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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 3/27/23 through 3/30/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5WIR11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 3/27/23 through 3/30/23. See Event ID #5WIR11. The following intakes were investigated: NC00199679, NC00199502, NC00199625, NC00199363, NC00198851, NC00198768, NC00198208, NC00195165, NC00195317, NC00194819, NC00194211, NC00194003, NC00197320, NC00192445, NC00192282, NC00190973, NC00190890, NC00190589, and NC00190565. 10 of 48 complaint allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to provide reasonable accommodations for 1 of 21 residents (Resident #19) reviewed for call light accessibility. Findings included:	F 558	F-558 Call Light was not within residents reach. Interventions for the affected resident On 3/27/23, Resident #19 call light was immediately placed within residents reach. Interventions for residents as having the	4/27/23

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

Electronically Signed | 04/23/2023

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F 558	Continued From page 1 Resident # 19 was admitted to the facility on 7/1/22 with diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set assessment dated 12/29/22 revealed Resident #19 was cognitively intact and required extensive assistance with bed mobility and activities of daily living. The care plan dated 3/23/23 revealed Resident #19 had impaired mobility and limited range of motion. He was at risk for falls and interventions included keeping call light and frequently needed items within reach. On 3/27/23 at 3:05 PM, an observation and interview were conducted with Resident #19 while he was lying in bed. His call light cord was clamped on the privacy curtain to his right-hand side of the bed beyond his reach. He indicated he was unaware it was out of reach, but he would not be able to call for help if it was not attached to his bed rail, and this caused him to worry. Resident # 19 tried to reach for the call light to demonstrate he could not reach it with his arm extended towards the privacy curtain. Resident #19 was unable to determine how long his call light cord was clamped to his privacy curtain. During an interview on 3/27/23 at 3:10 PM with the Nurse Assistant (NA) #14, who was assigned to Resident # 19 for the 7:00 AM to 3:00 PM shift, she revealed she was unaware the call light cord was not within reach. NA #14 explained she transported Resident #19 from activities back to his room at approximately 1:30 PM and forgot to place the call light cord within reach before	F 558	potential to be affected All residents have the potential to be affected. On 4/21/23, education was provided to nursing staff by the Staff Development Coordinator (SDC) on call bell placement with emphasis on ensuring call bell is within reach of the resident completed by Staff Development Coordinator (SDC). Systematic Change Audits will be conducted by the Interdisciplinary Team (IDT) for resident call bell placement - (5) five days per week for 12 weeks. Audits will be forwarded to the Administrator weekly for 12 weeks for review. All newly hired nursing staff will be provided education by Staff Development Coordinator (SDC) during their orientation period on call bell placement with emphasis on ensuring call bell is within reach of the resident. Monitoring of the change to sustain system compliance The results of the audits will be brought to QAPI monthly for a minimum of 3 months to determine when substantial compliance has been obtained and maintained.	

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F 558	Continued From page 2 leaving his room. NA # 14 indicated she normally places the call light within Resident # 19 ' s reach before leaving his room. During an interview on 3/27/23 at 3:15 PM with the Director of Nursing, she revealed the staff member who transported Resident #19 back to his room and assisted him back to bed should have placed his call light cord with reach. During an interview with the Administrator on 3/20/23 at 4:15 PM, he indicated staff were to always place call lights within reach of the residents. He stated staff who transports residents back to their room or provides care were responsible for placing call lights within reach before leaving the room. The Administrator further stated staff were to be mindful of this especially for dependent residents.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the	F 561		4/27/23

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F 561	Continued From page 3 facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to honor a resident's preference for a shower for 1 of 1 resident reviewed for choices (Resident #91). Findings included: Resident #91 was readmitted to the facility on 11/9/22 with diagnoses that included sever protein - calories malnutrition, major depression disorder and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated 2/14/23 revealed the resident was assessed as cognitively intact. Resident #91's Activity of Daily Living (ADL) was assessed as requiring supervision to limited assistance of one-person physical assist. Bathing activity was indicated as activity did not occur. The resident did not exhibit rejection of care and had no behavioral symptoms. Review of the shower sheets from 1/30/23 to 3/23/23 revealed the following: Shower sheets for 1/30/23, 2/2/23, 2/6/23,	F 561	F- 561 Resident's shower schedule preference was not honored. Interventions for the affected resident Resident #91 shower schedule was immediately changed to preferred time. Interventions for residents identified as having the potential to be affected. 100% shower scheduling audit was conducted by Nurse Supervisor on 3/31/23 All nursing staff will be re-educated by 4-21-23 by Staff Development Coordinator on notifying a nurse manager for resident request of schedule changes Systematic Change Director of nursing/Unit manager or designee will address resident preference with scheduling of showers on all new admissions. DON/UM or designee will complete 5 random shower scheduling audits weekly x 12 weeks All newly hired nursing staff will be educated in orientation by Staff	

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F 561	Continued From page 4 2/16/23, 2/23/23, 3/9/23, 3/13/23 indicated "refused prefer morning showers." Shower sheets on 2/9/23, 2/13/23, 2/20/23, 2/27/23, 3/23/23 indicated "refused due to wounds." Shower sheets on 3/1/23, 3/4/23, 3/15/23, 3/20/23 indicated "refused". Review of the shower schedule book revealed Resident #91's scheduled shower days were Wednesday and Friday during the second shift (3:00 PM- 11:00 PM). During an observation and interview on 3/27/23 at 11:21 AM, Resident #91 was observed sitting on her bed. Resident #91 was observed to be well groomed and clean. Resident #91 stated she did not receive any showers in a month. She indicated she received some bed baths. Resident #91 stated that when she requested staff for a shower during the day, she was informed that she would receive showers on scheduled shower days. Resident #91 indicated the showers were offered at 9 PM by second shift staff. She indicated her husband came to visit her on Wednesdays and other days at night and she did not want to go for showers while he was visiting her. Resident #91 stated when she requested staff for earlier showers, the staff would not offer them to her as it was not her scheduled time. Resident #91 further stated the shower schedule was not of her choice. During an interview on 3/28/22 at 4:10 PM, Nurse Aide (NA) #8 stated she was frequently assigned to the Resident #91 and worked second shift (3:00 PM - 11:00 PM). Resident #91 was scheduled for showers every Wednesday and Friday during second shift. NA #8 indicated the	F 561	Development Coordinator on notifying a nurse manage for request of schedule Monitoring of the change for sustain system compliance The results of the audit will be brought through the QA monthly meeting for a minimum of 3 months or until substantial compliance is met.	

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F 561	Continued From page 5	F 561		

resident needed limited assistance with showers. NA #8 stated Resident #91 had requested showers during the morning shift and this was reported to the nurse by NA #8. NA #8 further stated the resident frequently refused showers and was offered a complete bed bath or partial bed bath instead.

During an interview on 3/29/23 at 12:40 PM, Nurse #3 stated she was the evening shift supervisor and was notified by second shift staff that Resident #91 was refusing showers. Nurse #3 indicated Resident #91 was offered bed baths when showers were refused. Nurse #3 further indicated the resident has a wound on her back and was on wound vac for some time. The resident was refusing showers due to her wounds or just wanted the first shift to offer her showers. However, when the first shift staff offered the resident showers, the resident would refuse, and a bed bath was provided instead. Nurse #3 stated Resident #91's husband visited the resident in the evening and was with the resident until later at night. Nurse #3 further stated she was aware of resident's shower schedule change request but did not change the shower schedule as she thought it was just an excuse to refuse showers.

During an interview on 3/29/23 at 2:36 PM, the Director of Nursing (DON) stated that she was unaware of Resident #91's preference for showers. The DON further stated when any resident refused showers or any care, the staff reported it to the unit manager. The unit manager would then have some interventions in place to ensure the resident did not refuse any care. If the refusal behavior continued, then the DON was notified. DON stated she expected residents to be offered and given showers as scheduled and as

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F 561	Continued From page 6 requested. The residents had the right to choose when they would like to take a shower and this choice / request should be honored. During an interview on 3/29/23 at 5:18 PM, the Administrator indicated all residents' preferences should be honored. All residents should be offered showers on shower days and as needed or when requested. Staff were available to assist the residents with required care as needed.	F 561		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.	F 565		4/27/23

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F 565	Continued From page 7 §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and review of resident council minutes, the facility failed to address and resolve ongoing grievances about the quality, preference and palatability of food reported at resident council meetings by 5 of 5 residents who regularly attended the resident council meetings for 4 consecutive months ((12/7/22, 1/18/23, 2/8/23 and 3/8/23). (Resident #11, #32, #38, #46 and #58). The findings included: Review of resident council minutes dated 12/7/22 read in part: breakfast trays are late in mornings and food being served cold; the DM spoke with residents to assure them dietary was working on the issues. The Dietary Manager and Administrator were present. Review of the resident council minutes dated 1/18/23 read in part: the dietary manager was present at the meeting and there was no follow-up on the concerns from the previous month. Review of the resident council minutes dated 2/8/23 read in part: the residents stated they were tired of eating the same foods and would like	F 565	F -565 Facility failed to document detailed notes on residents input/concerns from monthly resident council meetings. Interventions for the affected resident All residents had the potential to be affected. Interventions for residents identified as having the potential to be affected Education was provided to the Director of Activities by the Administrator on 4/21/23 on recording of resident council meeting. Resident council minutes will be detailed to include all concerns or requests. Resident council minutes are to be forwarded to the Administrator for review and to facilitate departmental resolutions (as applicable). Systematic Change Administrator will review resident council minutes monthly to ensure any identified issues are communicated with the appropriate department for resolution. Resolution will be documented and communicated to the resident council at the next scheduled meeting. Monitoring of the change to obtain and maintain substantial compliance	

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F 565	Continued From page 8 fresh fruit daily. There was no evidence of resolution from the previous month. Review of the resident council minutes dated 3/8/23 read in part: the residents discussed food choices and there was no evidence resolution to dietary concern. Review of the resident council minutes did not reflect all the concerns identified by the residents as reported monthly. The president of resident council confirmed the minutes did not reflect all the concerns discussed monthly. I would suggest separating each month into its own paragraph. Make sure to include the concern and lack of response. Resident council meeting was held on 03/29/23 11:06 AM, there were five residents identified as alert and oriented who participated in the meeting. The members of the group reported they were regular attendees and had reported on-going food concerns during the resident council meetings as well as to management. The residents reported they had ongoing concerns with the meal of the day not being served and food items on the meal cards not available or served. In addition, the residents also reported the food preferences, likes/dislikes were not listed on the meal card and staff had no clue of what they like or not and what needs to be the substitute. The residents further stated the food was being served cold. In addition, the five members of the resident council reported administration and the previous dietary manager stated they would resolve their food concerns, but they were unaware of what action was taken to resolve the issues. The residents stated the food continued to be served cold and there were no changes in	F 565	The Administrator will communicate resident council meeting findings and resolutions to the QAPI committee monthly for three (3) months to determine when substantial compliance has been obtained and maintained.	

