		ID HUMAN SERVICES			FORM APPROVED
		MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DATE SURVEY COMPLETED
		345458	B. WING		C 07/26/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-
TREYBUR	IN REHABILITATION CEI	NTER		059 TORREDGE ROAD DURHAM, NC 27712	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
F 242 SS=D	to conduct a complain 7/16/17. Additional in 7/17/17, 7/18/17, 7/19 Therefore, the exit da 483.10(f)(1)-(3) SELF		F 242		8/9/17
33-0	(f)(1) The resident ha schedules (including health care and provi consistent with his or	s a right to choose activities, sleeping and waking times), ders of health care services her interests, assessments, other applicable provisions			
		s a right to make choices or her life in the facility that resident.			
	members of the comr community activities I facility.	s a right to interact with nunity and participate in poth inside and outside the is not met as evidenced			
	Based on observation interview, family inter one (Resident # 4) ou reviewed for dietary of assure the resident	n, record review, resident view, and staff interviews for it of five sampled residents choices, the facility failed to eceived food items she c. The findings included:		F-242 The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state a	
	Record review reveal admitted to the facility diagnosis of diabetes Review of the resider	/ on 12/13/16 with a		federal regulations as outlined. To rem in compliance with all federal and state regulations, the center has taken or wi take the actions set forth in the following plan of correction. The following plan of	ain e II ng
L					
		SUPPLIER REPRESENTATIVE'S SIGNATUI	KE	TITLE	(X6) DATE 08/04/2017
Election	cally Signed				00/04/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		345458	B. WING		0	C 17/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				2059 TORREDGE ROAD		
TREYBUR	N REHABILITATION CEI	NTER		DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 242	Continued From page	a 1	F 24	2		
1 212	10	nt, dated 4/18/17, revealed	F 24	correction constitutes the ce	ntor's	
		lerately cognitively impaired.		allegation of compliance. Al		
				deficiencies cited have beer	-	
		nt's care plan, revised on acility had identified the		completed by dates indicate		
		tic. A care plan intervention		Interventions for the affected	d resident:	
		listed as, "provide food		1. Resident #4 is receiving s	sugar free food	
	preferences and subs	stitutions."		items per her dietary prefere	-	
	Record review reveal	ed the resident's diet order		2. An audit has been condu	cted by the	
		Carbohydrate diet (CCHO		Dietary Manager regarding		
		review of the record with the		diabetes' preference being l		
		ON) on 7/16/17 at 12:45		ensure compliance in this a		
	PM, the resident had 12/30/16.	been on this diet since		An audit has been conducte	-	
	12/30/10.			Dietician/Dietary Manager re ticket reflecting current phys		
	Review of the resider	nt's tray card on 7/16/17		ensure compliance in this a		
	revealed there was a				cu.	
		es about a resident's diet		3. Licensed Nurses will be r	e-educated by	
	· ·	ere was no notation on		the Director of Nursing/ des		
	Resident # 4's tray ca			regarding ensuring dietary of		
	-	jar free or lower sugar items		forms are provided to dietar		
	placed on her meal tr	ay.		current physician order. Die	•	
	Desidental 4			be re-educated by the direc		
		served on 7/15/17 at 8:35		Nursing/designee regarding		
		fast tray before her, and The resident had a large		preferences are honored an the diet slip.	a renected on	
		item, toast, grits, bacon,				
		esident stated she routinely		4. The Dietary manager will	review	
	asked for sugar free i			resident's diet ensuring pref		
		things that she did not want		being honored and ensuring		
		diabetes. The resident		ticket reflects physician orde	•	
		astry breakfast item and juice		twelve (12) weeks. Re-educ		
		ot want either of those items		provided to the dietary staff		
		make her blood sugar go up.		follow the proper procedure	-	
		he wished she had some		be reported to QAPI commit		
		r toast, but they had not sent # 1 was observed to enter		review and recommendation three months and as neede	-	
	the room, and the res					

