PRINTED: 04/19/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 BOILBIIN		С		
		345458	B. WING		03/	19/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2059 TORREDGE ROAD			
TREYBUR	N REHABILITATION CE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	;	F 00	00			
F 600	conducted from 3/13/3/19/18, the survey to to conduct an extend survey. Immediate Jecury Edward Survey. Immediate Jecury Edward Survey. Immediate Jecury Edward Survey. Immediate Jecury Edward Survey. Immediate Jecury Femoved on 03/16/18 conducted.		F 60	00		4/10/18	
	Exploitation The resident has the neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chem treat the resident's me	involuntary seclusion and ical restraint not required to edical symptoms.					
LABORATORY	§483.12(a) The facilit			TITLE		(VC) DATE	
LABURATORY	DIKECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE	

Electronically Signed 03/30/2018

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.

		X1) PROVIDER/SUPPLIER/CLIA (X2) MULT IDENTIFICATION NUMBER:  A. BUILDIN		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
		345458	B. WING			С		
NAME OF D	ROVIDER OR SUPPLIER	0.10.100	1	С.	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	19/2018	
NAME OF PI	ROVIDER OR SUPPLIER							
TREYBUR	N REHABILITATION CEN	NTER			059 TORREDGE ROAD			
				ט	URHAM, NC 27712			
(X4) ID PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(IE	DATE	
F 600	Continued From page	e 1	F	600				
	8483.12(a)(1) Not use	e verbal, mental, sexual, or						
	physical abuse, corpo							
	involuntary seclusion;							
	This REQUIREMENT	is not met as evidenced						
	by: Based on observatio	n record review and			F600			
		sident, facility staff, and the			1000			
		failed to prevent neglect by			Preparation and execution of this			
	transferring a residen				plan of correction does not			
		chanical lift knowing that the			constitute admission or agreement of			
		ot functioning properly and			the facts alleged or conclusion set			
		The mechanical lift's leg			forth in this statement of			
		I not lock in place resulting in			deficiencies.			
		dent being dropped suddenly			The plan of correction is prepared			
	_	the overhead beam on the			and / or executed solely because it			
		nt's head. The facility staff			is required by both Federal and State			
	_	malfunctioning lift after the			laws.			
	incident. This was evi	•						
		r neglect (Resident #106).			The Hoyer lift in question was removed	, l		
					from service and repaired by the			
	Immediate Jeopardy	(IJ) began on 02/02/18,			Maintenance Director on 3/16/18 and			
		was transferred from the			remained out of service until it was			
		a malfunctioning lift. The lift			evaluated by an outside technician and	1		
	tilted resulting in the r	esident being dropped			deemed safe for use. ¿Preventative			
	_	eelchair and the overhead			maintenance has been increased from			
	beam on the lift strikir	ng the resident's head. The			monthly to at least weekly inspections	to		
	immediate jeopardy v	vas removed on 03/16/18			be done according to the manufacturer	ʻ□s		
	when the facility provi	ided and implemented an			recommendations of the lifts to identify			
	acceptable credible a	llegation of IJ removal. The			and fix any part that has started to loos	en.		
	facility remains out of	compliance at a lower			There was no injury to Resident #106 t	hus		
	scope and severity of	D (isolated with no actual			no other corrective action could be take			
	harm with potential fo	r more than minimal harm			for this resident. The resident was			
	that is not immediate	jeopardy) to complete staff			assessed by the licensed nurse, there			
		nat monitoring systems put			was no redness, swelling, laceration, o	r		
	into place are effectiv	e to prevent neglect.			bruising. The resident did not report ar	าง		
					pain and no pain medication was			
	The findings included	:			administered. Neuro checks were			
					implemented per facility policy with no			

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345458	B. WING		l	C <b>03/19/2018</b>	
0.0.00	<del> </del>	STREET ADDRESS CITY STATE ZID CODE	03/	/19/2016	
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ER		DURHAM, NC 27712			
UST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE	(X5) COMPLETION DATE	
	F 60	00			
nance Safety Inspection 2 that detailed 10 areas inspection or adjustment. The "shifter handle locks benever engaged." The coperators on page 21 The sis NOT positioning ting slot, DO NOT use se, injury and/or damage  at the facility on to finfection and fit hip prosthesis, chronic and type 2 diabetes  The prosthesis of the facility on to finfection and fit hip prosthesis of the prosthesis and type 2 diabetes  The prosthesis of the facility on to finfection and fit hip prosthesis of the prosthesis and type 2 diabetes  The prosthesis of the prosthesis and the resident was the first provided on the complications following the prosthesis of daily living. The the prosthesis of daily living of the prosthesis and deficits related the prosthesis of daily living of the prosthesis and deficits related the prosthesis of daily living of the prosthesis of the prosthesis and deficits related the prosthesis of the	F 60	negative outcomes. The resider to the hospital after an appointm days after the event secondary to of her hip replacement prosthese was not related to the event.  Root cause is the facility did not policy and procedure regarding reference the lift from service and filling ou maintenance request due to the training in the process regarding and removing equipment from sewhen faulty equipment is noted.  The incident reports for last six mover reviewed by the Director of on 3/16/18 to determine if there of other incidents related to hoyer lother incidents were identified. Maintenance Director examined mechanical lifts in the facility on ensure the lifts are functioning process.  An ad hoc QAPI committee mee held on 3/16/18 with Interim Adm ADON, Rehab Manager, Unit May Vice President of Operations and Regional Clinical Director in atternal Medical Director attended via tel The agenda included determinin cause of the event, what process be used to identify other resident may have been affected, determinant the deducation needed to be contained to the contained to the contained to be contained to the contained to be contained to the	ent four o infection es which  follow removing t a lack of reporting ervice  months f Nursing were any ifts. No The all 3/16/18 to roperly. ressed  ting was ninistrator, anagers, d the ndance. ephone. g the root s would ts that nining mpleted,		
		A. BUILDING  345458  B. WING  B. WING  WINT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)  IDENTIFYING INFORMATION)  F 600  T Manual for [brand name nance Safety Inspection 2 that detailed 10 areas inspection or adjustment. The "shifter handle locks benever engaged." The coperators on page 21 c is NOT positioning ting slot, DO NOT use se, injury and/or damage  witted to the facility on c of infection and ff hip prosthesis, chronic and type 2 diabetes  Data Set (MDS) dated that the resident was ent #106 was occasionally I extensive assistance for g. Two persons were  The prostrict of the prosthesis of the prostrict of the pros	A BUILDING  345458  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  PREFIX TAG  TO PREFIX TAG  F 600  In Manual for [brand name nance Safety Inspection 2 that detailed 10 areas inspection or adjustment. The "shifter handle locks tenever engaged." The 10 policy and procedure regarding the lift from service and filling ou maintenance request due to the 10 policy and procedure regarding the lift from service and filling ou maintenance request due to the training in the process regarding and removing equipment from so when faulty equipment is noted  Data Set (MDS) dated the tresident was ent #106 was occasionally lextensive assistance for g. Two persons were  Data Set (MDS) dated that the resident was ent #106 was occasionally lextensive assistance for g. Two persons were  The sisk and deficits related titvities of daily living. The se of a mechanical lift for  dated 02/02/18 by Nurse ent #106 "was being chair and was struck on mately 9:45 a.m. Vital urological checks cian notified."  A BUILDING  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  FREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  FREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  FREFIX TAG  STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712  FREFIX TAG  F 600  negative outcomes. The resider to the hospital after an appointm days after the event secondary to fher hip replacement prosthesis can object to the hospital after an appointm days after the event secondary to fher hip replacement prosthesis was not related to the event.  F 600  Reperix TAG  F 600  In gative outcomes. The scaled to the hospital after an appointm days after the event secondary to fher hip replacement prosthesis was not related to the event.  F 600  In gative outcomes. The scaled to the hospital after an appointm days after the event secondary to fher	A BUILDING  345458  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 2659 TORREDGE ROAD DURHAM, NC 27712  MENT OF DETICIENCIES UST BE PRECEDED BY PULL IDENTIFYING INFORMATION)  IT Manual for [brand name nance Safety Inspection 2 that detailed 10 areas inspection or adjustment, he "shifter handle locks tenever engaged." The coperators on page 21 is NOT positioning ting slot, DO NOT use se, injury and/or damage  ititled to the facility on the of infection and the prosthesis, chronic and type 2 diabetes  Data Set (MDS) dated that the resident was ent #106 was occasionally levalensive assistance for g. Two persons were  Data Set (MDS) dated that the resident was ent #106 was occasionally extensive assistance for g. Two persons were  A BULDING  STREET ADDRESS, CITY, STATE, ZIP CODE 2659 TORREDGE ROAD DURHAM, NC 27712  ID PREFIX TAG  F 600  F 600  F 600  Reprix TAG  Reprix TAG  Reprovices Plan of correction (Exch correction should be contented and go to the hospital after an appointment four days after the event secondary to infection of her hip replacement prostheses which was not related to the event.  Root cause is the facility did not follow policy and procedure regarding removing the lift from service and filling out a maintenance request due to the lack of training in the process regarding reporting and removing equipment from service when faulty equipment is noted  The incidents related to hoyer lifts. No other incidents related to	

