	-	ID HUMAN SERVICES				FOR	M APPROVED	
CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				OMB N	<u>O. 0938-0391</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED	
	345458		B. WING			C 05/18/2018		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
TREYBUR	N REHABILITATION CEN			2	2059 TORREDGE ROAD			
				I	DURHAM, NC 27712			
(X4) ID PREFIX TAG				x	N) BE RIATE	(X5) COMPLETION DATE		
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)(§483.10(a) Resident I The resident has a rig self-determination, an access to persons an outside the facility, ind this section. §483.10(a)(1) A facilit with respect and dign resident in a manner promotes maintenanch her quality of life, reco individuality. The facil promote the rights of §483.10(a)(2) The faci access to quality care severity of condition, must establish and m practices regarding the provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion	cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, ad communication with and d services inside and cluding those specified in by must treat each resident ity and care for each and in an environment that we or enhancement of his or ognizing each resident's ity must protect and the resident. clility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen	F	550	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	6/19/18	
	free of interference, c reprisal from the facili rights and to be suppo	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the SUPPLIER REPRESENTATIVE'S SIGNATURE	=		TITLE		(X6) DATE	

Electronically Signed

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.

05/30/2018

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345458		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING			C 05/18/2018		
NAME OF PI	ROVIDER OR SUPPLIER	L	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				20	059 TORREDGE ROAD		
TREYBUR	N REHABILITATION CEI	NTER		D	URHAM, NC 27712		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	TION SHOULD BE C THE APPROPRIATE	
F 550	Continued From page	- 1	 	FFO			
F 550	Continued From page			550			
		rights as required under this					
	subpart.						
		is not met as evidenced					
	by: Based on observatio			Propagation and execution of this star	of		
	Based on observatio and staff interview the			Preparation and execution of this plan correction does not constitute admission			
				or agreement of	UT		
		(Resident #3) of 3 sampled or care with dignity. Findings			the facts alleged or conclusion set fort	h in	
	included:	or care with dignity. Findings			this statement of deficiencies. The plan		
					correction is prepared and / or execute		
	Pesident #3 had a di	agnosis of quadriplegia. The			solely because it is required by both	u	
	documentation in the				Federal and State		
		sessment dated 4/20/18			laws.		
		s cognitively intact with no			14W3.		
		ssues. Resident #3 was			Resident #3 was interviewed by the		
		ssessment as having range			Director of Nursing (DON) on 5/18/18	to	
		on both sides of both upper			determine his preferences for toileting		
	-	as well as being incontinent			the care plan was updated at that time		
		adder. Resident #3 was			reflect his preferences. The nursing		
	coded as having ade				assistant (NA#1) was in-serviced		
		4			regarding the facility incontinence care	,	
	The documentation ir	n the care plan for Resident			policy and Resident #3 preferences for		
		ewed on 5/7/18, revealed the			toileting. NA#1 was also disciplined for		
		or impaired skin integrity			failing to provide timely incontinence c		
		nobility, muscle weakness,					
		continence. One of the			Root cause analysis determined that		
		care plan stated, "Check for			NA#1 was aware and had been educa	ted	
		s frequently, keep clean and			regarding the policy for incontinence c		
	dry after each inconti				however, there was a lack of		
		-			communication between Resident #3 a	and	
	An interview and obs	ervation was conducted with			NA#1 regarding his preferences for tim	ning	
	Resident #3 on 5/18/	18 at 11:15 AM. Resident #3			of the care to allow for his social needs		
	was observed to be in	n his room in his wheelchair.					
	The resident indicate	d in the interview that he			Any incontinent resident has the poten	itial	
	received incontinent	care on the third shift at			to be affected. Incontinent residents w	vith	
	approximately 6:30 A	M on that day and every			a BIMs score of 10 or greater were		
	day. The resident wa	s observed to point to the			interviewed to determine if the facility	was	
		is room with the time being			meeting their needs regarding		
	noted as 11.15 AM T	he resident indicated the			incontinence care and determine		