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F 565	Continued From page 9	F 565		

the quality of the food or the selection of food choices. The residents added there had been no individual discussions held with them by dietary or administration about the changes or resolution to their food concerns. The residents also stated that despite all the conversations held in resident council meetings discussion regarding food concerns, things have not improved. The residents further stated the registered dietician (RD) never came to talk to them, they were told one exist and we have never seen them or talk to them. They have no idea who the person was, and the dietary manager staff change so much, we have no idea what was happening with the food. The resident's stated they did not feel as though management was addressing their concerns with the food concerns. In addition, the residents further stated staff did not offer to reheat the food and when asked it took longer for the food to return. The meats were either half cooked, tough or not cooked enough. Resident #58 and #46 stated most meals you could not recognize, the oatmeal, grits and eggs were so hard it would stick to the spoon.

In the same interview, the five residents reported food issues had been an on-going issue for more than 4 months and nothing was done to correct the problem. The consensus of the group was the food does not come to them hot enough and it may be soggy or dry depending on what was served for the day. Residents #46, #58 and #11 reported they have asked their family members to bring them preferred food items, so they had something to eat when the food was bad. Resident # 45 and #58 reported the food was nasty and they were tired of receiving the same breakfast and meals in general. All residents reported they were unaware of what the meal of

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F 565	Continued From page 10	F 565		

the day was because there were no menus posted and no alternate to choose from. In addition, the residents reported they would receive random selection of foods thrown together that would include a lot of starch, no vegetables or meat, or a starch and small portion of whatever was available. Meals were late daily, cold food served at least three to four times a week. examples of poor food quality were, tough/burnt bacon, stiff/hard grits/oatmeal, mushy/soggy vegetables, too many starch foods, meats/dry tough, no fresh fruit offered/provided, eggs rubbery/overcooked, received dislikes or missing desired food items.

An interview was conducted on 3/29/23 at 12:00 PM, the Activity Director stated the residents, had reported concerns in the group about the meals being served cold, receiving the same foods, no flavor/taste, preferences not being honored, meal delivered late, food missing on trays, quality, and palatability of food. The AD further stated the food concerns were given to the dietary manager after each meeting, but she was not sure what happen to resolve the concern. The Dietary manager (DM) was present for some of the meetings when food concerns were presented by the group. She reported the grievance the forms were given to each of the department heads for their response. She added the dietary staff were aware of the individual and group concerns via the form. She stated dietary staff have not directly resolved the concerns for the past several months as there were repeated food concerns by different residents during the meetings.

An interview was conducted on 3/29/23 at 4:39 PM, the Administrator presented the resident council minutes that were incomplete of the

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F 565	Continued From page 11 resident concerns and resolutions of the identified concerns. The Administrator stated the group concerns should be submitted to the department heads after each meeting. The department head was responsible for resolutions by the next resident council meeting or sooner depending on the concern presented from meeting. The Administrator stated the expectation would be for the department heads to meet/discuss with resident/individuals the concern and resolve the concern to the resident satisfaction. An interview was conducted on 3/30/23 at 8:57 AM, with the Dietary Manager (DM) and the Administrator. The DM stated he attended a few of the resident council meetings and resolved the concerns for the residents in the group. The Administrator confirmed all the concerns were not documented in the resident council minutes to reflect the improvements that had been done. There was no evidence presented to reflect any resolution to any of the resident concerns for the past 4 months. There were no defined concerns from the group discussion the DM resolved. The DM stated he had attended the resident council meeting and was aware of the food concerns regarding temperatures, taste, and quality. The DM reported food temperatures were done daily and were accurate, but once the food left the kitchen, he did not ask residents directly about the food temperatures.DM did not follow-up with resident about any other concerns i.e., preference/likes/dislikes, food quality or variety etc.	F 565		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer.	F 623		4/27/23

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(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 623	Continued From page 12	F 623		

Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

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 03/30/2023

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F 623	Continued From page 13	F 623		

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility

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 03/30/2023

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F 623	Continued From page 14 must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interview of the facility staff, the facility failed to notify the ombudsman when residents were discharged (Resident #313, 164, and 413) for 3 of 3 residents reviewed for discharge. Findings Included: 1. Resident #313 was admitted to the facility from the hospital on 9/10/22. On 9/20/23 Resident #313 was discharged to the hospital. On 3/30/23 at 1:30 pm an interview was conducted with the Administrator. He stated that when Resident #313 was discharged on 9/20/22, Social Work did not inform the Ombudsman of any resident discharges for several months. She had not completed this task. There was currently no Social Work staff member, and the ombudsman would not be notified until that position was filled (currently pending a new	F 623	F-623 The facility failed to notify the OMBUDSMAN of discharges from the facility. Interventions for the affected resident All discharged residents were affected. Interventions for residents identified as having the potential to be affected By 4/21/23, a discharge audit will be conducted by the Social Services Manager reviewing past 30 days of discharges to validate required notification to the Ombudsman. Any identified issues will be addressed by submitting notification to the Ombudsman. Systemic Change On 4/21/23, education was provided to the Social Services Manager by the Administrator on ensuring notification to the Ombudsman as per F-623. For all discharges which require ombudsman notification, Social Services Manager will notify the Ombudsman via email	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 15 employee). 2. Resident # 164 was admitted to the facility from the hospital on 2/24/23 with a diagnosis of fracture of the right humerus. A review of the minimum data set discharge assessment dated 3/10/23 revealed Resident #164 discharged to the hospital with an anticipated return. Resident #164 has not been readmitted to the facility. The ombudsman was contacted but unavailable for interview. On 3/30/23 at 11:36am an interview was conducted with the Administrator. He revealed that he became aware upon his hire in December of 2022 that the social worker had not been sending the notification of emergency transfers to the ombudsman. At that time, he reeducated the social worker, but the social worker left the position the same month and the position has remained vacant. The administrator further revealed that he did not reassign this task to another staff member and confirmed that Residents #164 was discharged to the hospital and the ombudsman was not notified. 3. Resident #413 was admitted to the facility from	F 623	notification and/or fax notification monthly. Monthly for three (3) months, the facility Administrator will audit to ensure notification has been completed to the Ombudsman as required by F-623. Monitoring of the change to sustain compliance Results of the audits will be brought to QAPI monthly for a minimum of 3 months to obtain and maintain substantial compliance.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 623	Continued From page 16 the hospital on 6/23/22 with a diagnosis of cerebral infarction. A review of the minimum data set discharge assessment dated 8/18/22 revealed Resident #413 discharged to the hospital with an unanticipated return. The ombudsman was contacted but unavailable for interview. On 3/30/23 at 11:36am an interview was conducted with the Administrator. He revealed that he became aware upon his hire in December of 2022 that the social worker had not been sending the notification of emergency transfers to the ombudsman. At that time, he reeducated the social worker but the social worker left the position the same month and the position has remained vacant. The administrator further revealed that he did not reassign this task to another staff member and confirmed that Resident #413 was discharged to the hospital and the ombudsman was not notified.	F 623		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the	F 657		4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 17 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct care plan meetings with residents or resident representatives for 1 of 19 sampled residents reviewed for care plans. (Resident #91) Finding include: Resident #91 was readmitted on 11/9/22 with diagnoses that included sever protein calories malnutrition, depression disorder and anxiety disorder. A record review of the quarterly Minimum Data Set (MDS) assessment dated 2/14/23 revealed Resident #91 was assessed as cognitively intact. Review of Resident #19's care plan revealed the care plan was reviewed and revised on 2/21/23, but there was no indication that resident participated in the care plan meeting or development of the care plan.	F 657	F-657 Interventions for the affected residents All residents had the potential to be affected. Interventions for residents identified as having the potential to be affected By 4/27/23, a care plan audit will be completed by the Minimum Data Set (MDS) Nurse for the past thirty days to ensure any required care plan meeting was held. Any care plan meeting not held will be completed with the resident and/or responsible party by 4/27/23. Systematic Change A list of resident who require care plan meetings will be given to Social Services Manager by the Minimum Data Set (MDS) Nurse. Family member and resident will be notified to advise the date/time that works best for them via care plan meeting invitation. A copy of the care plan meeting	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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F 657	Continued From page 18 During an interview on 3/27/23 at 11:55 AM, Resident #91 indicated she had not been invited to attend a care plan meeting and did not recall participating in developing her plan of care. Resident #91 stated she was notified once by the staff (name unknown) that there was a care plan meeting at 1 PM. Resident #91 further stated when she went to the care plan meeting there was no one except her and the staff who invited her. Resident #91 stated it was joke as she just sat in the room and came out. There were no other staff members and no discussion about her plan of care. During an interview on 3/28/23 at 9:15 AM, the medical record staff indicated the facility did not have a social worker since the previous social worker quit in December 2022. The medical record staff indicated she was conducting residents care plan meetings in the absence of the social worker. The staff stated the MDS coordinator usually sent out a schedule and based on the schedule the care plan meetings were arranged. A letter was sent out to the families and residents regarding the care plan meeting by the receptionist. The medical record staff indicated per resident's records Resident #91's care plan was reviewed on 2/21/23, but no care plan meeting was conducted with the resident or resident representative. The medical record staff stated the resident's previous care plan meeting was conducted at the end of October 2022. The medical record staff indicated there was no documentation on who attended the meeting and was unable to confirm the staff who attended the meeting. During an interview on 3/28/23 at 9:45 PM, the	F 657	invitation will be retained by the Social Services Manager. Receptionist will update care plan meeting calendar. Social services will forward care plan meeting calendar to the Interdisciplinary team. Care plan meeting audits will be conducted by the Social Services Manager monthly for (3) months to ensure care plan meetings were held per F-657. Monitoring of the change to obtain and sustain substantial compliance Results of the audits will be brought to QAPI monthly for a minimum of 3 months to obtain and maintain substantial compliance.	