Facility ID: 923141

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2017 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345458	B. WING		_	(07/2) 26/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			20	59 TORREDGE ROAD			
TREYBUR	IN REHABILITATION CEN	ITER		URHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	want the pastry or juid The resident asked if sugar free jelly for her to the kitchen to see if returned with the sugar located in the facility I Resident # 4 was obs PM during the lunch r her room. One of the tray was a cookie. Th to see if it had sugar if back on her tray and the cookie because s sugar in it. The reside would make her blood Further interview with 12:30 PM revealed th sugar free items in ex sugar items which we stated she had told th the cooks, and she ha have some of the sug The resident stated th she would prefer over served. She also stat sugar free gelatin, sug some flavors of sugar sugar desserts. The r served frosted flakes preferred cherries or felt they did not make The resident stated si facility had to fix what therefore her family b preferred. The resider her blood sugar. The	ce because of her diabetes. the NA could find some . NA # 1 stated he would go f they had some. NA # 1 ar free jelly which he had kitchen. erved on 7/15/17 at 1:25 meal to be eating alone in food items on the resident's e resident bit into her cookie n it. The resident placed it said she did not want to eat he could taste there was ent stated she was afraid it d sugar go up. the resident on 7/16/17 at e resident had requested change for some of the re allowed on her diet. She is to the nurse aides and ad been told they did not ar free items she would like. here were many fresh fruits the desserts she was ted she preferred to have gar free ice cream, and free pudding in place of the esident stated she had been	F 242				

Facility ID: 923141

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 08/31/2017 MAPPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			_		C 26/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
TREYBUR	N REHABILITATION CEN	ITER			059 TORREDGE ROAD OURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	her blood sugars with Resident # 4's respon- interviewed on 7/15/1 Resident # 4 often red brownies, pound cake she did not eat. The F the resident fruit and a preferred. Interview with Nurse a revealed the resident "everybody" she talke to have sweet items a stated the resident ha nurses, and the dietan nurses, and the dietan nurses had verbally to but they kept sending Interview with the reg 7/15/17 at 3:40 PM re is liberalized to allow therefore the desserts for diabetic residents The RD confirmed tha 4 received on 7/16/17 been a cookie with su facility had recently of cookies and they were but were not placing t current time. The RD had talked to the resident sugar food items than allowed on her liberal should arrange to obt	diet and the pill alone. sible party (RP) was 7 at 1:35 PM. The RP stated ceived items such as a, and chocolate cake which RP stated she tried to bring sugar free items she 4 1 on 7/16/17 at 12:45 PM had made it known to d to that she preferred not rerved to her. The nurse d told her doctor, the ry staff. The nurse stated the old the dietary department, the sugar items. istered dietician (RD) on vealed that the CCHO diet	F	242		DEFICIENCY)		
	allowed on her liberal	ized diet, then the facility						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FO	ED: 08/31/20 RM APPROV IO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345458	B. WING		0	C 7/26/2017
IAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE	
REYBUR	RN REHABILITATION CEN	NTER		59 TORREDGE ROAD JRHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 242 F 425 SS=D	On 7/16/17 at 10:00 Å of the diabetic foods a kitchen. It was observe free cookies in two fla containers with no su free jelly in three flavo protein supplement d no sugar lemonade. T interviewed at the time she stated there was Interview with the die 11:45 AM via phone r CCHO diet was libera- items on her meal tra- stated she could obta substitute for the suga- manager stated in ord preparation staff to kr items on the resident would need to appear that she preferred the said she was slowly of resident request. She was in the facility free request. According to the resident to update preferences but she f the tray. 483.45(a)(b)(1) PHAF ACCURATE PROCEL (a) Procedures. A fac pharmaceutical service that assure the accur- dispensing, and admi	AM observations were made available in the facility yed the facility had sugar avors, applesauce gar, sugar free syrup, sugar ors, sugar free high calorie rinks, unsweetened tea, and The facility dietitian was e of the observations and no diabetic ice cream. tary manager on 7/16/17 at evealed the resident's alized and allowed for sugar y. The dietary manager in sugar free items to ar desserts. The dietary der for the meal tray now to place the sugar free 's tray, this information r on the resident's tray card ese. The dietary manager ordering diabetic foods per e stated diabetic ice cream ezer and was available upon the DM she routinely visited e her meal tray card for nad not updated it to include to have less sugar items on RMACEUTICAL SVC - DURES, RPH	F 242			8/9/17

