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 02/29/2024

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 and compliant investigation survey was conducted on 2/26/24 through 2/29/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #E3K211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/26/24 through 2/29/24. Event ID# E3K211. The following intakes were investigated NC00213826, NC00213813, NC00213840, NC00211054, NC00209815, NC00209466, NC00208580, NC00208313, NC00208223, and NC00208009. 1 of the 25 complaint allegations resulted in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		3/27/24

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

Electronically Signed | 03/23/2024

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records review, and staff interviews, the facility failed to have Advance Directives (code status) in the residents' records for 1 of 1 resident reviewed for Advance Directives (Resident #41). Findings included: Resident #41 was admitted to the facility on 12/22/23. The admission Minimum Data Set (MDS) dated 12/29/23 revealed Resident #41 was assessed as	F 578	Treyburn Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and purpose of this Plan of Correction to the extent the summary of findings is factually correct in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as written allegation of compliance. Preparation and submission of this Plan of Correction is in response to the CMS	

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F 578	Continued From page 2 severely cognitively impaired. Resident #41's comprehensive care plan dated 1/4/24 did not contain information regarding code status or Advance Directives. At the time of physician's orders review on 2/26/24, there was no active order for code status in Resident #41's medical record in neither the Electronic Health Record (EHR) nor hard copy chart. An interview was conducted with Nurse #1 on 2/27/24 at 12:15 PM. Nurse #1 stated the code status was usually displayed in EHR, next to the resident's picture, in the physician's orders or hard copy chart for Advance Directives. Nurse #1 confirmed that there was no documentation to indicate the code status for Resident #41. During an interview on 2/27/24 at 12:40 PM, the Director of Nursing (DON) stated the residents Advance Directives were entered by the social worker in the EHR and in the resident's hard copy chart. The DON further stated Nurses looked for a resident's code status under the resident profile, displayed next to the resident's picture in the EHR. In addition, the staff could look up the code status in the physician orders or in resident's hard copy chart. The DON reviewed Resident #41's medical records, including EHR, hard copy the crash cart and confirmed that there was no information regarding the resident's code status. DON stated the Social Worker (SW) and /or Social Worker Assistant were responsible for ensuring the resident's code status was reviewed with the resident and /or resident's representative and entered in the resident's chart.	F 578	2567 from the survey conducted on February 26-29, 2024. Treyburn Rehabilitation Center response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Furthermore, Treyburn Rehabilitation Center reserves the right to refute any deficiency on the Statement of Deficiencies through Informal Dispute Resolution, formal appeal and/or other administrative or legal procedures. F 578 Request/Refuse/Discontinue treatment; Formulate Advanced Directives On 2/27/2024, the Director of Nursing spoke with resident #41's representative confirming the residents advanced directive. On 2/27/2024, the Director of Nursing updated the residents advanced directive order using the template process that auto-populates the advanced directive to the resident's demographic header in the resident electronic medical record. On 2/27/2024, the Director of Nursing confirmed current residents have an accurate advanced directive with supporting documentation of code status and orders with the advanced directive noted on the resident's demographic header in the resident electronic medical record.	

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F 578	Continued From page 3 During an interview on 2/27/24 at 12:50 PM, the Social Worker assistant stated when any resident was newly admitted to the facility, the resident's code status was indicated in the discharge summary. During the baseline line/ initial care plan meeting the code status was discussed with the resident and/or resident's representative and the new code status was entered in the EHR near the resident's profile. The physician was given a copy of the resident's code status to be signed, and the order was entered in the resident's chart. She stated, if the resident / resident representative had opted for Do Not Resuscitate (DNR), then she would place a copy of the code status in the Code status book near the nursing station. The Social Worker assistant stated if any resident was "Full Code", then there was no documentation placed in the Code status book. She indicated Nurses could see the code status in the EHR near the resident profile, in the hard copy chart and in the code status book. During an interview on 2/28/24 at 1:15 PM, Nurse Practitioner #1 stated that the staff would discuss with the resident and/or resident representative about Advance Directives and code status. This information was notified to her, and the order was signed. The staff would then enter the information in the resident's record. During an interview on 2/29/24 at 9:58 AM, the Administrator stated the resident's code status should be entered in the resident's electronic medical record and hard copy chart at admission. Resident #41 should have a code status order and should be care planned based on his code status.	F 578	By 3/22/2024, the Director of Nursing/Staff Development Coordinator will complete education to licensed staff regarding the process to utilize the order template for advanced directive which auto-populates the advanced directive to the resident's demographic header in the resident electronic medical record and all supporting documentation of code status is completed. On 3/18/2024, the Nursing Administrator re-educated the Social Services Director and Social Service Assistant regarding the process for ensuring the residents advanced directive and supportive code status is accurately reflected in the resident's medical record on the resident's demographic header. Newly hired licensed nursing staff and social services staff will receive education upon hire by the Staff Development Coordinator or designee regarding the process for ensuring the resident's advance directives is added utilizing the advanced directive order template that auto populates the advanced director to the resident's demographic header in the resident electronic medical record and all supporting documentation of code status is completed. On 3/25/2024 an audit on newly admitted residents will be conducted by the Director of Nursing or designed to ensure the residents demographic header in the electronic medical record reflects the residents or responsible party's choice for advanced directives. This audit will be	

