PRINTED: 10/12/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345104		B. WING	B. WING		C 09/08/2017		
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2011
ZEDIII ON	REHABILITATION CENT	rep		5	509 WEST GANNON AVENUE		
ZEBULUN	REHABILITATION CENT	IEK		Z	ZEBULON, NC 27597		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
170			1,10		DEFICIENCY)		
F 281	281 483.21(b)(3)(i) SERVICES PROVIDED MEET			281			10/2/17
SS=D	PROFESSIONAL STA		F	20 I			10/2/17
55=D	1 Hot Eddio! WE divined						
	(b)(3) Comprehensive	e Care Plans					
	The services provided	d or arranged by the facility,					
		mprehensive care plan,					
	must-						
	(i) Meet professional	standards of quality					
	` · ·	is not met as evidenced					
	by:						
	1 =	ews and staff interviews, the			The statements included are not an		
	facility failed to provid	le appropriate			admission and do not constitute		
		lude documentation and			agreement with the alleged deficiencies	3	
	transportation to mee				herein. The plan of correction is		
	1	135) resulting in a capsule			completed in the compliance of state a		
	scheduled.	e not being conducted as			federal regulations as outlined. To remain compliance with all federal and state		
	Scrieduled.				regulations the center has taken or will		
	Findings included:				take the actions set forth in the following		
	i mango moradoa.				plan of correction. The following plan of		
	Resident #135 was a	dmitted to the facility on			correction constitutes the centers		
	10/14/16 and dischar	ged on 10/20/16. He was			allegation of compliance. All alleged		
	readmitted on 10/28/	16 and discharged on			deficiencies cited have been or will be		
		nt had multiple diagnoses			completed by the dates indicated.		
	I .	respiratory failure with					
	1	ructive pulmonary disease			1. Resident named in citation was	ĺ	
		, encephalopathy, heart			discharged from facility on 12/17/2016.		
	1	al hemorrhage, and iron			2 Any resident requiring an autoide		
	deficiency anemia.				Any resident requiring an outside service or appointment per MD order	ĺ	
	The care plan dated *	11/04/16, documented that			could be affected by this practice.		
		kygen therapy, peripheral			Therefore, the DON/IDT team complete	ed	
	I .	ase, type II diabetes, pain, a			a facility audit on 9/21/2017 of resident		
		and activities of daily living			appointments for past 30 days to ensur		
		rmance deficit. He was also			the proper documentation and		
		ficit, had four pressure			communication was evident in the med	ical	
	ulcers and was at risk				record.		
	development and had	I bladder incontinence.					
ARODATORY.	NIDECTOR'S OR PROVINER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITI F		(X6) DATE

09/27/2017 **Electronically Signed**

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.

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		345104	B. WING		C 09/08/2017	
	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	, 33,33,23,1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 281	set (MDS) dated 11/2 #135 had a brief inter (BIMS) score of 15; n impairment. The residuassistance with bed in Supervision was neede eating. Limited assist dressing and personal independent with battrejected care one to the pain management. The hospital discharge included a recomment endoscopy to be come gastroenterology clinic. The facility had a cale transportation book we for residents' appoint Resident #135's name the address of the mean appointment were dought time was needed to be at the atthe appointment time the appointment time the appointment place the written area with space. Documentation for the prescription for the befaxed to the attention 11/30/16 from the gasting as the side of the mean pointment time the appointment time the appointment time the appointment place the written area with space.	ent, on the minimum data 9/16, reported that Resident view for mental status of likely cognitive dent required extensive mobility and transfers. Deed for locomotion and ance was required for all hygiene. He was being. Resident #135 had here days and was receiving the summary dated 10/28/16 dation for a capsule pleted at the contact of the comments outside the facility. The elong with the name and edical center for the commented in the commented in the swritten stating the resident prointment one hour prior to and the contact number for e. A line was marked over cancelled written in the contact number and the contact number for e. A line was marked over cancelled written in the contact number and the contact number for e. A line was marked over cancelled written in the contact number and the contact number for e. A line was marked over cancelled and the contact number for the contact	F 28	3. The DON in serviced licensed st beginning 9/27/2017 to be complete 10/2/2017, regarding the expectatio communicating and documenting in medical record any changes in appointments or transportation arrangements. The DON/IDT team clinical rounds will audit the appointment/transportation book to ensure any changes from the previously appointment or transportation arrangements have been communicated and documented in the resident me record detailing the changes. 4. Results of the clinical rounds will brought to QA by the DON for 2 mo for review by the IDT team.	ed by ns for the during ous cated dical	