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM): 08/31/2017 // APPROVED). 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONST G		(X3) DATE SURVEY COMPLETED	
		345458	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TOEVOUD				2059 TOF	RREDGE ROAD		
IRETBUR	N REHABILITATION CEN	NIER		DURHA	M, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRE CROSS-REFEREJued From page 5F 425vice Consultation. The facility must or obtain the services of a licensed acist whoF 425vides consultation on all aspects of the on of pharmacy services in the facility; EQUIREMENT is not met as evidencedF -425on observation, record review, staff w, and pharmacist interview the facility o assure they had a system for accurate tion and administration of medications for esidents # 4 and # 13) out of four residentsF -425			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 425	Continued From page	9 5	F 4	25			
		-					
	provision of pharmacy This REQUIREMENT by: Based on observation interview, and pharma failed to assure they h acquisition and admin two (Residents # 4 an reviewed for pharmac included: 1. Record review revi admitted to the facility diagnosis of diabetes. Review of the physicia resident received Jan every day for her diab on 12/13/16.	y services in the facility; is not met as evidenced n, record review, staff acist interview the facility had a system for accurate histration of medications for hd # 13) out of four residents by services. The findings ealed Resident # 4 was y on 12/13/16 with a an orders revealed the uvia 50 milligrams (mg) betes. The order originated		The adm agre here com fede in co regu take plan corre alleg defic com	statements included are not an ission and do not constitute eement with the alleged deficiencie in. The plan of correction is pleted in the compliance of state a eral regulations as outlined. To rem ompliance with all federal and stat lations, the center has taken or w the actions set forth in the following of correction. The following plan ection constitutes the center's gation of compliance. All alleged ciencies cited have been or will be pleted by dates indicated.	and nain e ill ng of	
	assessment, dated 4/ was moderately cogn Review of the residen 5/9/17, revealed the fa	t's care plan, revised on acility had identified the		orde Cym 2. R and	esident #4 is receiving Januvia as ered. Resident#13 is receiving abalta as ordered. eview of residents receiving Janur Cymbalta has been completed ar	via	
	resident's care plan w diabetes medication a Review of the residen Administration Record	ic. An intervention on the vas that she receive her as ordered by the physician. It's May 2017 Medication d (MAR) revealed nurses vered Januvia 50 mg every		adm qual med ensu	lications are available and being inistered. The facility has complet ity review of medication cart and lication administration records to ure that medications ordered are in k and being administrated.		

Facility ID: 923141

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OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED C
	345458	B. WING		07/26/2017
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
N REHABILITATION CEI	ITER		2059 TORREDGE ROAD DURHAM, NC 27712	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COMPLETIN THE APPROPRIATE DATE
day. Review of the resider medication administra had initiated they had mg every morning ex the MAR was blank b Review of the resider sugars between the o revealed they ranged Review of nursing no made an entry on 6/2 the resident's Januvia administration. Nurse nursing was informed pharmacy send a refi date. The resident was inter AM and stated she th of her Januvia for abo before she noticed it resident stated she di thought her blood sug She said when she for them to order her me a different pharmacy interviewed again on stated she had kept th had ordered the Janu pharmacy. Review of Januvia had been oro up pharmacy on 6/20 the facility.	At's 6/1/17 to 6/20/17 ation record revealed nurses administered Januvia 50 cluding one day. On 6/1/17 eside the Januvia. At's documented blood lates of 6/1/17 and 6/20/17 from 108 to 200. At the servealed Nurse # 5 0/17 at 10:09 AM noting that a was unavailable for # 5 noted the director of and requested the II of the medication on that rviewed on 7/15/17 at 8:35 ought the facility had run out but one and a half weeks was not being given. The d not realize it until she gars were running higher. bund out about it she asked dication and it was sent from that day. The resident was 7/16/17 at 12:30 PM and he paper where the facility's back form the facility's back form the facility's back form the facility's back form the facility's back	F 42	 3. Licensed Nurses will be medication administration of Nursing/designee. Licer be re-educated on the proobtaining medication refills Consultant. The Pharmacy be re-educated on the promedications orders by the Consultant. 4. The Director of Nursing Managers will review Med Administration Records are carts to ensure medication ordered are in stock and at the residents weekly for twweeks. The Director of Nursing Slips and then check to ensure medication is in the facility administration weekly for twweeks. Finding will be repcommittee for further review for the facility administration weekly for tweeks. Finding will be repcommittee for further review for the facility administration weekly for the facility administration weekly for tweeks. Finding will be repcommittee for further review for the facility administration weekly for the facility administration weekly for tweeks. Finding will be repcommittee for further review for the facility administration weekly for the facility administration weekly for tweeks. Finding will be repcommittee for further review for the facility administration weekly for the facility administration weekly for tweeks. Finding will be repcommittee for further review for the facility for	by the Director head Nurses will cess for a by Pharmacy y technicians to cess for filling Pharmacy and Unit ication a medication has that are dministrated to yelve (12) rsing and Unit sicians orders to acy delivery sure the for welve (12) orted to QAPI w and y for three
	PF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER EN REHABILITATION CEN SUMMARY ST, (EACH DEFICIENC' REGULATORY OR I Continued From page day. Review of the resider medication administra had initiated they had mg every morning exit the MAR was blank b Review of the resider sugars between the d revealed they ranged Review of nursing not made an entry on 6/2 the resident's Januvia administration. Nurse nursing was informed pharmacy send a refil date. The resident was inter AM and stated she th of her Januvia for abo before she noticed it y resident stated she di thought her blood sug She said when she for them to order her men a different pharmacy interviewed again on stated she had kept th had ordered the Janu pharmacy. Review of Januvia had been oro up pharmacy on 6/20 the facility.	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345458 ROVIDER OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 day. Review of the resident's 6/1/17 to 6/20/17 medication administration record revealed nurses had initiated they had administered Januvia 50 mg every morning excluding one day. On 6/1/17 the MAR was blank beside the Januvia. Review of the resident's documented blood sugars between the dates of 6/1/17 and 6/20/17 revealed they ranged from 108 to 200. Review of nursing notes revealed Nurse # 5 made an entry on 6/20/17 at 10:09 AM noting that the resident's Januvia was unavailable for administration. Nurse # 5 noted the director of nursing was informed and requested the pharmacy send a refill of the medication on that date. The resident was interviewed on 7/15/17 at 8:35 AM and stated she thought the facility had run out of her Januvia for about one and a half weeks before she noticed it was not being given. The resident stated she did not realize it until she thought her blood sugars were running higher. She said when she found out about it she asked them to order her medication and it was sent from a different pharmacy that day. The resident was interviewed again on 7/16/17 at 1:2:30 PM and stated she had kept the paper revealed the Januvia had been ordered from the facility's back up pharmacy on 6/20/17 and sent at 11:20 AM to	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF ABUILDING 345458 B. WING	PFDEFICIENCIES (X1) PROVIDERSUPPLIERCLIA. (X2) MULTIPLE CONSTRUCTION A BUILDING