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F 578	Continued From page 4	F 578	conducted three times a week for four weeks, then two times a week for four weeks, and then weekly for four weeks. The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the Social Service Director/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. Date of compliance: 3/27/2024	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		3/27/24

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F 610	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to complete a thorough investigation for an allegation of physical abuse for 1 of 3 residents (Resident # 68) investigated for abuse. The findings included: Review of the abuse neglect policy dated 1/3/24, read in part: revealed the facility protocol included an investigation checklist which included a review of the staff schedule, interview(s) of employees directly involved and witness(es) who observed or had knowledge of the alleged incident or injury and complete statements of the event, interview the resident, other residents, visitors, vendors, and complete witness(es) statements of the event. Resident # 68 was admitted to the facility on 7/19/22. The quarterly Minimum Data Set(MDS) dated 11/15/24, revealed Resident #68's cognition was intact. The facility 24- hour incident report dated 10/3/23 at 11:00 AM, revealed the facility was made aware by Resident #68 that Nurse Aide #2 had pulled her hair and stuck a finger in her ear. The 5-day summary of investigation completed by the Administrator on 10/9/23 revealed oral statements were obtained from Resident #68 and Nurse Aide #2. There was no evidence a written statement was obtained from Resident #68 or Nurse Aide #1 and no evidence of interviews or written statements with witness(es) who observed	F 610	F 610 Investigate/Prevent/Correct alleged violations On 2/26/2024 resident #68 was re-interviewed by the Administrator and does not express any ongoing concerns with the initial allegation. On 2/26/2024, the Vice President of Operation re-educated the Nursing Home Administrator on the components of a thorough investigation to include but not limited to resident or responsible party interview, staff involved interview, witness interview, ancillary staff interview, resident record review, staff schedule review, vendors, visitors, and complete all statements related to the concern. On 3/8/2024, an audit was conducted by the Regional Clinical Director on state reportables submitted in the last 30-days to ensure a thorough investigation was completed. All reportables were found to be investigated thoroughly. By 3/22/2024, current licensed nursing staff were educated by the Director of Nursing on the components of completing a thorough investigation of abuse, neglect or exploitation. In an abundance of caution current staff were also re-educated on the center's abuse prohibition policy for abuse, neglect and exploitation.	