Facility ID: 923141

AND DI AN OF CORRECTION INTERCATION NUMBER:		` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		345458	B. WING		0.5	03/19/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	3/13/2010	
	10115211 011 001 1 2.2.1			2059 TORREDGE ROAD			
TREYBUR	N REHABILITATION	CENTER		DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 600	Continued From page	age 3	F 6	600			
	In an interview on #106 stated she w mechanical lift did She said both nurs wheelchair when the indicated the bar of the resident was being dropped into her left hip incision the following days.  In an interview on facility Medical Dirwith Resident #106 related to her left him that, based on her documentation, the incident with the modern seen the incident.  In an interview on Aide #4 and Nurse demonstration of w during Resident #106 assigned for use on needed, the lift was	03/15/18 at 3:20 p.m., Resident as "scared to death" when the not work correctly on 02/02/18. See aides were behind the ne top bar fell toward her. She ave her a "knot" on her head. unclear in her description of the concerned that the impact of the wheelchair had opened up the line which started to ooze over		the training was discussed facility was going to monito processes and system chathe event does not reoccur the meeting was to determicause of why the event occaping any idevelop a plan for monitoring the event does not reoccur was a definitive plan was pabate and prevent reoccurrevent.  Licensed and non-licensed re-education regarding Abuprohibition and policy was at the Director of Nursing, the Managers, the MDS Nurse Development Coordinator 3/16/18 and will continue uneducated. No staff will be after 3/16/18 until they receducation. The education definition of neglect meaning the failure of the facility, its service providers to provide services to a resident that a to avoid physical harm, paid anguish, or emotional distress that it is neglement and not respectful to knowingly use that is faulty or malfunction explained that it is the emp	ar the inges to ensure in the goal of ine the root curred, develop entified issues, ing to ensure in the outcome in the outcome in the outcome in place to rence of the inse/Neglect conducted by in the unit in graph in the starting in the outcome		
	returned to the uni			responsibility to tag and rer equipment from service the Unexplained injuries or injuinconsistent with a person	move the emselves. Iries that are		
		se Aide #5 guiding the lift pad		condition may indicate abu			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			l c		
		345458	B. WING			03/19/2018		
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	19/2010	
					059 TORREDGE ROAD			
TREYBUR	N REHABILITATION CEI	NTER			DURHAM, NC 27712			
	OUR MAA DV OT	TEMENT OF REFIGIENCIES						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	a 4	F	600				
	holding the resident.		' '	000	adjugation procented will be revised or			
		he two legs of the lift with the			education presented will be revised or updated based on updated research or			
	-	of the legs. During the			feedback from random validation interv			
		ent #106 into the chair, they			audits conducted to ensure understand	-		
	_	ne "suddenly dropping" and			of the education presented. Newly hire	•		
		nt in the wheelchair. She			employees will be educated regarding	·u		
		rely in the wheelchair but did			Abuse and Neglect Prohibition upon hi	re.		
		She was "dropped" from a			The Director of Nursing and the	٠.		
		ely one foot into the chair.			Maintenance Director were in-serviced	bv		
		the resident was screaming			the Regional Clinical Nurse regarding t	-		
	during the incident. W	When asked for clarification,			process of investigating and reporting			
	Nurse Aide #4 confirr	ned that as the mechanical			neglect that includes:			
	lift tilted to the left, bo	th wheels of the leg on the			Facility supervisors will immediately			
	right side of the lift lift	ted off the ground.			correct and intervene in reported or			
					identified situations in which abuse and	1		
	The overhead beam	<del>-</del>			neglect is at risk for occurring.			
		and sling struck Resident			The facility will conduct an investigation	ı of		
	-	er forehead. Both aides			any incidents or accidents			
	-	ere able to grab the bar as it			The importance of reporting equipment			
		event a major injury to the			failure and removing the equipment fro			
		#5 stated that she reported			service to alleviate the potential for inju			
		nent malfunction to the			The Director of Nursing was in-serviced			
		ately, and Nurse Aide #4 sign on the machine and			by an outside consultant pertaining to t facility and accident program with an	ne		
		init to the back service hall.			emphasis on who and when to comple	ło		
		THE TO THE BUCK SCIVICE Hall.			investigations and Root Cause Analysi			
	During the interview (	03/16/18 at 10:42 a.m.,			on 3/16/18.	,		
	_	d that the mechanical lift was			The procedure for the Incident/Accider	ıt		
		tioning up to the time of this			Management Investigation process wa			
		all shifter handle connected			revised on 3/16/18 to include:			
		chine, she showed that the			Initiate an investigation			
		id not engage correctly. The			The DON/designee is responsible for			
	shifter handle reposit				making sure an investigation is			
		I to do but did not lock them			completed.			
	into place. When the	shifter handle was moved to			Administrator/ DON will ensure all			
		gs closed in a parallel			investigation items are in order, comple	ete,		
	•	hifter handle was moved to			and maintained.			
		legs opened out at an angle			A complete investigation will include			
	to provide a more sta	ble foundation when weight			interviews and witness statements.			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONST		(X3) DATE SURVEY COMPLETED	
			A. BOILDII				С
		345458	B. WING _			١,	3/19/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		371372010
					RREDGE ROAD		
TREYBUR	N REHABILITATION	CENTER			M, NC 27712		
	O. H. M. A. D.	/ OTATEMENT OF DEFICIENCIES		70	·	T.O.	
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 600	Continued From page	age 5	F 6	800			
		r. The shifter handle on this			lical record review and a Root	Cause	
		, did not engage in the up		I	lysis.	oudoo	
		ack to neutral, preventing			ventative maintenance will be		
	·	he legs in both the open and		l l	pleted weekly per manufacture	er⊡s	
		Nurse Aides #4 and #5 both			ommendations to ensure the lift		
		reason the legs did not lock		work	king order. Preventative Maint	enance	
	and the lift tilted du	uring the resident's transfer on		Docu	umentation Form for the mech	anical	
	02/02/18.				vas revised to include tracking		
				I	vidual lifts and specific items re		
		ved the mechanical lift in the		I	lift to be checked per manufact	turer	
	short part of the hall to demonstrate that the			reco	ommendations.		
		when rolled across the floor.		la sia	d = -4 :4:4: : : : ! !		
		e did not trust the machine vith Resident #106 and now			dent investigations will be ewed/audited by the Interdiscip	dinory	
		placed one leg on the base		I	m during the weekly focus mee	-	
		ody weight on it to provide extra			100% compliance is maintained		
		ked about training, both aides			consecutive months to ensure	00 101	
	I -	y had a skills assessment on			stigations are complete and in	clude a	
	1	lifts on hire and then received		I	cause analysis, and intervention		
	refresher training a	annually from the facility.		put i	in place to prevent reoccurrence	ce.	
		03/19/18 at 11:50 a.m., Nurse		I	Administrator or designee will		
		has been working on the 100			ew/audit the Maintenance Requ		
		over a year. She confirmed that		l l	k and the Preventative Mainter		
		ctioned during the incident of same one that had been used			weekly until 100% compliance ntained for 2 consecutive mont		
		er assignment. The lift			ure that once the request is fille		
		ed for Resident #106 who has			airs are completed in a time fra		
		Hall since admission to the			ropriate for the type of repair a		
	facility last summe				ventative maintenance is compl		
				1 -	eduled		
	In an interview on	03/16/18 at 10:33 a.m., Nurse					
		assessment of Resident #106		Outo	comes of those reviews/audits	will be	
	following the incide	ent on 02/02/18. The resident		l l	sented to the steering QAPI		
	was lying in bed co	omplaining of pain. There was a			mittee monthly.		
		rehead without laceration,			steering committee will direct		
	_	g. Nurse #7 informed the Unit			ner analysis and interventions		
		e DON of the incident. She did			ed on reported outcomes and		
	not do anything wi	th the mechanical lift at the		direc	ct further investigations.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION  S		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	l	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u> </u>	03/19/2018
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	noted that Resident # (medical doctor) apply a.m., informed by SW was transferred to ho appointment." The re with a prosthetic joint  In an interview on 03. Maintenance Director lift used for Resident continued to be used until its removal on 03 acknowledged that th loose to keep the shir locking the legs in eit position. He was una documentation that th repaired after the tran and stated that neither remember working on  He stated that the Ma routine monthly preve on equipment and he checklist dated 02/06 Preventative Mainten the year 2018 include One recommended of Medical Equipment M patient lifting equipment to stand] lifts for defe that this check was p February.	d 02/06/18 by Nurse #7 #106 was "transported to MD pintment at approximately 9 V [social worker] that patient	F 60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	· · · · · · · · · · · · · · · · · · ·	03/13/2010
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F 600	Continued From pag	e 7	F 6	00		
	The Maintenance Dir model used on the 1 only model of that lift During the interview,	pecifically for that lift model. rector confirmed that the 00 and 300 Halls was the				
	adjustments to the mon 02/06/18. He also 03/12/18 when he had the scale component did not examine the stated that, in addition of facility equipment, other staff members problems with the money of the staff members and the staff members problems with the money of the staff members and staff members problems with the money of the staff members and staff	rachine when he inspected it inspected the lift recently on ad it in the shop for repair of it for weighing residents. He base of the machine. He in to his monthly monitoring he relied on nurse aides and to report concerns or				
	the back service hall On 03/16/18 at 5:15 machine was perform shop. The machine w door of the Restorati shifter handle verified adjustments had bee holding the shifter hall	p.m. an inspection of the lift ned after return from the vas stored behind the locked ve room. Operation of the				
	Maintenance Director since been removed  In an interview on 03 Director of Nursing (I Resident #106's injur 02/02/18. The reside when interviewed. The since	1/19/18 at 9:30 a.m., the r indicated that the lift had from the building. 1/19/18 at 3:16 p.m., the DON) stated she assessed ry after the incident on the was anxious and weeping the DON also stated she had be #4 to place a tag on the				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	03/19/2010
(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 CROSS-REFERENCED TO THE APPROFIDERICENCY)	O BE COMPLETION
F 600	to remove it from the The DON stated that that day on the unit b matter had come to the for follow-up. She shad more concerned about malfunctioning of the operation of it. She shad many years of eximechanical lifts. She concern about the state interview and dentacknowledged that the interview and dentacknowledged that the transfer Resident #10 and 300 Halls until the been working properly The DON acknowledgmembers were continuity with identified safety residents, endangering operation during transto potential trauma. In members tag malfundand remove it immed areas to prevent further The Administrator and informed of the immed at 4:21 p.m. On 03/16 provided the following removal:  The plan of correcting plan should address to the deficiency cited:	ying it as needing repair and unit to the back service hall. she did not see the lift later ut could not confirm that the ne attention of Maintenance ared that at the time she was ut the possible lift than the aides' proper ated that one of the aides perience operating was not aware of the aides' ability of the machine before nonstration on 03/16/18. She have mechanical lift used to 6 was still in use on the 100 at morning and had not y.  I ged in the interview that staff using to use a mechanical lift nazards to transfer the properties on safe after and exposing residents are expectation was that staff attioning equipment for repair ately from resident care	F 60	0	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G		ATE SURVEY DMPLETED
		345458	B. WING_			C 02/40/2049
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	l	03/19/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	CNAs [certified nurse policy and procedure legs retracted related legs was loose, and locked position, caus resident to be hit in tilift. The facility failed neglect by failing to resident to resident to be hit in the lift. The facility failed neglect by failing to resident end for the procedure regarding service and filling out to lack of training in the reporting and removing when faulty equipmed.  The procedure for implan of correction for 1. Address how the accomplished for the been affected by the "The [brand name] lift from service and rep Director on 3/16/18 auntil it has been evaluated the technician and deem maintenance has been at least weekly inspet to the manufacturer's lifts to identify and fix loosen.  There was no injury to other corrective actions and the resident. The reside	mechanical lift with two e aides] present who followed e during the transfer. The lift d to the handle that locks the did not fully engage to the sing the bar to swing and the he head with the bar from the to protect residents from emove a lift from service.  Cility did not follow policy and removing the lift from t a maintenance request due he process regarding ng equipment from service nt is noted."  Inplementing the acceptable the specific deficiency cited:  corrective action will be use residents found to have deficient practice:  It in question was removed aired by the Maintenance and will remain out of service	F6			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION  NG		ATE SURVEY OMPLETED
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u>'</u>	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	any pain and no pair administered. Neuro per facility policy with resident did go to the appointment four day to infection of her hip which was not relate.  2. Address how corraccomplished for the to be affected by the "The incident reports reviewed by the Dire determine if there we related to the mechawere identified. The examined all mechan 3/16/18 to ensure the properly. Any lift nee and removed from semechanical lift and to	g. The resident did not report a medication was a checks were implemented in no negative outcomes. The exhospital after an assaurant prostheses do to the event."  The ective action will be use residents having potential same deficient practice:  For last six months were corrector of Nursing on 3/16/18 to the energy of the process of the facility on the lifts are functioning ding repair was addressed ervice. There was one of the residual contents of the process of the	F	600		
	wear of one wheel. It service until the whe the wheels will be me preventative mainter can be replaced as r.  3. Address what mea systemic changes m deficient practice will  A. "An ad hoc QAPI performance improve was held on 3/16/18	ance inspections so they lecessary."  asures will be put in place or leade to ensure that the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:  A. BUILDING			` ′	(X3) DATE SURVEY COMPLETED	
