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 02/06/2025

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 000	INITIAL COMMENTS The surveyor entered the facility on 2/4/25 to conduct a complain survey and exited on 2/5/25. Additional information was obtained on 2/6/25. Therefore, the exit date was changed to 2/6/25. Event ID# XG3B11. The following intakes were investigated NC00226447, NC00226032, NC00224620, NC00221726, and NC00221330. One of the nine complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and residents, the facility failed to protect the right of a resident (Resident # 2) to be free of abuse when another resident (Resident # 3), who was experiencing an increase in agitated behaviors while diagnosed with a urinary tract infection, hit	F 600	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/14/2025

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 02/06/2025

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F 600	Continued From page 1	F 600		

Resident # 2 in the head with a reacher. (A reacher is a metal assistive device used to grab items that are out of reach). This was for one of three residents reviewed for abuse and neglect. The findings included:

Record review revealed Resident # 3 resided at the facility from 10/29/19 until his final discharge on 12/3/24. Although not inclusive of all diagnoses, Resident # 3 had a history of hip fracture, vascular dementia, and insomnia.

Review of Resident # 3's 10/9/24 quarterly Minimum Data Set (MDS) assessment revealed Resident # 3 was moderately cognitively impaired. He was not assessed to have behavioral problems during the assessment period. The resident was coded as using a wheelchair for mobility.

On 11/19/24 at 2:59 PM Nurse # 3 documented in a nursing entry the following information. Resident # 3 was yelling and attempting to be combative with staff. He was seen by the PA (Physician's Assistant) who ordered a urinalysis and urine culture.

On 11/19/24 PA # 1 documented she was seeing Resident # 3 for increased confusion. PA # 1 noted Resident # 3 thought he was in London, England and a urine specimen would be obtained.

On 11/19/24 Resident # 3 was also seen by the Psychiatric PA who documented the following information. Resident # 3 had a history of intermittent confusion. The Psychiatric PA further documented, "Was seen today exhibiting aggressive behaviors, increased agitation, and

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	345458	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 600	Continued From page 2	F 600		

anxiety. He was observed in his wheelchair in the hallway attempting to strike other residents and staff members with his grabber. His behaviors escalated to the point where he was obstructing the hallway, not allowing others to pass. According to the treatment nurse, these behaviors began in the morning during Medpass. Patient mentioned to the nurse about an imminent call from the 'Russians' and urged him to administer his medications quickly as they would be 'shooting at him soon.' After this interaction, he retreated to his room quietly until after lunch, when his behaviors began to escalate again. Throughout the day, patient was seen self-propelling his wheelchair up and down the hallways, appearing very agitated and difficult to redirect. His anxiety, agitation, and aggressiveness continued to escalate to the point where he threw a computer on the floor and was swinging his grabber around. Despite staff's attempts to redirect and de-escalate the situation, patient remained agitated. Patient was eventually guided back to his room where attempts were made to calm him down. He was offered snacks, food, and drinks as a distraction and to help de-escalate the situation. The medical team was made aware of his condition and ordered a urinalysis to check for a urinary tract infection. A one time dose of Ativan was ordered but not used." The Psychiatric PA noted the resident's behaviors could be secondary to worsening dementia or due to a possible urinary tract infection or other type of infection.

According to physician orders, a urinalysis and culture were ordered on 11/19/24. On 11/20/24 the resident was ordered to have an increase in his Trazodone (used for depression and insomnia). His dose was increased from 25

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 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 600	Continued From page 3	F 600		

milligrams to 50 milligrams at bedtime.

On 11/20/24 Nurse # 4 noted at 11:47 PM that Resident # 3 was alert and oriented times three, had experienced a calm evening, and there had been no behaviors.

On 11/21/24 PA # 1 documented she saw Resident # 3 "for improvement of behaviors" and that the resident had slept well. PA # 1 also documented the resident was still confused and reported to her he was "looking to catch a flight" to the local airport.

On 11/22/24 at 8:25 AM Nurse # 5 documented the resident was alert and had slept throughout the night.

According to orders the resident was begun on an antibiotic for treatment for a urinary tract infection on 11/22/24 when his urine culture result revealed the resident's urine grew E-coli.

