ designee. The resident care plan was reviewed and updated on 6/26/24 by Director of Nursing/ designee. A locked box was obtained and provided to the resident to keep her medications at bedside on 7/8/24. The resident was provided education regarding storage of the Albuterol inhaler in the locked box when not in use by Director of Nursing/	7/12/24

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

Electronically Signed | 07/09/2024

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F 554	Continued From page 1 A review of Resident #5's quarterly Minimum Data Set (MDS) assessment dated 4/7/24 revealed she was cognitively intact. She had impaired functional limitation of range of motion of her upper extremity on one side. Resident #5's record revealed a physician's order dated 5/20/24 for albuterol 90 microgram inhaler 2 puffs inhale orally every 6 hours as needed for wheezing and shortness of breath, may leave at bedside, entered by Nurse #1. No assessment for self-administration of medication was found in Resident #5's record. Resident #5's comprehensive care plan dated last revised on 6/13/24 did not reveal any focus area or interventions regarding self-administration of medication. On 6/25/24 at 8:03 AM Resident #5 was observed returning to her bed from the restroom. She was observed to be short of breath. Resident #5 was observed to sit on the side of her bed, pick up a hand held albuterol (a bronchodilator which opens airways in the lungs) medication inhaler from her bedside table, and administer 2 puffs of the medication to herself orally. An interview with Resident #5 indicated this medication was her rescue respiratory medication. She stated she had been taking the medication for 3 years. She went on to say she took 2 puffs of the medication when she felt short of breath which really helped. Resident #5 reported that because it could take from 15 to 30 minutes for a nurse to come when she needed this medication, her physician allowed her to keep the medication with her to use herself. On 6/26/24 at 1:49 PM an interview with Nurse #1	F 554	designee. On 6/28/24 the Director of Nursing/ designee completed an audit of current facility residents to ensure that residents with orders to self- administer medications and/ or had medication stored at bedside had been observed and are safe to self-administer the medication, no other residents identified. On 6/28/24 the Staff Development Coordinator/ designee will provide education to all licensed nursing staff and interdisciplinary team regarding the facility policy on Self- Administration of Medication, to include completing a self-administration of medication evaluation. Newly hired licensed nurses will receive education during new hire orientation. The Director of Nursing/ designee will observe five sampled residents to ensure that residents identified with medication at the bedside have been evaluated for self-administration of medication and have a Self- Administration of medication evaluation and care plan, and have access to a locked compartment or drawer to store their medications, weekly for 12 weeks. The Director of Nursing/ designee will report the findings of the audits to the Quality Assurance Committee monthly for three months. The committee will review the findings to determine if further action is needed.	

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F 554	Continued From page 2 indicated he obtained the physician's order for Resident #5 to keep her albuterol inhaler at her bedside on 5/20/24. He stated Resident #5 had requested this. He went onto say while he had made sure Resident #5 could use the medication safely herself and would keep the inhaler with her so it would not be accessible to any other residents, he had not completed a self-administration of medication assessment for Resident #5 or added self-administration of medication to her care plan. Nurse #1 reported he knew he was supposed to do these things but had gotten busy and forgotten. On 6/26/24 at 1:54 PM in an interview the Director of Nursing (DON) stated Nurse #1 should have completed a self-administration of medication assessment form and added self-administration of medication to Resident #5's care plan when he obtained the physician's order for Resident #5 to keep her albuterol medication at her bedside. On 6/27/24 at 10:56 AM an interview with the Administrator indicated there should have been a self-administration of medication assessment completed prior to Resident #5 being allowed to keep her inhaler at her bedside and self-administration of medication should have been added to Resident #5's care plan.	F 554		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		7/12/24

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F 641	Continued From page 3 Based on staff interviews and record review the facility failed to accurately code anticoagulant use on a Minimum Data Set (MDS) assessment for 2 of 3 resident reviewed for resident assessments. (Resident #52, Resident #31) Findings included: 1. Resident #52 was admitted to the facility on 4/26/24. Her active diagnoses included stroke, hypertension, and diabetes mellitus. Review of Resident #52's admission Minimum Data Set assessment dated 5/2/24 revealed she was coded as receiving an anticoagulant. Review of Resident #52's Medication Administration Record for 4/2024 and 5/2024 revealed she did not receive an anticoagulant medication during the 7-day lookback period of the Minimum Data Set assessment. During an interview on 6/26/24 at 10:09 AM the MDS Coordinator stated Resident #52 was not on an anticoagulant medication and it was coded inaccurately on the 5/2/24 Admission Minimum Data Set assessment. During an interview on 6/26/24 at 10:44 AM the Administrator stated MDS assessments should accurately reflect the medications the resident was receiving. 2. Resident #31 was admitted to the facility on 5/2/24 with a diagnosis of coronary artery disease. A review of Resident #31's quarterly Minimum Data Set (MDS) assessment dated 5/13/24 revealed he was moderately cognitively impaired.	F 641	Resident #52's admission Data Set assessment dated 5/2/24 revealed she was coded as receiving an anticoagulant however, resident #52's Medication Administration Record for 4/2024 and 5/2024 revealed that she did not receive an anticoagulant medication during the 7-day lookback period of the Minimum Data Set assessment. The MDS coordinator modified the MDS assessment on 6/26/24 to accuratley reflect the medications she was receiving. Resident # 31's quarterly Minimum Data Set assessment dated 5/13/24 revealed that he received anticoagulant medication however, resident 31's Medication Administration Record for 5/2024 did not reveal any documentation of an anticoagulant medication adminsitered to resdient # 31. The MDS coordinator modified the MDS assessment on 6/26/24 to accurately reflect the medication he was receiving. The MDS coordinator/ designee will complete an audit of current residents identified as receiving anticoagulation and antiplatelet medication to ensure the residents MDS data sets were coded correctly on the MDS. This audit was completed on 6/27/2024 with no other residents identified. On 6/27/24 Regional Clinical Director provided education to MDS coordinator regarding coding of MDS High Risk medication in section N related to E-anticoagulation medication and antiplatelet per RAI. Newly hired licensed	

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F 641	Continued From page 4 He received anticoagulant (blood thinning) medication. A review of Resident #31's May 2024 Medication Administration Record (MAR) did not reveal any documentation anticoagulant medication was administered to Resident #31. A review of Resident #31's physician's orders did not reveal any orders for anticoagulant medication. On 6/26/24 at 10:08 AM an interview with the MDS Coordinator indicated she completed the medication section of Resident #31's MDS assessment dated 5/13/24. She stated the look back period for this section would have been 7 days prior to the assessment date. She reported she would have used Resident #31's MAR as a reference to complete the section. She further indicated she did not see now where Resident #31 received any anticoagulant medication. She stated she completed the section incorrectly. The MDS Coordinator stated she could not say why she made the error. On 6/26/24 at 10:44 AM in an interview the Administrator stated Resident #31's MDS assessments should accurately reflect the medication he was receiving.	F 641	nurses will receive education during new hire orientation. The Director of Nursing/ designee will complete an audit of residents identified with anticoagulation and antiplatelet medication to ensure that Section N is coded correclty weekly for 12 weeks. The Director of Nursing/ designee will report the findings of the audtis to the Quality Assurance Committee monthly for three months. The committee will review the findings to determine if further action is needed.	