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F 610	Continued From page 6 or had knowledge of the alleged incident or injury or interviews with other residents who may have had contact with the Nurse Aide #2. Nurse Aide #2 was suspended for 3 days and later terminated for poor customer service. The facility did not substantiate the allegation. An interview was conducted with Resident #68 on 02/26/24 11:48 AM. Resident #68 reported she was interviewed by the Administrator and the Director of Nursing, and she told them was not harmed by the aide and felt bad they let the aide go because she was a good aide. A telephone interview was conducted on 2/27/24 at 7:20 AM. Nurse Aide #2 stated she was unaware of the allegation until she was called into the office on 10/3/23 by the Administrator and Director of Nursing, who informed her that Resident #68 had reported Nurse Aide #2 had pulled her hair and stuck a finger in Resident #68's ear and the resident felt abused. Nurse Aide #2 stated Nurse #2 was present during interaction with Resident #68. Nurse Aide #2 stated she was interviewed by the Administrator or the Director of Nursing but she had not be asked to write a statement about the allegation. An interview was conducted on 2/26/24 at 2:41 PM in conjunction with a record review with the Administrator who completed the 5 -day investigation summary dated 10/9/23. He revealed he and the former Director of Nursing obtained oral statements from Resident #68 and Nurse Aide #2 but did not have written statements from Resident #68 or Nurse Aide #2 documenting the allegation. He further stated the facility process would include interviews with witness(es) who observed or had knowledge of the alleged	F 610	Newly hired licensed nursing staff will receive education upon hire by the Staff Development Coordinator or designee on the components of completing a thorough investigation of abuse, neglect or exploitation. All newly hired staff will receive education by the Staff Development Coordinator or designee on the center's abuse prohibition policy for abuse, neglect, and exploitation. On 3/25/2024, an audit on the center's reportables of abuse, neglect, or exploitation to ensure a complete and thorough investigation is done will be conducted three times a week for four weeks, then two times a week for four weeks, and then weekly for four weeks. The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the Nursing Home Administrator/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. Date of compliance: 3/27/2024	

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F 610	Continued From page 7	F 610		

incident or injury, and interviews with other residents who may have had contact with the alleged Nurse Aide #2.The Administrator acknowledged the investigation process had not been followed or completed per the facility protocol when he did not obtain the written statements from Resident #68, Nurse Adie #2, or interview Nurse #2. The Administrator stated it was an oversight.

An interview was conducted on 2/27/24 at 8:17 AM, Nurse #2 stated she had worked with Nurse Aide #2 on the day of the alleged incident. Nurse #2 stated she did not witness the alleged abuse. She had become aware of the allegation after Nurse Aide #2 had been terminated. Nurse #2 stated any allegation of abuse, the process would have been, each person that was involved would have written a statement, shift nurses would have been interviewed, resident interview, resident assessment etc. Nurse #2 stated she was not asked to write a statement or asked any questions regarding the alleged staff interaction with Resident #68.

A telephone interview was conducted on 2/28/24 at 8:29. The former Director of Nursing stated that standard procedures for abuse investigation was to obtain written statements of all individuals involved, to include residents, staff, nursing would perform head to toe assessments, resident would be asked abuse interview questions She stated she could not recall if other staff that were present were interviewed. The former Director of Nursing stated she did not recall if statements were obtained from the Unit Supervisor or the staff working on the unit with the resident or the accused nurse aide (NA #2). NA #2 was not terminated based on the abuse allegation, but for

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F 610	Continued From page 8 poor customer services related to previous incidents.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		3/27/24

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F 655	Continued From page 9 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview the facility failed to conduct a baseline care plan within 72 hours of admission for 2 of 2 residents reviewed for base line care plan. (Resident #91 and Resident #252). Findings included: 1. Resident #91 was admitted to the facility on 2/7/24. Review of the admission Minimum Data Set (MDS) assessment dated 2/14/24 revealed Resident #91 was admitted on 2/7/24. The resident was assessed as cognitively intact. Review of the discharge return anticipated MDS dated 2/17/24 revealed the resident was discharged to hospital. The resident was readmitted to the facility on 2/22/24. Review of the Social Worker (SW) note dated 2/26/24 indicated the interdisciplinary team completed a 72-hour meeting for readmission. The code status and resident discharge plan to return home were discussed.	F 655	F 655 Baseline Care Plan On 3/19/2024, the Social Service Director and Director of Nursing met with resident #91 to review the residents baseline care plan and provide a copy of the baseline care plan to the resident and resident responsible party. On 3/9/2024, resident #252 was discharged from the center. On 3/18/2024, the Social Services Director and Director of Nursing were re-educated on the process for developing a baseline care plan within 48 hours and scheduling of the 72-hour care connect process to meet with the resident and or responsible party to review and provide a copy of the baseline care plan to them. On 3/19/2024, the Director of Nursing completed an audit of the prior 30 days of admissions, who are current residents, to ensure the baseline care plan was given to the resident and/or responsible party. Any resident found not to have the baseline care plan given to them had the current care plan reviewed with the resident and/or the responsible party.	