On 11/24/24 at 11:28 PM Nurse # 1 documented the resident was on an antibiotic for a urinary tract infection and had hit another resident with a reacher. The other resident had sustained a "scratch to his left ear." The Nurse Practitioner was called and orders were obtained to send Resident # 3 to the emergency room

According to hospital records, following the incident, Resident # 3 was sent to the hospital and hospitalized from 11/24/24 until 12/2/24. A review of Resident # 3's hospital discharge summary, dated 12/2/24, revealed he had been diagnosed with metabolic encephalopathy, a urinary tract infection, and hyperactive delirium. The hospital discharge summary included

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F 600	Continued From page 4	F 600		

information that the resident's delirium improved with treatment for his urinary tract infection. (Delirium is an acute state of mental confusion and disorientation that develops rapidly and usually lasts for a short period. Symptoms can include delusions and agitation.)

Nurse # 1 was interviewed on 2/5/25 at 1:11 PM and reported the following information. She had not witnessed the incident when Resident # 3 hit another resident. Nurse # 2 had told her about the incident. Prior to the incident, she did not recall any specific incidents during which Resident # 3 had hit another resident.

Review of the facility's investigation into the incident revealed the incident had occurred on 11/24/24 at 9:05 PM and the resident who had been hit with the reacher was Resident # 2. The facility's investigation also included documentation that another Resident (Resident #7) had witnessed the incident.

A review of Resident # 2's record revealed Resident # 2's 11/14/24 quarterly Minimum Data Set assessment coded Resident # 2 as cognitively intact and independent in his wheelchair mobility.

Resident # 2 was interviewed on 2/5/25 at 8:45 AM and reported the following information. On the date of the incident he (Resident # 2) had been "minding his own business" and talking to Resident # 7 when for some unknown reason another resident used a "grabber" and hit him in the head. Resident # 2 reported it had caused a cut on his head but "did not bother me too much." Resident # 2 also reported he had to defend himself and therefore he slapped back at 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 02/06/2025

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F 600	Continued From page 5	F 600		

resident who had hit him. Resident # 2 reported Resident # 7 had seen the incident.

A review of Resident # 7's record revealed Resident # 7's MDS assessments, dated 10/23/24 and 1/23/25, coded Resident # 7 as cognitively intact. Resident # 7 was interviewed on 2/5/25 at 1:25 PM and reported the following information. On the date of the incident, Resident # 2 had been in her room talking to her. There was another resident who came into her room while Resident # 2 was talking to her. She did not know this other resident's name. The intruding resident had a reacher and said, "I am going to hit you with this." She replied, "Please do not do that." At that point, Resident # 2 stated he wanted to get out of the room and started to back his wheelchair out of her room. The intruding resident then took the reacher and hit Resident # 2 on the ear and side of his head with the reacher. It made Resident # 2's head bleed where it cut him. She did not recall with certainty if Resident # 2 hit back at Resident # 3 or not.

A review of Resident # 2's record revealed an entry by Nurse # 2 dated 11/24/24 at 10:58 PM which read, "performed head to toe assessment after an incident with another resident, scratch found on left ear. Resident is alert and oriented X 4. No c/o (complaints) of pain or discomfort. 149/71 (blood pressure), 97.4 (temperature), 17 (respirations), 74 (pulse), 98% room air (oxygen saturation). Level of pain at 0."

Nurse # 2 was not available for interview during the survey.

On 11/25/24 at 1:40 PM the facility's Wound Nurse documented she assessed Resident #2's

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 02/06/2025

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 600	Continued From page 6	F 600		

ear and observed a scab to the ear with no drainage noted. The Wound nurse further noted Resident # 2 had no complaints of pain at the time.

Interview with the Administrator on 2/5/25 at 9:10 AM and again on 2/5/25 at 1:39 PM revealed the following information. Resident # 3 did not have a history of hitting other residents prior to the incident with Resident # 2. He had been diagnosed with a urinary tract infection, was on an oral antibiotic, and was experiencing an acute increase in confusion when the incident occurred. He seemed to be having flashbacks about war and his military service which were distressing to him. It was her understanding that her staff did not see the actual incident but heard the commotion and responded to separate the two residents. They had been trying to monitor and treat the resident when the incident occurred. She thought Resident #2 had slapped back at the reacher to protect himself and may have brushed Resident # 3's hand but he did not hurt Resident # 3. Resident 2's cut was not serious and was cleaned and cared for without any further long term problem. While Resident # 3 was hospitalized they initiated intravenous antibiotics in lieu of the oral antibiotic and this helped resolve his delirium and urinary tract infection. According to the Administrator, the facility had taken steps through their quality assurance program and implemented a corrective action plan.