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 03/30/2023

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F 657	Continued From page 19 MDS coordinator stated the admission staff were responsible to set up a 72 hour admission care plan meeting with residents and their family members. The Social worker was responsible for setting up other care plan meetings (annual, quarterly, and significant change). The calendar was sent out to the social worker, who then would print out the letters and give it to the receptionist to mail them. Families would then contact social services with dates and times convenient to them. The MDS coordinator stated the facility had no social worker and the medical records staff was assisting in setting up care plan meetings. The MDS coordinator further stated Resident #91's care plan was reviewed in February 2023; however the care plan meeting was not scheduled. The MDS coordinator stated Resident #91's last care plan meeting was scheduled in October 2022. She, however, could not confirm if any staff attended the meeting. During an interview on 3/29/23 at 5:15 PM, the Administrator stated it was his expectations that the facility met the Federal and State requirements when care plan meetings are conducted. The Administrator stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive and quarterly assessments. He further stated residents and/or resident's representatives should be involved in the care plan meeting and make decisions about their care.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		4/27/23

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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F 684	Continued From page 20 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and facility staff and Nurse Practitioner interviews, the facility failed to follow medical practitioner orders for laboratory tests to evaluate for gastrointestinal bleeding (Resident #313) for 1 of 2 residents reviewed for quality of care. Findings included: Resident #313's hospital record dated 8/20/22 to 9/10/22 documented the resident was admitted for a myocardial infarction (heart attack), thrombocytopenia (low blood platelets clotting), liver cirrhosis with recurrent ascites (fluid in the abdomen), and diabetic gastroparesis (disease of the gastrointestinal tract). The summary documented the resident was stable and doing well at time of discharge to the facility. The resident's baseline INR (International Normalized Ratio shows how long it takes for blood to clot, normal range below 1.1) was 1.4. The resident's lab result for platelets was 100,000 (normal range 150,000 - 450,000. The resident's hemoglobin was 12.1 and hematocrit was 38.5 at discharge (red blood cell counts, normal range hemoglobin 12 - 16 and hematocrit 36 - 48). The hospital discharge summary dated 9/10/22 recommended PPI (proton pump inhibitor, medication to block production of stomach acid)	F 684	F- 684 Physician order for laboratory test were not followed Interventions for the affected resident Resident is no longer at facility. Interventions for residents identified as having the potential to be affected. All lab orders and diagnostic orders from 9-1-22 to 3-29-23 were reviewed by nursing management team on 3-29-23. All labs reviewed from 9-1-22 to 3-29-23, there were 9 missing labs. All labs were re-ordered per physician orders and requisition form completed by nursing supervisor on 3-30-23. All labs drawn the next day. All Licensed nurses will be re-educated by 4-21-23 by Staff Development Coordinator on the new lab/diagnostic tracking process and the importance of following physicians orders Systematic Change Nursing Management Team will review the lab log daily during clinical meeting Lab audits will be conducted weekly by the Director of nursing/Unit Manager for 12 weeks All newly hired LPN/RN will be educated in orientation by Staff Development Coordination on the new lab/diagnostic	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 21 medication to treat occurrence of gastrointestinal bleed. Resident #313 was admitted to the facility from the hospital on 9/10/22 with the diagnoses of end stage renal disease (ESRD) dependent on hemodialysis, cirrhosis of the liver, abdominal ascites, diabetic gastroparesis, atrial fibrillation (heart dysrhythmia) and myocardial infarction (heart attack). Resident #313's admission Minimum Data Set dated 9/17/22 documented the resident had moderately impaired cognition. The active diagnoses were stroke, ESRD, cirrhosis of the liver, dependence on renal dialysis, and ascites. Resident #313's care plan dated 9/10/22 documented no focus, goals or interventions for potential gastrointestinal bleeding, cardiac, and liver disease in the baseline care plan. Nurses' note dated 9/10/22 written by Nurse #7 documented Resident #313 was admitted to the facility with no pain, alert and oriented, receiving 2 liters of oxygen, and was stable. Nurses' note dated 9/12/22 written by Nurse #10 documented Resident #313 seemed a little confused of her surroundings. The resident seemed stable (vital signs) and was being assessed by speech therapy. The resident needed assistance with holding things and had minimum jerking in her left hand. The plan was to continue to monitor and pass information to oncoming nursing staff (no further nursing documentation regarding jerking hand). Resident #313's physician order dated 9/13/22	F 684	tracking process and the importance of following physicians orders Monitoring of the change for sustain system compliance The results of the audit will be brought through the QA monthly meeting for a minimum of 3 months or until substantial compliance is met.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 684	Continued From page 22	F 684		

was delayed release aspirin 81 mg each day written by Physician #1.

Nurse Practitioner (NP) #1 note dated 9/14/22 documented Resident #1 had a history of an upper gastrointestinal bleed. The resident had diabetic gastroparesis (disease of gastrointestinal tract) and was not on diabetic medication. The hemoglobin A1C (measures average blood sugar level over the past 3 months) was 9.1% (normal range below 5.7%). Anticoagulant (thins the blood) treatment was deferred due to bleeding risk although the resident was receiving aspirin 81 milligrams for Atrial Fibrillation (irregular heartbeat). The hospital discharge labs were INR 2.0 and platelets (proteins that provide clotting) 100,000. The resident received hemodialysis for ESRD. The facility nursing staff requested Resident #313 be evaluated for an altered mental status (drowsy), dark watery stools, and to review the medications on 9/14/23. The resident was not on the hospital discharge medication PPI upon admission to the facility (9/10/22) which was started today (9/14/22). The resident's abdomen was significantly distended with a palpable (able to feel) liver. The resident was very drowsy and minimally interactive and reacted to physical stimulation only and would then not be verbally responsive. The resident was not interactive. The resident's family member was in the room and informed the NP that the resident was "hallucinating" and was concerned. NP was not sure of the resident's mentation baseline and thought she had an altered mental status. There was a concern for gastrointestinal bleeding, infection, or hepatic encephalopathy (diseased liver unable to clean the blood which can cause confusion). The plan was to check a complete blood count and trend to evaluate for

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 684	Continued From page 23	F 684		

gastrointestinal bleeding and ammonia level. A urinalysis was not ordered because the resident had not made any urine. The resident was started on lactulose (for blood ammonia) and PPI today (9/14/22).

Resident #313's order dated 9/14/22 for Protonix 40 mg every 12 hours for gastrointestinal bleed, lactulose 10 grams one time (removes ammonia from the blood), and labs for ammonia level, complete blood count, and liver panel written by NP #1.

A review of Resident #313's medical record revealed no labs were completed per the order written by NP #1 on 9/14/22.

Nurses' note dated 9/15/22 documented by Nurse #7 indicated the resident was stable (vital signs), alert, and with no complaints sitting in her bed.

Resident #313's physician order dated 9/15/22 was for lactulose 10 grams each day.

Nurses' note dated 9/19/22 by Nurse #8 documented Resident #313 was having heartburn and gastrointestinal upset. Offered medication to resolve and monitored for effectiveness. No further documentation from Nurse #8 with effectiveness was in the record.

Nurse Practitioner (NP) #1 note dated 9/19/22 documented staff reported Resident #313 had complained of indigestion characterized as acid reflux. The resident was more awake and interactive today. Her gastrointestinal pain was controlled. The abdomen was significantly distended, nontender, with a palpable liver edge. The resident had scattered bruising and

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 684	Continued From page 24	F 684		

continued with dark watery stool. The labs were not completed (ordered 9/14/22). The plan was to trend the complete blood count (evaluate for bleeding). Lactulose was started each day.

Nurses' note dated 9/21/22 at 12:44 pm written by Nurse #9 documented Resident #313 informed her "I don't feel real good, I'm nauseous and my side hurts." The resident vomited twice after breakfast, and she had blood in her brief. NP #1 was made aware, and the resident was evaluated. The NP tried to get the resident to go to the Emergency Department (ED) to be evaluated and the resident refused. An order was written for an abdominal ultrasound.

NP #1 note dated 9/21/22 at 1:02 pm documented Resident #313 complained of severe abdominal pain which started about 20-30 min ago level 9 out of 10, with 10 being the worst. The resident vomited twice this morning after eating. There was currently no nausea. Blood was noted in her diaper this morning by staff, and they were unsure if it was related to bowels or bladder. The resident declined transport to the Emergency Department stating that if it was her time to die, then she was ok with it. Plan to consider hospice discussion when patient not acutely ill. Abdominal ultrasound and labs ordered.

