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 03/14/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 03/11/19 through 03/14/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #O10T11.	E 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the discharge Minimum Data Set (MDS) assessment to reflect the discharge status for 1 of 8 residents, reviewed for assessment accuracy (Resident #107). Findings included: Resident #107 was admitted to the facility on 12/5/18 with diagnoses included anemia and hypertension. Record review of the Discharge MDS assessment, dated 12/14/18, revealed Resident #107 was discharged to acute hospital. Record review of the social service ' s notes, dated 12/14/18, revealed a discharge progress note, indicated that Resident #107 left the nursing home with family support. Home health, therapy service were arranged and discussed with the resident and family. Record review of physician ' s note, dated	F 641	Interventions for affected resident(s): Root cause for resident #107. Minimum Data Set (MDS) nurse inaccurately coded item set A2100 of discharge assessment, to reflect acute hospital which should have been coded as Community. Modification of the MDS was completed on 3.14.2019 to reflect accurate coding per the Resident Assessment Instrument (RAI) manual. Interventions for residents identified as having the potential to be affected: On March 21, 2019 education was completed by the Clinical Process Analyst on accuracy of assessments per the RAI manual with MDS nurse. All discharge assessments completed in the previous 90 days were reviewed by the MDS-RN and the Administrator for accuracy of coding A2100 of the discharge assessment. One additional assessment was noted to be coded inaccurately, and was modified per the RAI manual with a completion date of March 21, 2019.	4/9/19

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

Electronically Signed | 04/01/2019

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 03/14/2019

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 641	Continued From page 1 12/14/18, revealed that Resident 107 ' s medication list, doctor appointments were reviewed, and the resident left home from the facility via wheelchair, accompany with family member. Record review revealed Resident 164 ' s Discharge Summary, dated 12/14/18, indicated that the resident admitted to the nursing home after hospital treatment of intestinal bleeding. She positively responded to the treatment and was discharged home to continue therapy with home care. The document signed by physician. On 3/13/19 at 2:15 PM, during an interview, the MDS coordinator indicted that she was responsible for MDS assessment of Resident # 107. She stated the resident went home with his family on 12/14/18. The nurse stated that she put incorrect discharge coding for the discharge MDS assessment on 12/14/18 for Resident #107. On 3/13/19 at 3:00 PM, during an interview, the Director of Nursing expected the MDS nurses to provide accurate coding, reflecting actual resident ' s status.	F 641	Systemic Change: As of March 25, 2019 and moving forward, 3 MDS discharge assessments per week will be audited by the Director of Nursing (DON)/Designee x 3 months for accuracy of location of discharge. Monitoring the change to sustain system compliance ongoing: For a minimum of 3 months, the DON/Designees will report the audit results to the QA committee. The QA committee will review the audits to make recommendations to ensure compliance is ongoing and determine the need for further ongoing audit. Results will be tracked, trended, and submitted to the QAPI committee. Based on the information reviewed the QAPI committee will determine the need for ongoing auditing. Date of completion for this corrective action plan will be April 9, 2019.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/9/19

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 03/14/2019

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 761	Continued From page 2 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide the expiration date for three plastic containers of Valproic Acid Syrup, Potassium Chloride and Omeprazole Suspension on 1 of 5 medication administration carts, on 200 hall; failed to remove one expired insulin multi dose vial from 1 of 5 medication administration carts, on 500 hall; failed to provide the date of opening for 2 insulin pen injectors in 1 of 5 medication administration carts, on 500 hall, and 2 insulin multi dose vials in 1 of 5 medication administration carts, on 300 hall. Findings Included: 1. On 3/13/19 at 10:30 AM, during the observation of the medication administration cart on 200 hall, with Nurse #1, there were three medications in plastic containers found without expiration date: one container of Valproic Acid Syrup, 375 ml (milliliter), one container of	F 761	Interventions for affected resident(s): Root cause identified for the expired and discontinued medication was the medications were not removed as the process was not clearly defined as to who, when and what medications are removed. The root cause for the undated insulin was the nurse (s) did not follow proper procedure when she/he did not date the multi-dose vial and insulin pens when opened. The Valporic Acid Syrup, Potassium Chloride and Omeprazole Suspension were removed from the cart and discarded on 3/13/2019. The expired insulin multi-dose vial was removed from the cart on 3/13/2019. The open and undated insulin pens and multi -dose vials were removed from the cart on 3/13/2019. The removed medications were returned to the pharmacy. No residents received those	

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 03/14/2019

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 761	Continued From page 3 Potassium Chloride, 20 MEq (millequivalents), 112.5 ml and one container of Omeprazole Suspension, 2 mg (milligram)/ml, 150 ml. On 3/13/19 at 10:35 AM, during an interview, Nurse #1 indicated that the nurses, who worked on the medication carts, were responsible to check expiration date on medications. The nurse confirmed that she had not checked the expiration date on Valproic Acid Syrup, Potassium Chloride and Omeprazole Suspension in his medication administration cart at the beginning of his shift. On 3/13/19 at 11:55 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check all the medications in medication administration carts for expiration date. 2. On 3/13/19 at 10:50 AM, during the observation of the medication administration cart on 500 hall, with Nurse #2, there was one expired medications found: Novolog (insulin) multi dose vial, 100 units/ml, 3 ml. Per the label on the vial, the Novolog was opened on 2/5/19. The manufacturer recommended to discard the Novolog vial 28 days after opening, which would have been on 3/5/19. On 3/13/19 at 10:55 AM, during an interview, Nurse #2 indicated that the nurses, who worked on the medication carts, were responsible to remove expired medications from the medication administration cart. The nurse confirmed that she had not check the expiration date on Novolog multi dose vial in her medication administration cart at the beginning of her shift.	F 761	medications. New medications were ordered as appropriate for these residents. Interventions for residents identified as having the potential to be affected: On March 13, 2019 all medication carts and storage areas were inspected by the Director of Nursing and the Assistant Director of Nursing for expired, undated and discontinued medications. No other expired, undated, and discontinued medications were found in the medication storage areas or the medication carts. Measures /Systemic Change: On March 13, 2019 the Director of Nursing and Assistant Director of Nursing in-serviced licensed nurses on proper medication storage. Nurses will be in-serviced upon return to work and upon hire as part of their orientation process. Monitoring systemic changes to sustain compliance ongoing: As of March 18, 2019 medication storage areas and carts will be monitored using a Quality Improvement tool by the Director of Nursing/Designee as follows 5x/week for 2 weeks then, 3x a week for 2 weeks, then weekly for one month. The completed monitoring tools will be bought to the monthly QAPI for review and discussion. Any recommendations by the QAPI committee will be added to the plan of correction. This corrective action will be completed by April 9, 2019.	

