STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345104	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON REHABILITATION CENTER	509 WEST GANNON AVENUE , ZEBULON, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 07/21/25 through 07/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D0EAD-H1.	E0000		08/01/2025
F0000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 07/21/25 through 07/24/25. Event ID# 1D0EAD-H1. The following intakes were investigated: 860364, 860365, and 860368. 8 of the 8 complaint allegations did not result in deficiency.	F0000		08/01/2025
F0640 SS = A	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a	F0640		08/01/2025

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 reverse for further 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.

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

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F0640 SS = A	Continued from page 1 facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to transmit a quarterly Minimum Data Set (MDS) assessment within 14 days of completion for 1 of 3 residents reviewed for resident assessments (Resident #3). Findings included: On 7/22/25 at 2:19 PM a review of Resident #3's quarterly MDS assessment dated 7/1/25 revealed it was completed on 7/2/25 but not transmitted.	F0640		

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F0640 SS = A	Continued from page 2 During an interview on 7/22/25 at 2:24 PM the MDS Coordinator stated when MDS assessments were completed the system marked the assessments as complete, and they then had 14 days to transmit the assessment to CMS (Centers for Medicare & Medicaid Services). She stated Resident #3's MDS assessment dated 7/1/25 was marked in the assessment as do not transmit to CMS and she was unsure why this was marked. She did not recall marking it to not submit to CMS and was not aware of any other way that it could have been marked. She concluded she was going to change the assessment to transmit to CMS in the next batch. During an interview on 7/22/25 at 3:09 PM the Administrator stated MDS assessments should be transmitted timely.	F0640		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for	F0641	Resident #60 MDS assessment dated 7/14/25 was modified to reflect receiving Dialysis by the MDS coordinator on 7/22/25. Resident #9 MDS assessment dated 6/17/25 was modified to reflect the use of antiplatelet by MDS coordinator on 7/23/25. On 7/25/25 the Director of Nursing or designee completed an audit of resident identified with receiving Dialysis to ensure that reflected on MDS assessment. The audit did not reveal any other residents. On 7/25/25 the Director of Nursing or designee will complete an audit of resident identified as receiving anti- platelet medication to ensure that it is coded per RAI on MDS assessment. The audit did not reveal other residents. On 7/23/25 the Administrator provided education to MDS coordinator regarding coding of MDS High Risk medication in section N related to anti platelet medication per RAI. The education also included coding section O for receiving dialysis per RAI. Newly hired licensed nurses will receive education during new hire orientation. The Director of Nursing/ designee will complete an audit of residents identified with antiplatelet medication and dialysis to ensure that residents are coded correctly weekly for 12 weeks. The Director of Nursing/ designee will report the findings of the audits to the Quality Assurance Committee monthly for three months. The committee will review the findings to determine if further action is needed.	08/07/2025

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F0641 SS = D	Continued from page 3 each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis and medications. This was for 1 of 1 resident (Resident #60) reviewed for dialysis and 1 of 5 residents (Resident #9) reviewed for unnecessary medications. Findings included: 1. Resident #60 was admitted to the facility on 5/29/25. A physician's order for Resident #60 dated 5/30/25 revealed she received dialysis (a treatment for kidney failure) three times weekly on Monday, Wednesday and Friday. A review of Resident #60's July 2025 Medication Administration Record (MAR) revealed documentation indicating she received dialysis on 7/9/25 and 7/14/25. A review of Resident #60's quarterly MDS assessment dated 7/14/25 revealed she was not coded for receiving dialysis. On 7/22/25 at 1:17 PM an interview with the MDS Coordinator indicated she coded Resident #60's quarterly MDS assessment dated 7/14/25 in error. She reported she used a worksheet when she completed MDS assessments, and on the worksheet, she had for Resident #60's MDS assessment dated 7/14/25 she noted Resident #60 received dialysis. The MDS coordinator stated she meant to code Resident #60 for receiving dialysis on the 7/14/25 quarterly MDS assessment but she had not. 2. Resident #9 was admitted to the facility on 2/28/25. A review of Resident #9's physician's orders for June 2025 did not reveal any orders to administer insulin to Resident #9. A physician's order dated 6/12/25 revealed to administer Plavix (an antiplatelet medication) 75 milligrams (mg) by mouth daily to Resident #9 for blood clot prevention. A review of Resident #9's June 2025 Medication Administration Record (MAR) did not reveal any documentation indicating an insulin injection was	F0641		