Resident #313's physician order dated 9/21/22 to be completed on 9/22/22 was for a complete blood count (to evaluate for gastrointestinal bleeding) written by NP #1.

Resident #313's physician order dated 9/21/22 was for a stomach ultrasound for nausea and vomiting and abdominal pain written by NP #1.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 684	Continued From page 25	F 684		

Nurses' note dated 9/21/22 at 3:05 pm Nurse #9 documented she was informed by the staff that Resident #313 went to change the resident and the bed was full of blood, unsure if it was from her bottom or her vagina, spoke with NP #1 who was still in the facility. NP #1 had given an order to send the resident to the ED and the resident agreed. Emergency Medical Services left with the resident at 3:00 pm.

On 3/30/23 at 12:10 pm an interview was conducted with Nurse #9. She stated Resident #313 had dark stools and then had bright red blood in her brief. The resident was complaining of abdominal pain and decided to go to the hospital. She stated the resident was unaware how serious her condition was until staff spoke with her.

On 3/30/23 interviews were attempted with Nurse #7, #8, and #10. They no longer worked at the facility and were unable to be contacted.

On 3/30/23 at 2:35 pm an interview was conducted with NP #1. NP #1 stated that Resident #313 had dark watery stools identified by staff on 9/14/22 that were suspected to have been continued upper gastrointestinal bleeding. "I had ordered the complete blood count to assess the hemoglobin and hematocrit to evaluate for anemia and amount of gastrointestinal bleeding. If the lab value had gotten lower from admission, I would have sent the resident back to the hospital to be assessed for gastrointestinal bleeding on 9/14/22. The labs were not completed by nursing and were not recognized until my visit on 9/19/22." The labs were reordered on 9/19/22. The resident

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 684	Continued From page 26	F 684		

continued with black watery stools but her vital signs were stable. On 9/21/22 the resident had red bleeding in the bed, and I sent her to the hospital. The resident was found to have acute gastrointestinal bleeding. NP #1 stated she could not have predicted if the hemoglobin or hematocrit had dropped, and the resident was sent to the hospital on 9/14/22 if the outcome would have been different. The facility missed the PPI medication and labs that I ordered to evaluate for gastrointestinal bleeding. An increased INR lab result could indicate active bleeding.

Resident #313's hospital record dated 9/21/22 revealed she was admitted with a gastrointestinal bleed that was successfully treated (admitted on 9/21/22). The resident had frank (bright red blood) gastrointestinal bleeding from the rectum and required blood products (whole blood and platelets). The resident's INR (International Normalized Ratio shows how long it takes for blood to clot) was 3.9 (normal range1.1 or below and therapeutic range for anticoagulant 2 to 3). The resident was receiving aspirin 81 mg each day at the facility for atrial fibrillation (dysrhythmia of the heart). The resident had an EGD (esophagogastroduodenoscopy, visualization of the esophagus to the duodenum [start of the small intestine]). The resident had decreased fibrinogen (blood clotting protein) suggesting disseminated vascular coagulation (DIC abnormal blood clotting) as a result of gastrointestinal bleeding that was resolved.

On 3/30/23 at 10:10 am an interview was conducted with the Director of Nurse. She stated after record review, it was determined that the labs for Resident #313 ordered on 09/14/22 were

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 684	Continued From page 27 missed. The lab order was placed in the computer but not followed through by Nurse #10.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide the nutritional supplement as ordered by the physician for 3 of 3 sampled residents reviewed for nutrition (Resident #69, Resident #93, Resident #83). Findings included: 1. Resident #69 was readmitted to the facility on	F 692	F-692 Facility failed to provide supplements as ordered. Interventions for the affected resident All residents had the potential to be affected. Interventions for residents identified as having the potential to be affected All residents have the potential to be affected.	4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 28 9/15/22 with diagnoses that included dementia, adult failure to thrive, protein calorie malnutrition and dysphagia. Review of the physician order dated 9/23/22 revealed house shake two times a day. Review of a Dietitian note dated 12/23/23 revealed Resident #69 was triggered for significant weight loss. Note indicated the resident had a 20% weight loss in less than 90 days. Resident was on a regular diet and her intake record indicated her appetite varied with intake between 0-75%. Resident #69 was independent with eating and had possible increased intake with additional staff assistance. Interventions included fortified foods with all meals and house shakes (nutritional supplement) and magic cup (frozen nutritional treat) twice a day. Recommendations included ensuring the resident ate in the main dining room for additional encouragement and cueing as needed. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/23/23, indicated Resident #69 was assessed as severely cognitively impaired. The assessment indicated Resident #69 needed extensive assistance with one-person physical assistance for activities of daily living (ADL) except for eating the resident was independent with set up assistance. Assessment indicated the resident weighed 94 pounds (lbs.) and had significant weight loss. Review of the nutrition care plan dated 1/25/23 revealed the resident was at risk for decreased nutrition status related to advanced age, poor meal intake, low body mass index for age and need for multiple nutritional supplements. Goal	F 692	By 4/27/23, education will be provided to dietary staff by the Dietician and/or Certified Dietary Manager (CDM) on importance of tray card review for accuracy including ensuring any nutritional supplements are placed on the meal tray as per the tray card. By 4/27/23, education will be provided to nursing staff by the Staff Development Coordinator on ensuring the tray card is reviewed and compared to the meal tray for accuracy (validate for nutritional supplements). Systematic Change Dietary audits will be conducted by the CDM, Dietician or designee to ensure tray card accuracy including ensuring nutritional supplements are provided as ordered. These audits will be conducted three (3) times weekly for 12 weeks. All newly hired dietary staff will be educated by the CDM on importance of tray card review for accuracy including ensuring any nutritional supplements are placed on the meal tray as per the tray card. All newly hired nursing staff will be educated by the Staff Development Coordinator on ensuring the tray card is reviewed and compared to the meal tray for accuracy (validate for nutritional supplements). Monitoring of the change to obtain and sustain substantial compliance The results of the audits will be brought to QAPI monthly for a minimum of 3 months to determine when substantial compliance has been obtained and maintained.	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 29	F 692		

included the resident would be free from significant weight change. Interventions included assisting with meals as needed, providing diet and supplements as ordered, providing fortified foods as ordered, and providing food preferences and substitutions.

Review of the quarterly nutrition note documented by the Dietitian dated 1/23/22 revealed Resident #69 had a significant weight loss in 90 days. Resident #69 required staff assistance with meals and meal intake was recorded as mostly 0-50%. Interventions included fortified foods, house shakes and magic cup twice a day. Weight loss may be unavoidable due to dementia and overall stage of life. The note indicated the current nutrition interventions were appropriate and there were no new recommendations.

Physician order dated 2/20/23 revealed frozen nutritional treat two times a day on lunch and dinner trays.

Review of the Dietitian note dated 3/6/23 which was a weight warning note indicated resident weighed 85 lbs. The resident had a weight loss of 9.6% in 30 days, 13.6% in 90days. The resident mostly consumed 25-50%, eats independently after setup. The note further indicated the resident was receiving fortified foods, house shakes and nutritional treat twice a day, the resident was consuming mostly 100% supplements.

Review of nursing note dated 3/17/23 read in part "Resident discussed in Focus Meeting by IDT (interdisciplinary team). Resident triggered for weight. Current weight 78.0, BMI (Body mass index) 13.8, IBW (ideal body weight) 115.0.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 30	F 692		

Current diet Reg/Reg (Regular/ Regular texture). Requires set up for meals. Supplements of nutritional treat BID (twice a day), fortified foods with meals to assist in weight maintenance, house shake. Dietitian assesses per facility protocol. RP (resident representative) and MD (physician) aware. Continue with current POC (plan of care)"

During a continuous dining observation in the main dining room on 3/27/23 from 12:05 PM to 12:35 PM, Resident #69 was observed in the dining room, consuming her meal. Nurse Aide #1 was observed encouraging the resident to eat. Review of the resident's meal ticket revealed a regular diet and a house shake and frozen nutritional treat. Observation of the resident's tray revealed the resident did not receive supplements (house shake and frozen nutritional treat) on her tray.

During an interview on 3/27/23 at 12:30 PM, Nurse Aide (NA) #1 stated she usually assisted in serving residents meals in the dining room and had served Resident #69 her meal tray. NA #1 further stated she had not checked the tray to ensure the resident was provided supplements on her tray.

During an interview on 3/27/23 at 12:35 PM, the Scheduler stated she usually assisted in serving residents meals in the dining room. The scheduler stated she served beverages to Resident #69. The Scheduler stated she usually checked the tray tickets and had not done it at lunch and hence was unaware that the resident had not received her supplements.

During lunch observation in the main dining room

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 31	F 692		

on 3/28/23 at 12:15 PM, Resident #69 was observed in the dining room consuming her lunch. Observation of the resident meal tray revealed the Resident #69 received a house shake on her lunch tray but did not receive frozen nutritional treat as indicated on the meal ticket.

During an interview with the Dietary Manager on 3/28/23 at 3:10 PM, he stated on 3/27/23 the resident's meal trays were served first and later supplements and desserts. The Dietary Manager was unable to state how his staff would ensure nutritional supplements were served to the residents when the meal ticket was sent out with the meal tray. The Dietary Manager indicated on 3/28/23 the supplements were sent out with the meal trays. He further indicated the frozen nutritional treat was on the tray line, but unsure why it was not served to the resident. He indicated it was the responsibility of the dietary staff to ensure that meals and supplements were served accurately to all residents. The last dietary staff member on the tray line ensures the nutritional supplements and nutritional treats were placed on the tray, prior to sending out the trays to the dining room.