Facility ID: 923220

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345104	B. WING	B. WING		C 09/08/2017	
	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 09 WEST GANNON AVENUE 12 EBULON, NC 27597	1 03/	00/2017
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 281	have clear liquids on 6:00 PM, drink 8 ound solution every 15 min was gone. The reside or drink anything (NP 12/13/16, the day of twas supposed to star ounces of the bowel of minutes until the remaining of the medication and for 11/08/16 to 11/30/information (FYI) note "12/13/16 appointment day". A physician's order w stated mix the bowel directed at 6:00 PM the Drink 8 ounces every gone. At 5:00 AM, the repeat until gone. No order. Per the December 20 received his iron supprior to the procedure. No iron supprior to the procedure documented on the Drink administrator and (DON) were interview. AM. The administrator were familiar with Resident and the procedure familiar with Resident	en days prior to the 6." The resident was to 12/12/16. On 12/12/16 at ces of the bowel cleansing utes until half the container ent was not supposed to eat O) after midnight. On the procedure, the resident t at 5:00 AM and drink 8 cleansing solution every 15 ainder was gone. Iministration record (MAR) 16, there was a for your e written which said at; 12/12/16 clear liquids all as written on 12/12/16 cleansing solution as the day before the procedure. 15 minutes until half was the day of the procedure; time was written on the In 6 MAR, the resident clement from 12/01/16 to no documentation on the the in reference to this upplements for seven days to on 12/13/16 was not	F	281			

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345104	B. WING		C 09/08/2017	
	ROVIDER OR SUPPLIER REHABILITATION CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	1 09/00/2011	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 281	interviewed via pho why Resident #135 on 12/13/16. Nurse #1 was interval AM and stated the abecause Resident # that should have be appointment was rewas unsure of the crescheduled. She swant to go anyway" appointments at time admission and discrounds were conductive resident's assess completed and that were scheduled. Nurphone call from the the documents wern urse reported that bowel cleansing solution. The DON was interval and she stated that the 200 hall at the enurse and UM assistant.	13/16. 23 AM, Nurse #2 was ne. Nurse #2 was not sure is appointment was cancelled viewed on 09/08/17 at 11:44 appointment was cancelled if 135 had medications given then held. She stated that the escheduled a prior time but late or why it was tated "The resident did not . The MDS nurse scheduled the state of the harge paperwork. Clinical ceted each morning to ensure appointments and follow upsurse #1 stated she took the gastroenterology clinic and the faxed to her attention. The the resident refused the ution prep. Viewed on 09/08/17 12:24 PM she reviewed the MARs on and of each month. The MDS sted in reviewing the 100 hall	F 28			
	coordinator (SDC) a month reviews were before the end of the information was use book but not on the prep details were por The DON stated a re-	re was no staff development at that time. The end of the e usually done one week e month. Appointment ually written on the calendar MAR. Telephone orders and ut on the MAR for each month. nursing note should be written ed an appointment or prep.				

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		345104	B. WING _			C 09/08/2017
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597		33/00/2017
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 4	F 2	81		
	phone on 09/08/17 doctor stated Resid the procedure if that On 09/08/17 at 1:17 the UM wrote the in book and would set looked through the electronic medical monotes as to why cancelled. She also orders were dated by time in which the order with t	r PM, the DON advised that formation in the appointment up transport. The DON resident's paper chart and the ecord and stated there were the appointment was advised that physician's but did not always contain the der was written. Tiewed via phone on 09/08/17 scribed the resident, was gnoses and stated that he was the nurse stated that he was the stated that Resident #135 is at times and therapy much alled the resident would often k, wasn't able to do it or just the resident having an 13/16 but that he had the right d the appointment should be simissed and the desk nurse reschedule it. If a procedure mary provider and the clinic he RP should be contacted				
	Director (RCD) advi	PM, the Regional Clinical sed that the transport facility cancelled the date and time.				

