STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: F 314 Based on staff interview and record review the facility failed to assess a pressure ulcer which transitioned from a stage I wound to a stage II wound per its policy for 1 of 2 sampled residents (Resident #75) who developed pressure ulcers in the facility. Findings include: Resident #75 was admitted to the facility on 09/07/11. The resident's documented diagnoses included right hip fracture and dementia. The resident's 09/07/11 Admission Profile documented the only skin integrity issues the resident presented with were a surgical incision and bruising at multiple sites on her body. 09/16/11 physician orders initiated the use of Nystatin cream and Xenoderm to Resident #75's diaper area twice daily (BID). A 09/16/11 Physical Medicine and Rehabilitation Progress Note documented Resident #75 was being treated for diaper rash.	F 314	On the day of survey completion, all wounds in the Facility were reviewed by the nurses assigned to the residents. Wound documentation sheets were found to be present on those individual records. Following that a Mandatory Education Packet was presented to the Nursing staff to update the knowledge of the staff on staging and measuring wounds as well as available products. The packet also reinforced documentation standards for wound assessments to be 1. Implemented at the time the wound was identified, first measured and staged. 2. Continued weekly on Wednesday after the wound was identified. 3. Documentation of the presence of each wound with numbers corresponding to the wound sheet on the daily flow sheet is also required. 4. Recommended products for wound care in the WakeMed System. (See Attachement # 1, 2) Staff were given time to complete the packet with a 100% attendance rate. This activity is nearly complete. Melanie Johnson, RN, CWOCN was invited to come speak to the staff to provide a classroom learning experience with picture slides and practice on staging as soon as possible. These in-Service dates were 2 weeks after the learning packet was distributed to the staff. These two in-services have been completed with 75 % of the staff attending. (see attachment #3)	11/23/2011 11/23/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
F 314 SS=D	Continued From page 1 A 09/20/11 Physical Medicine and Rehabilitation Evaluation and Management Note documented the only skin integrity issues Resident #75 had were a surgical wound and a healing right eye bruise. The resident's 09/20/11 Admission Minimum Data Set (MDS) documented she suffered from severe cognitive impairment, had no pressure ulcers present but was at risk for pressure ulcer formation, and required extensive assistance from staff or was totally dependent on staff for bathing, bed mobility, transfers, and locomotion on and off the unit. The Pressure Ulcer Care Area Assessment (CAA) generated by the 09/20/11 MDS documented, "_____ (name of resident) does not have any pressure ulcers at this time. She does have a rash in her groin area and receives Nystatin cream to the area. Will continue to monitor skin for problems." The care plan generated by the 09/20/11 MDS identified Resident #75 being at risk for pressure ulcer development as a problem. A 09/23/11 Weekly Wound Measurement Sheet documented Resident #75 had a stage I wound to her right buttock which measured 0.1 x 0.1 centimeters (cm), and which presented without odor, tunneling, undermining, or drainage. The sheet documented the peri-wound was intact. The facility's SYSWD (systemwide) Skin Care, Pressure Ulcer Prevention/Treatment Incontinence, Skin Tear Orders, revised October	F 314	Beginning the following Thursday (11/17) wound sheets and Nurse's Notes will be audited weekly for completion on all residents at risk for skin breakdown for 3 months. The audits will be done by the Supervisor, Manager, and MDS Coordinator. Those who do not document with 100% compliance will be re-educated as soon as is practicable by delivering a Patient Safety Alert and Counseling Session. (Attachment #4) Results will be delivered to the quarterly QI meeting and interventions may be increased bases on the recommendation of the committee. Beginning the first Thursday in February 2012 (at the end of the weekly monitoring for 12 weeks) wound sheets and Nurse's Notes will be audited monthly for completion on all residents at risk for skin breakdown for 9 months. The audits will be done by the Supervisor, Manager, and MDS Coordinator. Those who do not document with 100% compliance will be re-educated as soon as is practicable by delivering a Patient Safety Alert and Counseling Session. Results will be delivered to the quarterly QI meeting and interventions may be increased based on the recommendation of the committee to extend the audits and provide further re-education. If Continuation sheet Page 2 of 8	11/23/2011
F 314	Continued From page 2	F 314		