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED				
	CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING	A. BUILDING			
		345458	B. WING	C 05/18/2018			
NAME OF P	ROVIDER OR SUPPLIER	.	•	STREET ADDRESS, CITY, STATE, ZIP CODE	·		
TREYBURN REHABILITATION CENTER							
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC		
F 550	nurse aide assigned not have the time to right before lunch. Re been sitting in a wet AM that day. The res wet incontinence brie assigned to him had there was nothing he asked if he had told to incontinence care at "She knows that if La going to need to be of asked if he had comp that his daughter we about a month ago to nothing changed. Wh him feel the resident swallow it because th An interview and obs the nurse aide (NA # Resident #3 on 5/18/ stated that the reside 2 hours for incontine she had not checked since the start of her third shift nurse aide: Resident #3 and she incontinent care for F to 11:00 AM daily an before her shift was several residents wh Resident #3 was not	e 2 to him on the first shift did provide incontinent care until esident #3 indicated he had incontinence brief since 9:00 sident stated he had to sit in a ef until the nurse aide time to change him and e could do about it. When the nurse aide he needed 9:00 AM, the resident stated, am up at 6:30 AM then I am changed by 9:00 AM." When plained to anyone he stated nt to the Director of Nursing o discuss the issue but nen asked how this made reiterated, "I just have to nere is nothing I can do." servation was conducted with f1) who was assigned to 18 at 11:30 AM. NA #1 ents are to be checked every nt care needs. She stated I or changed Resident #3 shift. NA #1 indicated that s had provided care to a would always provide Resident #3 around 10:30 AM d then again at 2:30 PM over. She indicated she had o needed her help and always in his room. NA #1	F 550		ct any garding d the sidents f care. s to nds g ll ut their are ing er ON and leted s of vill be onthly. lirect		

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	-	ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 06/18/201 FORM APPROVEI VIB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345458		(X1) PROVIDER/SUPPLIER/CLIA	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			3) DATE SURVEY COMPLETED
		B. WING _			C 05/18/2018		
NAME OF PROVIDER OR SUPPLIER TREYBURN REHABILITATION CENTER				STRE	EET ADDRESS, CITY, STATE, ZIP COE)E	
) TORREDGE ROAD RHAM, NC 27712		
		ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CO		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	- 3	F	550			
	5/18/18 at 2:15 PM. S employed as the Dire	She indicated she had been ector of Nursing at the facility veek. She stated that it was					
	her expectation that t	he nurse aides check with vo hours to see if they need					
F 656 SS=D		Comprehensive Care Plan	F6	656			6/19/18
	 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and 						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	1 APPROVED	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
345458		345458	B. WING _			C 05/18/2018		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
TREYBUR	N REHABILITATION CEN	ITER			059 TORREDGE ROAD			
				D	URHAM, NC 27712			
(X4) ID PREFIX TAG			ID PREFI) TAG				(X5) COMPLETION DATE	
F 656	desired outcomes. (B) The resident's pre- future discharge. Faci- whether the resident's community was asses- local contact agencies- entities, for this purpo- (C) Discharge plans in plan, as appropriate, in requirements set forth- section. This REQUIREMENT by: Based on observation- resident interview the incontinence care as 1 (Resident #3) of 3 s for implementation of included: Resident #3 had a dia documentation in the minimum data set asses coded Resident #3 as mood or behavioral is on the same assessment motion impairment on and lower extremities of both bowel and bla coded as having adec The documentation in #3, dated as last revise resident was at risk for relative to impaired m bowel and bladder inco- interventions on the c	ference and potential for lities must document a desire to return to the seed and any referrals to a and/or other appropriate se. In the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced in, record review, staff and facility failed to provide outlined in the care plan for ampled residents reviewed care plans. Findings agnosis of quadriplegia. The most recent annual ressment dated 4/20/18 is cognitively intact with no sues. Resident was coded tent as having range of both sides of both upper as well as being incontinent dder. Resident #3 was quate vision. the care plan for Resident weed on 5/7/18, revealed the r impaired skin integrity obility, muscle weakness, continence. One of the are plan stated, "Check for as frequently, keep clean and	F	556	Preparation and execution of this plan correction does not constitute admissic or agreement of the facts alleged or conclusion set forth this statement of deficiencies. The plan of correction is prepared and executed solely because it is required b both Federal and State laws. Resident #3 was interviewed by the Director of Nursing (DON) on 5/18/18 to determine his preferences for toileting a the care plan was updated at that time reflect his preferences. The nursing assistant (NA#1) was in-serviced regarding the facility incontinence care policy and Resident #3 preferences for toileting. Root cause analysis determined to be lack of training of the direct care license nurses regarding the care plan process Any incontinent resident with specific preferences for incontinence care or toileting has the potential to be affected	n i in / or py o and to ed		

