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 05/18/2018

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		6/19/18

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

Electronically Signed | 05/30/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to provide incontinent care for 1 (Resident #3) of 3 sampled residents reviewed for care with dignity. Findings included: Resident #3 had a diagnosis of quadriplegia. The documentation in the most recent annual minimum data set assessment dated 4/20/18 coded Resident #3 as cognitively intact with no mood or behavioral issues. Resident #3 was coded on the same assessment as having range of motion impairment on both sides of both upper and lower extremities as well as being incontinent of both bowel and bladder. Resident #3 was coded as having adequate vision. The documentation in the care plan for Resident #3, dated as last reviewed on 5/7/18, revealed the resident was at risk for impaired skin integrity relative to impaired mobility, muscle weakness, bowel and bladder incontinence. One of the interventions on the care plan stated, "Check for incontinence episodes frequently, keep clean and dry after each incontinence episode." 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	F 550	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. Resident #3 was interviewed by the Director of Nursing (DON) on 5/18/18 to determine his preferences for toileting and the care plan was updated at that time to reflect his preferences. The nursing assistant (NA#1) was in-serviced regarding the facility incontinence care policy and Resident #3 preferences for toileting. NA#1 was also disciplined for failing to provide timely incontinence care. Root cause analysis determined that NA#1 was aware and had been educated regarding the policy for incontinence care, however, there was a lack of communication between Resident #3 and NA#1 regarding his preferences for timing of the care to allow for his social needs. Any incontinent resident has the potential to be affected. Incontinent residents with a BIMs score of 10 or greater were interviewed to determine if the facility was meeting their needs regarding incontinence care and determine	

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F 550	Continued From page 2 nurse aide assigned to him on the first shift did not have the time to provide incontinent care until right before lunch. 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 the resident reiterated, "I just have to swallow it because there is nothing I can do." An interview and observation was conducted with the nurse aide (NA #1) who was assigned to Resident #3 on 5/18/18 at 11:30 AM. NA #1 stated that the residents are to be checked every 2 hours for incontinent care needs. She stated she had not checked or changed Resident #3 since the start of her shift. NA #1 indicated that third shift nurse aides had provided care to Resident #3 and she would always provide incontinent care for Resident #3 around 10:30 AM to 11:00 AM daily and then again at 2:30 PM before her shift was over. She indicated she had several residents who needed her help and Resident #3 was not always in his room. NA #1 provided incontinent care to Resident #3 from 11:36 AM to 11:41 AM. The incontinence brief for Resident #3 was observed to be wet and had a very foul odor. The Director of Nursing was interviewed on	F 550	preferences regarding timing of care. The plans of care were updated to reflect any reported preferences. The nursing staff was educated regarding the policy for incontinence care and the nursing assistants checking the residents at least every two hours for need of care. The in-service also included the responsibility of the licensed nurses to check and ensure incontinence rounds are being completed by the nursing assistants. The licensed nurses will periodically make rounds throughout their shift to ensure incontinence rounds are being completed timely by the nursing assistants. Five incontinent resident per shift per week will be audited/checked by DON and nursing supervisory staff to ensure incontinent rounds are being completed timely until two consecutive months of 100% compliance is met. Outcomes related to those audits will be reviewed in the QAPI committee monthly. The QAPI steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 550	Continued From page 3 5/18/18 at 2:15 PM. She indicated she had been employed as the Director of Nursing at the facility for approximately a week. She stated that it was her expectation that the nurse aides check with the residents every two hours to see if they need care.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		6/19/18

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F 656	Continued From page 4 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview the facility failed to provide incontinence care as outlined in the care plan for 1 (Resident #3) of 3 sampled residents reviewed for implementation of care plans. Findings included: Resident #3 had a diagnosis of quadriplegia. The documentation in the most recent annual minimum data set assessment dated 4/20/18 coded Resident #3 as cognitively intact with no mood or behavioral issues. Resident was coded on the same assessment as having range of motion impairment on both sides of both upper and lower extremities as well as being incontinent of both bowel and bladder. Resident #3 was coded as having adequate vision. The documentation in the care plan for Resident #3, dated as last reviewed on 5/7/18, revealed the resident was at risk for impaired skin integrity relative to impaired mobility, muscle weakness, bowel and bladder incontinence. One of the interventions on the care plan stated, "Check for incontinence episodes frequently, keep clean and dry after each incontinence episode."	F 656	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. Resident #3 was interviewed by the Director of Nursing (DON) on 5/18/18 to determine his preferences for toileting and the care plan was updated at that time to 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 licensed nurses regarding the care plan process. Any incontinent resident with specific preferences for incontinence care or toileting has the potential to be affected.	

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F 656	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 the resident reiterated, "I just have to swallow it because there is nothing I can do." An interview and observation was conducted with the nurse aide (NA #1) who was assigned to Resident #3 on 5/18/18 at 11:30 AM. NA #1 stated that all the residents are to be checked every 2 hours for care needs. She stated she had not checked or changed Resident #3 since the start of her shift (7:00 AM). NA #1 indicated that	F 656	Incontinent residents with a BIMs score of 10 or greater were interviewed to determine if the facility was meeting their needs regarding incontinence care/toileting and determine preferences regarding timing of care. The plans of care were updated to reflect any reported preferences. The nursing staff was educated regarding the regulation regarding the care plan to reflect the individual needs and preferences of the residents. The in-service included the responsibility of the nursing staff to update the care plans as 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 of the residents. Five care plans will be audited by the Administrative Nursing Team weekly to review and correct the accuracy of the care plan and ensure the care plan reflects the individual needs and preferences of the residents until two consecutive months of 100% compliance is met. Outcomes related to those audits will be reviewed in the QAPI committee monthly. The QAPI steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	

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F 656	Continued From page 6	F 656		

third shift nurse aides had provided care to Resident #3 and she would always provide incontinent care for Resident #3 around 10:30 AM to 11:00 AM daily and again at 2:30 PM before the end of her shift. She indicated she had several residents who needed her help and Resident #3 was not always in his room, but in another location in the building. NA #1 indicated that she had several dependent residents who she had to get ready first thing in the morning for rehabilitation services and other residents who required extra time to provide morning care. NA #1 stated she was assigned to 12 residents on that day but usually she was assigned to 10 residents to care for. NA #1 provided incontinent care to Resident #3 from 11:36 AM to 11:41 AM. The incontinence brief for Resident #3 was observed to be wet and had a very foul odor.

The Director of Nursing was interviewed on 5/18/18 at 2:15 PM. She indicated she had been employed as the Director of Nursing at the facility for approximately a week. She stated that it was her expectation that the nurse aides check with the residents every two hours to see if they need care.

The facility nursing consultant was interviewed on 5/18/18 at 3:52 PM. She indicated there was a communication issue between Resident #3 and NA #1 because Resident #3 was usually in another location in the building when the resident needed to be checked for incontinence. The nursing consultant indicated NA #1 would locate Resident #3 in the building every two hours to check if incontinent care was needed because this was an important issue for the resident.