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 08/31/201 FORM APPROVEI OMB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345458	B. WING		C 07/26/2017
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CC	
TREYBUR	RN REHABILITATION CEI	NTER		059 TORREDGE ROAD DURHAM, NC 27712	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION TE APPROPRIATE DATE
F 425	Resident # 4's Januv the back up pharmac not available at time of her understanding the she was not aware of A pharmacist, who we supplied medications interviewed on 7/17/1 pharmacist reviewed Resident # 4's Januv of the medication. Thi interview revealed the could only fill 14 dose 4 because Januvia we Since 4/18/17, the pho on 4/18/17, 5/1/17, 5/ pharmacy did not rec nor fill the Januvia me of 5/15/17 and 6/20/1 a phone call from the medication be sent, a up pharmacy. Accord facility should have h medication. Accordin facility would have has the dates of 5/15/17 at did not reorder it. The assistant director interviewed on 7/18/1 facility's failure to req According to the ADC (DON) was unavailable would return on 7/19/1 they would review the	ia had to be ordered from y on 6/20/17 because it was of administration, but it was e medication was sent and f any missed doses. orked at the pharmacy which to the facility, was 17 at 1:06 PM. The the facility's requests for ia refills and the dispensing e pharmacist review and her e following. The pharmacy es at one time for Resident # as a brand medication. harmacy filled the medication (15/17, and 6/20/17. The ever a facility refill request edication between the dates 7. On 6/20/17 they received facility requesting the and it was filled by the back- ling to the pharmacist the ad a three day supply of Januvia was being filled, so	F 425		

