| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345104 | A. Building<br>B. Wing | 07/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Zebulon Rehabilitation Center | 509 West Gannon Avenue<br>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 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE].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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE].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 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 [DATE] 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 [DATE]. 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. |

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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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>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. 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. |