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 07/26/2017

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 7/15/17 to conduct a complaint survey and exited on 7/16/17. Additional information was obtained on 7/17/17, 7/18/17, 7/19/17, 7/20/17, and 7/26/17. Therefore, the exit date was changed to 7/26/17.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, family interview, and staff interviews for one (Resident # 4) out of five sampled residents reviewed for dietary choices, the facility failed to assure the resident received food items she preferred as a diabetic. The findings included: Record review revealed Resident # 4 was admitted to the facility on 12/13/16 with a diagnosis of diabetes. Review of the resident's quarterly minimum data	F 242	F-242 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of	8/9/17

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

Electronically Signed | 08/04/2017

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 07/26/2017

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 242	Continued From page 1 set (MDS) assessment, dated 4/18/17, revealed the resident was moderately cognitively impaired. Review of the resident's care plan, revised on 5/9/17, revealed the facility had identified the resident was a diabetic. A care plan intervention for Resident # 4 was listed as, "provide food preferences and substitutions." Record review revealed the resident's diet order was for a Controlled Carbohydrate diet (CCHO diet). According to a review of the record with the director of nursing (DON) on 7/16/17 at 12:45 PM, the resident had been on this diet since 12/30/16. Review of the resident's tray card on 7/16/17 revealed there was an area where food preferences and notes about a resident's diet could be entered. There was no notation on Resident # 4's tray card that the resident preferred to have sugar free or lower sugar items placed on her meal tray. Resident # 4 was observed on 7/15/17 at 8:35 AM to have her breakfast tray before her, and was beginning to eat. The resident had a large iced pastry breakfast item, toast, grits, bacon, juice and milk. The resident stated she routinely asked for sugar free items, and the facility continued to give her things that she did not want to eat because of her diabetes. The resident pointed to her iced pastry breakfast item and juice and stated she did not want either of those items because they would make her blood sugar go up. The resident stated she wished she had some sugar free jelly for her toast, but they had not sent any. Nurse aide (NA) # 1 was observed to enter the room, and the resident told NA # 1 she did not	F 242	correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. Interventions for the affected resident: 1. Resident #4 is receiving sugar free food items per her dietary preference. 2. An audit has been conducted by the Dietary Manager regarding residents with diabetes' preference being honored to ensure compliance in this area. An audit has been conducted by the Dietician/Dietary Manager regarding tray ticket reflecting current physicians order to ensure compliance in this area. 3. Licensed Nurses will be re-educated by the Director of Nursing/ designee regarding ensuring dietary communication forms are provided to dietary to match current physician order. Dietary staff will be re-educated by the director of Nursing/designee regarding ensuring diet preferences are honored and reflected on the diet slip. 4. The Dietary manager will review resident's diet ensuring preferences are being honored and ensuring that tray ticket reflects physician order weekly for twelve (12) weeks. Re-education will be provided to the dietary staff that do not follow the proper procedure. Findings will be reported to QAPI committee for further review and recommendations monthly for three months and as needed thereafter.	

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 07/26/2017

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 242	Continued From page 2	F 242		

want the pastry or juice because of her diabetes. The resident asked if the NA could find some sugar free jelly for her. NA # 1 stated he would go to the kitchen to see if they had some. NA # 1 returned with the sugar free jelly which he had located in the facility kitchen.

Resident # 4 was observed on 7/15/17 at 1:25 PM during the lunch meal to be eating alone in her room. One of the food items on the resident's tray was a cookie. The resident bit into her cookie to see if it had sugar in it. The resident placed it back on her tray and said she did not want to eat the cookie because she could taste there was sugar in it. The resident stated she was afraid it would make her blood sugar go up.

Further interview with the resident on 7/16/17 at 12:30 PM revealed the resident had requested sugar free items in exchange for some of the sugar items which were allowed on her diet. She stated she had told this to the nurse aides and the cooks, and she had been told they did not have some of the sugar free items she would like. The resident stated there were many fresh fruits she would prefer over the desserts she was served. She also stated she preferred to have sugar free gelatin, sugar free ice cream, and some flavors of sugar free pudding in place of the sugar desserts. The resident stated she had been served frosted flakes in the past, and she preferred cherries or rice krispies because she felt they did not make her blood sugar as high. The resident stated she had been told that the facility had to fix what the majority would eat, and therefore her family brought her food items she preferred. The resident stated she took a pill for her blood sugar. The resident stated she was trying to avoid taking insulin and wanted to control

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 07/26/2017

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 242	Continued From page 3	F 242		

her blood sugars with diet and the pill alone.

