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 _____	10/20/2016

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
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and review of records, the facility failed to provide a call bell that could be easily engaged for 1 of 1 resident (Resident #58) with limited upper extremity mobility. Findings included: Resident #58 was admitted on 5/24/16 with diagnoses that included hemiplegia and hemiparesis secondary to a stroke and generalized muscle weakness. The 8/31/16 Quarterly Minimum Data Set revealed Resident #58 was moderately cognitively impaired. Extensive to total assistance was required for all activities of daily living. Resident #58 was identified with functional limitation in range of motion with one upper extremity and one lower extremity. The resident's care plan, revised on 9/12/16 identified the resident's functional impairment in joint mobility due to contractures of the left hand, left arm and left knee.	F 246	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the centers allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. 1. Resident number #58 had his call bell replaced with a padded bell and placed within reach. 2. Any resident requiring the use of a call bell to communicate needs in the facility can be affected by this practice. Facility DON did audit of residents requiring a call bell to communicate needs to assure call bell is appropriate for engagement and in place. Audit was completed on 11-2-16.	11/7/16

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

Electronically Signed | 11/04/2016

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 _____	10/20/2016

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
F 246	Continued From page 1 On 10/17/16 at 2:48 PM, Resident #58 was interviewed and observed. The call bell was positioned on the right side of the resident at shoulder height. The resident was unable to reach the call bell. When the call bell was placed in the resident's hands, he tried to engage the call bell, but stated he was unable to push the button to engage the call system. Resident #58 stated when he needed help, he either yelled out or just waited for a staff member to come by his room. The resident demonstrated he was unable to fully extend his left hand or raise his left arm. An observation was made on 10/18/16 at 2:45 PM. The resident was sleeping. The call bell was positioned on the right side of the resident, fastened to the pillow, at the height of Resident #58 ' s head. An observation was made on 10/19/16 at 8:00 AM of Resident #58 lying on his left side, facing the wall. The call bell was positioned at shoulder height on the right side. Resident #58 was heard calling for help. Nursing Assistant (NA) #1, who was the closest staff member, and found approximately 4 rooms from the resident, was asked to see what Resident #58 needed. At 1:30 PM on 10/19/16 an observation was made of the resident. He was lying in bed with his call bell placed on top of the covers within his reach. The resident stated although it was close, he was unable to use the call bell because he could not push the button. NA #2 was interviewed on 10/19/16 at 1:46 PM. The NA stated Resident #58 could ring the call bell for assistance. She acknowledged the resident had contractures of his arms, but stated	F 246	3. DON will educate staff by 11-7-16 on the importance of assuring residents needing a call bell to communicate needs have an appropriate call bell within reach, that can be easily engaged by resident. DON will do audit of 3 residents weekly times 6 weeks to assure call bell is in place and easily engaged by resident. 4. The Quality Assurance Committee will discuss and review the results of the audits monthly for 3 months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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 _____	10/20/2016

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
F 246	Continued From page 2	F 246		

his hands were not contracted. NA #2 stated due to the limited movement of Resident #58, he was unable to reach the call bell if it was behind him on the right side while lying on his left side and was unable to reach the call bell if had been placed at level of his head when he was in bed. The NA stated while she was assigned to care for Resident #58, she was not the one that had placed the call bell out of reach.

NA #1 was interviewed on 10/19/16 at 2:00 PM. The NA stated when the surveyor had asked her to assist Resident #58 he had wanted his legs uncrossed because having his legs crossed had not been comfortable. The NA was unable to remember how the resident was lying in bed and added she was unable to remember where the call bell had been positioned. NA #1 stated while Resident #1 could use the call bell, he rarely did because he preferred to call for help. NA #1 added if the call bell had been positioned by the resident ' s head he would have been unable to reach the bell since his range of motion was limited in his right arm.

On 10/19/16 at 3:03 PM, Nurse #1 was interviewed. She confirmed Resident #58 had contractures of the left hand and arm. The nurse added Resident #58 used the call bell infrequently and preferred to yell for help. At 3:25 PM, an observation of Resident #58 was made with Nurse #1. The resident was lying in bed with his hands under the covers and the call bell positioned over his hands on top of the covers. Nurse #1 instructed Resident #58 to remove his hands from under the covers. Resident #58 replied to Nurse #1 that he was unable to remove his hands from under the covers independently. Nurse #1 then placed the call bell in Resident #58

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 _____	10/20/2016

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
F 246	Continued From page 3 ' s hands and requested he engage the call system. The resident tried to engage the call system, but informed the nurse he was unable. Nurse #1 stated she was requesting a pad bell for Resident #58 so he could place his hand on the bell to call for assistance. The nurse stated even with full mobility, it would have been difficult for Resident #58 to engage the call system if the bell had been placed on his right side since his left side was contracted and movement was limited. An observation was made on 10/20/16 at 9:00 AM. Resident #58 was lying in bed with the pad bell in place. The resident acknowledged he was able to use the pad call bell to request assistance.	F 246		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record review, the facility failed to maintain a medication error rate of less than 5%. The facility had 3 errors in 25 opportunities for a medication error rate of 12%. Findings included: Resident #103 was admitted on 4/5/16 with diagnoses that included cervical disc disorder with myelopathy, spinal stenosis, chronic pain syndrome, anxiety disorder, major depression	F 332	1. DON notified MD on 10/18/16 for resident number #103. New orders were received for medication administering times for Xanax and Baclofen. 2. Any resident requiring medication administration can be affected by this practice. Licensed Nurses will be in serviced by 11-7-16 by DON regarding parameters of medication administration related to time constraints. Staff will also be educated by DON by 11-7-16 on the	11/7/16