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	COMP	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER ZEBULON REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) EXAMPLE STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANCE COMPLIA			345104	B. WING _		ı	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE: DATE:			TER		509 WEST GANNON AVENUE	1 00/	00/2017
	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETION DATE
F 281 Continued From page 5 F 281	F 281	Continued From page	e 5	F 2	81		
The primary provider was contacted again via phone on 09/08/17 at 1:52 PM. He advised that with the resident's history of multiple diagnoses, Resident #138 was not a surgical candidate. The procedure wouldn't have made any difference in the resident's outcome. With the resident on iron daily, there was not hing else that could have been done even if the test was conducted. On 09/08/17 at 2:41 PM, Nurse #4 was interviewed via phone. She stated she did remember the resident. The nurse reported that she would not have cancelled transport for a resident having a procedure done and that she was not the one the ambulance service spoke with that morning. On 09/08/17, the RCD stated she was informed by the ambulance service that the transport was scheduled on 11/30/16 by Nurse #1. The ambulance service arrived at the facility on 12/13/16 at 5:56 AM and they were told the transport was cancelled at 6:06 AM. No reason was provided for the cancellation. F 323 483.25(d/1)(2)(n/(1)-(3) FREE OF ACCIDENT F 323 SS=D (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use		phone on 09/08/17 a with the resident's his Resident #135 was a procedure wouldn't his the resident's outcome daily, there was noth been done even if the On 09/08/17 at 2:41 interviewed via phone remember the reside she would not have or resident having a prowas not the one the awith that morning. On 09/08/17, the RC by the ambulance service a 12/13/16 at 5:56 AM transport was cancel was provided for the 483.25(d)(1)(2)(n)(1) HAZARDS/SUPERV (d) Accidents. The facility must ensite the condition of the days of the condition of	t 1:52 PM. He advised that story of multiple diagnoses, not a surgical candidate. The ave made any difference in the With the resident on iron ing else that could have the test was conducted. PM, Nurse #4 was the stated she did not. The nurse reported that cancelled transport for a produce done and that she cambulance service spoke. D stated she was informed rice that the transport was 16 by Nurse #1. The prived at the facility on and they were told the led at 6:06 AM. No reason cancellation. -(3) FREE OF ACCIDENT ISION/DEVICES ure that - ronment remains as free is as is possible; and the eives adequate supervision the eives adequate supervision the story of the story of more than the story of	F3	23		10/2/17

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	ROVIDER OR SUPPLIER	TER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	1 03/00/2011	
(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 APPROPRING DEFICIENCY)		
F 323	bed rail. If a bed or s must ensure correct i maintenance of bed r to the following eleme (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the retailed informed consent prior (3) Ensure that the beappropriate for the retailed for the retailed informed consent prior (3) Ensure that the beappropriate for the retailed for the retailed for the retailed for the retailed for the findings included (3) Ensure that the beappropriate for the retailed for the findings included (4) Ensure that the findings included (5) Ensure that the findings included (6) Ensure that the findings included (7) Ensure that the findings included (8) Ensure that the beappropriate for the resident sampled for the findings included (8) Ensure that the beappropriate for the resident sampled for the findings included (8) Ensure that the beappropriate for the resident sampled for the findings included (8) Ensure that the beappropriate for the resident sampled for the findings included (8) Ensure that the beappropriate for the resident sampled for the findings included (8) Ensure that the beappropriate for the resident sampled for the	es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents. Int for risk of entrapment installation. Ind benefits of bed rails with int representative and obtain or to installation. Indicated a side of the desired entrapment installation. Indicated entrap	F 32	1. Resident number 86 had his handhed control device replaced. 2. Any resident with a handheld bed control device could be affected by thit deficient practice. Therefore, the Maintenance Director of 9/8/2017 completed an audit of facility beds with handheld controls to assure device was free from exposed internal wiring. Repairs were completed if warranted in results of audit on 9/8/20 Maintenance Director and Maintenance assistant were in serviced by the Administrator on 9/8/2017 on the importance of assuring that resident be control devices are free from exposed internal wiring. 3. Maintenance Director and Maintenance assistant were in service the Administrator on 9/8/2017 on the	n the 17. e	