Resident # 4's responsible party (RP) was interviewed on 7/15/17 at 1:35 PM. The RP stated Resident # 4 often received items such as brownies, pound cake, and chocolate cake which she did not eat. The RP stated she tried to bring the resident fruit and sugar free items she preferred.

Interview with Nurse # 1 on 7/16/17 at 12:45 PM revealed the resident had made it known to "everybody" she talked to that she preferred not to have sweet items served to her. The nurse stated the resident had told her doctor, the nurses, and the dietary staff. The nurse stated the nurses had verbally told the dietary department, but they kept sending the sugar items.

Interview with the registered dietician (RD) on 7/15/17 at 3:40 PM revealed that the CCHO diet is liberalized to allow for sugar items and therefore the desserts are sometimes the same for diabetic residents as non-diabetic residents. The RD confirmed that the cookie that Resident # 4 received on 7/16/17 at 12:30 PM would have been a cookie with sugar. The RD stated the facility had recently obtained some sugar free cookies and they were using those for snacks, but were not placing them on meal trays at the current time. The RD stated the dietary manager had talked to the resident more recently than she had in regards to her diet choices. According to the RD, if the resident preferred to have less sugar food items than the ones which were allowed on her liberalized diet, then the facility should arrange to obtain sugar free items per her choice.

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 07/26/2017

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 242	Continued From page 4 On 7/16/17 at 10:00 AM observations were made of the diabetic foods available in the facility kitchen. It was observed the facility had sugar free cookies in two flavors, applesauce containers with no sugar, sugar free syrup, sugar free jelly in three flavors, sugar free high calorie protein supplement drinks, unsweetened tea, and no sugar lemonade. The facility dietitian was interviewed at the time of the observations and she stated there was no diabetic ice cream. Interview with the dietary manager on 7/16/17 at 11:45 AM via phone revealed the resident's CCHO diet was liberalized and allowed for sugar items on her meal tray. The dietary manager stated she could obtain sugar free items to substitute for the sugar desserts. The dietary manager stated in order for the meal tray preparation staff to know to place the sugar free items on the resident's tray, this information would need to appear on the resident's tray card that she preferred these. The dietary manager said she was slowly ordering diabetic foods per resident request. She stated diabetic ice cream was in the facility freezer and was available upon request. According to the DM she routinely visited the resident to update her meal tray card for preferences but she had not updated it to include the resident's desire to have less sugar items on the tray.	F 242		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		8/9/17

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 07/26/2017

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 425	Continued From page 5 (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, and pharmacist interview the facility failed to assure they had a system for accurate acquisition and administration of medications for two (Residents # 4 and # 13) out of four residents reviewed for pharmacy services. The findings included: 1. Record review revealed Resident # 4 was admitted to the facility on 12/13/16 with a diagnosis of diabetes. Review of the physician orders revealed the resident received Januvia 50 milligrams (mg) every day for her diabetes. The order originated on 12/13/16. Review of the resident's minimum data set (MDS) assessment, dated 4/18/17, revealed the resident was moderately cognitively impaired. Review of the resident's care plan, revised on 5/9/17, revealed the facility had identified the resident was a diabetic. An intervention on the resident's care plan was that she receive her diabetes medication as ordered by the physician. Review of the resident's May 2017 Medication Administration Record (MAR) revealed nurses initialed they administered Januvia 50 mg every	F 425	F-425 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. 1. Resident #4 is receiving Januvia as ordered. Resident#13 is receiving Cymbalta as ordered. 2. Review of residents receiving Januvia and Cymbalta has been completed and medications are available and being administered. The facility has completed a quality review of medication cart and medication administration records to ensure that medications ordered are in stock and being administrated.	