		345458				C		
NAME OF PI	ROVIDER OR SUPPLIER	040400	]	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	03/	/19/2018	
				2059	TORREDGE ROAD			
TREYBUR	N REHABILITATION	CENTER		DUR	RHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 600	Continued From p	age 11	F	500				
	_	nagers, Vice President of						
	Operations and th	e Regional Clinical Director in						
	attendance. Medic	cal Director attended via						
	telephone. The ag	enda included determining the						
		event, what process would be						
		her residents that may have						
		ermining what education						
		pleted, the content of that						
		no would be responsible for						
		ucation. The means for aining was discussed and how						
	the facility was go							
	, ,	ges to ensure the event does goal of the meeting was to						
		t cause of why the event						
		a plan for correcting any						
		develop a plan for monitoring to						
		does not reoccur. The outcome						
		an was put in place to abate						
		urrence of the event.						
	B. Licensed and r	non-licensed staff re-education						
	regarding Abuse/N	Neglect prohibition and policy						
	was conducted by	the Director of Nursing, the						
	Unit Managers, th	e MDS Nurses and the Staff						
	Development Coo	rdinator starting 3/16/18 and						
		all staff are educated. No staff						
	will be able to wor	k after 3/16/18 until they receive						
		e education consisted of the						
		ct meaning "Neglect is the						
		ty, its employees or service						
		de goods and services to a						
		ecessary to avoid physical						
	•	ll anguish, or emotional						
		nphasized that it is neglect to						
		uipment and not report it, and it by by ingly use equipment that is						
	_	oning. It was explained that it is						
		sponsibility to tag and remove						
	Late employees le	opendionity to tag and follows	1	1			1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345458	B. WING		C 03/19/2018
	ROVIDER OR SUPPLIER	NTER	2	TREET ADDRESS, CITY, STATE, ZIP CODE 059 TORREDGE ROAD 0URHAM, NC 27712	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDERICS)	D BE COMPLETION
F 600	may indicate abuse. be revised or update research or feedback employees will be ed Neglect Prohibition un Nursing and the Main in-serviced by the Reregarding the process reporting neglect thato Facility supervisor and intervene in repowhich abuse and negrounder of the importance of and removing the equalleviate the potentian A. The Director of Noutside consultant personal program with when to complete in Analysis on 3/16/18.  B. The procedure for Management Investion 3/16/18 to include Initiate an investion 3/16/18 to include Initiate an investion and maintained. A completed Administration investigation items and maintained. A complete interviews and witnes record review and a supplemental procedure for making completed. Administration items and maintained. A complete interviews and witnes record review and a supplemental program with the supplemental procedure for making completed. Administration items and maintained. A complete interviews and witnes record review and a supplemental program with the supplemental procedure for making completed. Administration items and maintained and witnes record review and a supplemental procedure for making completed. Administration items and maintained and witnes record review and a supplemental procedure for making completed and procedure for making co	service themselves. or injuries that are erson's medical condition The education presented will d based on updated k from audits. Newly hired lucated regarding Abuse and upon hire. The Director of intenance Director were egional Clinical Nurse is of investigating and it includes: s will immediately correct orted or identified situations in glect is at risk for occurring. induct an investigation of any is. If reporting equipment failure uipment from service to I for injury.  ursing was in-serviced by an ertaining to the facility and than emphasis on who and vestigations and Root Cause  or the Incident/Accident gation process was revised	F 600		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345458	B. WING _			l	C <b>19/2018</b>
NAME OF P	ROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STATE, ZIP COD	<u></u> E		13/2010
TDEVBUG	N DELIABILITATION CEI	UTED		2059 TORREDGE ROAD			
IKEYBUR	N REHABILITATION CEI	NIER		DURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
F 600	Continued From page	e 13	F 6	600			
	ensure the lifts are in Maintenance Docume mechanical lift was reindividual lifts and spot to be checked per ma recommendations.  The title of the person implementing the accommendation of the credible allegation validated on 03/19/18 history for abuse and reviewed. The most ron 03/16/18 and was were trained on policing reporting, investigating and neglect.	working order. Preventative entation Form for the exised to include tracking for ecific items regarding the lift anufacturer  In responsible for eeptable plan of correction:  In of IJ removal was at 6:30 p.m. The facility's neglect training was ecent training was initiated ongoing. Staff members y and procedures for ag and documenting abuse					
	manufacturer's specific were given refresher the lift with return der managed the lift with mechanical compone support and positionismembers checked for safety of the lift pad, and body in the lift pad an equipment. Staff men checks before, during procedure. The mechincident was removed out of service. New mand the broken lift was	fications. Staff members training on the proper use of monstrations. Two persons one operating the ent and the other in front for ing of the resident. Staff or proper positioning and positioning of the resident's and functioning of the inbers performed safety					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	( (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 600	Continued From page 14		F 6	500		
	and several staff men regarding the reportin for incidents and acci	nplete a Maintenance aining record was reviewed abers were interviewed g and documenting process dents.				
F 655	transfer as well as proprovided with return of members. Training informalfunctioning or Staff members were inequipment from the underpression of the equipment or lifts lifts were to be placed. The Maintenance Dependent the service are repaired were service documented when it wout-of-service signs with Maintenance Books and unusing stations.  Severity/Scope = 4/1 Baseline Care Plan CFR(s): 483.21(a)(1)- §483.21 Comprehens Planning §483.21(a) Baseline (septiment) stational planning	the use of lifts for resident oper functioning was lemonstration by staff cluded reporting practices oroken lifts and equipment. Instructed to remove the nit and place an orange the their name, date and time were removed. Mechanical in the back service area. Dartment was expected to a daily to ensure items to be do and the repair was was completed. Orange were present in the evailable at each of the two solutions. It is the back service area are the provide of the two solutions are plan for each resident functions needed to provide centered care of the resident at standards of quality care.	F€	955		4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C 03/19/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		03/19/2016
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	admission.  (ii) Include the miniminecessary to properly including, but not limit (A) Initial goals based (B) Physician orders.  (C) Dietary orders.  (D) Therapy services.  (E) Social services.  (F) PASARR recommines successus (F) PASARR recommines in the comprehensive care care plan if the composition (ii) Meets the required (b) of this section (exthis section).  §483.21(a)(3) The faresident and their report the baseline care plimited to:  (i) The initial goals of (ii) A summary of the dietary instructions.  (iii) Any services and administered by the fon behalf of the facilititive comprehensive of the comprehensive of the comprehensive of the comprehensive comprehe	in 48 hours of a resident's  um healthcare information of care for a resident ted to- d on admission orders.  Intendation, if applicable.  Intellity may develop a plan in place of the baseline rehensive care plan- in 48 hours of the resident's  Intellity may develop a plan in place of the baseline rehensive care plan- in 48 hours of the resident's  Intellity must provide the presentative with a summary plan that includes but is not  If the resident. Intellity must provide the presentative with a summary plan that includes but is not  If the resident. Intellity must provide the presentative with a summary plan that includes but is not  If the resident to be accility and personnel acting	F 6	, , , , , , , , , , , , , , , , , , ,		
	Based on record rev facility failed to devel	iew and staff interviews, the op a baseline care plan mission with measurable bles to address the		Preparation and execution of the plan of correction does not	nis	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345458	B. WING		C 03/19/2018	
NAME OF P	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2010	
				2059 TORREDGE ROAD		
TREYBUR	N REHABILITATION CE	NTER		DURHAM, NC 27712		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		
F 655	Continued From page		F 65	5		
	immediate needs for with a urinary cathete	1 of 2 sampled residents er's Resident (#212).		constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies		
	Findings included:			The plan of correction is prepared and / or executed solely because it	5.	
	3/12/18. Diagnoses Mellitus, Heart failure	dmitted to the facility on included in part, Diabetes , chronic kidney disease,		is required by both Federal and Statillaws.		
	and hypertension.	set (MDS) 5 day assessment		A Baseline Care Plan with interventi and measurable objectives and time to address the immediate need of th	etable	
	dated 3/14/18 revealed	ed that Resident #212 was		urinary catheter was developed for		
	cognitively intact. The assessment was still in progress.	e assessment was suii in		resident #212. The nurse that comp the admission for resident #212 was in-serviced by the Director of Nursin	3	
	A review of the care p	olan dated 3/12/18 revealed lans or interventions		4/2/18 regarding the regulation pertator to the development of baseline care	_	
	regarding the indwell	ing urinary catheter.		with interventions and measurable objectives and timetable to address	the	
		sident #212 on 3/14/18 at esident lying with her eyes		immediate needs of the resident.		
	closed and the indwe urine.	elling catheter draining yellow		Root cause is the nurse that complete the admission acted singularly and	eted	
	An interview was cor	ducted with the MDS Nurse		violated the standard of care regard the admission process. The facility	_	
		BPM who indicated the ne MDS department started		identified a lack of system process f tracking the completion of admission	or	
	_	in Point Click Care(PCC) the		ensure all aspects of the admission done.		
		ducted with Nurse #2 on				
	3/15/18 at 3:01 PM w	ho indicated the MDS nurse care plan in PCC.		The Administrative Nursing Team reviewed the admissions for the last	130	
		ducted with MDS Nurse #1		days to ensure baseline care plans developed for identified issues. Any	were	
		rse started the care plan.		resident identified with issues not addressed on the care plan were		
		iducted with the Regional 8 at 3:09 PM who indicated		corrected.		
	there was no care pla	an for an indwelling urinary		The nursing staff was in-serviced by	the	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345458	B. WING _			C <b>03/19/2018</b>
	ROVIDER OR SUPPLIER  N REHABILITATION CEN	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE  2059 TORREDGE ROAD  DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PRECEDED BY FULL PREFIX (EACH COI		DRRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 655	catheter for Resident  An interview was con- Nursing on 3/15/18 at reason that Resident was because the cha-	#212. ducted with the Director of : 3:39PM who indicated the #212 didn't have a care plan rt review wasn't conducted. tation was the interim care	F 6	Staff Development Coordinat 4/2/16 regarding the regulatic addressing baseline care pla importance of developing the as part of the admission proc admissions will be reviewed whours of admission by a mem Administrative Nursing Team aspects of the admission are including the baseline care pla  The Director of Nursing or de audit new admissions until 10 compliance is met for two com months to determine if they h catheter and to ensure a bas plan is in place for the cathet  Outcomes of those audits will presented to the steering QA monthly.  The steering committee will of further analysis and intervent based on reported outcomes direct further investigations.	on and policy ns and the care plans less. New within 48 her of the to ensure all completed dan. lesignee will 00% hisecutive lave a urinary eline care er.  I be PI committee lirect ions	
F 689	CFR(s): 483.25(d)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		F 6	589		4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		I DENTIFICATION NUMBED:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
						(	С
		345458	B. WING _			03/	19/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	059 TORREDGE ROAD		
TREYBUR	N REHABILITATION C	ENTER		D	URHAM, NC 27712		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	Continued From pag	ae 18	F	689			
	by:	<b>5</b>	. `				
	•	ion, record review and			F689		
		esident, facility staff, and the			1 000		
		y failed to safely transfer a			Preparation and execution of this		
	1	ed to the wheelchair by using			plan of correction does not		
		echanical lift. The mechanical			constitute admission or agreement of		
		device did not lock in place			the facts alleged or conclusion set		
		ting, the resident being			forth in this statement of		
	dropped suddenly ir			deficiencies.			
	overhead beam on t	the lift striking the resident's			The plan of correction is prepared		
		taff continued to use the			and / or executed solely because it		
		fter the incident. This was			is required by both Federal and State		
	evident for one of th			laws.			
	accidents (Resident	#106).					
	L P. C. L I	(11) 1 00/00/40			The Hoyer lift in question was removed	1	
		y (IJ) began on 02/02/18, 3 was transferred from the			from service and repaired by the		
		air with a malfunctioning lift.			Maintenance Director on 3/16/18 and remained out of service until it was		
		ig in the resident being			evaluated by an outside technician and	1	
		nto the wheelchair and the			deemed safe for use. ¿Preventative	'	
		the lift striking the resident's			maintenance has been increased from		
		te Jeopardy was removed on			monthly to at least weekly inspections		
	03/16/18 when the f				be done according to the manufacturer		
		ceptable credible allegation of			recommendations of the lifts to identify		
		lity remains out of compliance			and fix any part that has started to loos		
	at a lower scope and	d severity of D (isolated with			There was no injury to Resident #106 t	hus	
	no actual harm with	potential for more than			no other corrective action could be take	en	
	minimal harm that is	s not immediate jeopardy) to			for this resident. The resident was		
		ng and ensure that monitoring			assessed by the licensed nurse, there		
		ce are effective to prevent			was no redness, swelling, laceration, o		
	accidents.				bruising. The resident did not report a	าง	
					pain and no pain medication was		
	The findings include	ea:			administered. Neuro checks were		
	The manufacture	Hoor Manual provided a			implemented per facility policy with no		
		User Manual provided a			negative outcomes. The resident did g		
		Inspection Checklist on			to the hospital after an appointment for		
	· •	etailed 10 areas for monthly			days after the event secondary to infec		
		on or adjustment. Included			of her hip replacement prostheses which	116	
	was ensuring the "S	hifter handle locks [the]			was not related to the event.		1