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F 655	Continued From page 10 During an interview on 2/26/24 at 10:42 AM, Resident #91 stated she does not recollect having a base line care plan meeting and a summary of baseline care plan provided to her. Resident further stated she returned from the hospital 4 days ago. During an interview on 2/28/24 at 9:54 AM, the Social Worker (SW) stated the Baseline care plan for all newly admitted residents was completed within 72 hours of admission. The SW indicated during the baseline care plan meeting the team discussed with resident and their representatives, their discharge goals, rehab, dietary and nursing goals. The SW further stated base line care plan summary was not provided to residents and/or resident's representatives. She indicated she documented the details of the meeting conducted in the resident's electronic medical record (EHR). The SW stated they had missed the baseline care plan meeting during the initial admission and had conducted a baseline care plan meeting on 2/26/24 upon readmission. 2. Resident # 252 was admitted to the facility on 2/21/24. Review of the 5 days Minimum Data Set (MDS) assessment dated 2/24/24 revealed the resident was assessed as cognitively intact. During an interview on 2/26/24 at 10:59 AM, Resident #252 stated she did not have any care plan meeting since her admission. She stated she did not receive any summary of her baseline care plan. During an interview on 2/28/24 at 10:22 AM, the	F 655	On 3/18/2024, the Regional Clinical Director re-educated the Director of Nursing, Unit Managers, Staff Development Coordinator, and Social Service Director on the process of developing a baseline care plan with all new admissions within 48 hours of admission and reviewing the baseline care plan with the resident and/or responsible party to include providing a copy of the baseline care plan to the resident and/or responsible party. By 3/22/2024, the Director of Nursing or Staff Development Coordinator will re-educate the licensed nurses on the process to develop a baseline care plan upon admission utilizing the nursing admission data set within 48 hours of admission. Newly hired social services staff and licensed nursing staff will be educated during orientation by the Staff Development Coordinator or designee on developing a baseline care plan within 48 hours of admission and reviewing with the resident and/or responsible party at the 72-hour care connect meeting. On 3/25/2024, an audit will be conducted of new admissions by the Director of Nursing or designee on ensuring the baseline care plan is developed upon admission within 48 hours of admission and the baseline care plan is reviewed and a copy is provided to the resident and/or responsible party. This audit will be	

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F 655	Continued From page 11 Social Worker (SW) stated the baseline care plan meeting with newly admitted residents and/or resident representatives was conducted within 72 hours of admission. She indicated the interdisciplinary team were meeting with the resident and resident representative today (2/28/24). The SW stated the Admission assistant was responsible to schedule the baseline care plan meeting with resident representative per their preference. During an interview on 2/28/24 at 10:43 AM, Admission assistant stated she usually schedules the baseline care plan meeting within 72 hours of admission with the resident and/ or resident's family. She indicated she had missed scheduling a baseline care plan meeting for Resident #252 within 72 hours of admission. The meeting was set up for today (2/28/24). During an interview on 2/28/24 at 11:00 AM, The Vice President of Operations stated baseline care plan meeting should be conducted with the resident and/or resident representative within 48 hours of resident's admission. A summary of the initial baseline care plan should be signed by the resident and /or resident representative and a copy should be provided to them.	F 655	completed three times a week for four weeks, two times a week for four weeks, and then weekly for four weeks. The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the Director of Nursing/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. Date of compliance: 3/27/2024	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to--	F 657		3/27/24

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F 657	Continued From page 12 (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident and staff interviews the facility failed to involve residents and/or resident's representatives in the care planning process for 1 of 1 sampled resident reviewed for care plan participation (Residents # 41). The findings included: Resident #41 was readmitted on 12/22/23 with diagnoses in part, end stage renal disease, dependence on renal dialysis, and dementia. A record review of the admission Minimum Data Set (MDS) assessment dated 12/29/23 revealed Resident #41 was assessed as severely cognitively impaired and was dependent on staff for most of the activity of daily living.	F 657	F 657 Care Plan Timing and Revision On 3/21/2024, a care plan meeting was held by the Interdisciplinary Team (MDS coordinator, Unit Manager, Rehabilitation Director, and Social Services Director) with resident #41 and the resident's representative to review the comprehensive care plan and modify if indicated. On 3/21/2024 an audit was completed by the Director of Nursing and Social Services Director of all comprehensive care plan meetings that were held in the past 30 days to ensure the resident and/or responsible party was involved. Any	

