DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345053	A. BUILDING ______ B. WING ______	04/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1515 W PETTIGREW ST DURHAM, NC 27705

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).	F 000		

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

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.

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	345053	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-PETTIGREW	1515 W PETTIGREW ST DURHAM, NC 27705

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type II(111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation on Friday 6/7/12 at approximately 9:00 AM onward the following was noted: 1) The Rose Guardian Dining room opens to two smoke compartments. The corridor door opening to the front hall of this room is not equipped with a self-closing device. 42 CFR 483.70(a)	K 027	K27 It is the practice of this center to assure that all door openings in smoke barrier walls are within compliance at all times to include: The Rose Guardian Dinning room closer will be placed with properly rated units by 'June 22, 2012'. All other doors in this center will be inspected and maintained by 'June 22, 2012'. All doors will be inspected and documented monthly during our routine Preventative Maintenance Room checks. Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for One year following the noted issue.	June 22, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Laticia Nicole Batty	ED	6·19·12

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.

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	345053	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 6/7/12 at approximately 9:00 AM onward the following was noted: 1) The storage room corridor door to the Laundry room did not close, latch and seal. 2) The storage room located on the short hall has holes in the wall that were not properly finished and sealed. 3) There are holes and or penetration in the ceiling that were not properly sealed. 42 CFR 483.70(a)	K 029	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K29 It is the practice of this center to assure that all hazardous locations are within compliance at all times to include: A. The storage room corridor Door to Laundry room was fix with rated unit by June 22, 2012. All doors will be inspected by June 22, 2012'. Any other doors found will be replaced by June 22, 2012. All doors will be checked for proper closing and latching by June 22, 2012'. All doors will be inspected monthly during routine Preventive Maintenance Room checks. These room checks will be documented in the centers Preventive Maintenance Log. B. The storage room located on Short hall hole in the wall has been repaired will be repaired using materials specifically designed for this task by June 22, 2012' C. Walls will be repaired using materials specifically designed for this task by June	June 22, 2012
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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K 067	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Friday 6/7/12 at approximately 9:00 AM onward the following was noted: 1) At the time of survey, the facility was using the corridor as a return air plenum. Note: If a waiver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm system must shut down all air handling units when activated.	K 067	22, 2012'. All hazardous location barrier walls will be inspected/sealed By June 22,2012 to ensure compliance throughout center. All smoke/fire barrier walls will be inspected Quarterly for one year and annually thereafter. These inspections will be documented in the center Preventive Maintenance Log Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year following the noted issue. K067 Waiver Request 1. All air- handling units are equipped with smoke detectors 2. All corridors are equipped with smoke detectors. 3. All smoke detectors are wired into the fire alarm system. 4. Fire alarm system shuts down all air handling units when activated.	June 22, 2012
K 072 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Friday 6/7/12 at approximately 9:00 AM onward the following was noted:	K 072		

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PRINTED: 06/19/2012
FORM APPROVED
OMB NO. 0938-0391

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K 072	Continued From page 3 1) The corridor or door to the Station #2 Bio Hazard room opens into the corridor less than 180 degrees as there were handrails installed. With this condition the doors must have a device installed to bring the door back to the closed and latched position after being opened. CFR#: 42 CFR 483.70 (a)	K 072	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K072 It is the practice of this center to assure that all miscellaneous life safety issues are within compliance at all times to include: A. The Corridor to Station #2 Bio Hazard room opens into the corridor less than 180 degrees as there were handrails installed. A latch and door closer will be installed by June 22, 2012 Preventive Maintenance Logs will be reviewed by the PI committee quarterly to ensure continued compliance for one year following the noted issue.	June 22, 2012