11/17/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
	2010, documented, "Treatment: Stage 2 Pressure Ulcers: Clean with Normal Saline, apply mepilex 6 x 6 with silicone adhesive to ulcer, and change Q (every) Wednesday and Saturday or PRN (as needed) soilage." A 09/26/11 physician order initiated mepilex to Resident #75's sacrum, to be changed every three days. A 09/26/11 Physical Medicine and Rehabilitation Progress Note documented nursing reported Resident #75 had sacral breakdown, "skin breakdown-mepilex." Record review revealed the 09/26/11 sacral breakdown was not assessed on the Weekly Wound Measurement Sheet, with no wound assessment after the 09/23/11 documentation concerning a stage I wound to the resident's right buttock. There was no documentation of sacral breakdown in Resident #75's Nursing Flowsheet Daily Progress Notes from 09/26/11 through 10/06/11. A 09/27/11 Physical Medicine and Rehabilitation Evaluation and Management Note did not document any problem's with Resident #75's skin integrity. The skin blocks which captured wound sites on Resident #75's Nursing Flowsheet documented on 09/30/11, 10/01/11, and 10/02/11 the resident was receiving mepilex to her sacrum. A 10/04/11 Physical Medicine and Rehabilitation			

If Continuation sheet Page 3 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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) COMPLETI ON DATE
	Evaluation and Management Note documented Resident #75's right hip was healing well, but did not document the presence of any other skin breakdown. A 10/06/11 Discharge Assessment documented Resident #75 was being discharged with a stage II sacral pressure ulcer. At 3:55 PM on 10/25/11 Nurse #1, who documented on the Weekly Wound Measurement Sheet on 09/23/11 that Resident #75 had a stage I wound to the right buttock, stated as far as she knew the stage I reddened area to the resident's buttock healed. She reported she did not think the resident ever hand any open pressure ulcers during her facility stay. At 4:02 PM on 10/25/11 nursing assistant (NA) #1 stated she did not think Resident #75 ever had any open pressure ulcers while in the facility. At 4:07 PM on 10/25/11 NA #2 stated she did not think Resident #75 ever had any open pressure ulcers while in the facility. At 9:23 AM on 10/26/11 Nurse #2 stated he did not remember Resident #75 having any open pressure wounds. However, he reported he thought the resident had some reddened areas to her buttocks which were treated with Nystatin powder. According to Nurse #2, it was facility policy to assess an open wound which developed in the facility on the Weekly Wound Measurement Sheet, and to conduct follow-up assessments weekly, on Wednesdays, which were to be documented on the same form. The nurse commented these assessments were supposed	F 314		

If Continuation sheet Page 4 of 8

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
	to include the location of the wound, the stage of the wound, a description of the wound bed, and documentation about the presence or lack of odor, tunneling, undermining, and drainage. He stated the presence, location, and stage of wounds were also recorded in the skin block on the daily Nursing Flowsheets. At 9:43 AM on 10/26/11 Nurse #3 stated she could not remember anything about Resident #75's skin integrity for sure, but she thought the only intervention used for Resident #75 was Nystatin powder to protect the groin and buttocks area. She reported when a wound was discovered in the facility it was assessed on the Weekly Wound Measurement Sheet. She explained the assessment included measurements, a description of the wound bed and peri-wound, staging of the wound, and documentation about the presence or lack of odor, tunneling, undermining, and drainage. According to this nurse, this same information was gathered and documented on the same form during weekly follow-up assessments, usually conducted on Wednesdays. She stated the presence, type, and location of wounds were also recorded in the skin block on the daily Nursing Flowsheets. At 1:30 PM on 10/26/11 the facility's Manager and Director of Nursing (DON) stated upon discovery of a wound, the hall nurse who found it or who was told about it was responsible for completing a pink Weekly Wound Measurement Sheet. She reported this initial assessment was completed by filling in all the blanks and checking all the boxes on the form. According to the DON, the wound was reassessed weekly on the same form,			
F 314		F 314		