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F 657	Continued From page 13 Review of the resident's comprehensive care plan revealed it was reviewed by staff on 1/4/24 but there was no indication that the resident and/or resident's representative participated in the care plan meeting or in the development of Resident #41's plan of care. During an interview on 2/26/24 at 12:31 PM, Resident #41 indicated he or his family had not participated in his care plan meeting and did not receive any invitation to participate in the care plan meeting. During an interview on 2/28/24 at 9:59 AM, the Social Worker (SW), stated Resident #41 was admitted on 12/22/23 and a baseline care plan meeting with resident's representative was completed on 12/27/23. The SW further stated the resident was cognitively impairment and was unable to participate in baseline care plan meeting. The SW indicated that comprehensive care plan meetings were not conducted with resident and/or resident representative. She stated the baseline care plan meetings were conducted within 3 days of admission with resident/and or resident representatives in very detail by all team members. She further indicated the Social Services completed their assessment and the resident's discharge planning, code status, financial details, therapy, and other issues were discussed in detail during the baseline care plan meeting. The SW stated she was not aware that a care plan meeting should be conducted after the comprehensive care plan was completed by the interdisciplinary team. The SW indicated the SW assistant was responsible for sending out care plan meeting letters and documented the care plan meeting in detail in	F 657	resident and/or responsible party found not to have been involved in the comprehensive care plan meeting will be contacted and scheduled to be reviewed with the Interdisciplinary Team. On 3/18/2024, the Interdisciplinary Team (Director of Nursing, MDS coordinator, Unit Manager, Rehabilitation Director, Certified Dietary Manager and Social Services Director) were re-educated by the Regional Clinical Director on the process of developing a comprehensive care plan, holding a care plan meeting that includes the interdisciplinary team, the resident and/or responsible party within 7 days of completing the comprehensive assessment. Newly hired Interdisciplinary Team members will be educated in orientation by the Staff Development Coordinator or designee on the requirement to develop a comprehensive care plan with the resident and/or responsible party within 7 days of completing the comprehensive assessment. On 3/25/2024 audits will be conducted to ensure a comprehensive care plan meeting is held with the interdisciplinary team, resident and/or responsible party within 7 days of the comprehensive assessment. This audit will occur three times a week for four weeks, two times a week for four weeks, and the weekly for four weeks.	

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F 657	Continued From page 14 residents' charts. SW confirmed only baseline care plan meeting was conducted at the time of admission and no comprehensive care plan meetings were conducted with residents and/or residents' representatives. During an interview on 2/28/24 at 10:19 AM, the Social Worker assistant stated she received a monthly calendar from the MDS nurse that indicated the quarterly, annual, and significant change MDS completion dates. She further stated that based on this calendar a letter was sent out to residents/resident representatives and a care plan meeting was scheduled. She indicated she maintained the attendance log as to who participated in the meeting. She further indicated She did not schedule the comprehensive care plan meeting for Resident #41 because it was not indicated in the monthly calendar sent to her. During an interview on 2/28/24 at 10:28 AM, the MDS Nurse coordinator stated a monthly calendar which includes the Assessment Reference Date (ARD) for quarterly, annual, and significant change MDS was given to the Social Services. The MDS Nurse coordinator stated the Social Services conducted a baseline care plan meeting with residents and their representatives and during that meeting, the comprehensive care plan meeting was scheduled with the residents and/or resident representatives. MDS Nurse Coordinator restated that the calendar sent to the Social Services did not include the comprehensive assessment ARD as it was thought that the Social Services department would had scheduled meetings for comprehensive care planning during their 72-hour care plan meeting.	F 657	The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the MDS Coordinator/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. Date of compliance: 3/27/2024	

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F 657	Continued From page 15 During an interview on 2/28/24 at 10:37 AM, the Vice President of Operations stated the expectation was that care plan meetings and notifications were sent to residents and/or resident representatives per the state/ federal regulations. The Vice President of Operations stated the care plan should be reviewed and revised by the interdisciplinary team after each assessment, including comprehensive assessments. He further stated residents and/or resident's representatives should be involved in the care plan meeting and make decisions about their care.	F 657		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		3/27/24

