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 09/08/2017

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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide appropriate communication to include documentation and transportation to meet the needs of 1 of 1 residents (Resident #135) resulting in a capsule endoscopy procedure not being conducted as scheduled. Findings included: Resident #135 was admitted to the facility on 10/14/16 and discharged on 10/20/16. He was readmitted on 10/28/16 and discharged on 12/17/16. The resident had multiple diagnoses that included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), emphysema, encephalopathy, heart failure, gastrointestinal hemorrhage, and iron deficiency anemia. The care plan dated 11/04/16, documented that Resident #135 had oxygen therapy, peripheral vascular/arterial disease, type II diabetes, pain, a swallowing problem and activities of daily living (ADL) self-care performance deficit. He was also at risk for nutrition deficit, had four pressure ulcers and was at risk for pressure ulcer development and had bladder incontinence.	F 281	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 named in citation was discharged from facility on 12/17/2016. 2. Any resident requiring an outside service or appointment per MD order could be affected by this practice. Therefore, the DON/IDT team completed a facility audit on 9/21/2017 of resident appointments for past 30 days to ensure the proper documentation and communication was evident in the medical record.	10/2/17

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

Electronically Signed | 09/27/2017

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F 281	Continued From page 1 The 30-day assessment, on the minimum data set (MDS) dated 11/29/16, reported that Resident #135 had a brief interview for mental status (BIMS) score of 15; no likely cognitive impairment. The resident required extensive assistance with bed mobility and transfers. Supervision was needed for locomotion and eating. Limited assistance was required for dressing and personal hygiene. He was independent with bathing. Resident #135 had rejected care one to three days and was receiving pain management. The hospital discharge summary dated 10/28/16 included a recommendation for a capsule endoscopy to be completed at the gastroenterology clinic. The facility had a calendar book referred to as the transportation book where information was written for residents' appointments outside the facility. Resident #135's name along with the name and the address of the medical center for the appointment were documented in the transportation book on 12/13/17. The 8:00 am appointment time was written stating the resident needed to be at the appointment one hour prior to the appointment time and the contact number for the appointment place. A line was marked over the written area with "cancelled" written in the space. Documentation for this procedure and the prescription for the bowel cleansing solution was faxed to the attention of Nurse #1 at the facility on 11/30/16 from the gastroenterology practice. The instructions for the procedure on 12/13/16 at 8:00 AM, stated "arrive at 7:00 AM. No iron	F 281	3. The DON in serviced licensed staff, beginning 9/27/2017 to be completed by 10/2/2017, regarding the expectations for communicating and documenting in the medical record any changes in appointments or transportation arrangements. The DON/IDT team during clinical rounds will audit the appointment/transportation book to ensure any changes from the previous day appointment or transportation arrangements have been communicated and documented in the resident medical record detailing the changes. 4. Results of the clinical rounds will be brought to QA by the DON for 2 months for review by the IDT team.	

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supplements for seven days prior to the procedure on 12/13/16." The resident was to have clear liquids on 12/12/16. On 12/12/16 at 6:00 PM, drink 8 ounces of the bowel cleansing solution every 15 minutes until half the container was gone. The resident was not supposed to eat or drink anything (NPO) after midnight. On 12/13/16, the day of the procedure, the resident was supposed to start at 5:00 AM and drink 8 ounces of the bowel cleansing solution every 15 minutes until the remainder was gone.

On the medication administration record (MAR) for 11/08/16 to 11/30/16, there was a for your information (FYI) note written which said "12/13/16 appointment; 12/12/16 clear liquids all day".

A physician's order was written on 12/12/16 stated mix the bowel cleansing solution as directed at 6:00 PM the day before the procedure. Drink 8 ounces every 15 minutes until half was gone. At 5:00 AM, the day of the procedure; repeat until gone. No time was written on the order.

Per the December 2016 MAR, the resident received his iron supplement from 12/01/16 to 12/17/16. There was no documentation on the December 2016 MAR in reference to this procedure. No iron supplements for seven days prior to the procedure on 12/13/16 was not documented on the December MAR.

The Administrator and the Director of Nursing (DON) were interviewed on 09/08/17 at 10:30 AM. The administrator and the DON stated they were familiar with Resident #135 but they were unsure of why the resident did not go to his

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appointment on 12/13/16.

On 09/08/17 at 11:23 AM, Nurse #2 was interviewed via phone. Nurse #2 was not sure why Resident #135's appointment was cancelled on 12/13/16.