On 2/6/25 the Administrator provided the following corrective action plan.

1. Address how corrective action will be accomplished for those residents found to have

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 02/06/2025

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F 600	Continued From page 7	F 600		

been affected by the deficient practice:

On 11/24/2024 Resident #3 (BIMS 12) struck Resident #2 (BIMS 15) with Reacher. Resident #3 and Resident #2 were immediately separated by staff. Skin check was performed by Nurse #2 on Resident #2 and noted to have a scratch on his left ear. Skin check was performed by Nurse #1 on Resident #3 with no negative findings. Provider notification for both Resident #3 and Resident #2 was completed by Nurse #1. Orders obtained and processed by Nurse #1 to send Resident #3 to the Emergency Department for further evaluation. Nurse #1 notified Resident #3's representative. Nurse #1 notified the Administrator who initiated the investigation.

On 11/24/2024 the administrator submitted initial report to Department of Health and Human Services (DHHS) on 11/24//2024 at approximately 10pm.

On 11/24/2024 the administrator notified Durham Police Department and Adult Protective Services on 11/24/2024 at 9:30pm.

Resident #2 was seen by the in-house provider on 11/25/2024 with new orders for triple antibiotic cream to be applied topically daily for 5 days.

The Director of Nursing/Designee completed interviews on 11/25/24 with Resident #2 and Resident #7, Resident #2 was visiting at time of incident. Interviews stated that Resident #3 was in hallway behind Resident #2 and when Resident #2 turned around to exit room Resident #3 lifted reacher and struck Resident #2. Nurse #1 was interviewed by the Director of Nursing/Designee on 11/24/2024 and did not witness the incident.

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F 600	Continued From page 8	F 600		

Administrator along with the Interdisciplinary Team members (Director of Nursing, Infection Prevention Control Officer, Staff Development Coordinator, Rehab Program Manager and Social Services Manager) held an Adhoc Meeting on 11/26/2024 to initiate Performance Improvement Plan.

The Administrator submitted the Initial Report to DHHS on 11/24/2024 and 5- day investigation to DHHS on 11/28/24. Resident #3 was admitted to the hospital with altered mental status.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:
Social Services Manager completed interviews on 11/25/2024 with Residents with a BIMS 13 or greater to ensure they felt safe in the Center, with no negative findings. Skin checks were initiated on 11/24/24 by Nursing Staff and Wound Care Nurse #1 on Residents with a BIMS 12 or less, skin checks completed by 11/28/24 with no negative findings.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:
The Staff Development Coordinator / designee educated all Center staff on Abuse and Neglect Prohibition and Caring for Residents with Behaviors and Communication. Education included identifying types of abuse, resident to resident altercations, and identifying behaviors, expressions, and triggers that may lead to abuse. Additionally, the training included how to effectively communicate, approach, and deescalate behaviors. Education completed 11/28/24.

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 02/06/2025

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 600	Continued From page 9	F 600		

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Beginning on 11/26/24, the Director of Nursing /designee will review during daily clinical morning meeting for changes in condition, new or worsening behaviors, resident altercations and altered mental status x 6 weeks. The decision was made to begin monitoring on 11/26/24 when the Performance Improvement Plan was reviewed by the Interdisciplinary Team.

Beginning on 11/26/24, Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 1 or until substantial compliance is obtained. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.

Date of Compliance: 11/29/24

The facility's corrective action plan was validated by the following:

Beginning on 2/4/25 at 9:50 AM a tour of the facility was conducted and multiple residents and family members were interviewed. These interviews revealed residents were not being mistreated or abused in any way.

During onsite observations conducted on 2/4/25 and 2/5/25, staff members were observed monitoring and responding to confused residents.

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	345458	A. BUILDING _____ B. WING _____	C 02/06/2025

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F 600	Continued From page 10 The facility presented documented evidence of their inservice training and audits as outlined in their corrective action plan. Interviews with staff confirmed education was completed per the corrective action plan. The facility's corrective action date of 11/29/24 was validated on 2/6/25.	F 600		