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 _____	C 08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET 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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, family interviews, staff interviews and record review, the facility failed to assist and provide community placement transfer information for 2 of 2 sampled residents with discharge plans (Resident #18 and #108). The findings included: Resident #18 was admitted to the facility on 9/9/14, The cumulative diagnoses included schizoaffective disorder, and dementia. The Minimum Data Set (MDS) dated 5/10/15 indicated Resident #18 was cognitively impaired and required total assistance with all activities of daily living. During an interview on 8/13/15 at 12:25PM, the family member stated she voiced not being happy with her mother ' s care at this facility and had verbalized her request to the social worker (SW) for assistance with transfer to an identified facility. She further stated that nothing had been done to assist her and her family as requested. The family further stated that she and the responsible person	F 242	Pettigrew Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Pettigrew Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pettigrew Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.	9/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/31/2015

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F 242	Continued From page 1 discuss and work together in the planning of Resident #18 care and decisions. She indicated that the responsible person had also made a request for transfer to another facility to the SW and no further information had been provided regarding the identified facility or any other facility in the county. During a telephone interview on 08/13/2015 1:55PM, the responsible person indicated she made a request at the care plan meeting dated 7/2/15, for a referral to be made by the social worker to the identified facility. She indicated that she personally went over to the facility to get further information because she had not heard anything from the social worker. She further stated that the facility indicated that they did not have a bed available at the time of her visit. In addition, she was not offered any other potential facilities in the county that she could visit. She indicated she felt the social worker had not done anything to assist the family in seeking alternate places. She further stated she was unaware of all the facility in the county that could have a bed available and she did not get any feedback from the social worker. During an interview with the social worker (SW) on 08/13/2015 at 2:55PM, she stated that the request was faxed to the identified facility on 7/29/15. She acknowledged that she had not documented any follow-up to the information that was faxed to the referred facility, nor had she discussed or offered the family any information regarding other facilities in the county. She further stated she did have a listing available of all the nursing homes in several counties, but only pursued the one identified facility on behalf of the family. In addition, she confirmed that it was	F 242	F242 Social Worker immediately contacted resident #18's POA to notify that the facility sent resident's information to six other SNF's in the surrounding area. Administrator made contact the Regional Ombudsman to assist resident, resident's family, and facility with transfer to another facility. Also, Social Worker was in-serviced on ensuring the facility provides residents with choices and documentation is in place. The Administrator in-serviced Social Worker on ensuring we are offering residents with choices and ensuring documentation is in place after notification has been given to the resident/resident's family member. The Administrator and/or Director of Nursing will monitor through direct observation, ensuring discharge choices are offered and documentation is in place once a week for 12 weeks using a QI audit tool. The Administrator and/or Director of Nursing will review the QI audit tool weekly for 12 weeks to assure the system is working and the facility is in compliance. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	

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F 242	Continued From page 2	F 242		

expected to offer the family other options of placement when discharge plans were discussed

During an interview on 8/13/15 at 3:25PM, the administrator indicated that if alternative or community placement request had been made the expectations were to investigate the reason for the resident ' s /family desire to leave and strive to resolve any issues if possible, the SW should initiate the referral process to the facility of choice and follow-up with referring facility, offer resident/family other options in the community and assist them in making contact with referring facility. The social worker should follow-up with resident/family and maintain communication of the status on the referral and document all efforts in resident ' s chart.

Review of the social work notes dated 12/2014 through 8/6/15, there was no documentation of discharge plan or options for alternative placement.

Resident #108 was admitted to the facility on 3/27/15. Her diagnoses included atrial fibrillation, hypertension, lupus and dementia. The Minimum Data Set (MDS) dated 4/3/15, indicated Resident #108 had sever cognition impairment. She required total care and assistance with activities of daily living. The care plan dated 3/20/15 did not include discharge planning and it was not coded on section Q of the MDS.

The responsible person was contacted on 8/10/15 at 12:18PM, and she indicated that her mother was in another facility and felt like the

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facility took too long to get her mother transferred even when they were told on admission that the family wanted the resident to be closer to home.

During an interview on 8/11/15 at 3:43PM, the SW indicated that when the resident was initially admitted to the facility the resident was a Medicare resident and Medicaid was applied and pending at the time the resident's family requested a transferred to another facility to be closer to the family. She indicated that SW and administrator had been explaining to the family the process for referrals and paperwork required for transfers but family consistently became upset about the length of time it took to get information sent over to other preferred facilities. SW further stated that she had sent over several referral to locations at family request but the facility denied admission because the resident was Medicaid pending. SW indicated that she was informed by the administrator that an unfamiliar person was in the resident's room packing up personal belongings. She indicated the administrator spoke with the gentleman directly and informed him of the process for discharge. She further stated that administrator had attempted to get the gentlemen to completed the required paperwork including AMA (against medical advice) paperwork once it was discovered the gentlemen was not returning with Resident #108. The APS and police department were contacted and that time.