Nurse #1 was interviewed on 09/08/17 at 11:44 AM and stated the appointment was cancelled because Resident #135 had medications given that should have been held. She stated that the appointment was rescheduled a prior time but was unsure of the date or why it was rescheduled. She stated "The resident did not want to go anyway". The MDS nurse scheduled appointments at times due to having the admission and discharge paperwork. Clinical rounds were conducted each morning to ensure the resident's assessment and care plans were completed and that appointments and follow ups were scheduled. Nurse #1 stated she took the phone call from the gastroenterology clinic and the documents were faxed to her attention. The nurse reported that the resident refused the bowel cleansing solution prep.

The DON was interviewed on 09/08/17 12:24 PM and she stated that she reviewed the MARs on the 200 hall at the end of each month. The MDS nurse and UM assisted in reviewing the 100 hall MARs because there was no staff development coordinator (SDC) at that time. The end of the month reviews were usually done one week before the end of the month. Appointment information was usually written on the calendar book but not on the MAR. Telephone orders and prep details were put on the MAR for each month. The DON stated a nursing note should be written if the resident refused an appointment or prep.

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The resident's primary doctor was interviewed via phone on 09/08/17 at 1:03 PM. The resident's doctor stated Resident #135 was able to refuse the procedure if that was his choice.

On 09/08/17 at 1:17 PM, the DON advised that the UM wrote the information in the appointment book and would set up transport. The DON looked through the resident's paper chart and the electronic medical record and stated there were no notes as to why the appointment was cancelled. She also advised that physician's orders were dated but did not always contain the time in which the order was written.

Nurse #3 was interviewed via phone on 09/08/17 at 1:41 PM. She described the resident, was familiar with his diagnoses and stated that he was alert and oriented. The nurse stated that he was "strong minded". She stated that Resident #135 refused medications at times and therapy much of the time. She recalled the resident would often say he was "too sick, wasn't able to do it or just couldn't do it" to things he didn't care to do but never gave an exact reason. The nurse stated she was unaware of the resident having an appointment on 12/13/16 but that he had the right to refuse. She stated the appointment should be rescheduled if it was missed and the desk nurse would be the one to reschedule it. If a procedure was refused, the primary provider and the clinic would be notified. The RP should be contacted and the nurse should make a note.

On 09/08/17 at 1:47 PM, the Regional Clinical Director (RCD) advised that the transport company stated the facility cancelled the transport; unknown date and time.

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F 281	Continued From page 5 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 #135 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 nothing 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 281		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (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	F 323		10/2/17

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F 323	Continued From page 6 appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, facility's document review and resident and staff interviews the facility failed to keep the handheld bed control device free from exposed internal wiring for 1 of 5 residents sampled for environmental hazards (Resident #86). The findings included: On 9/5/17 at 1:00pm, Resident #86's handheld bed control device was observed on the over bed table. Along 6 inches of the cord from the bottom of the device the outer protective covering was missing which exposed the internal wires. During an interview on 9/5/17 at 1:00pm Resident #86 stated the bed control device had been like that for "over a month." On 9/6/17 at 3:15pm an observation of the same bed control device revealed it continued to have exposed wires.	F 323	1. Resident number 86 had his handheld bed control device replaced. 2. Any resident with a handheld bed control device could be affected by this deficient practice. Therefore, the Maintenance Director on 9/8/2017 completed an audit of facility beds with handheld controls to assure the device was free from exposed internal wiring. Repairs were completed if warranted in results of audit on 9/8/2017. Maintenance Director and Maintenance assistant were in serviced by the Administrator on 9/8/2017 on the importance of assuring that resident bed control devices are free from exposed internal wiring. 3. Maintenance Director and Maintenance assistant were in serviced by the Administrator on 9/8/2017 on the	

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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 room monitoring. The Maintenance Director described "guardian angel" rounds. He stated each of the department managers was assigned to certain residents' rooms and they were to talk with the assigned residents about any concerns and monitor the rooms for any environmental concerns. On 9/8/17 at 10:05am an observation of the bed control cord revealed it continued to have exposed wires. The observation also revealed the name of the "guardian angel" for the room was the same as the name of the maintenance helper. During an interview on 9/8/17 at 10:29am the Maintenance Director and maintenance helper confirmed the "guardian angel" was the	F 323	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 QA times 2 months.	