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F 812	Continued From page 16 Based on observations, record review and interviews the facility failed to discard expired food from the walk-in refrigerator, label and date thickened liquids in reach-in refrigerator and maintain the kitchen equipment and bin holding scoops and ladles clean. The facility failed to label, and date opened dietary supplements and thickened liquids, and discard expired food from 2 of 2 nourishment refrigerator (Nourishment refrigerator in Kitchenette #2 and Kitchenette #1). These practices had the potential to affect food served to the residents. Finding included: 1. An observation of the walk-in refrigerator on 2/26/24 at 9:17 AM revealed an aluminum pan containing multiple individual cups of yogurt and nutritional supplements on ice. Observation revealed ten, 4-ounce cups of yogurt with an expiration date 2/25/24. During an interview with the Dietary Manager on 2/26/24 at 9:20 AM, she indicated the aluminum pan contained yogurt and supplements for lunch meal. She stated the expired dates for the yogurt cups were overlooked. She indicated the expired yogurt cups would be discarded. 2. An observation of the reach-in refrigerator on 2/26/24 at 9:30 AM revealed two opened 46 fluid ounce of nectar thick water cartons. There was no label indicating the open date or use by date on them. Review of the manufacturing recommendations on the carton revealed the product could be refrigerated for 10 days in the refrigerator after opening. The Dietary Manager during an interview on	F 812	F 812 Food Procurement Store/Prepare/Serve-Sanitary On 2/26/2024, the Certified Dietary Manager removed and discarded the individual cups of yogurt with the 2/25/2024 expiration date and the 46 fluid ounces of nectar thick water cartons from the walk-in refrigerator. On 3/8/2024, the deep fryer was drained of oil, scrubbed, de-grease of outside of fryer and inside the door panels by the center's dayshift cook. The Administrator revised the deep fryer cleaning schedule to reflect the days the deep fryer was to be routinely cleaned, a spot for PRN cleaning after a fish fry, the staff assigned to clean it and a place to sign certifying the deep fryer was cleaned per policy. On 2/29/2024, the Certified Dietary Manager ensured the plastic bin with scoops, ladles, and serving spoons were placed in the dish washing machine to be washed and sanitized. On 2/26/2024, the unit managers removed and discarded items that were not dated after opening, had no date on food brought in by a visitor for a resident, any opened undated supplements or thickened liquid from the nourishment room refrigerators (Kitchenette #1 & 2). On 2/28/2024, the Certified Dietary Manager was immediately re-educated by the Administrator on ensuring the deep fryer is clean and ready for use as per the cleaning schedule, ensuring the serving utensils and storage bin are run through the dish machine every evening, expired	

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F 812	Continued From page 17 2/26/24 at 9:30 AM, indicated all opened food/ nutrition supplements or thickened liquids should be labeled with an open date. The dietary manager stated that the thickened liquid cartons may have been opened during the weekend. 3. Review of the cleaning schedule for "February, Week 3" revealed the following: Deep fryer - Drain oil, scrub, and de-grease outside and inside door panels. Rinse and discard used oil. The document was marked "X" as cleaned on Sunday, Wednesday, Thursday, Friday, and Saturday. The document did not indicate the frequency of cleaning (daily, bi-weekly, weekly, bi-monthly, or monthly). A. Observation of the deep fryer on 2/26/24 at 9:37 AM revealed the fryer had dried food crumbs on the top panel of the equipment. There were light brown food particles floating in the oil. A large brown greasy stain was observed on the back splash of the equipment. During an interview with the Dietary Manager on 2/26/27 at 9:37 AM, she stated the staff would be cleaning the equipment that day. She further stated the Assistant Dietary Manager was responsible for cleaning the equipment and would be completing the task that day. During an interview on 2/28/24 at 1:51 PM, the Assistant Dietary Manager stated that he was responsible for cleaning the deep fryer and usually cleaned the deep fryer on Monday and Wednesday. He indicated the oil in the fryer was drained when fish was fried. He stated the Friday menu had chicken tenders and Catch of the day (fish fry). The oil was not drained, and equipment was not cleaned after that meal.	F 812	food items are removed and discarded prior to or on the expiration date. On 2/28/2024, the Certified Dietary Manager and Director of Nursing were immediately re-educated by the Nursing Home Administrator on ensuring both nourishment room refrigerators must be monitored daily for expired foods, undated and open supplements, or thickened liquids. On 2/28/2024, the Nursing Home Administrator completed an audit of the kitchen and nourishment rooms to ensure the deep fryer, serving utensils and bin was cleaned. The expired, undated, and opened food items were removed and discarded. Any areas of opportunity were corrected immediately on 2/28/2024. All residents had the potential to be affected by the deficient practice. On 3/19/2024, the Director of Nursing/designee re-educated the nursing staff on ensuring everything in the nourishment room refrigerators must be dated when opened or placed in the refrigerator to include resident identifiers for food brought in for residents. Items must be removed and discarded within 72 hours of the opening or placed into the refrigerator date. On 3/25/2024 audits will be conducted on kitchen sanitation to include monitoring the deep fryer scheduled cleaning, expired food items, nourishment	

