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	06/30/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interviews with staff and resident, the facility failed to get the resident out of bed for 3 consecutive days which caused the resident to feel frustrated because he was stuck in bed. The deficient practice affected 1 of 2 residents reviewed for choices (Resident #100).Findings included:Resident #100 was admitted to the facility on [DATE] with diagnoses of diabetes and neuropathy.The quarterly Minimum Data Set, dated [DATE] for Resident #100 documented he had an intact cognition. The resident was dependent for all activities of daily living including transfers.The care plan last updated on 5/14/26 with his assessment documented Resident #100 required assistance with all his activities of daily living. Transfer was by mechanical lift by 2 staff. On 6/23/2026 at 10:18 am Resident #100 was observed and interviewed. The Resident stated he was not assisted out of bed on 6/19/26, 6/20/26, and 6/21/26 and indicated he asked Nursing Assistant (NA) #3 to get him up as usual every morning on 6/19/26, 6/20/26, and 6/21/26. The resident commented that NA #3 had informed him each of the three days that there was no staff to get him out of bed. The resident stated he was frustrated that he was stuck in bed and not having enough staff was not an excuse to not get me out of bed and it was not my fault there was no staff. The resident again stated, that was not my problem. The resident further commented he liked to get out of bed by breakfast time, and he was usually back to his bed for care and dinner in the evening. The resident indicated he was also not assisted out of bed for those 3 days by the evening shift (3:00 pm to 11:30 pm) on 6/19/26 through 6/21/26. Resident #100 recalled he was assisted out of bed on 6/22/26 in the afternoon by the evening shift. On 6/23/26 at 10:40 am NA #3 was interviewed and confirmed she was assigned to Hall 200 where Resident #100 resided on day shift (7:00 am to 3:30 pm) on 6/19/26, 6/20/26, and 6/21/26. NA #3 stated she cared for the resident frequently and was aware that he liked to be out of bed early every morning. NA #3 indicated there were NA staff call outs each of the three days and no replacements when she asked the assigned Nurse #7 about staffing. NA #3 stated the nursing staff decided that the residents would remain in bed so staff would be able to provide care. NA #3 explained there was not enough time to get the residents out of bed and back to bed for care. NA #3 further commented that Resident #100 required mechanical lift by 2 staff and she was the only NA on her hall on 6/19/26 and 6/20. NA #3 confirmed Resident #100 had requested her to get him out of bed each of the 3 days, and he could not be accommodated because there was not the 2 required staff to transfer. NA #3 stated on Saturday 6/20/26 there were 4 NAs for the entire building on day shift and 5 NAs for the entire building on Sunday 6/21/26. NA #3 stated that she had 24 residents to provide care for her assignment on Friday and Saturday. The interview further revealed NA #3 was assigned to the resident on 6/23/26 and she assisted him into his wheelchair right after breakfast. Nurse #7 was assigned to Resident #100 on day shift on 6/19/26 and 6/20/26 and was unable to be contacted for interview. On 6/23/26 at 11:10 am an interview was conducted with Nurse #6 who was assigned to Resident #100 on Sunday 6/21/26 day shift 7:00 am to 3:30 pm. Nurse #6 indicated he was informed by staff that there were 4 NAs in the building 6/19/26 and 6/20/26 for day shift and nursing decided to keep the residents in their beds so staff would be able to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	06/30/2026

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide care. On Sunday, 6/21/26 there were staff call outs and the residents that requested to go to church were gotten up. Otherwise, the remaining residents were left in bed to be able to provide care with the staffing. Nurse #6 further commented that he was informed there was no staff to replace the call outs. On 6/24/26 at 2:10 pm an interview was conducted with the Director of Nursing (DON). The DON stated she was aware there were NA call outs on 6/19/26 through 6/21/26 day shift. The DON was not aware that residents were kept in bed so staff would be able to provide care and that Resident #100 requested to get out of bed and staff was unable to accommodate him.On 6/25/26 at 1:30 pm the Administrator was interviewed. The Administrator stated he was not aware there were nursing staff call outs on 6/19/26 through 6/21/26 and some residents remained in bed during the day for staff to provide care. The Administrator commented that he knew Resident #100 well and the resident would surely make his choice known as he was usually out of bed every day and liked to participate in activities.