If Continuation sheet Page 5 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
	Continued From page 5 completing all the same information requested on the initial assessment, until the wound healed. After examining Resident #75's Weekly Wound Measurement Sheet, the DON stated ideally the resident's sacral/buttocks wound should have been reassessed when it declined and opened on 09/26/11 and then a week later, but at the minimum the resident should have had at least one more assessment of the wound before discharge on 10/06/11. The DON reported the presence of a wound and any changes, including declines or healing, should be documented on in the Nursing Flowsheet Daily Progress Notes. She also commented the type of wound and location should be documented in the skin block daily on the Nursing Flowsheets. The DON stated the term "skin breakdown" used in the 09/26/11 Physical Medicine and Rehabilitation Progress Note indicated to her that Resident #75 now had an open ulcer on the sacrum. According to the DON, if she remembered correctly, mepilex was a product to be used on open ulcers because it stimulated some tissue growth. After reviewing documentation in Resident #75's chart, the DON stated wound assessments were not completed for the resident as outlined in facility policy.			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		
			If Continuation sheet Page 6 of 8	
F 371	Continued From page 6	F 371		

Tom Bone

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
	This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep kitchenware in storage dry which resulted in a raw food item being placed in wet kitchenware. Findings include: During food preparation observation in the kitchen at 2:08 PM on 10/25/11 eighteen plastic side dishes were found in storage stacked on top of one another inside a quarter tray pan which was sitting on top of the steam table. Steam was rising from the steam table, and all of the side dishes were very wet inside. At 4:48 PM on 10/25/11 the cook had thirteen plastic side dishes sitting on a tray. Twelve of the thirteen side dishes had moisture inside of them. With gloved hands the cook removed tossed salad from a colander, and placed it in one of the wet side dishes. After surveyor intervention, the cook discarded the salad placed in the wet side dish, and rewashed all plastic side dishes by running them through the dish machine. The cook stated he did see moisture in the plastic side dishes which he pulled to contain the tossed salad, and reported he retrieved the side dishes from the tray pan on the steam table where they were stacked on top of one another. At 10:31 AM on 10/26/11 eighteen china plates were stacked on top of one another and turned face down in a well of the steam table which was turned on. Steam was rising from the steam table, and all plates had a film of water on them. At this time the cook stated these plates were		As soon as the Food and Nutrition Staff were made aware that using the steam table to heat plates and bowls was an infection control issue, they changed to using freshly washed side containers from the dishwasher and heating plates in the oven. Each of the 5 staff members are receiving 1:1 education (see content in attachment # 5). A plate warmer was ordered for the Zebulon kitchen on 11/10/2011. In the meantime the plates and side dishes are warmed as described above. The Food Coordinator or Dietitian will conduct weekly unannounced audits for compliance with the new protocols at the breakfast, mid-day and the evening meal for a period of 12 weeks beginning the week of the group Food Service In-service (three meals per week). Audits will be presented at the quarterly QI committee and recommendations from the committee will be followed. Beginning in February 2012 (when the weekly monitoring interval is completed) the Food Coordinator or Dietitian will conduct monthly unannounced audits at the breakfast, mid-day or evening meal for a period of 9 months. Audits will be presented at the quarterly QI committee and recommendations from the committee will be followed. If Continuation sheet Page 7 of 8	11/23/2011 11/23/2011
F 371	Continued From page 7 washed and stacked this morning prior to 9:00	F371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDERS/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345308	A. BUILDING _____ B. WING _____	C 10/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WakeMed Zebulon/Wendell Outpatient and SNF	535 West Gannon Avenue Zebulon, NC 27545