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F 323	Continued From page 8 maintenance helper. The Maintenance Director observed the bed control device and stated the cord should have been replaced with one that did not have exposed wires. The Maintenance helper stated he had completed the "guardian angel" rounds earlier this week and he did not observe the cord with the exposed wires. During an additional interview with the Maintenance Director on 9/8/17 at 11:35 am he stated the facility did not document the guardian angel rounds but if there was a concern with anything that involved maintenance then it would be put into the maintenance log. A review of the maintenance log book on revealed no documentation of the bed control device or any exposed wires.	F 323		
F 371 SS=D	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in	F 371		10/2/17

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F 371	Continued From page 9 accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to 1) provide a barrier between ready to eat foods and the servers' bare hands for 2 of 4 nurse aids (NA) observed during meal service and 2) failed to use a hair restraint for a food service worked who was observed not wearing a beard cover duing 2 of 2 observations. Findings included: 1. a. On 9/05/2017 at 12:09 PM, NA #1 was observed serving lunch to Resident #53 in the resident's room. NA #1 was observed to unwrap a slice of bread, take the bread from the wrapping with her bare fingers and place it on Resident #53's lunch tray. An interview with NA #1 was conducted on 9/05/2017 at 12:10 PM. The NA stated she had been unaware of touching the bread and stated she should not touch the resident's food with her bare hand. 1. b. On 9/05/2017 at 12:20 PM, NA #2 was observed serving lunch to Resident #40 in the resident's room. NA #2 was observed to unwrap a slice of bread, take the bread from the wrapping with her bare fingers and place it on Resident #40's lunch tray. An interview with NA #2 was conducted on 9/05/2017 at 12:21 PM. The NA stated she	F 371	1. No resident was named in this citation. 2. Facility staff were in serviced on the importance of providing a barrier between ready to eat foods and the servers hands 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 in the kitchen area. 3. The Administrator will audit the kitchen area and meal delivery areas 1 time daily/ 3 times a week/ times 6 weeks to assure that proper handling of food includes providing a barrier between ready to eat 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 QA times 2 months by Administrator.	

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F 371	Continued From page 10 should not have used her bare hand to place the slice of bread on the resident's tray. An interview with the Dietary Manager (DM) was conducted on 9/08/2017 at 8:54 AM. The DM stated staff should not touch the residents' food with bare hands. An interview with the Director of Nursing (DON) was conducted on 9/08/2017 at 11:04 AM. The DON stated staff should not touch the residents' food with bare hands. 2. During the initial tour of the kitchen on 9/5/17 at 9:55 am Food Service Worker #1 was observed removing clean dishes from the dishwasher. He was observed to have a beard. He was not wearing a beard cover. During an observation of the lunch meal tray line service on 9/7/17 at 12:15pm Food Service Worker #1 was receiving the plated food from the cook, placing it on the tray and putting the dome cover over the plate of food. He continued to have a beard and was not wearing a beard cover. On 9/8/17 at 9:00am the Dietary Manager stated beard covers were available in the same dispenser as the hair nets. She said Food Service Worker #1 should wear a beard cover when working in the kitchen.	F 371		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that	F 514		10/2/17

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F 514	Continued From page 11 are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide complete and accurate documentation for 1 of 1 residents (Resident #135) resulting in a procedure not being conducted. Findings included: Resident #135 was admitted to the facility on	F 514	1. Resident named in citation was discharged from facility on 12/17/2016. 2. Facility residents can be affected by this deficient practice. Therefore, the DON/IDT team did audit on 9/21/2017 for residents with appointments for past 30 days to assure that MD orders were transcribed correctly and appointments	

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F 514	Continued From page 12 10/14/16 and discharged on 10/20/16. He was readmitted on 10/28/16 and discharged on 12/17/16. The resident had multiple diagnoses that included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), emphysema, encephalopathy, heart failure, gastrointestinal hemorrhage, and iron deficiency anemia. The hospital discharge summary dated 10/28/16 included a recommendation for a capsule endoscopy to be completed at the gastroenterology clinic. The facility had a calendar book referred to as the transportation book where information was written for residents' appointments outside the facility. Resident #135's name, name and address of the medical center for the appointment were documented in the transportation book on 12/13/17. The 8:00 am appointment time was written stating the resident needed to be at the appointment one hour prior to the appointment time and the contact number for the appointment place. A line was marked over the written area with "cancelled" written in the space. Documentation for this procedure and the prescription for the bowel cleansing solution, was faxed to the attention of Nurse #1 at the facility on 11/30/16 from the gastroenterology practice. The instructions for the procedure on 12/13/16 at 8:00 AM, stated "arrive at 7:00 AM. No iron supplements for seven days prior to the procedure on 12/13/16." The resident was to have clear liquids on 12/12/16. On 12/12/16 at 6:00 PM, drink 8 ounces of the bowel cleansing solution every 15 minutes until half the container was gone. The resident was not supposed to eat	F 514	were attended. 3. The DON/IDT team during clinical rounds will audit the MD orders to ensure proper transcription is accurate for following day. DON will in service license staff by 10/2/2017 regarding expectation for proper transcription of MD orders to assure accuracy. The expectation regarding transcription of MD orders to assure accuracy will be added to the facility orientation process for new employees. 4. Results of the clinical rounds will be brought to QA by the DON for 2 months for review by the IDT team.	