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Responsible Party, Cancer Clinic Supervisor, Physician, and Oncologist interviews the facility failed to ensure that Resident #93 with metastatic prostate cancer received the medically necessary recommended six-month oncology follow-up appointment for 1 of 1 sampled resident reviewed for medically necessary oncology follow-up services.The findings included:Resident #93 was admitted to the facility on [DATE] with diagnoses that included communication deficit, dementia, and metastatic prostate cancer involving the lymph nodes.The quarterly Minimum Data Assessment (MDS) assessment dated [DATE] revealed Resident #93 was severely cognitively impaired and had a diagnosis of cancer.Review of the cancer clinic visit dated 6/13/25 revealed Resident #93's documented diagnoses were prostate cancer with intrapelvic lymph node involvement. The recommendations included Resident #93's continuation of maintenance injection therapy and follow-up every six months to monitor the resident's condition, review laboratory studies, including prostate-specific antigen (PSA: blood test used to screen for prostate cancer) levels. Resident #93 received Lupron (hormone therapy used to treat prostate cancer) 45 milligrams (mg) and tolerated the injection well. The next injection is recommended due on or after 11/21/25. Review of the facility appointment record revealed oncology appointments had been scheduled on 12/16/25, 2/3/26 and 2/17/26 with the cancer clinic and Resident #93 did not go to the scheduled appointments. Review of Resident #93's medical record provided by the facility revealed there was no documented evidence that facility staff notified the resident's family regarding the appointment cancellation or the transportation options available for those appointments.A telephone interview was conducted on 6/26/26 at 2:58 PM with the Cancer Clinic Supervisor who stated Resident #93 was last seen in the clinic on 6/13/25. The Cancer Clinic Supervisor stated the clinic received communication from the facility on 12/16/25 that Resident #93 cancelled his scheduled appointment, on 2/3/26 it was documented in the patient portal that the facility cancelled Resident #93's scheduled appointment. The appointment was rescheduled for 2/17/26 and the resident did not show up for appointment. The Cancer Clinic nurse called the facility 2/17/26 to ask if Resident# 93 would be attending the appointment and was told by the facility that the family had cancelled the appointment. The Cancer Clinic Supervisor stated, the nurse at the cancer clinic received communication from the family on 2/18/26 through Resident #93's patient portal that the family had not cancelled the appointment. The family reported the facility was refusing to bring the resident to his appointments and the family could not provide transportation. The facility was canceling these appointments and communicating that they were canceling them on behalf of the family member when that was not in line with what the family wanted. The nurse encouraged the family to contact the facility to reschedule the appointment and if the family needed the clinic nurse to help with getting outside transportation arranged, they would assist. The family did not call back to the clinic after the 2/18/26 conversation about rescheduling the appointment.A telephone interview was conducted on 6/24/26 at 3:05 PM with Resident #93's Responsible Party (RP) who stated the family's primary concern was that Resident #93's recommended oncology follow- up appointments had not been maintained. The RP stated the family had been informed from the clinic on multiple occasions that appointments were cancelled because the family was unable to accompany Resident #93 to the appointments. However, the RP reported that the family expected the facility to transport the resident to the appointment regardless of whether a family member could accompany the resident or not. The RP stated she believed the facility cancelled the appointments because staff were unavailable to accompany Resident #93 to the scheduled appointments. The RP reported that Resident #93's last appointment occurred on 6/13/25, at which time the oncologist indicated the resident was responding well to the prescribed maintenance injections and recommended continued follow-up care. The RP stated the family became increasingly concerned after multiple oncology appointments were missed, (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she specifically recalled Resident #93 had an appointment scheduled for 2/17/26, and Resident #93 was not transported to the appointment. The RP indicated she had accessed Resident #93's patient portal and found documentation that stated the appointment had been cancelled at the family's request. The RP asserted that neither she nor any other family member requested cancellation of the appointment and disputed the accuracy of that notation by calling the clinic directly and informing them that the family had not cancelled the appointment. The RP indicated the family was concerned that the resident had not been receiving the prescribed maintenance injection for prostate cancer and was