STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING ______ B. WING ______	C 05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - TREYBURN	**2059 TORREDGE ROAD DURHAM, NC 27712**

(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 463 SS=E	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and resident interviews, the facility failed to provide a functioning system to be able to contact staff for assistance for three out of three residents (Resident #3, 5, & 6). A review of medical record on 5/20/15 at 2:00pm revealed that Resident #5 was admitted on 5/3/15 and 2/18/2011. Diagnosis included neurogenic bladder, parapalegic, pressure uclers, and colostomy surgery. Quarterly review of Minimum Data Set (MDS) record on 2/18/15 reveals resident is cognitively intact, requires assist of two for bed mobility, transfers, and toileting and assit of one for dressing and personal hygiene. Resident # 5 is limited assist for meals. A review of the care plan dated 3/26/15 included pain related to pressure ulcer, at risk for skin breakdown related to impaired mobility, frequently incontinent of bladder, and colostomy, and stage four pressure ulcer to left buttock. Approaches included assess and monitor for signs and symptoms of pain, administer pain medication, handle resident gently when moving, keep call light and personal items within reach at all times, wound nurse to follow, pressure relieving mattress and cushion when resident in chair or bed, and increase nutrional needs to promote wound healing.	F 463	Disclaimer: Peak Resources acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions, the Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 from the 5/19/15 - 5/21/15 Complaint Investigation. Peak Resources response to the statement of deficiencies and plan does not denote agreement with the deficiency nor does it constitute an admission that the deficiency is accurate. Further, Peak Resources Treyburn reserves the right refute any deficiency through informal dispute resolution formal appeal and/or other administrative or legal procedures. Residents affected by the deficient practice: Resident #3 had no adverse effects related to the communication system to receive resident calls.	6/18/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/12/2015

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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F 463	Continued From page 1 An observation on 5/20/15 at 2:30pm of Resident #5 revealed an alert and oriented resident lying in bed with trapeze above his head. Resident #5 had a hand bell on his bedside table within reach. Resident #5 rang hand bell at 2:30pm. No one responded to this bell. Resident #5 rang the bell again at 2:44pm. At 2:57 CNA #2 arrived to room. An interview with Resident #5 on 5/20/15 at 2:30 revealed that when resident needs assistance he rings the hand bell. Resident #1 reported it can take a long time (sometimes more than 20 minutes) for someone to answer the bell when he rings it. Observation of Resident #6 on 5/20/15 at 2:35 revealed an alert and oriented resident lying in bed without a bell or whistle. Interview with Resident #6 (roomate of Resident #5) on 5/20/15 at 2:35 revealed that the resident is alert and oriented and able to ring a bell if he needed assistance. Resident #6 reports that when he needs help he asks Resident #5 to ring his bell. Resident #6 further reported that he did not tell anyone that his bell was missing. An interview with CNA #2 on 5/20/15 at 2:57pm revealed that the call lights have not been working since 5/13/15. CNA #2 reports that she did not answer Resident #5 ' s bell because she did not hear it while she was in another room doing patient care. CNA #2 further revealed that roomate of Resident #5 should have a hand bell and proceeded to get him one. Observation of Resident #6 on 5/20/15 at 3:20 revealed a hand bell on side table within reach.	F 463	Resident #5 had no adverse effects related to the communication system to receive resident calls. Resident #6 had no adverse effects related to the communication system to receive resident calls. Resident¿s #3, #5, and #6 did not suffer any adverse issues as a result of the call bell system. On or before 6/17/15, all nursing staff will be educated on this situation and the potential adverse issues that could have resulted. This will be conducted by the Staff Development Coordinator/Designee. Effective 5/21/15, the electronic call bell system was fixed for the entire building. This was conducted by the Director of Maintenance/Designee. On or before 6/17/15, all staff will be educated on acceptable call bell response time, routine rounding procedure, and checking to ensure that call bells are within resident¿s reach during routine rounds. This will be conducted by the Staff Development Coordinator/Designee. Effective the week starting 6/15/15, audits of the current (electronic) call bell response system will be conducted. 10 call bell responses, per shift, per week (for a total of 30 call bell responses per week) will be audited x 4 weeks. Then, 10 call bell responses, per shift, per month (for a total of 30 call bell responses per month) will be audited x 2 months. This will be	