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 09/08/2017

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or drink anything (NPO) after midnight. On 12/13/16, the day of the procedure, the resident was supposed to start at 5:00 AM and drink 8 ounces of the bowel cleansing solution every 15 minutes until the remainder was gone.

On the medication administration record (MAR) for 11/08/16 to 11/30/16, there was a for your information (FYI) note written which stated "12/13/16 appointment; 12/12/16 clear liquids all day".

A physician's order was written on 12/12/16. The order read mix the bowel cleansing solution as directed at 6:00 PM the day before the procedure. Drink 8 ounces every 15 minutes until half was gone. At 5:00 AM, the day of the procedure; repeat until gone. No time was written on the order.

Per the December 2016 MAR, the resident received his iron supplement from 12/01/16 to 12/17/16. There was no documentation on the December 2016 MAR in reference to this procedure. No iron supplements for seven days prior to the procedure on 12/13/16 was not documented on the December MAR.

The Administrator and the Director of Nursing (DON) were interviewed on 09/08/17 at 10:30 AM. The administrator and the DON stated they were familiar with Resident #135 but they were unsure of why the resident did not go to his appointment on 12/13/16.

On 09/08/17 at 11:23 AM, Nurse #2 was interviewed via phone. Nurse #2 was not sure why Resident #135's appointment was cancelled on 12/13/16.

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Nurse #1 was interviewed on 09/08/17 at 11:44 AM and stated the appointment was cancelled because Resident #135 had medications given that should have been held. She stated that the appointment was rescheduled a prior time but was unsure of the date or why it was rescheduled. She stated "The resident did not want to go anyway". The MDS nurse scheduled appointments at times due to having the admission and discharge paperwork. Clinical rounds were conducted each morning to ensure the resident's assessment and care plans were completed and that appointments and follow ups were scheduled. Nurse #1 stated she took the phone call from the gastroenterology clinic and the documents were faxed to her attention. The nurse reported that the resident refused the bowel cleansing solution prep.

The DON was interviewed on 09/08/17 12:24 PM and she stated that she reviewed the MARs on the 200 hall at the end of each month. The MDS nurse and Unit Manager (UM) assisted in reviewing the 100 hall MARs because there was no staff development coordinator (SDC) at that time. The end of the month reviews were usually done one week before the end of the month. Appointment information was usually written on the calendar book but not on the MAR. Telephone orders and prep details were put on the MAR for each month. The DON stated a nursing note should be written if the resident refused an appointment or prep.

The resident's primary doctor was interviewed via phone on 09/08/17 at 1:03 PM. The resident's doctor stated Resident #135 was able to refuse the procedure if that was his choice.

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On 09/08/17 at 1:17 PM, the DON advised that the UM wrote the information in the appointment book and would set up transport. The DON looked through the resident's paper chart and the electronic medical record and stated there were no notes as to why the appointment was cancelled. She also advised that physician's orders were dated but did not always contain the time in which the order was written.

Nurse #3 was interviewed via phone on 09/08/17 at 1:41 PM. She described the resident, was familiar with his diagnoses and stated that he was alert and oriented. The nurse stated that he was "strong minded". She stated that Resident #135 refused medications at times and therapy much of the time. She recalled the resident would often say he was "too sick, wasn't able to do it or just couldn't do it" to things he didn't care to do but never gave an exact reason. The nurse stated she was unaware of the resident having an appointment on 12/13/16 but that he had the right to refuse. She stated the appointment should be rescheduled if it was missed and the desk nurse would be the one to reschedule it. If a procedure was refused, the primary provider and the clinic would be notified. The RP should be contacted and the nurse should make a note.

On 09/08/17 at 1:47 PM, the Regional Clinical Director (RCD) advised that the transport company stated the facility cancelled the transport; unknown date and time.

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 #135 was not a surgical candidate. The

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procedure wouldn't have made any difference in the resident's outcome. With the resident on iron daily, there was nothing 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 but provided no details. 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.