DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A BUILDING ______ B WING	C 10/03/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - TREYBURN	2059 TORREDGE ROAD DURHAM, NC 27712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended on 10/18/13	F 000	Disclaimer Peak Resources- Treyburn acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of Quality of Care of residents, the Plan of Correction is submitted as a written allegation of compliance. Preparation and submission of this plan of correction is in response to the CMS 2567 form from the October 2, 2013 to October 3, 2013 complaint survey. Peak Resources Treyburn response to the statement of deficiencies and plan does not denote agreement with the deficiencies nor does it constitute an admission that any deficiency is accurate. Further Peak Resources-Treyburn reserves the right to refute any deficiency through Informal Dispute Resolution formal appeal and/or other administrative or legal procedures.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to provide documentation in the clinical record to reflect feeding tube care was provided according to the physician's orders for 1 (Resident #1) of 1 resident reviewed. The findings included: Resident #1 was admitted to the facility on 7/26/13 and discharged on 9/19/13 to another facility. His diagnoses included dysphagia due to stroke and dementia The Minimum Data Set (MDS) dated 8/2/13 indicated that Resident #1 was severely cognitively impaired	F 514	Residents affected by the deficient practice: No resident suffered as a result of not documenting feeding tube care in the medical record. Residents having potential to be affected by the same deficient practice: Documentation via the current electronic charting system was reviewed. This new charting system will minimize the potential for any other resident to be affected.	12/3/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carmen Machado RN, DON
TITLE
(X6) DATE: 10/30/13

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.

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	345468	A. BUILDING ______ B. WING	C 10/03/2013

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F 514	Continued From page 1 A review of the monthly Treatments Flowsheet for July 2013 revealed an order which read "Clean PEG (feeding) tube site with normal saline (NS) and apply dry drainage gauze." The order was to be completed once per day beginning on 7/26/13 There was no stop/end date In the time column was listed 3 00 pm - 11 00 pm indicating the treatment should be done on the 3 pm-11 pm shift. There was no entry for the treatment from 7/26/13 through 7/31/13 A review of the monthly Treatments Flowsheet for August 2013 revealed the same treatment order for the feeding tube site treatment for the month of August The Treatment Flowsheet revealed 16 boxes with initials for the month which indicated the treatment was provided for Resident #1 The other 15 boxes had no initials/entry A review of the monthly Treatments Flowsheet for September 2013 revealed the same treatment order for the feeding tube treatment for the month of September By 9/9/13, the September Flowsheet had 2 boxes with initials and the other 7 boxes were empty The resident was discharged on 9/9/13 In an interview on 10/02/13 at 3 25 pm, Nurse # 2 indicated that she was the nurse who cleaned the feeding tube site based on the order for this to be done during the 3-11 shift In an interview on 10/03/13 at 11:12 am Nurse #2 indicated that she did not document the dressing change In an interview with Nurse #1 on 10/3/13 at 10 45 am, she reported she worked from 6 45 am until 11 15 pm on Saturdays and Sundays She stated	F 514	What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: The Director of Nursing completed a 100% audit of all G-tube orders and treatment to ensure that completed treatment/care was documented. All Nursing staff was re-educated by the DON and SDC. The education included but was not limited to documentation that will be required in our new electronic charting system. Any staff on LOA/FMLA will be educated prior to returning to the floor. Monitoring: The Administration Compliance Report will be generated on a weekly basis by the DON. The Director of Nursing will review the electronic charting documentation report weekly for 4 weeks then every 2 weeks for 6 weeks then monthly. Electronic charting documentation will be checked daily by unit managers each shift for any incomplete documentation. How the facility monitors its performance/QAA: The Quality Assessment Committee to include the Administrator and DON will review the results of the electronic charting documentation during QAA meeting and make recommendations. The results will be submitted to the QA committee for a period of three months. The QA committee will determine if any action is needed based on the results of the electronic charting.	10/4/13 10/14/13 10/15/13 ongoing 10/22/13

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F 514	Continued From page 2 that the order was just a nursing order so if no drainage was seen then no dressing was applied After she viewed the Treatments Flowsheet, Nurse #1 stated the order was not an as needed order and should have been signed off She noted that the Treatment Flowsheet did not have nursing initials to indicate the treatment was performed In an interview with the Director of Nursing (DON) on 10/03/13 at 2 25 pm she indicated she would expect the treatment to be documented on the Treatment Flowsheet if it was performed	F 514		