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A review of Resident # 3 ' s medical record on 5/20/15 at 3:50pm reveals that Resident # 3 was admitted on 1/11/15 (latest return) and original admission date on 10/22/13. Resident is cognitively intact. Cumulative diagnosis included heart failure, high blood pressure, diabetes, difficulty breathing due to lung disease, osteoporosis, obesity, peripheral vascular disease, muscle weakness and broken left leg. A review of the Minimum Data Set (MDS) dated 4/7/15 reveals that Resident #3 is cognitively intact and requires assist of two with bed mobility, totally dependent with two assist for transfers, total dependence with one assist for personal hygiene and dressing, supervised with one assist for meals, and one assist for toilet use.

A review of Resident # 3 ' s care plan dated 3/26/15 revealed care plans for at risk for injury related to use of 1/2 side rails for turning and repositioning, approaches included to have call light and personal items within reach at all times. Resident # 3 also has a care plan for continuous oxygen related to ineffective breathing pattern secondary to hypoxia (difficulty breathing).

During an observation at 3:09pm on 5/20/15, Resident # 3 was lying in bed with a nasal cannula in place with oxygen running and a trapeze over her head. Resident #3 was on telephone and having a conversation with no difficulty with breathing noted. Resident # 3 pressed her call light to confirm that the light did not work. Resident # 3 had a whistle tied on a string around her neck.

During an interview with Resident # 3 on 5/20/15 at 3:11pm she blew the whistle 2 times.

conducted by Director of Nursing/Designee.

Effective 6/17/15, to decrease the likelihood of a routine generator load test damaging the electronic call bell system again, Prime Power (service contractor for generator), will be present during monthly generator load test. This will occur monthly x 2 months. Monthly test will be conducted by Director of Maintenance/Designee.

Effective immediately, if the electronic call bell system temporarily stops functioning in the future, manual bells and whistles will be distributed to all affected residents. Residents will be educated on how to utilize the manual bells and whistles. Signs will also be hung in all affected resident¿s rooms, notifying residents to utilize the manual bells and whistles. This will be conducted by Nursing Supervisor/Designee.

Effective 6/17/15, manual bells and whistles, and necessary signage will be kept in Nursing Supervisor¿s Office.

On or before 6/17/15, all staff will be educated on necessary actions to take, if the electronic call bell system temporarily stops functioning in the future. This in-service will cover: manual bells, whistles and signage to be distributed to residents and the storage location of the manual bells, whistles and signage. This will be conducted by the Staff Development Coordinator/Designee.

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F 463	Continued From page 3 An observation at 3:11pm revealed there was no staff near room or visible in hallway. The nurse was at the nurse ' s station down the end of the hall. No staff responded to the whistle blow. While continuing the interview with Resident # 3 it was reported that when she blows the whistle no one comes to see her. Resident# 3 reports that she has difficulty blowing the whistle continously due to her breathing status and being on oxygen. Resident # 3 further added that when other residents ring their bells, staff doesn ' t seem to know where to go to find whose bell it is. Resident # 3 reports that she prefers the whistle instead of hand bell and that she uses her cell phone and calls the nurses desk to get assistance when they don ' t respond to the whistle. It depends on where they are in the hallway as to how long it takes to get a response to the whistle. Resident # 3 revealed when she calls the nurses desk with her cell phone it still takes about 1/2 hr to get assistance. Resident # 3 reports that in the day time it is easier to get help; evening and night shift is harder to get assistance. Observed Resident #3 blow whistle again at 3:23pm. No one responded to the whistle. Resident # 3 blew whistle again at 3:40pm. No one responded. During an observation outside of Resident # 3 ' s room on 5/20/15 at 4:00pm there was a nurse at the medication cart and a CNA sitting at a computer. Resident #3 blew whistle again and the CNA went in to see resident. The CNA was sitting in the hall at a computer when she responded to the whistle. Nurse was standing	F 463	Effective 6/17/15, if the electronic call bell system temporarily stops functioning in the future, additional staff would be added to the schedule. These staff member(s) would not be assigned to specific resident rooms, but would walk the halls and notify direct care staff when they are needed by a resident. This would ensure that staff are available in the hallways and able to hear the manual bells and whistles. This would be overseen by the Director of Nursing/Designee. Effective 6/17/15, if the electronic call bell system temporarily stops functioning in the future, direct care staff will make more frequent rounds on resident rooms. Current policy is to routinely make rounds every 2 hours. If the call bell system temporarily stops functioning in the future, direct care staff will make more frequent rounds more frequent than every 2 hours. This will be conducted by Nursing Supervisor/Designee. On or before 6/17/15, all staff will be educated on additional staff to monitor the hallways and more frequent rounding, if the electronic call bell system temporarily stops functioning in the future. This will be conducted by the Staff Development Coordinator/Designee. Effective 6/17/15, if the call bell system temporarily stops functioning in the future, daily audits of call bell response times will be conducted. If manual bells and whistles are being utilized, 10 call bell	