uncertain about the current status of Resident #93's condition because the recommended oncology appointment had not occurred. The RP stated the family's expectation was that the facility would schedule, coordinate, and maintain medically necessary oncology appointments on the resident's behalf, including arranging transportation and staff accompaniment when needed, rather than canceling appointments based on staff availability or because family members were unable to attend.An interview was conducted on 6/24/26 at 9:00 AM with the Scheduler who was responsible for scheduling and coordinating residents outside medical appointments, including Resident #93's oncology follow up appointments. The Scheduler explained that when an appointment was scheduled, she notified the resident and the RP of the date, time and location of the appointment and offered the RP the opportunity to accompany the resident to the appointment or meet them at the provider's office. If the RP was unable to attend, the appointment was maintained, and the facility arranged transportation and staff to accompany the resident to ensure the resident received the recommended medical care. The Scheduler acknowledged that she did not have documentation of her conversation with the Resident #93's RP about the cancellation or any requested changes to the appointment.An interview in conjunction with a record review was conducted with the Director of Nursing on 6/25/26 at 11:00 AM and confirmed Resident #93 did not receive the recommended oncology follow up within the time frame established by the treating Oncologist.A follow-up interview was conducted on 6/25/26 at 1:00 PM with the Director of Nursing who stated it was the responsibility of the Unit Manager and nursing staff to review documentation received from outside providers for follow-up appointments, laboratory testing, treatments or other recommendations. The Director of Nursing further stated the Unit Manager and nursing staff were responsible for putting the documentation in the physician communication book. The Director of Nursing acknowledged the recommended follow-up appointment was an oversight, and the facility did not have a specific tracking system in place to ensure appointments were done and recommendations for follow-up appointments from outside providers were consistently monitored and completed as scheduled.An interview was conducted on 6/25/26 at 1:28 PM with the Unit Manager who stated she was unaware that Resident # 93's Oncologist had recommended a six-month follow-up evaluation and maintenance injections for his prostate cancer. The Unit Manager indicated she did not review the recommendations from his last appointment. The Unit Manager stated she was responsible for ensuring that recommended follow-up appointments were documented in the medical record and that appropriate coordination occurred to facilitate those appointments. The Unit Manager stated she did not receive notification from the Charge Nurse or the Scheduler of the appointment for Resident #93. The Unit Manager explained that the facility process was for the Resident and or the family to notify the Charge Nurse when they returned from an appointment so that follow-up appointments could be scheduled. The Charge Nurse then communicated the appointment information to the Scheduler, who was responsible for arranging the transportation and the staff to accompany the resident to the appointment. Following the appointment, nursing staff were expected to obtain and review the specialist recommendations, including any orders for additional treatment, laboratory testing, diagnostic studies, or follow up appointments, and communicate those recommendations to the attending Physician and to a Nurse Practitioner for implementation. The Unit Manager stated that once an appointment was scheduled the Scheduler then contacted the Resident and/or the Responsible Party to provide the appointment date, time, location and offer the Responsible Party the opportunity to accompany the Resident or (continued on next page)

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	06/30/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	meet the Resident at the provider's office. The Unit Manager stated that if the Responsible Party was unable to attend, the appointment should remain scheduled, and the facility should arrange transportation to ensure the resident received the recommended medical care. The Unit Manager stated that if an appointment was cancelled or rescheduled by the Resident or Responsible Party, staff should document the cancellation in the medical record, including who requested the cancellation, the reason for the cancellation and the action taken to reschedule the appointment. The Unit Manager stated that unless there was a legitimate reason to cancel or reschedule the appointment should be maintained regardless of whether the resident's family could attend or not.An interview and record review was conducted on 6/25/26 at 2:35 PM with the Regional Nurse Consultant who stated that the residents recommended oncology follow up appointment should have been completed in accordance with the treating specialist recommendations. The Regional