During an interview 3/28/23 at 3:37 PM, the Dietitian stated Resident #69 was on a regular diet, regular texture with frozen nutritional treat and house shakes (nutritional supplement) with lunch and dinner. The Dietitian indicated the resident was able to self-feed and needed assistance with meal set up only. Resident #69's meal intake varied from 25- 75%. The Dietitian stated Resident #69 had lost 8.2% weight in 30 days due to variable intake, age related and dementia. The Dietitian indicated the weight loss was unavoidable due to dementia. The Dietitian

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 32	F 692		

stated the nursing staff should be offering snacks in between meals and encouraging resident to consume meals during mealtime. The Dietary staff were responsible for tray accuracy and nutritional treats and supplements should be provided to residents as indicated on the diet card. Dietitian reiterated that nutritional treats and supplements should be provided to resident for weight improvement.

During an interview on 3/29/23 at 2:20 PM, the Director of Nursing (DON) stated Resident #69 was triggered for significant weight loss. The Interdisciplinary team which included the dietitian were closely monitoring the resident and nutritional supplements were introduced per dietitian recommendations. The resident had dementia and the weight loss of unavoidable. The DON stated staff should be monitoring the residents during meals and ensuring the resident receives both house shakes, and frozen nutritional treats as ordered by the physician.

During a telephone interview on 3/29/23 at 3:13 PM, the Nurse Practitioner (NP), stated Resident #69 had advanced dementia and unfortunately the weight loss was unavoidable. The resident was on fortified foods and nutritional supplements for weight management. NP further stated Resident #69 does not have the capacity to focus on her meals due to her dementia. Staff should be offering the resident nutritional supplements and treats as ordered by the physician.

2. Resident #93 was admitted to the facility on 2/16/22 with diagnoses that included moderate protein calories malnutrition and muscle weakness.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 33	F 692		

Review of the annual MDS assessment dated 2/23/23 revealed Resident #93 was assessed as severely cognitively impaired and needed extensive assistance with one-person physical assistance for ADL. The resident was assessed as independent with set up assistance only for eating. The assessment indicated Resident #93 with no known weight loss.

Review of the nutrition care plan dated 2/28/23 indicated the resident was at risk for decreased nutritional status and dehydration due to advanced age, low for age body mass index and need for supplements. The goal was to maintain nutrition comfort through food and fluid choices and be free from any significant weight loss. Interventions included revealed providing supplements as ordered and assisting with meals as needed.

Review of the Physician order dated 3/14/23 revealed house shake (nutritional supplement) in the afternoon for weight maintenance with lunch tray.

Review of the Dietitian note dated 3/20/23 revealed the resident was underweight, on a regular diet and meal intake was between 25 - 100%. The note indicated the resident received fortified foods and house shakes and was consuming 100% of supplements. Recommend decreasing house shakes to once a day due to good meal intake and weight gain.

During a continuous dining observation in the main dining room on 3/27/23 from 12:05 PM to 12:35 PM, Resident #93 was observed in the dining room consuming her meals. Review of the resident's meal ticket revealed Resident #93 was

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 34	F 692		

on a regular diet with supplements (house shake) and preferred beverage - cola. Observation of the resident's lunch tray revealed the resident did not receive nutritional supplement or preferred beverage on her tray.

During an interview on 3/27/23 at 12:30 PM, Nurse Aide (NA) #1 stated she usually assisted in serving residents meals in the dining room and served Resident #93 her meal tray. NA #1 further stated she had not checked the tray to ensure the resident was provided supplements on her tray.

During an interview with the Dietary Manager on 3/28/23 at 3:10 PM, he stated on 3/27/23 the resident's meal trays were served first and later supplements and desserts. The Dietary Manager was unable to state how his staff would ensure nutritional supplements were served to the residents when the meal ticket was sent out with the meal tray. The Dietary Manager indicated the dietary staff on the tray line had the responsibility to ensure that meals and supplements were served accurately to all residents. The last dietary staff member on the tray line ensures the nutritional supplements and nutritional treats were placed on the tray, prior to sending out the trays to the dining room.

During an interview on 3/28/23 at 3:30 PM, the Dietitian stated the resident #93 was on a regular diet with regular texture, fortified food and house shakes once a day at lunch. Resident could self-feed and usually consumed 50 -100% of her meals. The Dietitian indicated the resident had a low body weight and her weight has been slowly improving. The Dietitian stated the resident supplements were reduced from twice a day and once a day due to steady weight gain. The

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 35	F 692		

Dietitian indicated the resident was on supplements for weight management and she expected the resident to receive the supplements.

During an interview on 3/29/23 at 2:28 PM, DON stated staff should ensure the resident received supplements as ordered by the physician.

During a telephone interview on 3/29/23 at 3:45 PM, the NP stated the residents' weight was stable versus trending up. Resident's weight was low for her age and usually weighed around 106 -109 lbs. NP stated nursing staff should be offering supplements as ordered by the physician for resident's weight management.

3. Resident #83 was readmitted to the facility on 8/18/21 with diagnoses that included dementia, dysphagia, and muscle weakness.

The nutrition care plan review dated 12/18/22 revealed the resident was at risk for decreased nutrition status related to advanced age, varied meal intake, need for nutritional supplements and fortified foods. The goal included will maintain nutritional comfort through food/fluids of choice; and would be free from significant weight change. Interventions included assisting the resident with meals as needed and providing diet and supplements as ordered.

Review of the nutrition weight review note documented by the Dietitian dated 1/2/23 revealed resident with a weight loss of 3.9% in 30 days. Meal intake recorded at 75- 100% and 3 meal refusals in 30 days. Supplements in place for weight management.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 36	F 692		

Review of the quarterly MDS assessment dated 1/9/23 indicated Resident #83 was admitted on 4/29/21. Resident #83 was assessed as cognitively impaired. The resident was assessed as needing extensive assistance to total dependence with one- two-person physical assistance for ADL. Resident was assessed as needing supervision with one-person physical assistance with eating. Assessment indicated Resident #83 weighed 117 pounds (lbs.) with no weight loss.

Review of resident's weights revealed Resident #83 weighed 117.2 pounds (lbs.) on 12/19/23; on 1/23/23 weighed 116.4 lbs., On 2/20/23 weighed 114.8 lbs. and on 3/13/23 weighed 115.8 lbs.

The Physician order dated 1/16/22 revealed nutritional treat two times a day for weight loss prevention, sent from kitchen on lunch and dinner trays.

Review of the physician order dated 2/10/22 revealed house shakes (nutrition supplements) with meals, sent from the kitchen on meal trays.

During a continuous dining observation in the main dining room on 3/27/23 from 12:05 PM to 12:35 PM, Resident #83 was observed in the dining room consuming his meal. The Speech Therapist was assisting the resident. Review of the resident's meal ticket revealed Resident #83 was on a regular pureed diet. The supplements on the meal ticket indicated house shake and frozen nutritional treat. Observation of the resident's tray revealed the resident did not receive supplements (house shake and nutritional treat) on his tray.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 37	F 692		

During an interview on 3/27/23 at 12:35 PM, the Scheduler stated she usually assisted in serving residents meals in the dining room. She indicated she did serve Resident #83 his meal tray. The Scheduler stated she usually checked the tray tickets and had not done it at lunch and hence was unaware that the resident had not received her supplements.

During an interview with the Dietary Manager on 3/28/23 at 3:10 PM, he stated on 3/27/23 the resident's meal trays were served first and later supplements and desserts. The Dietary Manager was unable to state how his staff would ensure nutritional supplements were served to the residents when the meal ticket was sent out with the meal tray. The Dietary Manager indicated the dietary staff on the tray line had the responsibility to ensure that meals and supplements were served accurately to all residents. The last dietary staff member on the tray line ensures the nutritional supplements and nutritional treats were placed on the tray, prior to sending out the trays to the dining room.

During an interview on 3/28/23 at 3:37, the Dietitian indicated the resident was on house shake and nutritional treat for supplements as resident has episodes of not eating well. Resident #83 consumed 100% of the nutritional treat and 50% of the supplements. The supplements were introduced for weight management. The Dietitian indicated the staff should be providing the resident with supplements and nutritional treats for weight management.

During an interview on 3/29/23 at 2:31 PM, the DON stated the resident needed a lot of cueing with eating. The resident should be offered