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 07/26/2017

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 425	Continued From page 6 day. Review of the resident's 6/1/17 to 6/20/17 medication administration record revealed nurses had initiated they had administered Januvia 50 mg every morning excluding one day. On 6/1/17 the MAR was blank beside the Januvia. Review of the resident's documented blood sugars between the dates of 6/1/17 and 6/20/17 revealed they ranged from 108 to 200. Review of nursing notes revealed Nurse # 5 made an entry on 6/20/17 at 10:09 AM noting that the resident's Januvia was unavailable for administration. Nurse # 5 noted the director of nursing was informed and requested the pharmacy send a refill of the medication on that date. The resident was interviewed on 7/15/17 at 8:35 AM and stated she thought the facility had run out of her Januvia for about one and a half weeks before she noticed it was not being given. The resident stated she did not realize it until she thought her blood sugars were running higher. She said when she found out about it she asked them to order her medication and it was sent from a different pharmacy that day. The resident was interviewed again on 7/16/17 at 12:30 PM and stated she had kept the paper where the facility had ordered the Januvia from a different pharmacy. Review of the paper revealed the Januvia had been ordered from the facility's back up pharmacy on 6/20/17 and sent at 11:20 AM to the facility. Interview with the Director of Nursing (DON) on 7/16/17 at 8:12 AM revealed she was aware	F 425	3. Licensed Nurses will be re-educated on medication administration by the Director of Nursing/designee. Licensed Nurses will be re-educated on the process for obtaining medication refills by Pharmacy Consultant. The Pharmacy technicians to be re-educated on the process for filling medications orders by the Pharmacy Consultant. 4.The Director of Nursing and Unit Managers will review Medication Administration Records and medication carts to ensure medications that are ordered are in stock and administrated to the residents weekly for twelve (12) weeks. The Director of Nursing and Unit Managers will review Physicians orders to compare with daily pharmacy delivery slips and then check to ensure the medication is in the facility for administration weekly for twelve (12) weeks. Finding will be reported to QAPI committee for further review and recommendations monthly for three months and as needed thereafter.	

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 07/26/2017

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 425	Continued From page 7	F 425		

Resident # 4's Januvia had to be ordered from the back up pharmacy on 6/20/17 because it was not available at time of administration, but it was her understanding the medication was sent and she was not aware of any missed doses.

A pharmacist, who worked at the pharmacy which supplied medications to the facility, was interviewed on 7/17/17 at 1:06 PM. The pharmacist reviewed the facility's requests for Resident # 4's Januvia refills and the dispensing of the medication. The pharmacist review and her interview revealed the following. The pharmacy could only fill 14 doses at one time for Resident # 4 because Januvia was a brand medication. Since 4/18/17, the pharmacy filled the medication on 4/18/17, 5/1/17, 5/15/17, and 6/20/17. The pharmacy did not receive a facility refill request nor fill the Januvia medication between the dates of 5/15/17 and 6/20/17. On 6/20/17 they received a phone call from the facility requesting the medication be sent, and it was filled by the back-up pharmacy. According to the pharmacist the facility should have had a three day supply of medication when the Januvia was being filled, so that the facility would not run out of the medication. According to the pharmacist, the facility would have had a deficit of pills between the dates of 5/15/17 and 6/20/17 because they did not reorder it.

The assistant director of nursing (ADON) was interviewed on 7/18/17 at 9:35 AM regarding the facility's failure to request refills for the Januvia. According to the ADON the director of nursing (DON) was unavailable at the current time and would return on 7/19/17. According to the ADON they would review the administration record and refill requests for the Januvia to determine if there

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 07/26/2017

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 425	Continued From page 8	F 425		

was an explanation for why the resident was documented as receiving the medication when the pharmacy had not sent the medication.

According to a follow up interview with the DON on 7/20/17 at 2:55 PM and again on 7/25/17 at 4:30 PM the facility's review had not revealed a definitive explanation for why the Januvia was not reordered and why the MAR indicated the Januvia was administered when there was no known supply of the medication to be administered.

On 7/26/17 at 10:18 AM a pharmacist from the facility, which currently supplied medications to the facility, was interviewed. According to the pharmacist another pharmacy had supplied medications to the facility prior to 4/1/17 and they began supplying medications on 4/1/17. The pharmacist stated they assisted the staff on 3/30/17 and 3/31/17 to move the medications from one cart to another at that time but their pharmacy had not maintained records of what was in the carts during the change over.

On 7/26/17 at 10:50 AM the DON arranged for interviews to be held with three of the nurses who had been responsible for administering the Januvia during the time period in which the pharmacy records showed the supply had run out. The nurses were Nurse # 1, Nurse # 5, and Nurse # 7. All three of the nurses stated if they signed for the medication then the medication would have been in the medication cart and was given. None of the nurses offered definitive evidence of where the Januvia would have come from. Nurse # 1 stated maybe there had been left over Januvia pills from when there was a prior pharmacy provider.

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 07/26/2017

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 425	Continued From page 9	F 425		

On 7/26/17 at 12:13 PM interview with the DON revealed she had found accounting records of the last Januvia pills supplied by their prior pharmacy for Resident # 4. The DON stated the Januvia was last filled by the other pharmacy on 3/31/17 and 14 doses had been sent.