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 _____	10/20/2016

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
F 332	Continued From page 4 and rheumatoid arthritis. The 10/5/16 Quarterly Minimum Data Set (MDS) indicated Resident #103 was alert and oriented, required extensive assistance with all activities of daily living except eating. The MDS indicated the resident was almost constantly in pain and the pain affected Resident #103 ' s ability to sleep and limited her day to day activities. The resident described the pain as very severe/horrible. Antianxiety medication was coded as given 7 days during the assessment period. Review of Resident #103 ' s October 2016 physician ' s orders indicated she received Baclofen (a muscle relaxant), 20 milligrams (mgs) four times a day. The scheduled times for the Baclofen was listed as 9:00 AM, 1:00 PM, 5:00 PM and 9:00 PM. The resident ' s Xanax 0.5 mgs was listed to be given three times daily at 9:00 AM, 1:00 PM and 5:00 PM. Resident #103 was scheduled to receive Morphine Sulfate (MS Contin) 60 mgs for pain at 6:00 AM, 2:00 PM and 10:00 PM On 10/18/16 at 3:05 PM, during medication pass, Nurse #2 prepared Baclofen 20 mgs and Xanax 20 mgs to be given to Resident #103. When the nurse took the medications into the room, the resident looked at the cup of medications and stated, "I was supposed to get something for pain at 2:00 PM". Nurse #2 informed the resident she would review the Medication Administration Record (MAR). On review of the MAR, the nurse commented she had not turned to the last page and therefore had not seen the resident ' s MS Contin was due at 2:00 PM. The nurse then took the pain medication to the resident.	F 332	policy of MD notification if medication administration times are not within parameters for further MD orders prior to giving medication. 3. DON will observe 1 resident AM med pass 1 times a week for 6 weeks. DON will observe 1 resident PM med pass 1 times a week for 6 weeks. 4. The Quality Assurance Committee will discuss and review the results of the audits monthly for 3 months. Suggestions and recommendations will be made as needed by the Quality Assurance Committee to ensure compliance is sustained ongoing.	

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 _____	10/20/2016

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
F 332	Continued From page 5	F 332		

On interview at 3:15 PM, Nurse #2 stated she would have found the MS Contin omission when she reviewed the MAR prior to leaving work. The nurse added she had 1 hour before and 1 hour after any scheduled medication to give the medication. The nurse stated based on that, the MS Contin was late. She added she usually worked at the desk and was not familiar with the residents or the medication they received. Nurse #2 stated she had arrived around lunch to fill in for a nurse that had left early. The nurse stated she was unaware of any facility policy or procedure that had to be completed when a medication was not given at the right time. The nurse did not acknowledge she had given the Xanax and Baclofen more than 2 hours after the scheduled time.

Nurse #3 was interviewed on 10/18/16 at 4:37 PM. The nurse stated the facility policy was to administer medications 1 hour before or after the scheduled time. He stated if the medications were not given within that time frame, the physician should be notified for guidance in giving the missed medications. Nurse #3 stated Nurse #2 had told him Resident #103 ' s MS Contin had been given at 3:15 PM instead of the 2:00 PM scheduled time. Nurse #3 added Nurse #2 had not informed him that Resident #103 had not received her 1:00 PM scheduled Baclofen and Xanax until 3:15 PM. Review of the MAR with Nurse #3 indicated Nurse #2 had not documented she gave Resident #103 the Baclofen, Xanax or the MS Contin. Review of the narcotic count sheet with Nurse #3 revealed Nurse #2 had documented she gave the MS Contin and Xanax at 3:15 PM.

The Director of Nursing (DON) was interviewed

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 _____	10/20/2016

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
F 332	Continued From page 6 on 10/18/16 at 4:50 PM. She stated if medications were not given within the parameters of the scheduled time, which was 1 hour before or 1 hour after the scheduled time, she expected nurses to notify the resident ' s physician for further instructions. The DON added Nurse #2 should have notified the physician that she had given the MS Contin over an hour late and notified the physician that Resident #103 ' s Xanax and Baclofen had been given over 2 hours past the scheduled administration time. At 5:00 PM, the DON reported the MD had been notified and had ordered the Xanax to be held until 8 PM. An interview was held with Resident #103 on 10/20/16 at 11:00 AM. She stated she had remembered getting her pain medication late and remembered getting her Baclofen and Xanax late. The resident stated the effects of receiving her medications late consisted of getting really stiff, increased anxiety and her pain returning sooner than it should.	F 332		