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 692	Continued From page 38 supplements as ordered by the physician for weight management. During a telephone interview 3/29/23 at 3:47 PM, NP stated the resident had supplements ordered for weight management. The staff should encourage the resident to eat and consume the supplements. The supplements should be offered to resident as ordered by the Physician.	F 692		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Nurse Practitioner interviews, the facility failed to administer the medication proton pump inhibitor (PPI, blocks stomach acid) to manage gastrointestinal bleeding for 1 of 2 residents reviewed for quality of care (Resident #313). Findings included: Resident #313 was admitted to the facility from the hospital on 9/10/22 with the diagnoses of end stage renal disease (ESRD) dependent on hemodialysis, cirrhosis of the liver, abdominal ascites, diabetic gastroparesis, atrial fibrillation (heart dysrhythmia) and myocardial infarction (heart attack). The hospital discharge summary dated 9/10/22 had an order to continue Protonix, proton pump inhibitor (PPI), medication used to block production of stomach acid, and treat occurrence	F 760	F- 760 Resident medication order was missed upon admission Interventions for the affected resident Resident is no longer at facility. Interventions for residents identified as having the potential to be affected. All new admissions from 3-1-23 to present discharge orders were reviewed by Assistant Director Of Nursing/Unit Manager on 4-4-23 for accuracy. All orders were reviewed from March 1 to present with no issues identified. All Licensed nurses will be re-educated by 4-21-23 by Staff Development Coordinator on verifying orders with Physician and/or Nurse Practitioner, to document who verified the orders and the nurses signature of whom is taking the orders. If any changes are made to an order to document the changes on the discharge	4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 39 of gastrointestinal bleed. Resident #313's admission Minimum Data Set dated 9/17/22 documented the resident had moderately impaired cognition. Review of Resident #313's physician orders for the admission 9/10/22 to 9/21/22 did not reveal an order for PPI medication. On 3/30/23 at 3:20 pm an interview was attempted with Nurse #10 who admitted the resident and entered the physician order. She was unable to be reached. On 3/30/23 at 10:10 am an interview was conducted with the Director of Nursing. She stated she was not employed at the facility on 9/10/22 when Resident #313 was admitted. She stated after record review, it was determined that Resident #313's PPI medication that was to be continued after hospital discharge was missed. Nurse Practitioner (NP) #1 note dated 9/14/22 documented Resident #1 had a history of an upper gastrointestinal bleed. The resident had diabetic gastroparesis (disease of gastrointestinal tract) and was not on diabetic medication. The hemoglobin A1C (measures average blood sugar level over the past 3 months) was 9.1% (normal range below 5.7%). Anticoagulant (thins the blood) treatment was deferred due to bleeding risk although the resident was receiving aspirin 81 milligrams for Atrial Fibrillation (irregular heartbeat). The hospital discharge labs were INR 2.0 and platelets (proteins that provide clotting) 100,000. The resident received hemodialysis for ESRD. The facility nursing staff requested Resident #313 be evaluated for an altered mental status (drowsy), dark watery stools, and to review	F 760	summary and in a progress note. Systematic Change All new admission orders will be verified by nurse management team for accuracy during clinical meeting for 12 weeks. All newly hired LPN/RN will be educated in orientation by Staff Development Coordinator on verifying orders with Physician and/or Nurse Practitioner, to document who verified the orders and the nurses signature of whom is taking the orders. If any changes are made to an order to document the changes on the discharge summary and in a progress note. Monitoring of the change for sustain system compliance The results of the audit will be brought through the QA monthly meeting for a minimum of 3 months or until substantial compliance is met.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 40	F 760		

the medications on 9/14/23. The resident was not on the hospital discharge medication PPI upon admission to the facility (9/10/22) which was started today (9/14/22). The resident's abdomen was significantly distended with a palpable (able to feel) liver. The resident was very drowsy and minimally interactive and reacted to physical stimulation only and would then not be verbally responsive. The resident was not interactive. The resident's family member was in the room and informed the NP that the resident was "hallucinating" and was concerned. NP was not sure of the resident's mentation baseline and thought she had an altered mental status. There was a concern for gastrointestinal bleeding, infection, or hepatic encephalopathy (diseased liver unable to clean the blood which can cause confusion). The plan was to check a complete blood count and trend to evaluate for gastrointestinal bleeding and ammonia level. A urinalysis was not ordered because the resident had not made any urine. The resident was started on lactulose (for blood ammonia) and PPI today (9/14/22).

Resident #313's order dated 9/14/22 for Protonix 40 mg every 12 hours for gastrointestinal bleed, lactulose 10 grams one time (removes ammonia from the blood), and labs for ammonia level, complete blood count, and liver panel written by NP #1.

Resident #313's Medication Administration Record for January 2022 was reviewed, and the PPI was given as ordered on 9/14/22.

Nurses' note dated 9/21/22 at 3:05 pm Nurse #9 documented she was informed by the staff that Resident #313 went to change the resident and

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 760	Continued From page 41	F 760		

the bed was full of blood, unsure if it was from her bottom or her vagina, spoke with NP #1 who was still in the facility. NP #1 had given an order to send the resident to the ED and the resident agreed. Emergency Medical Services left with the resident at 3:00 pm.

On 3/30/23 at 12:10 pm an interview was conducted with Nurse #9. She stated Resident #313 had dark stools and then had bright red blood in her brief. The resident was complaining of abdominal pain and decided to go to the hospital. She stated the resident was unaware how serious her condition was until staff spoke with her.

On 3/30/23 interviews were attempted with Nurse #7, #8, and #10. They no longer worked at the facility and were unable to be contacted.

On 3/30/23 at 2:35 pm an interview was conducted with NP #1. NP #1 stated that Resident #313 had dark watery stools identified by staff on 9/14/22 that were suspected to have been continued upper gastrointestinal bleeding. "I had ordered the complete blood count to assess the hemoglobin and hematocrit to evaluate for anemia and amount of gastrointestinal bleeding. If the lab value had gotten lower from admission, I would have sent the resident back to the hospital to be assessed for gastrointestinal bleeding on 9/14/22. The labs were not completed by nursing and were not recognized until my visit on 9/19/22." The labs were reordered on 9/19/22. The resident continued with black watery stools but her vital signs were stable. On 9/21/22 the resident had red bleeding in the bed, and I sent her to the hospital. The resident was found to have acute

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 760	Continued From page 42 gastrointestinal bleeding. NP #1 stated she could not have predicted if the hemoglobin or hematocrit had dropped, and the resident was sent to the hospital on 9/14/22 if the outcome would have been different. The facility missed the PPI medication and labs that I ordered to evaluate for gastrointestinal bleeding. An increased INR lab result could indicate active bleeding. Resident #313's hospital record dated 9/21/22 revealed she was admitted with a gastrointestinal bleed that was successfully treated (admitted on 9/21/22). The resident had frank (bright red blood) gastrointestinal bleeding from the rectum and required blood products (whole blood and platelets).	F 760		
F 761 SS=E	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 §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	F 761		4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 761	Continued From page 43 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 record review, observations and staff interviews, the facility failed to date opened medications in 3 of 5 medication administration carts (100, 200 and 500 halls.) and failed to remove expired medications stored in 1 of 5 medication administration carts (100 hall.) Findings Included: 1. On 3/27/23 at 10:05 AM, an observation of the medication administration cart on 200 hall with Nurse #11 revealed one opened and undated multi-dose Insulin Levemir Flex Pen Injector. A review of the manufacturer's literature indicated to discard the insulin multi-dose pen-injector 42 days after opening. On 3/27/23 at 10:10 AM, during an interview, Nurse #11 indicated that the nurses, who worked on the medication carts, were responsible for putting the date of opening on insulin multi-dose injectors. The nurse indicated that she had not checked the date of opening on insulin pen-injectors in her medication administration cart at the beginning of her shift. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse did not administer undated insulin this shift.	F 761	F- 761 Insulin pens were not dated in medication cart. Expired medications were in medication cart. Interventions for the affected resident No residents were affected. Interventions for residents identified as having the potential to be affected. 100% medication cart and treatment cart audit was conducted by nurse supervisor and treatment nurse on 3/30/23 All Licensed nurses will be re-educated by 4-21-23 by Staff Development Coordinator on labeling and storage of medications in the medication/treatment carts. Systematic Change Director of nursing/Unit manager or designee will complete medication and treatment cart audits 3 times a week for 4 weeks, then 2x a week for 4 weeks, then weekly for 4 weeks. Newly hired LPN/RN will be educated in orientation by Staff Development Coordinator on labeling and storage of medications in the medication/treatment carts. Monitoring of the change for sustain system compliance The results of the audit will be brought	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 44 2. On 3/27/23 at 10:20 AM, an observation of the medication administration cart on the 100 hall with Nurse #12 revealed two opened Geri-Mox Antacid Liquid 12 fluid ounces, expired on February 2023. On 3/27/23 at 10:25 AM, during an interview, Nurse #12 indicated that the nurses, who worked on the medication carts, were responsible to check all the medications in her medication administration cart for expiration date and remove expired medications. The nurse indicated that she checked expiration date on medications at the beginning of her shift but missed expired Geri-Mox Antacids. The nurse did not administer expired medication this shift. On 3/28/23 at 8:05 AM, an observation of the medication administration cart on 500 hall with Nurse #1 revealed one opened and undated multi-dose Insulin Lantus Pen Injector. A review of the manufacturer's literature indicated to discard the insulin multi-dose pen-injector 28 days after opening. 3. On 3/28/23 at 8:15 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible for putting the date of opening on insulin pens-injectors. The nurse indicated that she checked the date of opening on medications in her cart but did not see the opened insulin injector without date at the beginning of her shift. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medications. The nurse did not administer undated insulin this shift. On 3/28/23 at 11:10 AM, during an interview, the	F 761	through the QA monthly meeting for a minimum of 3 months or until substantial compliance is met.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 45 Director of Nursing (DON) indicated that all the nurses were responsible for putting the date of opening on insulin pens-injectors, check all the medications in medication administration carts for expiration date and remove expired medications every shift. The DON stated that weekly, the pharmacy staff checked the expiration dates and removed expired medications. She expected that no expired items be left in the medication carts.	F 761		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to have sufficient dietary staff with competencies to carry out meal preparation and food service tasks for 101 of 103 residents who received meal trays.	F 802	F-802 Facility failed to have sufficient dietary staffing Interventions for the affected resident All Residents had the potential to be	4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 802	Continued From page 46 The findings included: During an interview on 3/27/23 at 10:15 AM, the dietary manager stated he was not having sufficient staff as some of the dietary staff had quit. The dietary manager stated there was no cook in the morning as a result was responsible for cooking breakfast and lunch for the residents. He further stated he had only two dietary aides who assisted him with cleaning and other kitchen jobs. He stated the plate warmers needed to be cleaned over the weekend and there was no adequate staff to complete the cleaning task. During an interview on 3/27/23 at 10:40 AM, dietary aide #1 stated there was usually one cook and 2 dietary aides in the morning. She further stated that the cook was not coming in for few days and the dietary manager was working as the cook. She indicated she had yet to complete cleaning of the carts before she could clean other kitchen equipment. During a continuous observation of meal preparation and tray line on 3/28/23 from 11:25 AM to 12:00 PM, the dietary manager was observed cooking resident's meals. There was no alternate menu prepared and available for the residents on the tray line. During an interview on 3/28/23 at 2:40 PM, the dietary manager stated that the dietary department needed staff. The department had no cook, and he was working as a cook. He stated he did not have adequate time to complete cooking of the alternate entrée and hence was not served at lunch. He further stated he was responsible for cleaning the nourishment	F 802	affected. Interventions for residents as having the potential to be affected All residents have the potential to be affected. Facility continues with recruiting and hiring process. Facility is utilizing contract staffing to meet facility and resident needs. Systematic Change Administrator, HR and CDM will review weekly openings for dietary staff and ensure recruiting, hiring and use of contract employees continue until staffing needs met. Monitoring of the change to sustain system compliance Current staffing levels with a listing of open positions will be brought to QAPI monthly for a minimum of 3 months to determine when substantial compliance has been obtained and maintained.	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 802	Continued From page 47	F 802		

refrigerators but hadn't been having time due to lack of staffing. He stated there were 2 dietary aides and himself in the morning. One dietary aide usually comes around 12 PM and a cook comes in the afternoon to complete the evening cooking.