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED	
						С	
		345458	B. WING _			19/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	•		
				2059 TORREDGE ROAD			
TREYBUR	RN REHABILITATION (	CENTER		DURHAM, NC 27712			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)	
PREFIX TAG	,	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 689	Continued From pa	age 19	F 6	889			
		henever engaged." The User					
	Manual advised lift	t operators on page 21 that "If		Root cause is the facility did n	ot follow		
		s NOT positioning completely		policy and procedure regarding			
		lot, DO NOT use the patient lift		the lift from service and filling			
	Otherwise, injury	and/or damage may occur."		maintenance request due to the			
				training in the process regardi			
		s admitted to the facility on		and removing equipment from			
	_	noses of infection and		when faulty equipment is note	ed		
		o a left hip prosthesis, chronic		The incident reports for last of	v mantha		
	mellitus.	ailure and type 2 diabetes		The incident reports for last si			
	meinus.			were reviewed by the Director on 3/16/18 to determine if the	•		
	The quarterly Minis	mum Data Set (MDS) dated		other incidents related to hove	-		
		ited that the resident was		other incidents related to hove			
		Resident #106 was occasionally		Maintenance Director examine			
		quired extensive assistance for		mechanical lifts in the facility			
		pileting. Two persons were		ensure the lifts are functioning			
	needed for residen			¿Any lift needing repair was a			
				and removed from service.			
	The current care p	lan (most recently reviewed on					
	12/04/17) had entr	ies for complications following		An ad hoc QAPI committee m	eeting was		
	left hip replacemer	nt, falls risk and deficits related		held on 3/16/18 with Interim A	dministrator,		
	to the performance	e of activities of daily living. The		ADON, Rehab Manager, Unit	Managers,		
	1	the use of a mechanical lift for		Vice President of Operations			
	transfers.			Regional Clinical Director in a			
				Medical Director attended via	-		
		s note dated 02/02/18 by Nurse		The agenda included determine	-		
		lesident #106 "was being		cause of the event, what proc			
		ed to chair and was struck on		be used to identify other resid			
	-	oproximately 9:45 a.m. Vital		may have been affected, dete	•		
	signs were obtained, neurological checks instituted, and the physician notified.			what education needed to be the content of that education,			
	חוסוונונים, מווט נוופ	priyaidian nouncu.		would be responsible for com			
	The Director of Nu	rsing (DON) provided the		education. The means for val			
		the names of the two nurse		the training was discussed an			
		#4 and Nurse Aide #5) who		facility was going to monitor th			
		mechanical lift at the time		processes and system change			
		itten statements. When asked,		the event does not reoccur. T			
		at no written investigation of the		the meeting was to determine	-		

Facility ID: 923141

PRINTED: 04/19/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
							С
		345458	B. WING _			03	/19/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TDEVDUD	N DELLA DIL ITATIONI	OFNITED		2	2059 TORREDGE ROAD		
IKEYBUK	N REHABILITATION	CENTER			DURHAM, NC 27712		
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	3E	(X5) COMPLETION DATE
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	AIE	57.11.2
F 689	Continued From p	age 20	F 6	689			
	incident had been	completed by management.			cause of why the event occurred, deve	-	
	The witness stater	ments provided a brief			a plan for correcting any identified issued develop a plan for monitoring to ensur		
	description. Nurse	Aide #4 wrote "the [brand			the event does not reoccur. The outcome		
		r bar closed and the [brand			was a definitive plan was put in place		
		d back and the lift hit her (the ce." Nurse Aide #5 wrote "we			abate and prevent reoccurrence of the event.	<del>!</del>	
	,	lent's] leg while lowering her in			Licensed and non-licensed staff		
		ift just closed in on her and hit			re-education regarding Abuse/Neglect		
	her forehead."	•			prohibition and policy was conducted	эу	
					the Director of Nursing, the Unit		
		03/15/18 at 3:20 p.m., Resident			Managers, the MDS Nurses and the S	taff	
		ras "scared to death" when the n't work correctly on 02/02/18.			Development Coordinator starting 3/16/18 and will continue until all staff	are	
		es were behind the wheelchair			educated. No staff will be able to work		
	when the top bar f	ell toward her. She indicated			after 3/16/18 until they receive the		
	the bar gave her a	"knot" on her head and it			education. The education consisted of		
		er thigh giving her a bruise. The			definition of neglect meaning Neglect		
		ear in her description of the			the failure of the facility, its employees		
		concerned the incident had			service providers to provide goods and		
		hip incision line which started wing days. She was readmitted			services to a resident that are necessare to avoid physical harm, pain, mental	ary	
		02/06/18 and diagnosed with a			anguish, or emotional distress. It also		
		ection of the left hip.			emphasized that it is neglect to discov		
		·			faulty equipment and not report it, and		
		03/19/18 at 4:45 p.m., the			neglectful to knowingly use equipment		
	-	ector indicated her familiarity			that is faulty or malfunctioning. It was		
		6 and the hospitalizations			explained that it is the employee□s		
		nip replacement. She did not			responsibility to tag and remove the		
		cted about the head injury			equipment from service themselves.		
		02/02/18. She stated that,			Unexplained injuries or injuries that ar	е	
	based on her revie				inconsistent with a person □s medical		
		ere was no indication that the			condition may indicate abuse. The		
		nechanical lift contributed to the			education presented will be revised or		
		from the left hip area that			updated based on updated research of		
		er hospitalization four days			feedback from random validation inter		
		If staff members or the resident			audits conducted to ensure understan	•	
	•	about disruption to the incision ct of her landing in the chair,			of the education presented. Newly hire employees will be educated regarding		
	ווווכ מונכו נווכ ווווףמ	or or ner landing in the chall,	1		T Employees will be educated regarding		1