Facility ID: 923141

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STATE MENT OF DERICENCIES AND FLOW OF CORRECTION (X1) PROVIDERSUPPLIER IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BULDING IDENTIFICATION NUMBER: (X3) PROVIDERSUPPLIER IDENTIFICATION NUMBER (X3) PROVIDERSUPPLIER IDENTIFICATION CENTER (X3) PROVIDERSUPPLIER IDENTIFICATION CENTER (X3) PROVIDERSUPPLIER IDENTIFICATION CENTER (X3) PROVIDERSUPPLIER IDENTIFICATION CENTER (X4) PROVIDERSUPPLIER IDENTIFICATION CENTER <th></th> <th></th> <th>ID HUMAN SERVICES MEDICAID SERVICES</th> <th></th> <th></th> <th></th> <th>FOR</th> <th>D: 08/31/2017 M APPROVED D. 0938-0391</th>			ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 08/31/2017 M APPROVED D. 0938-0391
345458 B. WING OT726/ NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE 2097 TOREEDE ROAD DURHAM, NC 27712 Continued From page 8 F 425 According to a follow up interview with the DON on 7/20/17 at 2:55 PM and again on 7/25/17 at 10:18 AM again on 7/25/17 at 10:19 AM to revealed a definitive explanation for why the Januvia was not recreated a definitive explanation for why the Januvia was not recreated and when there was no known supply of the medications to the administered. O 7/26/17 at 10:18 AM a pharmacist from the facility, which currently supplied medications to the facility, which to the staff on 3/30/17 at 10:50 AM the DON arranged for interviews to be held with three of the nurses who had been responsible for administering the Januvia was in the cards during the change over. O 7/26/17 at 10:50 AM the DON arranged for interviews to be held with three of the nurses who had been responsible for administering the Januvia was in the cards during the change over. O 7/26/17 at 10:50 AM the DON arranged for interviews to be held with three of the nurses stated if they signed for the medication net medication on the medication net medication	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '			(X3) DATE SURVEY COMPLETED	
TREYBURN REHABILITATION CENTER 289 TORREDGE ROAD DURIAM, NC 27712 WILD PRETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REQUENCY NO IS CLEANTIPHING INFORMATION) D D DEFICIENCY MUST BE PRECEDED BY FULL TAG D DEFICIENCY MUST BE PRECEDED BY FULL TAG D DEFICIENCY MUST BE PRECEDED BY FULL TAG D D DEFICIENCY MUST BE PRECEDED BY FULL TAG D D D DEFICIENCY MUST BATTON OF DEFICIENCY TAG D			345458	B. WING				C /26/2017
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WING DER OR SUPPLER STREET ADDRESS, CITY, STRE, 2IP CODE EHABILITATION CENTER DURHAM, NC 27712 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC DETTEYING INFORMATION) ID PREX TAG PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC DETTEYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR USC DETTEYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BY (EACH CORRECTIVE ACTION SHOLD BY (EA	OR MEDICARE & MEDICAID SERVICES OMM NC PROENCES (X3) DATE PROENCES (X3) DATE STREETON 246458 N WING COMP DER OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2067 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2068 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2067 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2068 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2067 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2068 OR SUMPLICE STREET ADDRESS, CITY, STATE, ZIP CODE 2068 OR SUMPLICE PROVIDERS PLAN OF CORRECTION 2069 TORECODE ROAD PROVIDERS PLAN OF CORRECTION 2061 TOR SUMPLICE PROVIDERS PLAN OF CORRECTION 2062 TORECODE ROAD PROVIDERS PLAN OF CORRECTION 2063 TORECODE ROAD PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION OR STRUCTION OF CORRECTION PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION OF CORRECTION STRUCTION PROVIDERS PLAN OF CORRECTION 2064 TORE CORRECTION STRUCTION OF CORRECTION STRUC

Facility ID: 923141

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	DATE SURVEY C
		345458	B. WING				07/26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TREYBUR	IN REHABILITATION CEN	NTER			2059 TORREDGE ROAD DURHAM, NC 27712		
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F 425	Continued From page	e 10	F	425	i		
	supply of Duloxetine I Nurse # 6. The new s was observed to have There was one pill us supply which had bee 6 stated the used pill administered that mod Interview with the dire 7/16/17 at 10:20 AM is supply of Duloxetine I till late during the nigh would have been too the delayed release in This interview confirm his 7/15/17 dose. It w DON that they did not their facility back up s A pharmacist, who we supplied medications interviewed on 7/17/1 pharmacist reviewed Resident # 13's Dulox orders for the medica dispensing of the medica dispensing of the medica 2017 and June 2017 of the medication. The supply of Duloxetine I 6/7/17 the pharmacy for the same medicati instructions not to fill facility still had a supp	rning (7/16/17). ector of nursing (DON) on revealed the resident's HCL DR had not been sent at of 7/15/17, and therefore it late to have administered medication to the resident. The the resident had missed as also confirmed with the thave this medication in supply of medications. The the facility, was 7 at 1:06 PM. The the facility's requests for ketine HCL DR refills, the tion, and the pharmacy dication. The pharmacist g information from her The resident had been the HCL DR 60 mg also in May without any discontinuation the pharmacy filled a 30 day HCL DR on 5/31/17. On received a new prescription					

