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	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Treyburn Rehabilitation Center	2059 Torredge Road Durham, NC 27712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 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 [DATE]. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #41 was assessed as 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. (continued on next page)

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 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 [DATE]. The quarterly Minimum Data Set(MDS) dated [DATE], 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 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. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 [NAME] #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 poor customer services related to previous incidents.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 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 [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #91 was admitted on [DATE]. The resident was assessed as cognitively intact. Review of the discharge return anticipated MDS dated [DATE] revealed the resident was discharged to hospital. The resident was readmitted to the facility on [DATE]. 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. 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 [DATE]. Review of the 5 days Minimum Data Set (MDS) assessment dated [DATE] 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. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/28/24 at 10:22 AM, the 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 [NAME] 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 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 [DATE] 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 [DATE] revealed Resident #41 was assessed as severely cognitively impaired and was dependent on staff for most of the activity of daily living. 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 [DATE] 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 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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. During an interview on 2/28/24 at 10:37 AM, the [NAME] 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 [NAME] 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.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 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 [DATE] 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 [DATE]. During an interview with the Dietary Manager on [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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 [DATE] 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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] 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. B. Observation of the plastic bin containing scoops, ladles and serving spoon during tray line observation on [DATE] 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 [DATE] at 9:40 AM, revealed a white plastic bag dated [DATE], containing a takeout container with food in it, a wet brown bag with 3 take out containers dated [DATE], a small, opened snack tray containing slices of apples and pretzels with use by date [DATE]. 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 [DATE] 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 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 [DATE] at 9:45 AM revealed a plastic bag containing takeout food dated [DATE]. 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 [DATE]. During an interview with the Dietary Manger on [DATE] 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 [DATE] 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.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48916 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 [DATE]. This was for recited deficiencies in the areas of Food 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 [DATE]. 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 [DATE], 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 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 [DATE], the facility failed to conduct care plan meetings with residents or resident representatives for 1 of 19 sampled residents reviewed for care plans. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An Interview with the administrator and the Regional Director (RD), conducted on [DATE] at 2:30pm, revealed the administrator had been in the position since [DATE], 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.