Facility ID: 923141

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7 5012511	_		(	
		345458	B. WING_			l	19/2018
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010
				20	059 TORREDGE ROAD		
TREYBUR	N REHABILITATION CEN	NTER		D	URHAM, NC 27712		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 689	Continued From page	e 21	F 6	689			
	she was not aware of	it.			Abuse and Neglect Prohibition upon hi	e.	
	In an interview on 03/	/16/18 at 10:42 a.m., Nurse			Maintenance Director were in-serviced	by	
	Aide #4 and Nurse Ai	•			the Regional Clinical Nurse regarding t	he	
		at had happened during			process of investigating and reporting		
		sfer on 02/02/18. The DON			neglect that includes:		
		ne interview. The mechanical			Facility supervisors will immediately		
		nstration was present on the			correct and intervene in reported or		
		same lift used on 02/02/18			identified situations in which abuse and neglect is at risk for occurring.	l	
		ne machine was permanently he 100 and 300 Halls. When			The facility will conduct an investigation	of	
		ransferred to the other side			any incidents or accidents	1 01	
	of the building for tem				The importance of reporting equipment		
	returned to the unit.	porary doe and alon			failure and removing the equipment fro		
					service to alleviate the potential for inju		
	During the demonstra	ation Nurse Aide #4 indicated			The Director of Nursing was in-serviced	-	
		ig the lift on 02/02/18 with			by an outside consultant pertaining to t		
	Nurse Aide #5 guiding	g the lift pad holding the			facility and accident program with an		
		hair was positioned between			emphasis on who and when to complet		
	_	with the open seat facing			investigations and Root Cause Analysis	3	
		ng the lowering of Resident			on 3/16/18.		
		ney described the machine			The procedure for the Incident/Acciden		
	,	and depositing the resident			Management Investigation process wa	S	
		e was not seated squarely in and on the floor. She was			revised on 3/16/18 to include:		
		ght of approximately one foot			Initiate an investigation The DON/designee is responsible for		
		des stated that the resident			making sure an investigation is		
		g the incident. When asked			completed.		
		e Aide #4 confirmed that			Administrator/ DON will ensure all		
	•	g on the right side of the			investigation items are in order, comple	ete,	
		ne ground as the mechanical			and maintained.	•	
	lift tilted to the left.				A complete investigation will include		
					interviews and witness statements,		
	The overhead beam of				medical record review and a Root Cau	se	
		nd sling struck Resident			Analysis.		
	-	r forehead. They stated they			Preventative maintenance will be		
	_	bar as it was happening to			completed weekly per manufacturer s		
		to the resident. Neither			recommendations to ensure the lifts are		
	aide saw the beam hi	t the resident's thigh as the			working order. Preventative Maintenar	ice	
ORM CMS-256	7(02-99) Previous Versions Obs	solete Event ID: 58ZQ11		Fac	cility ID: 923141 If continu	ation shee	t Page 22 of 50

· /		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C <b>3/19/2018</b>	
	ROVIDER OR SUPPLIER  N REHABILITATION CE	NTER		STREET ADDRESS, CITY, STATE, ZIP COD 2059 TORREDGE ROAD DURHAM, NC 27712	•	G. 16/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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	(X5) COMPLETION DATE	
F 689	pain at the time of the stated that she report malfunction to the character had been machine and removed. During the interview, the mechanical lift was malfunctioning. Using connected to the base showed that the lock engage correctly. The legs of the machinot lock them into plawas moved to the left parallel position. Who moved to the right are an angle to provide a when weight was lifted handle on this machin in the up position and preventing proper locopen and closed position and the lift tilted on 02/02/18.  Nurse Aide #4 moves short part of the hall did not stay locked with the locked with th	d she did not complain of hip e incident. Nurse Aide #5 ted the injury and equipment arge nurse immediately, and I she placed a sign on the ed it from the unit.  Nurse Aide #4 shared that as still prone to g the tall shifter handle se of the machine, she ing mechanism did not e shifter handle repositioned in eas designed to do but did ace. When the shifter handle at and up, the legs closed in a sen the shifter handle was and up, the legs opened out at a more stable foundation ed in the air. The shifter ne, however, did not engage d fell back to neutral, cking of the legs in both the ait she reason the legs did not during the resident's transfer d the mechanical lift in the to demonstrate that the legs when rolled across the floor. Sid not trust the machine in Resident #106 and now acced one foot on the base	F 68	,	cking for ms regarding nufacturer disciplinary smeetings ntained for usure and include a eventions are urrence.  The will review ok and the gweekly until ed for 2 that once are propriate for tative scheduled will be PI irect ions		
	with most of her body provide extra stability training, both aides of skills assessment on	y weight shifted on it to y. When asked about confirmed that they had a using mechanical lifts on ed refresher training annually					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345458	B. WING _			C 03/19/2018	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		03/13/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	service hall behind claides' demonstration and Corporate Vice Forder to prevent staff  In an interview on 03 Aide #6 stated she had 300 Halls for overthe lift that malfunction 02/02/18 was the sar on the unit since her continued to be used resided on the 300 H facility last summer.  In an interview on 03 #7 recounted her assigned following the incident was lying in bed commed mark on her forely bleeding or bruising, mentioned any injury informed the Unit Summer and the Unit Summer	ft was moved to the back osed doors after the nurse by the Maintenance Director President of Operations in members from using it.  /19/18 at 11:50 a.m., Nurse as been working on the 100 er a year. She confirmed that oned during the incident of me one that had been used assignment. The lift for Resident #106 who has all since admission to the  /16/18 at 10:33 a.m., Nurse ressment of Resident #106 on 02/02/18. The resident plaining of pain. There was a nead without laceration, The resident had not to the thigh or hip. She pervisor and the DON of the d not do anything with the	F	389			
	Nurse stated that she for a "clear fluid-filled [centimeters] along s thigh lateral aspect, s	e evaluated Resident #106					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		345458	B. WING _			C 03/19/2018	
	TREYBURN REHABILITATION CENTER    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)    F 689   Continued From page 24			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		33,13,2313	
PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689			F6	889			
	noted that Resident [medical doctor] app a.m., informed by S\ was transferred to he	#106 was "transported to MD ointment at approximately 9 V [social worker] that patient					
	Maintenance Director lift used for Resident continued to be used until its removal on 0 acknowledged that to loose to keep the shocking the legs in eight position. He was una documentation that the repaired after the training and stated that neith remember working of	or inspected the mechanical #106's transfer and that d on the 100 and 300 Halls 03/16/18 at 11:15 a.m. He he base mechanism was too ifter handle engaged in ther the open or closed able to provide any written the mechanical lift had been insfer incident on 02/02/18 her he nor his assistant on the machine at that time.					
	routine monthly prevon equipment, and hecklist dated 02/00 Preventative Mainter the year 2018 include One recommended Medical Equipment I patient lifting equipmechanical lift] and for defects." Checkm	aintenance department did rentative maintenance checks le provided a completed 6/18. The facility's five-page nance Monthly Checklist for led 20 areas for monitoring. Icheck was listed under Management: "Check all lient, [brand name [brand name sit-to-stand] lifts harks indicated that this light in January and February.					
	used the general fac	rector further stated that he ility checklist rather than a pecifically for that model of					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		345458	B. WING _			C 03/19/2018		
	ROVIDER OR SUPPLIER  N REHABILITATION CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		00/13/2010		
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 689	model used on the 1 only model of that lift During the interview, stated that he did no adjustments to the mon 02/06/18. He also 03/12/18 when he had the scale component did not examine the Maintenance Director from the back service. On 03/16/18 at 5:15 machine was perform shop. The machine was perform shop. The machine was door of the Restoratishifter handle verified adjustments had been holding the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip on the last position of the shifter handle did not slip of the shifter han	e Director confirmed that the 00 and 300 Halls was the in the building.  the Maintenance Director thotice a need for any eachine when he inspected it inspected the lift recently on additional in the shop for repair of the forweighing residents. He chase of the machine. The rest then moved the machine the hall to the shop area.  p.m. an inspection of the lift need after return from the was stored behind the locked we room. Operation of the	F6	· · · · · · · · · · · · · · · · · · ·				
	stated she assessed the incident on 02/02 Nurse Aide #4 to pla lift identifying it as no from the unit to the b stated that she did no the unit but could no come to the attentior follow-up. She share more concerned abo	A/19/18 at 3:16 p.m., the DON Resident #106's injury after A/18. She had instructed the a tag on the mechanical reding repair and to remove it rack service hall. The DON but see the lift later that day on the confirm that the matter had a of Maintenance for d that at the time she was						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION  IG	, ,	(X3) DATE SURVEY COMPLETED	
		345458	B. WING _			C <b>3/19/2018</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2059 TORREDGE ROAD DURHAM, NC 27712		3/19/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	aides had many year mechanical lifts. She concern about the state the interview and deracknowledged that the transfer Resident #10 and 300 Halls until the working properly, plainjury due to the pote. The Administrator and informed of the immeration 4:21 p.m. On 03/10 provided the following removal:  "A resident was being wheelchair utilizing a CNAs [Certified Nursfollowed policy and p The lift legs retracted locks the legs was lost to the locked position and the resident to be from the lift. The facil from neglect by failing service.  Root cause is the fact procedure regarding service and filling out to lack of training in the reporting and removing when faulty equipment.	rated that one of the nurse is of experience operating was not aware of the aides' ability of the machine before monstration on 03/16/18. She is mechanical lift used to 16, and still in use on the 100 at morning, had not been cing residents at risk for intial for accidents.  In Director of Nursing were diate jeopardy on 03/16/18 at 9:41 p.m., the facility goredible allegation of IJ gransferred from bed to mechanical lift with two is expected a did not fully engage in the handle that in the head with the barriety failed to protect residents go to remove a lift from a maintenance request due the process regarding the gransferrice in the process regarding and equipment from service	F6	889			