Facility ID: 923141

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED		
				с		
345458		B. WING	05/18/2018			
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
TREYBURN REHABILITATION CENTER		:				
		NIER	I	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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	SHOULD BE COMPLET	
F 656	Continued From pag	e 5	F 656			
	56 Continued From page 5 An interview and observation was conducted with Resident #3 on 5/18/18 at 11:15 AM. Resident #3 was observed to be in his room in his wheelchair. The resident indicated in the interview that he received incontinent care on the third shift at approximately 6:30 AM on that day and every day. The resident was observed to point to the clock on the wall in his room with the time being noted as 11:15 AM. The resident indicated the nurse aide assigned to him on first shift not have the time to provide incontinent care until right before lunch. Resident #3 indicated the first shift nurse aide had not checked or changed him for incontinence since the start of her shift at 7:00 AM. Resident #3 indicated he had been sitting in a wet incontinence brief since 9:00 AM that day. The resident stated he had to sit in a wet incontinence brief until the nurse aide assigned to him had time to change him and there was nothing he could do about it. When asked if he had told the nurse aide he needed incontinence care at 9:00 AM, the resident stated, "She knows that if I am up at 6:30 AM then I am going to need to be changed by 9:00 AM." When asked if he had complained to anyone he stated that his daughter went to the Director of Nursing about a month ago to discuss the issue but nothing changed. When asked how this made him feel			 Incontinent residents with a BIMs so 10 or greater were interviewed to determine if the facility was meeting needs regarding incontinence care/toileting and determine prefere regarding timing of care. The plans care were updated to reflect any repreferences. The nursing staff was educated reg the regulation regarding the care pl reflect the individual needs and preferences of the residents. The in-service included the responsibilit nursing staff to update the care plan needs and preferences are identified. The care plans will be reviewed with nursing assistants and the licensed nurses at least quarterly to ensure the care plan is accurate and reflects the individual needs and preferences or residents. Five care plans will be audited by the Administrative Nursing Team week review and correct the accuracy of care plan and ensure the care plan reflects the individual needs and preferences of the residents until two consecutive months of 100% comp 	g their ences s of ported arding an to y of the ns as d. n the ie f the ie f the y to the y to the	
	the nurse aide (NA # Resident #3 on 5/18/ stated that all the res every 2 hours for car	ervation was conducted with 1) who was assigned to 18 at 11:30 AM. NA #1 idents are to be checked e needs. She stated she had ged Resident #3 since the		Outcomes related to those audits w reviewed in the QAPI committee me The QAPI steering committee will d further analysis and interventions b on reported outcomes and direct fu investigations.	onthly. irect ased	

Facility ID: 923141

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	MENT OF HEALTH AN	D HUMAN SERVICES MEDICAID SERVICES				FORM): 06/18/2018 1 APPROVED 0. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE SURVEY COMPLETED	
345458		B. WING		_	C 05/18/2018		
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
TREYBUF	RN REHABILITATION CEN	ITER		059 TORREDGE ROAD OURHAM, NC 27712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	third shift nurse aides Resident #3 and she incontinent care for R to 11:00 AM daily and the end of her shift. S several residents who Resident #3 was not a another location in the that she had several of she had to get ready is rehabilitation services required extra time to #1 stated she was as that day but usually si residents to care for. care to Resident #3 fr The incontinence brie observed to be wet an The Director of Nursin 5/18/18 at 2:15 PM. S employed as the Dire for approximately a w her expectation that the the residents every tw care. The facility nursing co 5/18/18 at 3:52 PM. S communication issue NA #1 because Reside another location in the needed to be checked nursing consultant inco Resident #3 in the bu check if incontinent ca	had provided care to would always provide esident #3 around 10:30 AM again at 2:30 PM before he indicated she had o needed her help and always in his room, but in e building. NA #1 indicated dependent residents who first thing in the morning for and other residents who provide morning care. NA signed to 12 residents on he was assigned to 10 NA #1 provided incontinent om 11:36 AM to 11:41 AM. f for Resident #3 was and had a very foul odor. Ag was interviewed on the indicated she had been ctor of Nursing at the facility eek. She stated that it was he nurse aides check with vo hours to see if they need	F 656				

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