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 01/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	**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 The survey team entered the facility on 1/16/18 to conduct a complaint investigation survey and was unable to return to the facility on 1/20/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/20/18 and completed the survey on 1/20/18. Event ID XIHY11	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews the facility failed to assist with feeding (Resident #8) for 1 of 6 residents sampled for activities of daily living. The findings included: Resident #8 was readmitted to the facility on 10/28/17. Her diagnoses included: cerebral palsy, dysphagia, dementia, osteoarthritis, and convulsions. Review of the nutrition assessment dated 11/3/17 revealed Resident # 8 required one person feeding assistance. Review of the most recent quarterly Minimum Data Set (MDS) dated 01/03/18 revealed Resident #8 was assessed as having moderately impaired cognition. Resident # 8 was assessed as having unclear speech and difficulty	F 677	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 Care Plan and Kardex for resident #8 was updated to indicate the need for assistance with eating. The nursing staff were in-serviced by the Director of Nursing (DON) regarding resident #8 need for assistance while eating and ensuring the resident is asked if she likes the tray and ensuring the resident is asked if she likes	2/17/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/06/2018

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 01/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 677	Continued From page 1 communicating some words and finish thoughts. Activities of daily living (ADL) for the resident was coded as requiring extensive two person assist for bed mobility and transfer and extensive one person assist for toileting, personal hygiene and eating. No behaviors or rejection of care was identified on the MDS. Review of Point of Care documentation from December 2017 to January 2018, revealed Resident #8 was documented as needing extensive assistance and was provided assistance with feeding. Review of Point of Care documentation revealed Resident # 8 need to be monitored and encouraged adequate fluid intake. On 1/16/18 during a continuous dining observation in the dining hall from 12:00 PM to 12:27 PM, observation revealed Nurse Aide (NA) # 7, NA # 8, one rehab aide, the Nurse, Director of Nursing (DON) and two (2) corporate staff assisting with serving lunch to about 15 residents dining in the dining hall. Resident # 8 was served a lunch tray at 12:05 PM. At 12:16 PM Resident #8 ' s roommate sitting beside Resident # 8 indicated to the surveyor that Resident # 8 needed assistance with feeding and staff was not assisting her. Resident # 8 was observed sitting at the table and staring at the tray. Lunch tray was not touched by the resident. Resident # 8 was not offered assistance by staff. Surveyor brought this observation to the attention of rehab aide and DON. Resident #8 indicated to staff she does not like her tray. At 12:18 PM Resident # 8 was offered a sandwich. Resident #8 s was lowly able to consume her sandwich and left the dining hall. An interview at 12:18 PM with the rehab aide	F 677	the tray and offering an alternative if she does not. The other facility residents were Reviewed by the interdisciplinary team to determine if their Care Plan and Kardex accurately reflected their need for assistance with eating. The Care Plans and Kardexes were updated as necessary. The nursing staff were educated by the DON regarding checking the Care Plan and Kardex to ensure they are knowledgeable regarding the assistance needed by each resident. The interdisciplinary team developed a list of any residents needing assistance with eating to be placed in the dining room to be available to staff to alert them of the residents that need assistance with feeding. The Administrator developed a schedule for Department Heads to be in the dining room to monitor the meal and ensure the residents are being provided assistance as needed. The DON will monitor the meal of five residents per week of residents identified as needing assistance for eating for four weeks and then three residents per week until 100% compliance	

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 01/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	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 677	Continued From page 2 assisting in the dining hall, revealed Resident # 8 can feed herself sometimes. The rehab aide indicated she usually works in the dining hall and has observed resident feed herself sometimes. During an interview on 1/16/18 at 1:30 PM, Resident # 8 stated she was assisted with feeding and sometimes able to feed herself foods like sandwich and fries. Resident # 8 indicated that she does not like to bother staff and did not ask for assistance as staff was assisting other residents. Interview with Nurse Aide (NA) #6 on 01/16/18 at 2:00 PM revealed Resident # 8 was assisted with feeding. NA# 6 stated she usually assists the resident with breakfast in resident ' s room. NA # 6 stated that Resident # 8 has difficulty feeding herself as her hand shakes due to cerebral palsy. NA # 6 stated that the resident was totally dependent with her ADL ' s and needed on person extensive assistance with eating. She indicated Resident # 8 dines in the dining hall during lunch and she was unsure who assisted the resident with feeding in the dining hall. During an interview on 1/16/18 at 2:10 PM, NA #7 indicated she frequently assisted residents in the dining hall. She indicated she was refilling ice tea for the residents and had not noticed that resident not consuming her meals. She stated Resident #8 needed assistance with feeding. During an interview on 1/16/18 at 2:15 PM, Nurse #2 indicated that resident was totally dependent and needed assistance with her ADL. Nurse # 2 indicated Resident # 2 had cerebral palsy and had trouble feeding herself.	F 677	is maintained for two consecutive weeks to ensure the residents are receiving appropriate assistance as needed. Outcomes related to those audits will be reviewed with the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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 01/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TREYBURN REHABILITATION CENTER	**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 677	Continued From page 3 During an interview on 1/16/18 at 2:10 PM, NA #8 indicated she frequently assisted residents in the dining hall. She further stated she was not aware that Resident #8 needed assistance with feeding and hence did not offer her any assistance. Interview with NA #9 on 01/16/18 at 4:30 PM revealed Resident #8 was totally dependent and was assisted with feeding. NA # 9 stated Resident #9 prefers to sit with her friend in the dining hall. NA #9 also stated Resident # 8 was assisted with feeding when NA #9 was assigned dining duty. NA stated Resident # 8 has difficulty scooping her food due to shaky hands. During an Interview on 1/16/18 at 4:47 PM, Director of Nursing (DON) indicated Resident # 8 was sometimes able to feed herself. DON also indicated she was not sure why Resident # 8 was not offered any meal substitution or was not monitored during lunch. She further stated that it was her expectation that staff should communicate better with each other, monitor residents during meals , offer meal substitutions as needed, assist as needed and update the Point of Care based on resident ' s needs.	F 677		