A review of the dietary staff schedule revealed on 3/27/23 there was one person assigned as cook and two dietary aide for the morning shift. There was one cook and two aide for the evening shift. Observation revealed on 3/27/23 the dietary manager was the cook on duty for the morning shift and there were 2 dietary aides on the morning shift. Review of the dietary staff schedule revealed on 3/28/23, revealed there was no one assigned as a cook. There were 2 dietary aide assigned for morning shift. There was one cook and two aide for the evening shift. Observation on 3/28/23 revealed the dietary manager was the cook on duty for the morning shift and there were 2 dietary aides on the morning shift. One cook and 2 dietary aides were observed in the evening shift.

Review of the dietary staff schedule from 3/16/23 - 3/29/23 revealed on 3/16/23 and 3/17/23 there was only one dietary aide for evening shift; On 3/20/23 and 3/21/23 there was no cook assigned on morning shift. On 3/24/23 there was only one dietary aide assigned in the evening shift. On 3/25/23 there was no cook assigned to the morning and in the evening shift. There was only one dietary aide assigned on 3/26/23 for both morning and evening shift.

During an interview with the Dietary manager on 3/28/23 at 2:20 PM, he indicated the dietary department did not have adequate staff and he

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 802	Continued From page 48 stepped in as a cook when there was no cook or any call outs. Review of the food temperature chart logs from 2/1/23 to 3/27/23 revealed 20 daily food temperature chart log sheets that did not contain at least one meal food temperatures entered in them. During an interview with the dietary manager stated he was aware the evening cooks were not entering the food temperatures of menu items after cooking and prior to plating. He indicated he had requested the staff to enter them multiple times. During an interview on 3/29/23 at 4:51 PM, the Administrator stated four (4) dietary staff had quit few weeks ago. The facility was actively recruiting since, and multiple interviews had been conducted. The jobs had also been offered to few based on their background checks, however they were no show. The Administrator stated the dietary manager's primary function has been a cook until the facility has adequate dietary staff.	F 802		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observations, test tray evaluation,	F 804	F-804	4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 804	Continued From page 49 resident interviews (Resident #314, Resident #18, Resident #76), and staff interviews, the facility failed to serve nutritive, appealing, and palatable foods to residents. Findings included: Resident #314 was admitted to the facility 3/17/23. The admission Minimum Data Set (MDS) assessment dated 3/24/23 was in progress. Review of the nursing note dated 3/18/23 revealed the resident was alert and oriented and could make her needs known. Resident #314 was interviewed on 3/27/23 at 1:52 PM. Resident #314 reported that the food served on the tray was bland and sometimes served cold. There was no salt or spices added to the food. Resident #18 was admitted to the facility 3/1/23. The admission MDS dated 3/5/23 assessed Resident #18 to be cognitively impaired. During an observation and interview on 3/27/23 at 12:16 PM. Resident #18 was observed not eating her meal tray and complaining that the food was tasteless and over cooked. Resident #76 was admitted to the facility 3/10/23. The admission MDS dated 3/15/23 assessed Resident #76 to be cognitively intact. Resident #76 was interviewed on 3/27/23 at 3:00 PM. Resident #76 reported that the food was not palatable, over cooked, and bland.	F 804	Facility failed to provide meals consistently with Nutritive Value Appearance, Palatable at acceptable Temps. Interventions for the affected resident All residents had the potential to be affected. Interventions for residents identified as having the potential to be affected All residents have the potential to be affected. Dietary will prepare meals in a fashion that has Nutritive Value, is appealing, palatable, preferences honored and acceptable food temperatures. By 4/27/23, dietary manager and dietary staff will be educated by the Dietitian and/or Administrator or designee on ensuring meals are prepared in a fashion that has nutritive value, is appealing, palatable, acceptable temperature, preferences are honored and menu□s are followed. Systematic Change Dietary Audits will be conducted by the Dietician and/or Administrator or designee to ensure meals are prepared in a fashion that has nutritive value, is appealing, palatable, menus are followed, preferences are met, and temps are within acceptable ranges. These audits will be conducted weekly for 12 weeks. All newly hired dietary staff will be educated by the Dietary Manager on ensuring meals are prepared and served in a fashion that has Nutritive Value, is appealing, palatable, preferences honored, acceptable food temperatures and menu□s are followed. Monitoring of the change to obtain and	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 804	Continued From page 50 During a continuous observation of meal preparation and tray line on 3/28/23 from 11:25 AM to 12:00 PM, the dietary manager was cooking resident's meals. During the tray line observation, the menu vegetable (cauliflower, squash, and brussels sprouts) that was on the steam table appeared to be mushy and without any seasoning. The starch (cheddar mashed potatoes) appeared to be running. The dietary manager who was plating resident's food stated the vegetable on the steam table was for mechanically altered diets and hence was well cooked. He further stated that no seasoning were added to the vegetables as it was served on therapeutic diet tray and these diets should not be served any salt. A two-test tray was requested on 3/28/23 at 12:00 PM. One was a regular diet tray, and another was a mechanically altered diet tray. These were the last tray after all the residents were served their lunch meal. The test tray was sampled with the dietitian on 3/28/23 at 1:30 PM. The regular diet tray had oven fried chicken, cheddar mashed potatoes and mixed vegetables. The mixed vegetables were served in the bowl and placed on the plate with chicken and mashed potatoes The plate was covered by a dome. The consistency was the mashed potatoes was runny and not scooped. The mixed vegetables very extremely salty to taste. The dietitian also tasted the test tray and agreed the vegetables were too salty and mashed potatoes were not correct consistency. She stated the cook should be following the recipe. The mechanically altered tray had mashed potatoes, mechanically altered meat (appeared like semi shredded chicken with a lot of gravy) and vegetables (cauliflower, squash, and	F 804	sustain substantial compliance The results of the audits will be brought to QAPI monthly for a minimum of 3 months to determine when substantial compliance has been obtained and maintained.	

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	345458	A. BUILDING _____ B. WING _____	C 03/30/2023

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TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 804	Continued From page 51	F 804		

brussels sprouts). The vegetables were served in a bowl and placed on the plated. The plate was covered with a dome. The mashed potatoes was runny, the mechanically altered meat had a lot of gravy and the food was running off the plate. The color of the plate was not appealing and appetizing. The vegetables were overcooked and had no salt or any seasoning in them. The dietitian also tasted the test tray. The dietitian stated she felt the mechanically altered tray was not appealing and the food was running out of the plate. She agreed the mashed potatoes and the meat were too runny and vegetables had no seasoning and was very bland. It was not an appealing or palatable plate.

During an interview on 3/28/23 at 2:50 PM, the dietary manager indicated the standard recipes were followed when food were cooked for the residents. However, when seasoning or salt was added to the mechanically altered vegetables, he received complaints that the food was very salty. He indicated it was due to this reason, he has not been adding any seasoning to the vegetables. He indicated he did not report to the dietitian when he received complaints about the food being salty when seasonings were added.

During an interview on 3/28/23 at 3:05 PM, the dietitian stated the recipes were available for the dietary cooks. The recipes indicate how a therapeutic diet should be prepared and cooked. The recipes also indicate the ingredients to be used, including the type and amount of seasonings needed for the menu item. The dietitian stated the dietary cooks should follow standard recipes that were printed from the nutritional software system.