2. Record review revealed Resident # 13 was initially admitted to the facility on 2/18/11. Record review revealed the resident had a diagnosis of depressive disorder.

Review of Resident # 13's July 2017 physician orders revealed a current order for Duloxetine hydrochloride (HCL) 60 milligrams delayed release (DR) every day for the treatment of depression. The order originated on 2/9/15.

Review of the resident's 7/1/17 to 7/15/17 Medication Administration Record (MAR) revealed the Duloxetine HCL DR was scheduled to be given at 8 AM every morning. Review of this July MAR revealed nurses checked and initialed they gave the medication on every day excluding two days. These two dates were 7/11/17 and 7/15/17. On both of these dates that the medication was not administered, Nurse # 5 documented she could not give the medication. On all other dates between 7/1/17 and 7/15/17 the medication was documented as administered by either Nurse # 5 or Nurse # 8.

On 7/15/17 at 3 PM Nurse # 5 was interviewed. Nurse # 5 stated she had not been able to give Resident # 13's Duloxetine HCL DR the current morning of 7/15/17 because it was not in the facility and a request had been placed on 7/15/17 to the pharmacy to refill and send it.

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 07/26/2017

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 425	Continued From page 10	F 425		

On 7/16/17 at 10:15 AM Resident # 13's new supply of Duloxetine HCL DR was observed with Nurse # 6. The new supply of Duloxetine HCL DR was observed to have been filled on 7/15/17. There was one pill used from the new thirty day supply which had been sent on 7/15/17. Nurse # 6 stated the used pill was the one she had administered that morning (7/16/17).

Interview with the director of nursing (DON) on 7/16/17 at 10:20 AM revealed the resident's supply of Duloxetine HCL DR had not been sent till late during the night of 7/15/17, and therefore it would have been too late to have administered the delayed release medication to the resident. This interview confirmed the resident had missed his 7/15/17 dose. It was also confirmed with the DON that they did not have this medication in their facility back up supply of medications.

A pharmacist, who worked at the pharmacy which supplied medications to the facility, was interviewed on 7/17/17 at 1:06 PM. The pharmacist reviewed the facility's requests for Resident # 13's Duloxetine HCL DR refills, the orders for the medication, and the pharmacy dispensing of the medication. The pharmacist provided the following information from her records and review. The resident had been prescribed Duloxetine HCL DR 60 mg also in May 2017 and June 2017 without any discontinuation of the medication. The pharmacy filled a 30 day supply of Duloxetine HCL DR on 5/31/17. On 6/7/17 the pharmacy received a new prescription for the same medication and dosage with instructions not to fill at that time because the facility still had a supply of the medication on hand. On 7/3/17 the facility requested a refill of

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 07/26/2017

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 425	Continued From page 11	F 425		

the Duloxetine HCL DR on the old prescription number. The old prescription had been discontinued in the pharmacy's system when the pharmacy technician looked into the system. Therefore the pharmacy technician did not refill and send the medication. According to the pharmacist the technician should have looked in their system and found the new prescription number for the Duloxetine HCL DR that had been sent to the pharmacy on 6/7/17, and used that to fill the medication. The pharmacist stated following the unfulfilled 7/3/17 request, the facility did not request the medication again until 7/15/17. According to the pharmacist, there had been errors by both the pharmacy and the facility. The pharmacist stated 60 milligrams of Duloxetine HCL DR is not maintained in the facilty's back up supply and by her calculations the facility would have run out of the medication prior to 7/15/17 and should have followed up with the pharmacy when they did not receive their refill request on 7/3/17.

The assistant director of nursing (ADON) was interviewed on 7/18/17 at 9:35 AM regarding the facility's failure to request refills for the Duloxetine HCL DR. According to the ADON the director of nursing (DON) was unavailable at the current time and would return on 7/19/17. According to the ADON they would review the administration record and refill requests for the Duloxetine HCL DR to determine if there was an explanation for why the resident was documented as receiving the medication when the pharmacy had not sent the medication.

According to a follow up interview with the DON on 7/20/17 at 2:55 PM and again on 7/25/17 at 4:30 PM the facility's review had not revealed a

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 07/26/2017

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 425	Continued From page 12	F 425		

definitive explanation for why the Duloxetine HCL DR was not reordered and why the MAR indicated it was administered when there was no known supply of the medication to be administered.