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	\ , ,	(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C 3/19/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2059 TORREDGE ROAD DURHAM, NC 27712		5/19/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	accomplished for the been affected by the "The [brand name] lift from service and rep. Director on 3/16/18 a until it has been eval technician and deem maintenance of the limonthly to at least work completed per manuto identify and fix any loosen.  There was no injury to other corrective action resident. The resident licensed nurse, there laceration, or bruising any pain and no pain administered. Neuro per facility policy with resident did go to the appointment four day to infection of her hip which was not related.  2. Address how corraccomplished for the to be affected by the "The incident reports reviewed by the Directed to the mecha were identified. The I	corrective action will be se residents found to have deficient practice:  It in question was removed aired by the Maintenance and will remain out of service uated by an outside ed safe for use. Preventative fits has been increased from eekly inspections, and will be facturer's recommendations, or part that has started to  To Resident #106 thus no on could be taken for this at was assessed by the ewas no redness, swelling, g. The resident did not report a medication was checks were implemented in no negative outcomes. The explanation has after an area after the event secondary or replacement prostheses did to the event."  The ective action will be se residents having potential same deficient practice:  Tor the last six months were correctly of the same	F 68	89			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345458	B. WING _			C 03/19/2018	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u> </u>	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	and removed from si [brand name] lift and sit-to-stand] lifts. On sit-to-stand] lifts was one wheel. It has be the wheel is replaced be monitored by wee maintenance inspect as necessary."  3. Address what me systemic changes madeficient practice will A. "An ad hoc QAPI performance improving was held on 3/16/18 ADON (assistant direction of the event attendance. Medical telephone. The age root cause of the event used to identify othe been affected, deterneeded to be completed to be completed to identify was going and system changes not reoccur. The good determine the root coccurred, develop a identified issues, devensure the event document of the event document in the facility was going and system changes not reoccur. The good determine the root coccurred, develop a identified issues, devensure the event document in the facility was going and system changes not reoccur. The good determine the root coccurred, develop a identified issues, devensure the event document in the facility was going and system changes not reoccur. The good determine the root coccurred, develop a identified issues, devensure the event document.	eding repair was addressed ervice. There was one other I two [brand name e of the [brand name e identified with slight wear of en removed from service until d. Wearing of the wheels will ekly preventative tions so they can be replaced easures will be put in place or eade to ensure that the I not occur:  (quality assurance and ement) committee meeting with Interim Administrator, ector of nursing), Rehab gers, Vice President of Regional Clinical Director in Director attended via anda included determining the ent, what process would be residents that may have mining what education eted, the content of that would be responsible for ation. The means for aning was discussed and how go to monitor the processes all of the meeting was to ause of why the event plan for correcting any velop a plan for monitoring to es not reoccur. The outcome was put in place to abate	F6				

		IDENTIFICATION NUMBED:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2059 TORREDGE ROAD DURHAM, NC 27712		03/19/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 689	the Director of Nursin MDS Nurses and the Coordinator regarding mechanical lifts with 3/12/18 and will contilicensed nurses are included inspecting to use, operation of the demonstration, report equipment if any fau employee is responsified in the important of the mainties. All facility staff regeducation regarding removing malfunction completion of the Mathematical transfer of the mainties. All facility to tag afrom service by placity and not using the equipment of the mainties. Described in the inservice of the mainties of the mainties of the mainties of the mainties. Incidents will be reconsidered by the mainties.	ed nurses were educated by ng, the Unit Managers, the e Staff Development g transfers utilizing return demonstration starting inue until 100% CNAs and educated. The in-service he lifts and slings prior to lift with return ting and not using the lts/issues are noted, the ible for tagging and g the equipment from n the service hall, and tenance request.  gardless of position or title process for reporting and ning equipment and aintenance Request Form. asized it is the staff members and remove the equipment ng it in the service hallway uipment until it has been enance staff for use.	F 6	89			
	and interventions are reoccurrence."  The title of the perso	eause analysis is completed, e put in place to prevent					
	The credible allegation validated on 03/19/1						

* *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE COMP	SURVEY LETED
			A. BOILD			C	
		345458	B. WING				19/2018
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
TREVEIIR	N REHABILITATION CEI	NTER		2	2059 TORREDGE ROAD		
IKEIBUK	N REHABILITATION CEI	NIER		1	DURHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	were observed while mechanical lifts. Two with one operating the and the other in front of the resident. Staff proper positioning an positioning of the resident proper functioning members performed and after the lift procedure reported they were president transfers with through the weekend mechanical lift involved removed from the unit of the Maintenance Decim-service training on checks and procedure manufacturer instruct maintenance checks mechanical lifts. Lift in the maintenance checks mechanical lifts was refor individual lifts. The Documentation Form in each nursing station reviewed.  Staff members were to document and report equipment and to con Request Form. The training station reviews to mechanical form.	inspected. Staff members demonstrating proper use of opersons managed the lift e mechanical component for support and positioning members checked for d safety of the lift pad, ident's body in the lift pad g of the equipment. Staff safety checks before, during edure. Staff members rovided in-service training on h use of a lift on 03/12/18 of 03/17/18. The ed in the incident was it and placed out of service.  partment was provided expected maintenance es for equipment with ions on the proper use and for different types of inspections were added to extract the contract of the preventive effective.	F	689			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C / <b>19/2018</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	03	119/2016
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From page	e 31	F 68	39		
F 690	transfer as well as proprovided with return of members. Training in for malfunctioning or Staff members were equipment from the upout-of-service sign with the equipment or lifts lifts were to be placed. The Maintenance Decheck the service are repaired were service documented when it out-of-service signs with Maintenance Books and nursing stations. Severity/Scope = 4/1 Bowel/Bladder Incont CFR(s): 483.25(e)(1) The fact resident who is continued \$483.25(e)(1) The fact resident who is continued condition is or become not possible to maintal \$483.25(e)(2)For a reincontinence, based of comprehensive assessed ensure that- (i) A resident who entindwelling catheter is	the use of lifts for resident oper functioning was demonstration by staff cluded reporting practices broken lifts and equipment. instructed to remove the init and place an orange the their name, date and time were removed. Mechanical doin the back service area, partment was expected to be a daily to ensure items to be and the repair was was completed. Orange were present in the available at each of the two distinence, Catheter, UTI—(3)  Ince.  Cility must ensure that the nent of bladder and bowel on ervices and assistance to unless his or her clinical des such that continence is ain.	F 69	90		4/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345458	B. WING		C 03/19/2018	
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	03/13/2010	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		N
F 690	indwelling catheter or is assessed for remove as possible unless the demonstrates that care and (iii) A resident who is receives appropriate prevent urinary tract is continence to the extension of the extension	ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to infections and to restore ent possible.  esident with fecal on the resident's esment, the facility must to who is incontinent of bowel treatment and services to inal bowel function as  is not met as evidenced iew, staff interviews and is and order for the use of catheter for 1 of 2 sampled  dmitted to the facility on included in part, Diabetes chronic kidney disease,  et (MDS) 5 day assessment	F 69	F690  Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws.  The physician was contacted and the diagnosis and physician order was obtained for use of the urinary cathete The nurse that completed the admission for resident #212 was in-serviced by the Director of Nursing on 4/2/18 regarding	e	

NAME OF PROVIDER OR SUPPLIER
TREYBURN REHABILITATION CENTER    XIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG)   DURHAM, NC 27712
SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG
DURHAM, NC 27712     PROVIDER'S PLAN OF CORRECTION (20)     CACH DEFICIENCY MUST BE PRECIDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)     PREFIX TAG     Review of the admission nursing note dated 3/12/18 revealed no documentation of the indwelling urinary catheter. Review of the urinary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter. Review of the urinary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter. Review of the urinary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter. Review of the urinary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter. An observation of Resident #212 on 3/14/18 at 11:10AM revealed Resident #212 nad an indwelling catheter draining yellow urine. An interview was conducted on 3/15/18 at 12:03 PM Nurse #1 indicated Resident #212 had an indwelling catheter. An interview was conducted on 3/15/18 at 3:01 PM Murse #2 indicated the admitting nurse checked the admission orders and put them into the EHR. When she reviewed the hard chart revealed there was no order for the indwelling urinary catheter. An interview was conducted on 3/15/18 at 3:01 PM Murse #2 indicated the admitting nurse checked the admission orders and put them into the EHR. When she reviewed the hard chart she indicated that Health and Physical (H&P) assessment dated 2/2/11/8 Resident #212 had a catheter for urinary retention.  An interview was conducted on 3/15/18 at 3:09 PM with the Regional Consultant indicated there
SUMMARY STATEMENT OF DEFICIENCIES   PRECISE
FREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 690  Continued From page 33  Review of the admission nursing note dated 3/12/18 revealed no documentation of the indwelling urinary catheter.  Review of the uninary output documentation beginning on 3/12/18 indicated an indwelling urinary catheter.  An observation of Resident #212 on 3/14/18 at 11:10AM revealed Resident lying with her eyes closed and the indwelling catheter draining yellow urine.  An interview was conducted on 3/15/18 at 12:03 PM Nurse #1 indicated Resident #212 had an indwelling catheter. She stated that there was no order in the electronic healthcare record (EHR). Review of the hard chart revealed there was no order for the indwelling urinary catheter.  An interview was conducted on 3/15/18 at 3:01 PM Nurse #2 indicated the admitting nurse checked the admission orders and put them into the EHR. When she reviewed the hard chart she indicated that Health and Physical (H&P) assessment dated 2/21/18 Resident #212 had a catheter for urinary retention.  An interview was conducted on 3/15/18 at 3:09 PM with the Regional Consultant indicated there  F 690  The regulation and policy and procedure pertaining to the appropriate diagnoses of the treathers and importance of obtaining rothers and importance of obtaining rotheres to catheter and care of the catheter.  Root cause is the nurse that completed the admission process. The facility also identified all ack of system process for tracking the completion of admissions to ensure all aspects of the admissions are done.  The Administrative Nursing Team reviewed the charts of the residents identified with urinary catheters to determine if appropriate diagnoses and orders are present for those residents.  Any resident identified mith urinary catheters to determine if appropriate diagnoses and orders are present for those residents.  Any resident identified mith urinary catheters.  New admiss
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PM with the Regional Consultant indicated there  Administrative Nursing Team to ensure all
was no order for the indwelling catheter.
including the diagnosis and appropriate
An interview was conducted on 3/15/18 at 3:39 orders for urinary catheters.
PM with the Director of Nursing reviewed  Pagidonto #212 hard short and EHP indicated  The Director of Nursing or designed will
Residents #212 hard chart and EHR indicated  that there was no order or diagnoses for an  The Director of Nursing or designee will audit new admissions until 100%
indwelling urinary catheter. She indicated that if compliance is met for two consecutive the resident had a catheter she expected the months to ensure they have a urinary
nurse to obtain an order for the catheter.  Infolius to ensure they have a unitary  catheter and to ensure an appropriate

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		045450	D WING		С
NAME OF P	ROVIDER OR SUPPLIER	345458	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	03/19/2018
TREYBUR	N REHABILITATION CE	NTER		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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 908	admitted Resident #2 unsuccessful on 3/16 3/19/18 at 2:06 PM.  An interview was cor PM Nurse # 3 indicate were checked by the supervisor, and then order entry was accur  An interview conducte # 6 indicated that ord hospital and checked EHR. A second nurse accuracy. Severity/Scope = 2/1 Essential Equipment, CFR(s): 483.90(d)(2) §483.90(d)(2) Mainta and patient care equi condition. This REQUIREMENT by: Based on observatio interviews with the re facility failed to keep a properly to ensure a r transferred from the b mechanical lift's leg p lock in place resulting being dropped sudde overhead beam on th head. The facility staf malfunctioning lift after	a telephone Nurse #4 who 12 on 3/12/18 was /18 at 2:51 PM and on  Inducted on 3/16/18 at 3:00 Inducted on 3/16/Inducted on 3/16/Inducted on 3/	F 908	diagnosis and physician orders are present.  Outcomes of those audits will be presented to the steering QAPI commi monthly.  The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	4/10/18