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F 812	Continued From page 18 B. Observation of the plastic bin containing scoops, ladles and serving spoon during tray line observation on 2/28/24 at 11:50 AM revealed dirt and dried food particles in the bin. The dietary manager stated this bin was constantly used by staff during tray line and does have some dried food particles on the base. 4. Review of the "Food from Outside Sources Use and Storage" policy revealed perishable foods should be discarded after 72 hours of the date placed in the refrigerator. Review of the manufacturer's recommendations for nutritional supplement "Ready Care 2.0" read, in part "Shelf Life: 9 months from date of manufacture. Refrigerate after opening and use within 72 hours." A. Observation of the nourishment refrigerator #2 (Kitchenette #2) on 2/26/24 at 9:40 AM, revealed a white plastic bag dated 2/22/24, containing a takeout container with food in it, a wet brown bag with 3 take out containers dated 2/22/24, a small, opened snack tray containing slices of apples and pretzels with use by date 2/2/24. The apple slices had some brown colored fluid on them. The refrigerator also contained four 32 fluid ounce Nutritional Supplements that were opened. There was no label indicating the open date or use by date on them. During an interview on 2/26/24 at 9:40 AM, the Dietary Manager indicated she conducted daily checks in the morning and discarded expired food. She further indicated that she had completed the daily check of the nourishment refrigerator that morning and had not noticed	F 812	refrigerators, and cleaning of utensil bin will be completed three times a week for four weeks, two times a week for four weeks, and then weekly for four weeks. The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the MDS Coordinator/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. Date of compliance: 3/27/2024	

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F 812	Continued From page 19 these bags of takeout food. The Dietary Manager indicated the nursing staff were responsible to label any opened nutrition supplement or thickened liquid carton with an open date. B. Observation of the nourishment refrigerator #1 (Kitchenette #1) on 2/26/24 at 9:45 AM revealed a plastic bag containing takeout food dated 2/20/24. The refrigerator also contained two opened 46 fluid ounce nectar thick water cartons with no open date on them and, two opened nutritional supplements dated 2/17/24. During an interview with the Dietary Manger on 2/26/24 at 9:45 AM, she indicated the nursing staff were responsible to label all opened nutritional supplements with an open date. During an interview on 2/28/24 at 2:58 PM, the Director of Nursing (DON) stated the nurses should label all opened nutrition supplements with an open date. DON indicated nutritional supplements use on the medication cart should be discarded within 24 hours of opening. Any thickened liquid when opened should be discarded within 72 hours of opening. The DON indicated all perishable food brought by families for residents should be discarded within 72 hours if the resident does not consume them. The DON stated the dietary department was responsible to ensure these foods were discarded within 72 hours.	F 812		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written	F 867		3/27/24

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policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

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§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct

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F 867	Continued From page 22 distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility's Quality's Assessment and Performance Improvement (QAPI) Committee failed to maintain implemented procedures and monitor the interventions that were put in place following the annual recertification and complaint survey conducted on 3/30/23. This was for recited deficiencies in the areas of Food	F 867	F 867 QAPI/QAA Improvement Activities The center's Quality Assurance and Assessment/Quality Assurance and Performance Improvement committee failed to maintain implemented procedures and monitor the interventions the interventions that the committee put in place following the complaint investigation	

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	345458	A. BUILDING _____ B. WING _____	C 02/29/2024