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 03/14/2019

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 761	Continued From page 4	F 761		

On 3/13/19 at 11:55 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to check all the medications in medication administration carts for expiration date and remove expired medications. Her expectation was that no expired items be left in the medication carts.

3. a. On 3/13/19 at 11:00 AM, during the observation of the medication administration cart on 500 hall, with Nurse #2, there were two insulin pen injectors found with no date of opening: Basaglar KwikPen Solution, 100 units/ml, 3 ml and Levemir Flextouch, 100 units/ml, 3 ml.

On 3/13/19 at 11:05 AM, during an interview, Nurse #2 indicated that both insulin injectors were opened. She confirmed that the nurses, who worked on the medication carts, were responsible to put the date of opening on insulin pen injectors.

On 3/13/19 at 11:55 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to put date of opening on insulin pen injectors and multi dose vials.

b. On 3/13/19 at 11:20 AM, during the observation of the medication administration cart on 300 hall, with Nurse #3, there were two insulin multi dose vials found with no date of opening: Novolog vial, 100 units/ml, 3 ml and Levemir fFextouch, 100 units/ml, 3 ml.

On 3/13/19 at 11:25 AM, during an interview, Nurse #3 indicated that both insulin vials were opened. She confirmed that the nurses, who worked on the medication carts, were responsible to put the date of opening on insulin multi dose vials.

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 03/14/2019

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 761	Continued From page 5 On 3/13/19 at 11:55 AM, during an interview, the Director of Nursing indicated that all the nurses were responsible to put date of opening on insulin pen injectors and multi dose vials.	F 761		
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain the walk-in freezer in a safe operating condition. The kitchen's walk-in freezer had accumulated ice on the freezer floor and on food stored inside the freezer. Findings included: An observation of the walk-in freezer on 3/11/19 at 9:50 AM revealed a thin layer of ice on the freezer's floor. The walk-in freezer strip door curtain had a layer of ice on it. The freezer's compressor had icicle hanging from it. The observation of the boxes of food placed under the freezer compressor revealed the boxes had a layer of ice on them. A white box label "whole strawberries" and a white box labelled "yellow sheet cake 4 pounds (lb.)", were wet and had ice on them. An opened brown box labeled "whipped topping" had a layer of ice on it. During an interview on 3/11/19 at 9:55 AM, Dietary Manager indicated she was not sure why the boxes had ice formed on them. She further stated ice on the floor and on the strip curtains	F 908	Interventions for affected resident(s): On March 14, 2019 the Maintenance Director contacted the Service company to assess the walk-in freezer. The Technician assessed the walk-in freezer and corrected the timing sensor. Boxes stored near the compressor were moved from that area. The ice was removed by the Dietary staff and Maintenance Director from the freezer. No residents were affected by the malfunctioning timer in the freezer. Interventions for residents identified as having the potential to be affected: The walk -in cooler and standing refrigerator were checked and logs reviewed by the Dietary Manager and Maintenance Director for temperature compliance to maintain the cold foods below 41 degrees. There were no ice formations or concerns regarding proper functioning. Systemic Change:	4/9/19

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 03/14/2019

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 908	Continued From page 6 may be due to the freezer door been opened for staff to stock weekly supplies. During an interview on 03/14/19 at 9:48 AM, the maintenance personnel indicated the walk - in freezer was serviced a month ago and he did not notice any issues during that time. During an interview on 03/14/19 at 1:29 PM, the maintenance personnel stated the service company had completed the emergency service and noted the compressor was out of sync and was defrosting at wrong time resulting in the ice issue in the walk- in freezer. During an interview on 03/14/19 at 3:35 PM, the administrator stated it was her expectation that the walk -in freezer was maintained in good working condition and food was stored at appropriate temperatures.	F 908	On March 14, 2019 the Administrator in-serviced the Maintenance Director and Dietary Manager regarding maintaining all equipment in safe operating manner. They were also in-serviced regarding the ice build up and storing items away from the compressor to allow adequate airflow. The Dietary Manager/ Assistant Dietary Manager in-serviced the dietary staff on safe and proper functioning of the walk-in freezer. Monitoring the change to sustain system compliance ongoing: The walk in freezer will be monitored using a Quality Improvement tool by the Maintenance Director / Dietary Manager as follows 5x/week for 2 weeks then, 3x a week for 2 weeks, then weekly for one month. The completed monitoring tools will be bought to the monthly QAPI for review and discussion. Any recommendations by the QAPI committee will be added to the plan of correction. This corrective action will be completed by April 9, 2019.	