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F0641 SS = D	Continued from page 4 administered to her. It further revealed documentation indicating that Plavix 75 mg was administered to Resident #9 daily as ordered by her physician. A review of Resident #9's 5-day Minimum Data Set (MDS) assessment dated 6/17/25 revealed she was coded as receiving 1 insulin injection and not coded as receiving antiplatelet medication during the look-back period of the assessment. In an interview on 07/23/2025 at 8:30 AM the MDS Coordinator stated she coded Resident #9's MDS assessment dated 6/17/25. She reported the look back period for this assessment would be from 6/11/25-6/17/25. She indicated the coding of an insulin injection would be an error as there was no documentation Resident #9 received one. The MDS Coordinator stated documentation on Resident #9's MAR indicated Resident #9 received antiplatelet medication during the look back period of the 6/17/25 MDS assessment. She indicated her lack of coding this antiplatelet medication on Resident #9's 6/17/25 MDS assessment would be an error. She reported she had the worksheet she used for coding Resident #9's 6/17/25 MDS assessment indicating she had the anticipation of coding the antiplatelet medication, but she missed it and did not know why. On 7/24/25 at 11:24 AM an interview with the Administrator indicated resident's MDS assessments should be accurately coded to reflect the care and medications residents received. On 7/24/25 at 11:50 AM an interview with the Director of Nursing indicated that resident's MDS assessments should be accurately coded to reflect the care and medications residents received.	F0641		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F0761	On 7/22/25 Cart# 1 was observed unlocked. The assigned charge nurse immediately locked the medication cart On 7/22/25 Maintenance Director inspected all center medication carts to ensure all locked appropriately. No new areas of concern were identified. On 7/22/25 Director of Nursing provided the licensed nurses education to ensure all medication carts and medications are locked when the medication cart is unattended. Any licensed nursing staff that have not received this education before 8/7/25 will be educated prior to working their next shift and all newly hired licensed nurses will receive education during new hire orientation.	08/07/2025

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F0761 SS = D	Continued from page 5 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation and staff interviews, the facility failed to keep medications in a locked medication cart for 1 of 2 medication carts observed (Medication Cart #1). Findings included: During continuous observation on 7/22/25, which started at 8:30 AM, Medication Cart #1 was observed unlocked and unattended on the 100-hall. A nurse aide was observed near the unlocked medication cart, and she passed it as she moved to and entered another resident's room. One resident was observed on the hall and was 3 rooms away from the unlocked medication cart and then entered the room he was sitting in front of at 8:32 AM. At 8:32 AM a nurse aide walked past the unlocked medication cart. At 8:33 AM a human resources staff member walked past the unlocked medication cart. At 8:33 AM a nurse aide walked past the unlocked medication cart and at 8:34 AM a nurse aide and human resources staff member walked past the unlocked medication cart. At 8:35 AM a nurse aide walked past the unlocked medication cart. At 8:36 AM 2 nurse aides walked past the unlocked medication cart. At 8:37 AM a nurse aide walked past the unlocked medication cart. At 8:38 AM an occupational therapist walked past the unlocked medication cart pushing a resident in a wheelchair down the hall. At 8:39 AM an occupational therapist walked past the unlocked medication cart. At 8:40 AM a maintenance staff member and nurse aide walked past the unlocked medication cart. At 8:41 AM the Unit Manager walked up to the surveyor to ask if the surveyor needed anything and noted that the medication cart was unlocked and locked the medication cart.	F0761	Continued from page 5 The Director of Nursing/ designee will complete an audit of all medication carts to ensure they are locked when unattended weekly for 12 weeks. The Director of Nursing/ designee will report the findings of the audits to the Quality Assurance Committee monthly for three months. The committee will review the findings to determine if further action is necessary.	

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F0761 SS = D	Continued from page 6 During an interview on 7/22/25 at 8:41 AM the Unit Manager stated the 100-hall medication cart was left unlocked and unattended and should have been locked when left unattended. He stated Nurse #1 was the one responsible for the 100-hall medication cart. She stated this was a safety hazard because with the cart unlocked people including staff, residents, and visitors could get into the medications and this also created a privacy issue due to resident names in the medications on the cart. During an interview on 7/22/25 at 8:45 AM Nurse #1 stated she usually locked her medication cart prior to leaving it unattended so no one else could go into the medication cart. She stated she thought she had locked the medication cart and did not know why it was unlocked. During an interview on 7/22/25 at 9:47 AM the Director of Nursing stated medication carts were to be locked when unattended. She concluded this was for the safety of the residents and staff.	F0761		