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 867	Continued From page 23 Procurement/Prepare/serve-Sanitary (F812) and Care Plan Timing and Revision(F657). These deficiencies were recited during an annual recertification and complaint survey conducted on 2/29/24. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAPI program. Findings included: This tag is cross-referenced to: F812: Based on observations, record review and interviews the facility failed to discard expired food from the walk-in refrigerator, label and date thickened liquids in reach-in refrigerator and failed to maintain the kitchen equipment clean. The facility failed to label, and date opened dietary supplements and thickened liquids, failed discard expired food and failed to maintain the refrigerator clean for 2 of 2 nourishment refrigerator. These have the possibility to affect all residents. During the complaint/recertification survey dated 3/30/23, the facility failed to label and date food stored in the walk-in refrigerator, discard foods with expired use by date in the walk-in refrigerator and reach in refrigerator. The facility failed to discard expired food in 2 of 2 nourishment refrigerators reviewed for food storage (Nursing station #1 and Nursing station #2). The facility failed to ensure the plate warmer and the nourishment refrigerator #2 (near nursing station #2) were maintained clean. The Dietary Manager failed to change gloves and perform hand hygiene in between tasks when observed during meal preparation. F657- Based on record reviews, resident and staff interviews the facility failed to involve	F 867	survey of 2/26/2024. This includes the recited deficiencies in the areas of F657 Care plan timing and revisions, and F812 Food Procurement, Store/Prepare/Serve-Sanitary. By 2/29/2024, all areas associated with Food Procurement, Store/Prepare/Serve-Sanitary citation were corrected. By 3/21/2024, all areas associated with Care plan timing and revisions citation were corrected. On 3/22/2024 the Vice President of Operation re-educated the Nursing Home Administrator on the components of a facilitating a successful Quality Assurance Assessment/Quality Assurance Performance Improvement process to ensure all opportunities for improvement are brought to the Quality Assurance Assessment/Quality Assurance Performance Improvement and substantial compliance is achieved. On 3/25/2024 the Vice President of Operations conducted education with the Quality Assurance Performance Improvement Committee on F657 and F812 with emphasis on ensuring sustained compliance when a deficient practice has been identified and corrected. The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	

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F 867	Continued From page 24 residents and/or resident's representatives in the care planning process for 1 of 1 sampled resident reviewed for care plan participation (Residents # 41). During the complaint/recertification survey 3/30/23, the facility failed to conduct care plan meetings with residents or resident representatives for 1 of 19 sampled residents reviewed for care plans. An Interview with the administrator and the Regional Director (RD), conducted on 02/29/24 at 2:30pm, revealed the administrator had been in the position since August 2023, and he stated he was still learning about all the procedures involved in the survey process. The RD stated that he continued to train the administrator in policy and procedures that relate to QAPI and follow-up of the Plan of Correction (POC) post survey. The RD further explained the QAPI/Quality Assurance (QA) Manual was being updated and improvement performance was being monitored and evaluated for better outcomes. The administrator further stated it was his responsibility to make sure process and follow-ups continued and the planned outcome was met. The RD revealed that since the last survey changes had been made to the process of the MDS scheduling and admission assessments.	F 867	On 3/25/2024, audits will be conducted on kitchen sanitation by the Nursing Home Administrator/designee to include monitoring the deep fryer scheduled cleaning, expired food items, nourishment refrigerators, and cleaning of utensil bin will be completed three times a week for four weeks, two times a week for four weeks, and then weekly for four weeks. On 3/25/2024, audits will be conducted by the Director of Nursing/designee to ensure a comprehensive care plan meeting is held with the interdisciplinary team, resident and/or responsible party within 7 days of the comprehensive assessment three times a week for four weeks, two times a week for four weeks, and then weekly for four weeks. The results of these audits will be brought to the monthly Quality Assurance and Assessment/ Quality Assurance Performance Improvement meeting by the Nursing Home Administrator/designee and the Director of Nursing/designee. The Quality Assurance and Assessment/Quality Assurance Performance Improvement Performance committee will make further recommendations until substantial compliance is achieved. The Quality Assurance and Assessment/Quality Assurance Performance Improvement committee will present the finding monthly to the Vice President of Operations and/or the Regional Clinical Director to determine if substantial compliance has been	

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F 867	Continued From page 25	F 867	achieved. Date of compliance: 3/27/2024	