(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
	AM. The dietary manager (DM) reported plates were stacked in the steam well to keep them hot so when residents received their food the temperature of the food would be acceptable. She commented she would look for a source of dry heat so the plates would still would be warm, but would not have moisture on them. At 10:38 AM on 10/26/11 the DM stated kitchenware was supposed to be dry when food was placed in or on it. She reported bacteria could be a problem when moisture was present on kitchenware for long periods of time. At 10:42 AM on 10/26/11 the cook stated she was told to store the plastic side dishes stacked in a tray pan on top of steam table. However, she reported she learned in ServSafe training that kitchenware was supposed to be clean and dry before placing it in storage. She also commented she did not think that kitchenware was supposed to be stacked in storage. The cook stated she learned that moisture trapped between or on kitchenware was dangerous because of bacterial formation. She commented she thought the facility was supposed to be checking into a drying rack to help solve the problem with wet kitchenware.			
			If Continuation sheet Page 8 of 8	

11/17/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345469	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEMED ZEBULON/WENDELL OUTPATIENT & SNF	535 W GANNON AVE 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
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/21/2011 the door to the dry storage room in the kitchen was wedged open. 42 CFR 483.70 (a)	K 029	K 029 • Food and Nutrition staff were re-educated the day of survey that no unattended door may be propped. • A general reminder will be given to all WMZ staff not to prop a door with anything when a door is not in active use to get patients or equipment in and out of the space. • Generally doors are only held open for use by a staff member not a door stop device. • The nursing supervisor will audit proper closing of doors weekly X 12 weeks and then monthly submitting data to the quarterly QI committee. • Audits will be continued based on recommendations from the committee. • Door stop devices found at WMZ are forbidden (attachment 1).	1/5/2012
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 11/21/2011 the staff	K 050 SS=D	• The day of survey the employees present were re-educated on the missed component of the fire drill procedure. That is, Use a pull station when a fire or signs of fire are identified. • A Mandatory re-education packet will be distributed to all WMZ Employees to study fire drill components. • Audits of staff knowledge of all components will be done unannounced and randomly every week for 12 weeks beginning the first week in December. • After the 12 week period audits will go to monthly. • All audit data will be submitted to the quarterly QI committee. Education and monitoring will be increased based on less than 100% accuracy in employee response to knowledge questions of the drill (Attachment 2).	1/5/2012

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

12/7/11

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.

CD

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345469	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKEMED ZEBULON/WENDELL OUTPATIENT & SNF	535 W GANNON AVE 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
K 050	Continued From page 1 interviewed did not know the fire drill procedure. 42 CFr 483.70 (a)	K 050		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation on 11/21/2011 there were 02 cylinders that were not secured stored in the room out side. 42 CFR 483.70 (a)	K 076	• The maintenance mechanic from Property Management secured the two unsecured tanks the day of survey. • An additional oxygen storage cart was ordered. • The addition of 12 storage sections will insure that there is always enough space available to secure oxygen tanks in the future. • The clinical staff members have been re-instructed not to leave tanks unsecured in the oxygen storage area (see attachment3). • The nursing supervisor or her designee will audit the oxygen storage areas weekly to be sure tanks are secured for a period of three months. • Audits will be submitted to the QI committee and should audits be <100% the supervisor will repeat education of clinical staff regarding oxygen storage and audits will continue. (see monitoring sheet attachment 1, pg 2)	1/5/2012

12/7/11

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

FORM APPROVED

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
345469	WAKEMED ZEBULON/WENDELL OUTPATIENT & SNF

Type of Survey (select all that apply)

[I]

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life Safety Code
I Recertification
J Sanctions/Hearing
K State License
L CHOW
M Other

Extent of Survey (select all that apply)

[A]

A Routine/Standard Survey (all providers/suppliers)
B Extended Survey (HHA or Long Term Care Facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's identification number.

Surveyor ID Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
Team Leader ID								
1. 20019	10/24/2011	10/26/2011	1.50	0.00	19.75	0.00	3.25	0.50
2. 18975	10/24/2011	10/26/2011	0.50	0.00	19.75	0.00	3.25	6.50
3. 22445	10/24/2011	10/26/2011	0.50	0.00	19.75	0.00	3.25	0.50
4. 29131	10/24/2011	10/26/2011	0.50	0.00	19.75	0.00	3.25	0.50
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								

Total SA Supervisory Review Hours..... 5.00

Total RO Supervisory Review Hours.... 0.00

Total SA Clerical/Data Entry Hours.... 2.00

Total RO Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey?.... No