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	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zebulon Rehabilitation Center	509 West Gannon Avenue Zebulon, NC 27597

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 Based on observations, record review, and resident and staff interviews the facility failed to complete a self-administration of medication assessment and care plan self-administration of medication before leaving medication at the bedside for 1 of 5 residents (Resident #5) reviewed for unnecessary medication. Findings included: Resident #5 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease. A review of Resident #5's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. She had impaired functional limitation of range of motion of her upper extremity on one side. Resident #5's record revealed a physician's order dated 5/20/24 for albuterol 90 microgram inhaler 2 puffs inhale orally every 6 hours as needed for wheezing and shortness of breath, may leave at bedside, entered by Nurse #1. No assessment for self-administration of medication was found in Resident #5's record. Resident #5's comprehensive care plan dated last revised on 6/13/24 did not reveal any focus area or interventions regarding self-administration of medication. On 6/25/24 at 8:03 AM Resident #5 was observed returning to her bed from the restroom. She was observed to be short of breath. Resident #5 was observed to sit on the side of her bed, pick up a hand held albuterol (a bronchodilator which opens airways in the lungs) medication inhaler from her bedside table, and administer 2 puffs of the medication to herself orally. An interview with Resident #5 indicated this medication was her rescue respiratory medication. She stated she had been taking the medication for 3 years. She went on to say she took 2 puffs of the medication when she felt short of breath which really helped. Resident #5 reported that because it could take from 15 to 30 minutes for a nurse to come when she needed this medication, her physician allowed her to keep the medication with her to use herself. (continued on next page)

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.

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 1:49 PM an interview with Nurse #1 indicated he obtained the physician's order for Resident #5 to keep her albuterol inhaler at her bedside on 5/20/24. He stated Resident #5 had requested this. He went onto say while he had made sure Resident #5 could use the medication safely herself and would keep the inhaler with her so it would not be accessible to any other residents, he had not completed a self-administration of medication assessment for Resident #5 or added self-administration of medication to her care plan. Nurse #1 reported he knew he was supposed to do these things but had gotten busy and forgotten. On 6/26/24 at 1:54 PM in an interview the Director of Nursing (DON) stated Nurse #1 should have completed a self-administration of medication assessment form and added self-administration of medication to Resident #5's care plan when he obtained the physician's order for Resident #5 to keep her albuterol medication at her bedside. On 6/27/24 at 10:56 AM an interview with the Administrator indicated there should have been a self-administration of medication assessment completed prior to Resident #5 being allowed to keep her inhaler at her bedside and self-administration of medication should have been added to Resident #5's care plan.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 Based on staff interviews and record review the facility failed to accurately code anticoagulant use on a Minimum Data Set (MDS) assessment for 2 of 3 resident reviewed for resident assessments. (Resident #52, Resident #31) Findings included: 1. Resident #52 was admitted to the facility on [DATE]. Her active diagnoses included stroke, hypertension, and diabetes mellitus. Review of Resident #52's admission Minimum Data Set assessment dated [DATE] revealed she was coded as receiving an anticoagulant. Review of Resident #52's Medication Administration Record for 4/2024 and 5/2024 revealed she did not receive an anticoagulant medication during the 7-day lookback period of the Minimum Data Set assessment. During an interview on 6/26/24 at 10:09 AM the MDS Coordinator stated Resident #52 was not on an anticoagulant medication and it was coded inaccurately on the 5/2/24 Admission Minimum Data Set assessment. During an interview on 6/26/24 at 10:44 AM the Administrator stated MDS assessments should accurately reflect the medications the resident was receiving. 41009 2. Resident #31 was admitted to the facility on [DATE] with a diagnosis of coronary artery disease. A review of Resident #31's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired. He received anticoagulant (blood thinning) medication. A review of Resident #31's May 2024 Medication Administration Record (MAR) did not reveal any documentation anticoagulant medication was administered to Resident #31. A review of Resident #31's physician's orders did not reveal any orders for anticoagulant medication. On 6/26/24 at 10:08 AM an interview with the MDS Coordinator indicated she completed the medication section of Resident #31's MDS assessment dated [DATE]. She stated the look back period for this section would have been 7 days prior to the assessment date. She reported she would have used Resident #31's MAR as a reference to complete the section. She further indicated she did not see now where Resident #31 received any anticoagulant medication. She stated she completed the section incorrectly. The MDS Coordinator stated she could not say why she made the error. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 10:44 AM in an interview the Administrator stated Resident #31's MDS assessments should accurately reflect the medication he was receiving.