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		345104	B. WING _			C	
NAME OF D	ROVIDER OR SUPPLIER	343104		STREET ADDRESS, CITY, STATE, ZIP COD	•	09/08/2017	
NAIVIE OF PI	ROVIDER OR SUPPLIER			, , , ,	_		
ZEBULON	REHABILITATION CENT	TER		509 WEST GANNON AVENUE ZEBULON, NC 27597			
(X4) ID PREFIX TAG			DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		RRECTION N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 323	F 323 Continued From page 7		F 3	23			
F 323	Continued From page 7 On 9/7/17 at 10:25am an observation of the same bed control device revealed it continued to have exposed wires. Additional observation revealed a sign on the wall that provided the name of the "guardian angel" for that room. During an interview on 9/7/17 at 10:31am Housekeeper #1 stated she was responsible for cleaning rooms on that hall which included cleaning the cords for the call bells or any other cords in the room. She stated if she had any concerns about the equipment in the room, including any exposed wires, she would tell the maintenance staff and/or write it in the maintenance log book. During an interview on 9/8/17 at 10:00am the Maintenance Director stated beds were randomly monitored for safety concerns and that he completed rounds frequently but the rounds were conducted on random rooms. He stated he did not have any documentation about the random		F3	importance of assuring that resident bed control devices are free from exposed internal wiring. The Maintenance Director will add to the weekly Preventative Maintenance rounds starting 9/11/2017 the checking of resident bed control devices to assure the device is free from exposed internal wiring. 4. Results of the Preventative Maintenance rounds will be brought to Q times 2 months.			
	described "guardian a each of the departme to certain residents' rowith the assigned res and monitor the room concerns. On 9/8/17 at 10:05am control cord revealed exposed wires. The other name of the "guarwas the same as the helper. During an interview of	observation also revealed rdian angel" for the room name of the maintenance n 9/8/17 at 10:29am the rand maintenance helper					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345104	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	345104	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	09	/08/2017	
7EBULON	DELIABII ITATION CENT	ren		509 WEST GANNON AVENUE			
ZEBULUN	REHABILITATION CENT	IEK		ZEBULON, NC 27597			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		D BE	(X5) COMPLETION DATE	
F 371 SS=D	observed the bed corcord should have been not have exposed with helper stated he had angel" rounds earlier observe the cord with During an additional in Maintenance Director stated the facility did angel rounds but if the anything that involved be put into the mainterevealed no document device or any expose 483.60(i)(1)-(3) FOOI STORE/PREPARE/S (i)(1) - Procure food for considered satisfactor authorities. (i) This may include for from local producers, and local laws or regulations from using progradens, subject to consider growing and food from consuming food from consuming food	The Maintenance Director atrol device and stated the en replaced with one that did es. The Maintenance completed the "guardian this week and he did not a the exposed wires. Interview with the end one of the one of the one of the exposed wires are was a concern with distance log. Interview with the end of the one of		371		10/2/17	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	TER		50	TREET ADDRESS, CITY, STATE, ZIP CODE D9 WEST GANNON AVENUE EBULON, NC 27597	1 03/	00/2017
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 371	(i)(3) Have a policy refoods brought to resivisitors to ensure saft handling, and consult This REQUIREMEN' by: Based on observation facility failed to 1) proto eat foods and the 4 nurse aids (NA) ob and 2) failed to use a service worked who beard cover duing 2 Findings included: 1. a. On 9/05/2017 a observed serving lun resident's room. NA: slice of bread, take the with her bare fingers #53's lunch tray. An interview with NA 9/05/2017 at 12:10 Findings included: 1. b. On 9/05/2017 at 12:10 Findings included: 3. b. On 9/05/2017 at 12:10 Findings included: 4. b. On 9/05/2017 at 12:10 Findings included: 5. c.	ressional standards for food regarding use and storage of dents by family and other re and sanitary storage, mption. To is not met as evidenced rons and staff interviews, the poide a barrier between ready servers' bare hands for 2 of served during meal service a hair restraint for a food was observed not wearing a	F	371	1. No resident was named in this citati 2. Facility staff were in serviced on the importance of providing a barrier between ready to eat foods and the servers han by DON/Administrator on 9/27/2017. Facility staff were in serviced by DON/Administrator on 9/27/17 on the importance of wearing a hair restraint/beard guard cover for any staff the kitchen area. 3. The Administrator will audit the kitch area and meal delivery areas 1 time da 3 times a week/ times 6 weeks to assurthat proper handling of food includes providing a barrier between ready to ea foods and the servers hands. Audit will also assure hair restraints and beard covers are utilized in the kitchen area during these audit times. 4. Results of audit will be brought to Quitimes 2 months by Administrator.	een ds ff in nen nilly/ re	