Facility ID: 923141

If continuation sheet Page 11 of 17

		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 08/31/2017 RM APPROVED IO. 0938-0391
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NAME OF PI	ROVIDER OR SUPPLIER	•	·	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
TREYBUR	N REHABILITATION CEI	NTER				
				DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 425	number. The old press discontinued in the pl pharmacy technician Therefore the pharma and send the medicar pharmacist the techni- their system and four number for the Dulox sent to the pharmacy fill the medication. The following the unfulfilled did not request the medication. The facility's back up supp the facility would have prior to 7/15/17 and s the pharmacy when the request on 7/3/17. The assistant director interviewed on 7/18/1 facility's failure to req HCL DR. According to	DR on the old prescription scription had been harmacy's system when the looked into the system. acy technician did not refill tion. According to the ician should have looked in ad the new prescription etine HCL DR that had been on 6/7/17, and used that to be pharmacist stated ed 7/3/17 request, the facility edication again until the pharmacist, there had he pharmacy and the facility.	F 42	5		
	the ADON they would record and refill reque DR to determine if the why the resident was the medication when the medication. According to a follow	n on 7/19/17. According to d review the administration ests for the Duloxetine HCL ere was an explanation for documented as receiving the pharmacy had not sent up interview with the DON M and again on 7/25/17 at				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
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345458			B. WING			07/26/2017		
NAME OF PROVIDER OR SUPPLIER				ę	STREET ADDRESS, CITY, STATE, ZIP CODE			
TREYBURN REHABILITATION CENTER					2059 TORREDGE ROAD			
				L				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SHOULD BE COMPLETION		
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	known supply of the medication to be administered.							
	facility, which currentl the facility, was interv pharmacist another p medications to the fac began supplying med pharmacist stated the 3/30/17 and 3/31/17 t from one cart to anoth							
	interviewed again. Th for the medication the was there and she ga July, 2017. Nurse # 5	e nurse stated if she signed en that meant the medication ive it during the month of 5 stated on the dates she did r process was to fax the						
		view with the DON on Nurse # 8 was no longer an could not be reached for						
	revealed she had four last Duloxentine HCL prior pharmacy. The I	PM interview with the DON nd accounting records of the 60mg pills supplied by their DON stated the Dulxentine the other pharmacy on a had been sent.						

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		ID HUMAN SERVICES MEDICAID SERVICES			F	TED: 08/31/2017 ORM APPROVED NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
345458			B. WING			C 07/26/2017		
NAME OF PF	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE,	ZIP CODE			
TREYBURN REHABILITATION CENTER				2059 TORREDGE ROAD				
				DURHAM, NC 27712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE		
F 428	Continued From page	2 13	F 42	28				
	428 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW,		F 42			8/9/17		
	c) Drug Regimen Rev	view						
	(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.							
	brain activities associ and behavior. These	ug is any drug that affects ated with mental processes drugs include, but are not e following categories:						
	(i) Anti-psychotic;(ii) Anti-depressant;(iii) Anti-anxiety; and(iv) Hypnotic.							
	to the attending physi	ctor and director of nursing,						
	drug that meets the c	le, but are not limited to, any riteria set forth in paragraph an unnecessary drug.						
	during this review mu separate, written repo attending physician a director and director of minimum, the resider	noted by the pharmacist st be documented on a brt that is sent to the nd the facility's medical of nursing and lists, at a it's name, the relevant drug, e pharmacist identified.						
		vsician must document in the cord that the identified						