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 804	Continued From page 52 During an interview on 3/29/23 at 5:04 PM, the Administrator stated the expectation was the food served to the residents was nutritious, appealing, and palatable. The cook and dietary staff cooking residents' food should be following standard recipes. The Administrator indicated the dietary Manager had access to standard recipes and these were also available online.	F 804		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(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. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to label and date food stored in the walk-in refrigerator, discard foods with expired use by date in the walk-in refrigerator and reach in refrigerator. The facility failed to discard expired food in 2 of 2	F 812	F-812 Facility failed to ensure all food items were labeled and dated with expired items disposed of timely in dietary, hand hygiene between tasks, keep plate warmer clean and nourishment room	4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 812	Continued From page 53 nourishment refrigerators reviewed for food storage (Nursing station #1 and Nursing station #2). The facility failed to ensure the plate warmer and the nourishment refrigerator #2 (near nursing station #2) were maintained clean. The Dietary Manager failed to change gloves and perform hand hygiene in between tasks when observed during meal preparation. Finding included: 1a. On 3/27/23 at 10:00 AM, observation of the reach in refrigerator revealed an aluminum pan half filled with creamy yellow colored fruit chunks labeled "Apples - 3/20/23". During an interview, the Dietary Manager stated the food in the pan was cut apples. The Dietary Manager further stated the food should be stored in the refrigerator for 3 days only and after 3 days should be discarded. 1b. On 3/27/23 at 10:02 AM observation of the walk-in refrigerator revealed a zip closure bag with deli meat with no label, two zip closure bags with 2 small cubes of sliced cheese with no label, a plastic container with yellow colored creamy, pudding like consistency food with date "3/4/23" on it. An aluminum pan containing a creamy colored food labeled "Egg salad, 3/19/23", a 32 oz (ounce) yogurt container with expiration date "3/23/23" printed on it, a zip closure bag with half cut cucumber with "3/20/23" written on it. A plastic bag half filled with chopped greenish yellowish vegetable dated "3/18". During an interview with the Dietary Manager, he stated the deli meat was ham and both the ham and cheese were used earlier to make sandwiches. He further stated the creamy pudding like food was pudding and should have	F 812	fridges clean. Interventions for the affected resident No residents were affected. All undated and expired items in the kitchen and nourishment rooms were disposed of by Dietary Staff on 3/27/23. The plate warmer in the kitchen was cleaned by dietary staff on 3/27/23. Interventions for residents identified as having the potential to be affected All residents had the potential to be affected. By 4/27/23, education will be completed for all dietary staff by the Dietician and/or Administrator on ensuring food items are labeled and dated, expired items are disposed of timely in the kitchen and in all nourishment room, refrigerators in nourishment rooms are clean hand hygiene is completed between tasks and ensuring plate warmer cleanliness is maintained. By 4/27/23, education will be completed by the Administrator and facility managers who participate in Manager on Duty assignments to ensure nourishment room refrigerators are checked daily for temperatures, cleanliness and items are labeled/dated, and disposed of timely. Systematic Change Facility managers will complete nourishment room refrigerator audits daily (Monday-Friday) for 12 weeks to ensure refrigerators are clean, food items are labeled and not expired and refrigerator temperature logs are completed daily. Dietary Audits will be completed by the Dietitian, Dietary Manager and/or Administrator or designee to ensure food	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 812	Continued From page 54 been discarded. The greenish yellowish vegetable was chopped celery and that too should have been discarded. The Dietary Manager indicated the egg salad should be stored only for 3 days and should have been discarded. 1c. On 3/27/23 at 10:08AM, observation of the walk- in freezer revealed an opened plastic bag with frozen meat with ice on it. An opened bag with some frozen meat that looked like chicken nuggets with ice on them. There was no label on either of these bags. The Dietary Manager stated the frozen meat that looked like chicken nuggets were chicken nuggets. He indicated both the foods should be labeled and dated. 2. On 3/27/23 at 10:10 AM, observation of the plate warmer revealed the plate warmer had few a plates in it. There was no dome on the plate warmer. There were multiple white and brown stains on the walls and on the base of the plate warmer. During an interview with the Dietary Manager, he indicated the plate warmer was supposed to be cleaned over the weekend and has not been cleaned. He stated he did not have adequate kitchen staff and that there were only 2 dietary aides working that morning. He further stated the aides would get to it when they had finished cleaning the dishes. 3a. An observation of the nourishment room refrigerator #1(near nursing station #1) on 3/27/23 at 10:20 AM, revealed a personal insulated lunch bag with no name, 2 personal water bottles (one pink colored and one black colored) with no name, One small plastic container with homemade food that was labeled	F 812	items are appropriately labeled and dated, any expired items are disposed of timely, hand hygiene between tasks and plate warmer is clean. These audits will be conducted daily for 12 weeks. All newly hired dietary staff will be educated by the Dietary Manager on food items labeled and dated with expired items disposed of timely in the kitchen and in all nourishment rooms, refrigerators in nourishment rooms are clean, hand hygiene between tasks, keep plate warmer clean. Monitoring of the change to obtain and sustain substantial compliance The results of the audits will be brought to QAPI monthly for a minimum of 3 months to determine when substantial compliance has been obtained and maintained.	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 812	Continued From page 55	F 812		

"room 310 - 2/24", one take out container containing yellow colored food labeled "room 318 - 2/11/23", one grocery bag containing two - 0.53 ounce (oz.) yogurt -labelled Room 105.
During an interview with the Nurse Aide (NA) #5 indicated the insulated lunch bag and water bottles belonged to staff. She further stated there was no resident in Room 105 and the food should be discarded when the resident discharged from facility. NA #5 stated all the other foods in the refrigerator were food brought in by resident's family members and should be discarded as these were very old.

3b. An observation of the nourishment room refrigerated #2 (near nursing station #1) on 3/27/23 at 10:28 AM, revealed a personal insulated lunch bag with no name or date, a white plastic grocery bag with three (3) take out containers which looked like Chinese food take out cardboard container with "206" written on it. There was no date or resident name on it. A 32 ounce (oz) take out beverage cup filled with fluid with no name or date on it. The refrigerator was observed to have multiple, yellow-colored stains on the racks and on the floor. The nourishment freezer floor had a large yellow stain on the floor.
During an interview with NA #7 she indicated the personal insulated lunch bag belonged to a resident. She further stated she was unsure when the bag was placed in the refrigerator. NA #7 indicated the takeout containers may be resident's food and unsure which resident it belonged to and when it was placed in the refrigerator. NA #7 indicated the kitchen was responsible for cleaning the nourishment refrigerator.

During an interview with the Dietary Manager on

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 812	Continued From page 56	F 812		

3/28/23 at 2:30 PM, he stated he was responsible to clean the nourishment refrigerator and had not been able to clean it lately as there was no cook during the morning and multiple dietary staff had quit recently. He further stated he had tried to clean the stain in the nourishment refrigerator, but it was a stubborn stain and was hard to remove.

4. During a continuous meal preparation observation on 3/28/22 from 11:25 AM - 12:10 PM, the Dietary Manager was observed cooking residents lunch meal. During the process, the Dietary Manager went to the 3 compartment sink and removed a dirty dish from the wash compartment. He later placed the pan to the side. Did not change his gloves and went to the food processor and removed the container with lid from the food processor. The surveyor stopped the Dietary Manager and asked him to change his gloves and wash hands before he went ahead and touched cooked food. The Dietary Manager discarded his gloves and performed hand hygiene. Again, during the cooking process, the dietary manager went to the wash sink again and removed the dish soaking in the washed sink. He later put it to the side, came to the rack that contained cleaned dishes that were air dried and picked up a clean aluminum pan. The surveyor again stopped the Dietary Manager and requested him to change his gloves and perform hand hygiene.

During an interview with the Dietary Manager, he indicated he had placed his hands with gloves under the sanitizer solution hose and cleaned the gloves with sanitizer solution. Hence did not think he needed to change the glove again.

During an interview on 3/29/23 at 4:51 PM, the

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 812	Continued From page 57 Administrator stated it was the expectation for dietary staff to comply with federal and state regulation regarding food. He further stated the dietary staff should be trained based on the regulation and food and nutrition policies. He added there should be checks in place to ensure the food and nutrition policies were followed by dietary staff. The Administrator stated the dietary department cleaning schedules should be followed by dietary staff to ensure the equipment and refrigerators were maintained clean.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.	F 867		4/27/23

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 58 §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities.	F 867		

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	2059 TORREDGE ROAD DURHAM, NC 27712

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F 867	Continued From page 59	F 867		

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 867	Continued From page 60 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions put into place by the Committee after the annual recertification/complaint investigation on 3/3/22 with a citation that was recited on the current recertification survey of 3/30/23. This was evident for one recited deficiency in the area of Food Safety Requirements (F812). The continued failure of the facility during two federal surveys of record within the past 3 years show a pattern of the facility's inability to sustain an effective QAA Program. Findings included: This tag is cross-referenced to: F812: Based on observations, staff interviews and record review the facility failed to label and date food stored in the walk-in refrigerator, discard foods with expired use by date in the walk-in refrigerator and reach in refrigerator. The facility failed to discard expired food in 2 of 2 nourishment refrigerators reviewed for food storage (Nursing station #1 and Nursing station #2). The facility failed to ensure the plate warmer and the nourishment refrigerator #2 (near nursing station #2) were maintained clean. The Dietary	F 867	F-867 Interventions for the affected residents All residents had the potential to be affected. Interventions for residents identified as having the potential to be affected A plan of correction has been written, implemented, and reviewed by the facility QAPI committee to address (F-802, F-812, F-692 and F-804) with assistance from the corporate Vice President of Operations. Compliance audits have been initiated and education has been provided by the Dietary Manager and Dietician to dietary staff to ensure sustained compliance. Compliance date of 4/27/23. Systematic Change On 4/21/23, the facility quality assurance (QA) Committee conducted a meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) committee and review on-going compliance issues as it related to dietary services. Corrective action has been taken for the identified concerns related to repeat deficiency. On 4/21/23, the Vice President of Operations provided education to the QAPI Committee regarding F tag □ 867 with emphasis upon ensuring compliance	

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 03/30/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 867	Continued From page 61 Manager failed to change gloves and perform hand hygiene in between tasks when observed during meal preparation. During the complaint/recertification survey of 3/30/23, the facility failed to discard expired foods, date label opened foods, check food temperature before plating, and keep the nourishment refrigerator clean and failed to have adequate staff to follow the recipe and supply food alternates. On 3/30/23 at 4:45 pm an interview was conducted with the Administrator. He stated he was new to the facility, about 3 months. He was responsible for the management of the kitchen and staff. He stated that he was not aware dietary staff was not consistently following the meal recipe, taking the temperature of food before serving, providing food alternates, and cleaning the nourishment refrigerator.	F 867	is maintained for identified quality concerns as it relates to dietary service (F-802, F812, F692, F804). The QAPI Committee will continue to identify other areas of quality concern through the quality improvement (QI) review process, for example: review of audit findings and review of contracted dietician quality recommendations. Monitoring of the change to obtain and maintain substantial compliance The QAPI committee will meet at a minimum of monthly X 3 months to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Results of the audits will be brought to QAPI monthly X 3 months. The QAPI committee has the authority to amend plans of correction for (F-802, F812, F692, F804) to sustain ongoing compliance.	