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F 371	An interview with the conducted on 9/08/2 stated staff should no with bare hands. An interview with the was conducted on 9/DON stated staff should food with bare hands 2. During the initial to 9:55 am Food Service removing clean dished was observed to have wearing a beard cover over the plate have a beard and was On 9/8/17 at 9:00 am beard covers were a	d her bare hand to place the resident's tray. Dietary Manager (DM) was 017 at 8:54 AM. The DM of touch the residents' food Director of Nursing (DON) 08/2017 at 11:04 AM. The huld not touch the residents' is our of the kitchen on 9/5/17 at the Worker #1 was observed the from the dishwasher. He the a beard. He was not the error of the lunch meal tray line 12:15pm Food Service wing the plated food from the te tray and putting the dome of food. He continued to the sign of the literary Manager stated	F3	71		
F 514 SS=D	when working in the 483.70(i)(1)(5) RES	nould wear a beard cover kitchen. ETE/ACCURATE/ACCESSIB	F 5	14		10/2/17
	standards and practi	th accepted professional ces, the facility must ords on each resident that				

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(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE COMPLETION
F 514	(iii) A record of the record o	nented; ple; and rganized prd must contain- tion to identify the resident; sident's assessments; sive plan of care and services ry preadmission screening evaluations and ucted by the State; e's, and other licensed ess notes; and plogy and other diagnostic equired under §483.50. T is not met as evidenced riews and staff interviews, the de complete and accurate of 1 residents (Resident	F 514	1. Resident named in citation was discharged from facility on 12/17/201 2. Facility residents can be affected to this deficient practice. Therefore, the DON/IDT team did audit on 9/21/201	ру
	Findings included: Resident #135 was a	admitted to the facility on		residents with appointments for past days to assure that MD orders were transcribed correctly and appointmen	30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345104	B. WING _			C 09/08/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	I ZIP CODE	03/06/2017	
				509 WEST GANNON AVENUE			
ZEBULON REHABILITATION CENTER			ZEBULON, NC 27597				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 514	readmitted on 10/28 12/17/16. The reside that included chronic hypoxia, chronic obs (COPD), emphysem failure, gastrointestin deficiency anemia. The hospital discharincluded a recomme endoscopy to be corgastroenterology clin. The facility had a catransportation book for residents' appoint Resident #135's narmedical center for the documented in the total 12/13/17. The 8:00 a written stating the reappointment one hotime and the contact place. A line was may with "cancelled" written to the contact place in the total place. A line was may with "cancelled" written to the contact place in the contact place. A line was may with "cancelled" written to the contact place in the contact place. A line was may with "cancelled" written to the contact place in the contact place. A line was may with "cancelled" written the contact place in the contact place. A line was may with "cancelled" written the contact place in the contact plac	riged on 10/20/16. He was /16 and discharged on ent had multiple diagnoses or respiratory failure with structive pulmonary disease a, encephalopathy, heart hal hemorrhage, and iron ge summary dated 10/28/16 an	F 5		during clinical D orders to ensure ccurate for I in service license arding expectation of MD orders to expectation of MD orders to added to the ess for new all rounds will be DN for 2 months		
	11/30/16 from the gainstructions for the p AM, stated "arrive at supplements for sev procedure on 12/13/ have clear liquids or 6:00 PM, drink 8 our solution every 15 mi						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345104	B. WING _			C 09/08/2017	
NAME OF PROVIDER OR SUPPLIER ZEBULON REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	<u>'</u>	30/00/2011	
(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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 514		PO) after midnight. On	F 5	14			
	was supposed to sta	the procedure, the resident rt at 5:00 AM and drink 8 cleansing solution every 15 nainder was gone.					
	for 11/08/16 to 11/30 information (FYI) not	dministration record (MAR) /16, there was a for your e written which stated ent; 12/12/16 clear liquids all					
	order read mix the bidirected at 6:00 PM Drink 8 ounces even gone. At 5:00 AM, the	vas written on 12/12/16. The owel cleansing solution as the day before the procedure. y 15 minutes until half was e day of the procedure; o time was written on the					
	received his iron sup 12/17/16. There was December 2016 MAI procedure. No iron s	upplements for seven days e on 12/13/16 was not					
	(DON) were interview AM. The administrativere familiar with Re	nd the Director of Nursing wed on 09/08/17 at 10:30 or and the DON stated they esident #135 but they were sident did not go to his 3/16.					