Facility ID: 923141

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED A. BUILDING	FORM APPROVED			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED A. BUILDING 345458 C C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 07/26/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD TREYBURN REHABILITATION CENTER DURHAM, NC 27712 2059 TORREDGE ROAD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPL (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPL F 428 Continued From page 14 F 428 F 428 E Continued From page 14 F 428	OMB NO. 0938-0391			
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irregularity has been reviewed and what, if any,	u L			
irregularity has been reviewed and what, if any,				
irregularity has been reviewed and what, if any,				
be no change in the medication, the attending				
physician should document his or her rationale in				
the resident's medical record.				
(5) The facility must develop and maintain policies				
and procedures for the monthly drug regimen				
review that include, but are not limited to, time				
frames for the different steps in the process and				
steps the pharmacist must take when he or she				
identifies an irregularity that requires urgent action				
to protect the resident. This REQUIREMENT is not met as evidenced				
by:				
Based on record review and staff interview the F-428				
facility's consultant pharmacist failed to report a				
medication warning to the physician for one of The statements included are not an				
four residents (Resident #6) who had a diagnosis admission and do not constitute				
that the FDA warned that the medication should agreement with the alleged deficiencies				
not be given to a resident that had heart failure. herein. The plan of correction is				
The findings included:				
The findings included: federal regulations as outlined. To remain in compliance with all federal and state				
Review of Resident # 6's closed record revealed regulations, the center has taken or will				
the resident resided in the facility from 5/27/17 take the actions set forth in the following				
until 6/22/17. plan of correction. The following plan of				
correction constitutes the center's				
An FL2 form was completed on 5/24/17 prior to allegation of compliance. All alleged				
the resident's facility admission. Two of the deficiencies cited have been or will be				
diagnoses on the FL2 form were listed as completed by dates indicated.				
congestive heart failure and coronary artery				
disease. 1. Resident #6 no longer resides in the				
Review of the resident's minimum data set				
assessment, dated 6/13/17, revealed the resident 2. An audit was conducted by the Director				
was moderately cognitively impaired.				
ensuring there were no medications with				
Review of the resident's care plan, dated 5/31/17, black box warnings unidentified by the				