On 7/26/17 at 10:18 AM a pharmacist from the facility, which currently supplied medications to the facility, was interviewed. According to the pharmacist another pharmacy had supplied medications to the facility prior to 4/1/17 and they began supplying medications on 4/1/17. The pharmacist stated they assisted the staff on 3/30/17 and 3/31/17 to move the medications from one cart to another at that time but their pharmacy had not maintained records of what was in the carts during the change over.

On 7/26/17 at 10:50 AM Nurse # 5 was interviewed again. The nurse stated if she signed for the medication then that meant the medication was there and she gave it during the month of July, 2017. Nurse # 5 stated on the dates she did not sign for it then her process was to fax the reorder for it and electronically request the medication.

According to an interview with the DON on 7/26/17 at 10:50 AM Nurse # 8 was no longer an employee. The nurse could not be reached for interview.

On 7/26/17 at 12:13 PM interview with the DON revealed she had found accounting records of the last Duloxentine HCL 60mg pills supplied by their prior pharmacy. The DON stated the Dulxentine HCL was last filled by the other pharmacy on 3/13/17 and 30 doses had been sent.

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 07/26/2017

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 428	Continued From page 13	F 428		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified	F 428		8/9/17

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 07/26/2017

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 428	Continued From page 14 irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's consultant pharmacist failed to report a medication warning to the physician for one of four residents (Resident #6) who had a diagnosis that the FDA warned that the medication should not be given to a resident that had heart failure. The findings included: Review of Resident # 6's closed record revealed the resident resided in the facility from 5/27/17 until 6/22/17. An FL2 form was completed on 5/24/17 prior to the resident's facility admission. Two of the diagnoses on the FL2 form were listed as congestive heart failure and coronary artery disease. Review of the resident's minimum data set assessment, dated 6/13/17, revealed the resident was moderately cognitively impaired. Review of the resident's care plan, dated 5/31/17,	F 428	F-428 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicated. 1. Resident #6 no longer resides in the facility. 2. An audit was conducted by the Director of Nursing to ensure compliance with ensuring there were no medications with black box warnings unidentified by the	

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 07/26/2017

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 428	Continued From page 15 revealed the facility identified the resident had congestive heart failure and required monitoring. Review of physician orders revealed an order, dated 6/2/17, for Pletal 100 milligrams (mg) twice per day. The reason noted for the medication was leg pain and peripheral artery disease. The Pletal remained a current order for the resident through her discharge date of 6/22/17. Review of the resident's June 2017 medication administration record (MAR) revealed the resident began receiving the Pletal on 6/4/17 at 8 AM. Excluding four scheduled times the resident was documented as receiving the medication as ordered. The four times were as follows: On 6/12/17 at 8 AM there were no nurses initials, on 6/13/17 and 6/14/17 at 8 PM the nurse's initials were circled indicating it was not given, and on 6/22/17 at 8 AM the resident was documented as refusing the medication. Review of the pharmacy consultant's documentation revealed the consultant reviewed Resident # 6's record on 6/13/17. The pharmacist noted she had reviewed the resident's diagnoses and that the resident was prescribed Pletal 100 milligrams twice per day. The pharmacist noted she had no recommendations for the physician. Record review revealed Resident # 6 was evaluated at a hospital clinic on 6/22/17 and then later that same day admitted to the hospital for care. Review of the hospital clinic and hospital records, dated 6/22/17, revealed that the resident's Pletal was discontinued because there was "a black box warning for increased mortality if a person had heart failure."	F 428	pharmacist. 3. The Pharmacist will review the drug regimen of each resident monthly and report any irregularities to the attending physician and DON. The Director of Nursing will conduct monthly audits of pharmacist drug regimen review and ensure physician follow up. Findings will be reported to QAPI committee for further review and recommendations monthly for three months and as needed thereafter.	

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 07/26/2017

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 428	Continued From page 16 According to the Federal Drug Administration, black box warnings are designed to call attention to serious or life threatening risks. A review of the black box warning for Pletal revealed Pletal was contraindicated in patients with heart failure of any severity. Interview with the facility's physician on 7/18/17 at 2:33 PM revealed the black box warning had not been called to her attention by a pharmacist. The facility's consultant pharmacist was interviewed on 7/18/17 at 4:50 PM. The consultant pharmacist stated she had missed calling the black box warning to the attention of the physician and normally would have done so. The consultant pharmacist stated it was her understanding that the increased blood vessel dilation brought about by Pletal increased the blood volume to the heart, and the drug was therefore not recommended to individuals with heart failure.	F 428		