	-	3 AM, Nurse #2 was e. Nurse #2 was not sure appointment was cancelled					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345104	B. WING _			C 09/08/2017	
	ROVIDER OR SUPPLIER REHABILITATION CEN	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	<u>'</u>	30,00,2011	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	TION SHOULD BE COMPLE THE APPROPRIATE DAT		
F 514	AM and stated the a because Resident # that should have be appointment was rewas unsure of the direscheduled. She st want to go anyway". appointments at time admission and discrounds were conduct the resident's assess completed and that were scheduled. Nu phone call from the the documents were	iewed on 09/08/17 at 11:44 ppointment was cancelled 135 had medications given en held. She stated that the scheduled a prior time but ate or why it was ated "The resident did not The MDS nurse scheduled es due to having the harge paperwork. Clinical sted each morning to ensure sment and care plans were appointments and follow ups rse #1 stated she took the gastroenterology clinic and faxed to her attention. The sche resident refused the	F 5	14			
	The DON was intervand she stated that the 200 hall at the enurse and Unit Manareviewing the 100 hands staff development time. The end of the done one week before Appointment informathe calendar book borders and prep deteach month. The Doshould be written if the appointment or preportion of the resident's primare phone on 09/08/17 and the calendar book borders and prep deteach month. The Doshould be written if the appointment or preportion of the primare phone on 09/08/17 and the calendar book borders and prep detection of the primare phone on 09/08/17 and the calendar book borders and prepared the calendar borders and the	riewed on 09/08/17 12:24 PM she reviewed the MARs on and of each month. The MDS ager (UM) assisted in all MARs because there was at coordinator (SDC) at that month reviews were usually are the end of the month. Action was usually written on aut not on the MAR. Telephone ails were put on the MAR for DN stated a nursing note the resident refused an at 1:03 PM. The resident's ent #135 was able to refuse					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345104	B. WING			C 09/08/2017	
NAME OF PROVIDER OR SUPPLIER ZEBULON REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597		09/06/2017	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			(X5) COMPLETION DATE	
F 514	the UM wrote the info	PM, the DON advised that properties or the properties of the appointment	F 5	14			
	looked through the re electronic medical re no notes as to why the cancelled. She also a	advised that physician's it did not always contain the					
	at 1:41 PM. She desifamiliar with his diagralert and oriented. The "strong minded". She refused medications of the time. She recassay he was "too sick couldn't do it" to thing never gave an exact she was unaware of appointment on 12/1 to refuse. She stated rescheduled if it was would be the one to may refused, the print refused.	ewed via phone on 09/08/17 cribed the resident, was noses and stated that he was se stated that Resident #135 at times and therapy much lled the resident would often wasn't able to do it or just gs he didn't care to do but reason. The nurse stated the resident having an 3/16 but that he had the right the appointment should be missed and the desk nurse reschedule it. If a procedure nary provider and the clinic e RP should be contacted make a note.					
	Director (RCD) advis company stated the fi transport; unknown of The primary provider phone on 09/08/17 a with the resident's his	acility cancelled the					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345104	B. WING			08/ 2017	
NAME OF PROVIDER OR SUPPLIER ZEBULON REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 509 WEST GANNON AVENUE ZEBULON, NC 27597	<u> </u>	00/2017	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 514	procedure wouldn't hat the resident's outcome daily, there was nothing been done even if the On 09/08/17 at 2:41 Finterviewed via phone remember the resident The nurse reported the cancelled transport for procedure done and the ambulance service specified in the cancelled transport for procedure done and the ambulance service specified in the cancelled on 11/30/1 ambulance service ar 12/13/16 at 5:56 AM at 12/13/16 at 5:56 AM at 12/13/16 at 5:56 AM at 12/13/16 at 12/13/16 at 15:56 AM at 14/15/16 at 15:56 AM at 14/15/16 at 15:56 AM at 14/15/16 at 14/15/	eve made any difference in e. With the resident on iron ing else that could have test was conducted. PM, Nurse #4 was e. She stated she did not but provided no details. It is that she would not have in a resident having a hat she was not the one the booke with that morning. Distated she was informed evice that the transport was 6 by Nurse #1. The rived at the facility on and they were told the ed at 6:06 AM. No reason	F 5	14			