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F 463	Continued From page 4 beside the CNA at the nurses station. It was noted that it took a total of 50 minutes for a staff member to finally respond to Resident #3 ' s whistle. The CNA answered the whistle at 4:00pm. An interview with the Maintenance Director on 5/20/15 at 4:20pm revealed that on 5/13/15, the facility was performing the generator low test which is done once per month. The generator low test is done by shutting off the power for 10 seconds and then turning the power back on. When it came back on, there was a power surge that caused the call light board on the 200/400/500 halls to burn out. The Maintenance Director reports that bells and whistles were given to the appropriate residents on the 200/400/500 halls. The Maintenance Director further reports that inservices have been done for staff to make frequent rounds on residents and to listen for bells and whistles. The Maintenance Director ordered the part needed to repair the call light board on 5/13/15. He further reports that the part should be arriving on 5/21/15. An interview with Nurse #2 on 5/20/15 at 4:00pm revealed that there are two CNA ' s assigned to the 200 floor on 3-11 shift and a 3rd CNA who splits the 200 hall with another hall. Nurse #2 further added that if she leaves the floor, the CNA ' s are to stay on floor. Nurse #2 reports that there is always someone covering the hall. Nurse #2 reports that the aids and herself were helping other people and they cannot hear the bells and whistles when they are in resident ' s rooms. On 5/21/15 at 6:00am an interview was done with CNA #3 on the 200 hall. The CNA #3 said the call lights were not working at this time and that	F 463	responses, per day, will be audited. This will be conducted by Director of Nursing/Designee. Effective 6/18/15, this plan of correction and all call bell response audits will be reviewed at the monthly Quality Assurance meeting. This will occur monthly x 3 months. This will be conducted by Administrator/designee.	

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the residents are using bells or whistles. The CNA #3 further reported that she can't hear the bells or whistles when she goes in the shower room or when she is in a room doing patient care. She reports she can hear them if she is in the hall or at the nurses station. The CNA #3 further added that she does rounds every two hours or as needed. She does not do round more frequently unless a bell or whistle goes off.

An interview with Nurse # 3 on 5/21/15 at 6:15am revealed that when she is in the hall, she can hear the bells or whistle. Nurse #3 further revealed if a resident rang the bell or whistle while the staff are in a room helping other residents, the staff can ' t hear them ringing. The staff does not know if they need assistance when they come out unless the resident rings again while they are in the hall. Nurse # 3 reports that when the call lights are working at least you can see it still going off when you come out of a room. Nurse # 3 Reports the CNA ' s do rounds every 2 hours and as needed.

An interview with the Director of Nursing (DON) on 5/21/15 at 4:45pm revealed that it is the expectation of the DON that there is a functioning system in place for resident ' s to be able to call for assistance and the expectation of the resident ' s wait time should be no more than 5 to 10 minutes.