Nurse Consultant stated the facility was responsible for coordinating medically necessary specialty appointments and ensuring continuity of the residents' care. The Regional Nurse Consultant further stated that all communication with the residents' Responsible Party regarding cancellation or rescheduling of appointments should be documented in the Resident's medical record. She indicated the documentation should clearly identify the date of the communication, the individual involved, the reason for any cancellation or rescheduling and follow up action taken by the facility. Additionally, the Regional Nurse Consultant stated that when a medically necessary appointment was cancelled or rescheduled, the facility should document the communication held with the specialty provider, confirm the status of the appointment and or ensure a new appointment was scheduled as appropriate. She acknowledged that based on her review of Resident #93's medical record, the documentation supporting communication with the RP and coordination of Resident #93's oncology follow up appointment was incomplete.An interview was conducted on 6/25/26 at 12:45 PM with the facility Physician who stated he was unaware the Oncologist had recommended a six-month follow-up appointment until he was informed by the Director of Nursing on 6/25/26 after learning the appointment had not occurred. The Physician stated that regardless of whether the family cancelled the appointment or was unable to attend the facility should have coordinated the medically necessary oncology appointment on the resident's behalf. The Physician further stated the absence of symptoms did not rule out disease progression and that updated PSA testing and oncology evaluation were necessary to determine the resident's current cancer status.A telephone interview was conducted on 6/29/26 at 2:04 PM with Resident #93's treating Oncologists who stated Resident #93 had a long-standing history of metastatic prostate cancer involving the lymph nodes and had responded to maintenance therapy prior to admission. The Oncologist stated routine follow up every six months was necessary to monitor disease progression, review prostate specific antigen (PSA) results, evaluate treatment effectiveness, and determine whether changes in therapy were warranted. The Oncologist reported he had been informed the appointment on 2/17/26 was cancelled by the family but could not verify that information. The Oncologist further stated that because the recommended follow-up did not occur, he was unable to determine whether Resident #93's cancer had remained stable or progressed. Updated laboratory testing and clinical assessment will be necessary to evaluate Resident #93's current condition. Although, Resident #93 had not demonstrated a confirmed adverse outcome, the oncologist stated the resident still needed to be monitored.

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	06/30/2026

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to follow a pharmacy recommendation to discontinue a medication for 1 of 5 residents reviewed for unnecessary medication (Resident #100). Findings included:Resident #100 was admitted to the facility on [DATE] with diagnoses of diabetes and neuropathy.The quarterly Minimum Data Set, dated [DATE] for Resident #100 documented he had an intact cognition. The monthly medication pharmacy review dated 5/21/26 for Resident #100 revealed a documented recommendation to discontinue the Zinc Sulfate 220 milligrams each day. The pharmacist documented that the resident's skin was intact, and the zinc was no longer needed. The recommendation was signed and approved by the Nurse Practitioner (NP) dated 6/1/26.A review of Resident #100's medication orders revealed there was not an order to discontinue Zinc Sulfate 220 milligrams each day. A review of Resident #100's Medication Administration Record (MAR) revealed the resident had documented nursing initials for administration of Zinc Sulfate 220 milligrams each day from 6/1/26 through 6/24/26. On 6/24/26 at 2:10 pm an interview was conducted with the Director of Nursing (DON). The DON stated the pharmacist's recommendation to discontinue the Zinc that was signed/approved by the NP 6/1/26 for Resident #100 was not provided to nursing by the NP. The DON explained that the NP was required to provide any signed recommendation to nursing for the order change. The DON stated the NP gave the Zinc pharmacy order change to be scanned into the resident's chart and not to nursing. The DON was not aware of Resident #100's order to discontinue the Zinc until today (6/24/26) when discussed. The DON further commented that the medication was signed for by nursing staff with initials on the MAR which indicated the Zinc medication was administered from 6/1/26 to 6/24/26. The NP that signed the pharmacy recommendation to discontinue Resident #100's Zinc was no longer working at the facility and was unable to be reached.On 6/25/26 at 1:30 pm the Administrator was interviewed. The Administrator stated he was not aware that Resident #100's pharmacy recommendation to discontinue the Zinc and signed/approved by the NP was not provided to nursing to process the order.