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				_		(	c
		345458	B. WING			03/	19/2018
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
TREYBUR	N REHABILITATION CEN	NTER			059 TORREDGE ROAD URHAM, NC 27712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 908	when Resident #106 bed to the wheelchair The lift tilted resulting suddenly into the wheelchair The lift tilted resulting suddenly into the wheelchair The lift tilted resulting suddenly into the wheelchair The Immediate Jeopa 03/16/18 when the far implemented an accell Jremoval. The facilit at a lower scope and no actual harm with principal manufacture staff training systems put into place equipment are maintabefore use to transfer. The findings included The manufacturer's Upof lift] provided a Mair Checklist on pages 40 for monthly institution Included was ensurin [the] adjustable base User Manual advised that "If the shifter han completely into its mothe patient lift Other may occur."	(IJ) began on 02/02/18, was transferred from the with a malfunctioning lift. in the resident dropping elchair and the overheading the resident's head.  ardy was removed on cility provided and ptable credible allegation of y remains out of compliance severity of D (isolated with otential for more than not immediate jeopardy) to g and ensure that monitoring e are effective to ensure ained and working properly residents.  Elser Manual for [brand name intenance Safety Inspection 0-42 that detailed 10 areas all inspection or adjustment. In the lift operators on page 21 die is NOT positioning bunting slot, DO NOT use wise, injury and/or damage	F	908	The Hoyer lift in question was removed from service and repaired by the Maintenance Director on 3/16/18 and remained out of service until it was evaluated by an outside technician and deemed safe for use. ¿Preventative maintenance has been increased from monthly to at least weekly inspections to be done according to the manufacturer recommendations of the lifts to identify and fix any part that has started to loos. There was no injury to Resident #106 to no other corrective action could be take for this resident. The resident was assessed by the licensed nurse, there was no redness, swelling, laceration, obruising. The resident did not report are pain and no pain medication was administered. Neuro checks were implemented per facility policy with no negative outcomes. The resident did go to the hospital after an appointment food days after the event secondary to infect of her hip replacement prostheses which was not related to the event.  Root cause is the facility did not follow policy and procedure regarding preventative maintenance, there was a lack in processes of review to ensure preventative maintenance was completed and it was determined the preventative maintenance log did not specify which or which part of the lift was checked pet the manufacturer secommendations.	en hus en ray our tion ch the red, lift	
	inflammation due to a	left hip prosthesis, chronic re and type 2 diabetes			The Maintenance Director examined al mechanical lifts in the facility on 3/16/1		