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-					FORM	1 APPROVED	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI						OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
345458			B. WING			_ 26/2017	
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
YBURN REHABILITATION CENTER							
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)						(X5) COMPLETION DATE	
revealed the facility id congestive heart failur Review of physician of dated 6/2/17, for Pleta per day. The reason r leg pain and periphera remained a current or her discharge date of Review of the residen administration record resident began receiv AM. Excluding four so was documented as r ordered. The four time 6/12/17 at 8 AM there 6/13/17 and 6/14/17 a were circled indicating 6/22/17 at 8 AM there for refusing the medication Review of the pharma documentation reveal Resident # 6's record noted she had review and that the resident w milligrams twice per d she had no recomment Record review reveale evaluated at a hospital later that same day ad care. Review of the hospital	entified the resident had re and required monitoring. Arders revealed an order, al 100 milligrams (mg) twice hoted for the medication was al artery disease. The Pletal der for the resident through 6/22/17. It's June 2017 medication (MAR) revealed the ing the Pletal on 6/4/17 at 8 cheduled times the resident ecciving the medication as as were as follows: On were no nurses initials, on the 8 PM the nurse's initials g it was not given, and on esident was documented as on. Incy consultant's ed the consultant reviewed on 6/13/17. The pharmacist ed the resident's diagnoses was prescribed Pletal 100 ay. The pharmacist noted ndations for the physician. ed Resident # 6 was al clinic on 6/22/17 and then dmitted to the hospital for ospital clinic and hospital 7, revealed that the discontinued because there	F	428	pharmacist. 3. The Pharmacist will review the drug regimen of each resident monthly and report any irregularities to the attendin physician and DON. The Director of Nursing will conduct monthly audits of pharmacist drug regimen review and ensure physician follow up. Findings w be reported to QAPI committee for fur review and recommendations monthly	g /ill :her for		
	S FOR MEDICARE & I F DEFICIENCIES CORRECTION OVIDER OR SUPPLIER N REHABILITATION CEN SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page revealed the facility id congestive heart failur Review of physician or dated 6/2/17, for Pleta per day. The reason r leg pain and periphera remained a current or her discharge date of Review of the residen administration record resident began receiv AM. Excluding four sc was documented as r ordered. The four time 6/12/17 at 8 AM there 6/13/17 and 6/14/17 a were circled indicating 6/22/17 at 8 AM there fordered. The four time fordered the pharma documentation reveal Review of the pharma documentation reveal	CORRECTION IDENTIFICATION NUMBER: 345458 OVIDER OR SUPPLIER N REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	SPOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A BUILDI 345458 B. WING OVIDER OR SUPPLIER IDENTIFICATION NUMBER: ID NEHABILITATION CENTER ID PREFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 15 revealed the facility identified the resident had congestive heart failure and required monitoring. Fr Review of physician orders revealed an order, dated 6/2/17, for Pletal 100 milligrams (mg) twice per day. The reason noted for the medication was leg pain and peripheral artery disease. The Pletal remained a current order for the resident through her discharge date of 6/22/17. Fr Review of the resident's June 2017 medication administration record (MAR) revealed the resident began receiving the Pletal on 6/4/17 at 8 AM. Excluding four scheduled times the resident was documented as receiving the medication as ordered. The four times were as follows: On 6/13/17 and 6/14/17 at 8 PM the nurse's initials were circled indicating it was not given, and on 6/22/17 at 8 AM there were no nurses initials, on 6/13/17 and 6/14/17 at 8 PM the nurse's initials were circled indicating it was not given, and on 6/22/17 at 8 AM there resident's diagnoses and that the resident was prescribed Pletal 100 milligrams twice per day. The pharmacist noted she had no recommendations for the physician. Record review revealed Resident # 6 was evaluated at a hospital clinic on 6/22/17 and then later that same day admitted to the hospital for care. Review of	S FOR MEDICARE & MEDICAID SERVICES F DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A BUILDING_ 345458 OVIDER OR SUPPLIER 345458 B. WING	SPOR MEDICARE & MEDICAID SERVICES PREFIGURIES CORRECTION (X) PROVIDERSUPPLIERCLA IDENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING 345458 STREET ADDRESS, CITY, STATE, ZIP CODE CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VREHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE CONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE VREHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE Continued From page 15 PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL RECOULDENTFYING INFORMATION) PROVIDERS PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOLD E CROSS REFERENCED TO THE APPROPRING DEPICIENCY) Continued From page 15 F 428 pharmacist revealed the facility identified the resident had congestive heart failure and required monitoring. F 428 pharmacist will review the drug regimen of each resident monthly and report any irregularities to the attendin physician and DON. The Director of Nursing will conduct monthly audits of pharmacist drug regimen revealed to CA217 at 8 AM there sident was documented as rectiving the medication as ordered. The four times were as follows: On G/12/17 at 8 AM there sident was documented as refusing the medication. F 428 Review of the pharmacy consultant's documentation revealed the consultant reviewed Resident # 6's record on G/13/17. The pharmacist noted she had reviewed the resident's diagnoses and that the resident was preximal to the she had no recommendations of	SFOR MEDICARE & MEDICAID SERVICES OMM NC In DEPICIENCIES (x3) PROVIDERSUPLERCUA (x3) MULTIFLE CONSTRUCTION (x3) ADM OVER OR SUPPLIER A BULDING (x3) DAM (x4) MULTIFLE CONSTRUCTION (x3) DAM OWDER OR SUPPLIER 345458 B. WNG (7) OWDER OR SUPPLIER STREETADDRESS.CITY.STATE_2P CODE 2099 TORREDOR ROAD DURHAM, NC 27712 SUMMARY STATEMENT OF DEFIDIENCIES D PREVIDER'S PLAN OF CORRECTION (REAL DEPICIENCY MUST BE PRECEDED BY FULL D PREVIDER'S PLAN OF CORRECTION EACH COMPECTIVE ACTION SHOULD BE Continued From page 15 revealed the facility identified the resident had congesitive heart dialure and required monitoring. F 428 Review of physician orders revealed an order, dated 6/2/17. for Pletal 100 milligrams (mg) twice per day. The reason noted for the medication was leg pain and peripheral artery disease. The Pletal remained a current order for the resident through her discharge date of 6/2/17. 3. The Pharmacist divid regimen review and resure physician follow up. Findings will be reported to QAPI committee for further review and rescure physician follow up. Findings will be reported to QAPI committee of further review and rescure to the nearbities the resident was documented as record on 6/3/17 at 6/3/17 at 6/14/17 at 8 AM there were no nurses initials, on 6/12/17 at 8 AM there were no nurses initials, on 6/12/17 at 8 AM there were on osultant's diagnoses and that resident was documented as resident was documented as reviewed the resident staticure and osecords of 6/2/17. The pharmacist noted she had reviewed	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 08/31/2017 1 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		· /	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
345458		B. WING		_	C 07/26/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
TREYBURN REHABILITATION CENTER				2059 TORREDGE ROAD			
				DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 428	Continued From page According to the Fede black box warnings at to serious or life threa black box warning for contraindicated in pat any severity. Interview with the fact 2:33 PM revealed the been called to her atte The facility's consulta interviewed on 7/18/1 consultant pharmacis calling the black box of the physician and nor The consultant pharm understanding that the dilation brought about blood volume to the h	e 16 eral Drug Administration, re designed to call attention atening risks. A review of the Pletal revealed Pletal was tients with heart failure of ility's physician on 7/18/17 at black box warning had not ention by a pharmacist.	F 42				

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