Facility ID: 923141

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	PLE CONSTRUCTION  G		(X3) DATE COMP	SURVEY LETED
		345458	B. WING			C 03/19/2018	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIP CODE		1 03/	13/2010
				2059 TORREDGE ROAD			
TREYBUR	N REHABILITATION CEI	NTER		DURHAM, NC 27712			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)			COMPLÉTION DATE
F 908	Continued From page	e 36	F 90	80			
	mellitus.			ensure the lifts are functioning	properly		
	monituo.			¿Any lift needing repair was a			
	The quarterly Minimu	m Data Set (MDS) dated		and removed from service. The			
		that the resident was		one other hoyer lift and two Sa			
	cognitively intact. Res	sident #106 was occasionally		One of the Sara lifts was ident	ified with		
	incontinent and requi	red extensive assistance for		slight wear of one wheel. It ha	as been		
	bed mobility and toile	ting. Two persons were		removed from service until the	wheel is	;	
	needed for resident to	ansfers.		replaced. Wearing of the whe		e	
				monitored by weekly preventa			
	-	(most recently reviewed on		maintenance inspections so the	iey can b	е	
		for complications following		replaced as necessary.			
		falls risk and deficits related f activities of daily living. The		An ad hoc QAPI committee m	ooting we		
		e use of a mechanical lift for		held on 3/16/18 with Interim A			
	resident transfers.	c use of a meenamear intro		ADON, Rehab Manager, Unit			
				Vice President of Operations a	_	<b>o</b> ,	
	A nursing progress no	ote dated 02/02/18 by Nurse		Regional Clinical Director in at		e.	
		ident #106 "was being		Medical Director attended via			
	transferred from bed	to chair and was struck on		The agenda included determing	ning the re	oot	
	the forehead" at appr	oximately 9:45 a.m. Vital		cause of the event, what proce	ess would	t	
	signs were obtained,			be used to identify other reside			
	instituted, and the ph	ysician notified.		may have been affected, dete	_		
				what education needed to be	•	d,	
		ng (DON) provided the		the content of that education,			
	•	ne names of the two nurse		would be responsible for comp	_		
		and Nurse Aide #5) who		education. The means for val			
		echanical lift at the time		the training was discussed and		,	
		n statements. When asked, no written investigation of the		facility was going to monitor the processes and system change		ıro	
		mpleted by management.		the event does not reoccur. T			
	moldent nad been ooi	impleted by management.		the meeting was to determine	_	,,	
	Witness statements r	provided a brief description.		cause of why the event occurr		lop	
		"the [brand name] lift		a plan for correcting any ident			
		and the [brand name] lift was		develop a plan for monitoring			
		hit her (the resident) in the		the event does not reoccur. T			
	face." Nurse Aide #5	wrote "we adjusted the		was a definitive plan was put i			
	[resident's] leg while	lowering her in the chair and		abate and prevent reoccurren	ce of the		
	the lift just closed in o	on her and hit her forehead."		event.			
				Education of the Maintenance	Director		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	NIIMDED:		ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
							С	
		345458	B. WING _			03	3/19/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
				20	059 TORREDGE ROAD			
TREYBUR	N REHABILITATION	CENTER		D	URHAM, NC 27712			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID PREFI)	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
TAG	REGULATORT	OR LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			
F 908	Continued From p	age 37	F	908				
	In an interview on	03/15/18 at 3:20 p.m., Resident			regarding the Preventative Maintenand	ce		
		as "scared to death" when the			Policy and Procedure by the Regional			
	mechanical lift did	not work correctly on 02/02/18.			Vice President of Operations on			
		se aides were behind the			3/16/18.All facility staff regardless of			
	wheelchair when t	he top bar fell toward her. She			position or title education regarding			
	indicated the bar g	gave her a "knot" on her head.			process for reporting and removing			
	The resident was i	unclear in her description of the			malfunctioning equipment and comple	tion		
	incident.				of the Maintenance Request Form. Th	ıe		
					in-service emphasized it is the staff			
	In an interview on	03/16/18 at 10:33 a.m., Nurse			members responsibility to tag and rem	ove		
	#7 recounted her a	assessment of Resident #106			the equipment from service by placing	it in		
	on 02/02/18 follow	ing the incident. The resident			the service hallway and not using the			
	was lying in bed co	omplaining of pain. There was a			equipment until it has been cleared by	the		
		rehead without laceration,			maintenance staff for use. The			
	bleeding or bruising	g. Nurse #7 informed the Unit			Preventative Maintenance Documenta			
		e DON of the incident. She did			Form for the mechanical lift was revise			
	not do anything wi	th the mechanical lift at the			to include tracking for individual lifts ar	ıd		
	time.				specific items regarding the lift to be			
					checked per manufacturer			
		ated 02/06/18 by Nurse #7			recommendations. Preventative			
		nt #106 was "transported to MD			maintenance of other equipment utilize	ed :		
		opointment at approximately 9			in the facility will be reviewed by the			
		SW [social worker] that patient			Director of Operations to ensure the			
	was transferred to				equipment is reviewed per			
		resident was later diagnosed			manufacturer □s recommendations.			
	with a prostnetic jo	oint infection of the left hip.			Preventative maintenance related to he	•		
	In an intensious on	02/16/19 at 10:42 a.m. Nursa			lifts will be completed by the Maintena			
		03/16/18 at 10:42 a.m., Nurse a Aide #5 provided a			Director or designee per manufacturer recommendations. The Administrator			
		vhat had happened during			designee will review Preventative	UI		
		ansfer. The DON was present			Maintenance Log to ensure preventative	V 0		
		w. The mechanical lift used for			maintenance is being completed as	, ,		
		was present on the 300 Hall			scheduled weekly until 100% compliar	ice		
		lift used on 02/02/18 for			is maintained for 2 consecutive months			
		e machine was permanently			Outcomes of those reviews will be	<i>,</i> .		
		on the 100 and 300 Halls. When			presented to the steering QAPI			
	. •	s transferred to the other side			committee monthly.			
		temporary use and then			The steering committee will direct			
	returned to the uni				further analysis and interventions			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C 03/19/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP COD 2059 TORREDGE ROAD DURHAM, NC 27712	E	03/13/2010
(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	(X5) COMPLETION DATE
F 908	that she was operating Nurse Aide #5 guiding resident. The wheeled the two legs of the lift one of the legs. Duri #106 into the chair, the suddenly dropping in the wheelchair but did was "dropped" from a one foot into the chair resident was scream When asked for claric confirmed that both was ide of the machine I mechanical lift tilted to the overhead beam attached swivel bar at #106 on the top of he stated that she report malfunction to the chair Nurse Aide #4 stated machine and removed.  During the interview the mechanical lift was malfunctioning. Using connected to the bas showed that the lock engage correctly. The legs of the machine to lock them into play was moved to the left parallel position. When moved to the right are an angle to provide a when weight was lifted when weight was lifted was lift	ation Nurse Aide #4 indicated by the lift on 02/02/18 with go the lift pad holding the hair was positioned between the with the open seat facing and the lowering of Resident the year described the machine and depositing the resident the was not seated squarely in donot land on the floor. She as height of approximately and the incident. The aides stated that the sing during the incident. Fication, Nurse Aide #4 wheels of the leg on the right iffed from the ground as the pool that the individual struck Resident for the lift holding the struck Resident for the injury and equipment arge nurse immediately, and she placed a sign on the right if the lift from the unit.	F 90	based on reported outcomes direct further investigations.	and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY MPLETED
		345458	B. WING		١,	C 03/19/2018
	ROVIDER OR SUPPLIER  N REHABILITATION CE	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	'	757 1372010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 908	preventing proper lo open and closed positive and closed positive and reason the legs did during the resident's aides were aware the bolt became loose of sent to the maintena occasions. During the apparently the bolt velocking of the lift legaresident when her was machine tilted.  Nurse Aide #4 moves short part of the hall did not stay locked we short part of the hall did not stay locked with the incident with when using it, she per with most of her bod provide extra stabilitationing, both aides of skills assessment or hire and then receive from the facility.	d fell back to neutral, cking of the legs in both the sitions.  #5 both cited this as the not lock and the lift tilted transfer on 02/02/18. The lat the locking mechanism over time, and that it had been	F 96	,		
	aides' demonstration and Corporate Vice order to prevent staf In a later interview o Nurse Aide #4 states "constantly complain	n by the Maintenance Director President of Operations in if members from using it. on 03/16/18 at 3:15 p.m.,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u>'</u>	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 908	course of months and communication and Maintenance Book at further stated that at shown the lift to the Administrator while of (The former Administration of Administrator while of (The former Administration of	icated that this was over the ad involved both face-to-face written communication in the at the nurses' station. She cone point she had physically DON and the former expressing her concerns. It trator left his position at the strator left his position at the strat	F9	08		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345458	B. WING_			C 03/19/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2059 TORREDGE ROAD DURHAM, NC 27712	CODE	03/19/2016
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 908	a.m. He acknowledge was too loose to keep in locking the legs in position. He was una documentation that the repaired after the trained stated after the trained stated that neither remember working on the stated that the Maroutine monthly preveron equipment, and he checklist dated 02/06 Preventative Mainten the year 2018 include One recommended of Medical Equipment of Medical Equipmen	use on 03/16/18 at 11:15 ed that the base mechanism of the shifter handle engaged either the open or closed ble to provide any written ne mechanical lift had been nsfer incident on 02/02/18 er he nor his assistant in the machine at the time.  Anintenance department did entative maintenance checks e provided a completed /18. The facility's five-page ance Monthly Checklist for ed 20 areas for monitoring. heck was listed under lanagement: "Check all ent, [brand name orand name sit-to-stand] lifts arks indicated that this I in January and February.  ector further stated that he lity checklist rather than a pecifically for that model of Director confirmed that the loo and 300 Halls was the	FS	908		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		DATE SURVEY COMPLETED
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712		03/13/2010
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 908	Continued From page	e 42	F 9	08		
	from the back service	•				
	shop. The machine w door of the Restorativ shifter handle verified					
	holding the shifter ha	n made. The mechanism ndle was tighter, and the tof position when engaged.				
		19/18 at 9:30 a.m., the indicated that the lift had from the building.				
	Consultant #1 confirm	19/18 at 4:00 p.m., Regional ned that the facility had no cedure on faulty or broken ent.				
	stated she assessed the incident on 02/02 instructed Nurse Aide mechanical lift identif to remove it from the The DON stated that that day on the unit b matter had come to the	19/18 at 3:16 p.m., the DON Resident #106's injury after 1/18. She also stated she had 1/18 to place a tag on the 1/19 ying it as needing repair and 1/19 unit to the back service hall. 1/19 she did not see the lift later 1/19 to could not confirm that the 1/19 attention of Maintenance 1/19 ared that at the time she was 1/19 the possible				
	malfunctioning of the operation of it. She st had many years of exmechanical lifts. She	lift than the aides' proper ated that one of the aides				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345458	B. WING _			C 03/19/2018	
	ROVIDER OR SUPPLIER  N REHABILITATION CE	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u>'</u>	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 908	Continued From pag		F 9	800			
	acknowledged that the transfer Resident #10 and 300 Halls until the	monstration on 03/16/18. She ne mechanical lift used to 06, and still in use on the 100 hat morning, had not been cing residents at risk for accidents.					
	ongoing concerns wi There had been issu the machine, and she Maintenance. She di	not aware of staff members' th the functioning of the lift. es with the battery pack in e said she referred those to d not remember either her or ng shown the faulty locking					
	members were continuity with identified safety residents, endangeric operation during transto potential trauma. If members tag malfun	ng those who relied on safe sfer and exposing residents Her expectation was that staff ctioning equipment for repair liately from resident- care					
	informed of the imme at 4:21 p.m. On 03/1	d Director of Nursing were ediate jeopardy on 03/16/18 6/18 at 9:41 p.m., the facility g credible allegation of IJ					
	wheelchair utilizing a CNAs [Certified Nurs followed policy and p The lift legs retracted locks the legs was lo to the locked position	g transferred from bed to [brand name] lift with two le Aides] present who lift with two lift with two lift with two lift with the lift with two lift with the bar lift with with with the bar lift with with with the bar lift with the bar lift with the bar lift with two lift wit					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, Z 2059 TORREDGE ROAD DURHAM, NC 27712	IP CODE	1 00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD B TO THE APPROPRIA	DATE
F 908	from neglect by failing service."  "Root cause is the far and procedure regarmaintenance, there review to ensure precompleted, and it was preventative maintenanter which lift or which pathe manufacturer's run The procedure for in plan of correction for 1. Address how the accomplished for the been affected by the "The [brand name] lift from service and republication on 3/16/18 auntil it has been evantechnician and deen maintenance has be at least weekly inspet to the manufacturer lifts to identify and fill loosen.  There was no injury other corrective actions of bruising any pain and no pain any pain and no pain and procedure regarders."	cility failed to protect residents and to remove a lift from  acility did not follow the policy rating preventative was a lack in processes of eventative maintenance was as determined the nance log did not specify art of the lift was checked per ecommendations."  Inplementing the acceptable of the specific deficiency cited: corrective action will be one residents found to have the deficient practice:  Iff in question was removed to be a deficient practice:  Iff in question was removed to be a deficient out of service and will remain out of service and will remain out of service and will remain out of service and safe for use. Preventative the precions, to be done according to sections, to be done according as recommendations, of the examp part that has started to to Resident #106 thus no controlled to the the was no redness, swelling, and the resident did not report in medication was	FS	908		
	administered. Neuro	checks were implemented h no negative outcomes. The				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		345458	B. WING _			C 3/19/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2059 TORREDGE ROAD DURHAM, NC 27712	•	3/19/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 908	Continued From pag	e 45	F 9	908		
		rs after the event secondary replacement prostheses d to the event."				
		ective action will be se residents having potential same deficient practice:				
	the lifts are functioning repair was addressed. There was one other [brand name sit-to-st name sit-st name sit-to-st name sit-st name sit-	e facility on 3/16/18 to ensure and properly. Any lift needing and removed from service.  [brand name] lift and two and] lifts. One of the [brand as was identified with slight has been removed from all is replaced. Wearing of onitored by weekly ance inspections so they				
		asures will be put in place or ade to ensure that the not occur:				
	performance improve was held on 3/16/18 ADON (assistant dire Manager, Unit Manager, Un	da included determining the ent, what process would be residents that may have mining what education eted, the content of that would be responsible for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCT	ION	(X3) DATE	SURVEY
		345458	B. WING _				C / <b>19/2018</b>
	ROVIDER OR SUPPLIER	NTER		STREET ADDRE		1 00/	13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD DSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 908	the facility was going and system changes not reoccur. The goal determine the root ca occurred, develop a pidentified issues, and monitoring to ensure The outcome was a coplace to abate and prevent.  B. Education of the Mander of the Procedure by the Operations on 3/16/1  C. All facility staff regeducation regarding premoving malfunction completion of the Mander o	ing was discussed and how to monitor the processes to ensure the event does of the meeting was to use of why the event plan for correcting any develop a plan for the event does not reoccur. Definitive plan was put in event reoccurrence of the district of the event does not reoccur. Definitive plan was put in event reoccurrence of the district of the event reoccurrence of the district of the event does not reoccur. Definitive plan was put in event reoccurrence of the district of the event reoccurrence of the district of the event does not reoccurrence of the district of the service half way district of the event district of the event district of the event district of the equipment utilized in the ed by the Director of the equipment is reviewed	F	908			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345458	B. WING _			C 03/19/2018
	ROVIDER OR SUPPLIER	NTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2059 TORREDGE ROAD DURHAM, NC 27712	<u> </u>	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 908	Continued From pag	e 47	F 9	08		
	cited remains correct the regulatory require	ted and/or in compliance with ements:				
		nce and under the direction or designee, beginning				
		ntenance related to [brand mpleted by the Maintenance per manufacturer's				
	Preventative Mainter preventative mainten	ance is being completed as till 100% compliance is				
	The title of the perso implementing the acc Administrator	n responsible for ceptable plan of correction:				
	lifts were inspected. observed while demonstrated in the observed while demonstrated in the observed with one operating the and the other in front of the resident. Staff proper positioning are positioning of the result and functioning of the performed safety check the lifts procedure. So were provided in-sentransfers with use of weekend of 03/17/18	Staff members were enstrating proper use of persons managed the lift members checked for a safety of the lift pad, ident's body in the lift pad e equipment. Staff members ecks before, during and after taff members reported they vice training on resident a lift on 03/12/18 through the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345458			' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING			C 03/19/2018		
NAME OF PROVIDER OR SUPPLIER  TREYBURN REHABILITATION CENTER				STREET ADDRESS, CIT 2059 TORREDGE ROA DURHAM, NC 2771	AD	1 03/	19/2010
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 908	unit and placed out of The Maintenance Delin-service training on checks and procedure manufacturer instruct maintenance checks mechanical lifts. Lift in the maintenance checks mechanical lifts. Lift in the maintenance Docume Maintenance Docume mechanical lifts was r for individual lifts. The Documentation Form in each nursing statio reviewed.  Staff members were to document and reporting to document and reporting to incidents and accionaccion. The facility ordered new language of the fac	coartment was provided expected maintenance es for equipment with ions on the proper use and for different types of aspections were added to cklist to ensure they were afrequently. The Preventive entation Form for revised to include tracking a Preventive Maintenance for mechanical lifts present an maintenance book was rained 03/16/18 on the need out and malfunctioning applete a Maintenance aining record was reviewed and abers were interviewed g and documenting process dents.  The week mechanical lifts are the use of lifts for resident oper functioning was lemonstration by staff actuded reporting practices oroken lifts and equipment. Instructed to remove the init and place an orange th their name, date and time	F	908			
	expected to check the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) C	(X3) DATE SURVEY COMPLETED	
		345458	B. WING			C 03/19/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		03/19/2016	
TREYBURN REHABILITATION CENTER				2059 TORREDGE ROAD			
	THE TABLET ATTON 5			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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 908	ensure items to be the repair was docu	repaired were serviced and imented when it was out-of-service signs were tenance Books available at sing stations.	FS	908			