During an interview on 8/11/15 at 4:00PM, the administrator indicated that on 5/15/15 of the resident's departure staff reported to him there was an unknown gentleman in the resident's room packing up her personal belongs. He

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indicated that when he spoke with the gentleman about taking the resident out of the facility. The gentlemen indicated that he was the family #1 and taking his mother out for a visit. Once the resident got closer to the car, the gentleman indicated that the resident was not returning and he refused to complete the required paperwork for proper discharge/AMA. The contact person was called to inform her of the status of Resident #108 and there was no answer. The APS and the local police department were contacted and informed of the situation. Administrator indicated that the police were able to reach the responsible person and the police reported to the administrator that the family #2.indicated that it was her brother taking her mother from the facility and she was aware of where she was being taken. Administrator indicated that he later found out the resident was sent to another facility. He further stated after contact with the police no formal report was completed since the police department had contacted the family. The information was faxed to the facility by the SW.

Review of the SW note dated 5/15/15 4:00PM: SW was notified that resident and someone named (person named) took the resident from the facility and we do not think they are returning the resident. The Social Worker then called the APS (adult protective service) and spoke with APS worker to report this APS referral also SW and director/administrator reported this to the local police departments, Social worker also reached out to resident's emergency contact who hung up on SW. The SW called back and left a message for responsible person.

During a follow-up interview on 8/12/15 at

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10:40AM, the SW indicated that she did not document the initial conversation regarding the family discharge plans, but was aware the family wanted the resident to be transferred closer to home. There was no discharge plan located in the chart and SW confirmed she did not document her attempts to locate alternative placement. SW worker stated she had sent referrals to other facilities and the resident had been declined due to Medicaid status but she did not have any documentation of what facilities she sent to the referrals to or the responses. SW indicated that she did not offer the resident or family any other options for referrals of facilities in the area of interest to the family.

During an interview on 8/13/15 at 9:13AM, the administrator indicated that the expectation would have been for the SW to document the efforts and actions taken to assist the family in appropriate transfer process to another facility of their choice. He indicated that on admission the team was aware the family ' s desire for the resident to be discharged to another facility. The intent was Resident #108 would complete the therapy services and then plans would be made for the discharge to another facility. He stated there was no set specific date for the discharge at the time of admission, but he was aware the resident wanted to be transferred to a facility near the family in the identified area. He further stated that conversations were held between he, social worker and the family about the discharge process and the family did not seem to understand the process and wanted the resident to be discharge sooner after the completion of the therapy services. The family was informed of the paperwork process and the determination process of the receiving facility to accept or reject

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the resident. He indicated that the information was faxed over to the identified facility on 5/13/15. The decision from the receiving facility to decline admission was based on the pending Medicaid. He added that when the family decided to come into the facility and take the resident out, there was no decision made from the facility receiving facility it was later that he was informed the decline was based on Medicaid status.

Review of the chart revealed there was no documentation of the discussion or care plan for discharge planning held by the social worker or the administrator.

Reviewed the MDS dated 4/3/15 did not indicated or code discharge plans. The administrator confirmed the SW should have documented the effort done to facilitate discharge plans with family and discussed in the care plan meeting (held 3/30/15). In addition, the family should have been offered information of other potential facilities in the identified area of choice.

During an interview on 8/13/15 at 9:59AM, the current Minimum Data Set Coordinator (MDS) indicated that she was not present during the time of the resident admission. Reviewed the MDS dated 4/3/15 section Q resident desire to return to the community. There was no CP that addressed discharge planning. She indicated that typically if the resident or family interest in discharge plans to another facility or return home the information would be documented in the chart and the social worker would assist the family in the preparation process.

During an interview on 8/13/15 at 12:05PM, the

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F 242	Continued From page 7 admission coordinator at the identified facility indicated t Resident#108 was not residing in there facility at this time. She indicated that she had spoken with the administrator at the referring facility and indicated that the resident was denied admission. She further stated she had also spoke with a relative of the resident and also informed them of the denial for admission and thought the resident had been transferred to another facility in the local area. The family did inform them that they wanted the resident closer to the facility. She indicated the resident was not accepted to the facility due to pending Medicaid status and behaviors. During an interview on 8/13/15 at 3:21PM, the director of nursing (DON) indicated that the expectation was that discharge planning should be taken place on admission and the SW was responsible for initiating and completing the discharge process with the family/ resident choice and if the resident could not be accepted in the facility of choice the SW should look in other areas in the preferred location During an interview on 8/13/15 at 3:24PM, the administrator indicated that it was the SW responsibility to assist the family in making referrals to facility of choice and provide options to other areas in the area of choice, the SW should follow- up with the resident/family if the facility of choice is denied other facilities should be contacted. SW should document the referrals and contacts made with other facilities.	F 242		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		9/10/15

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F 334	Continued From page 8 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F 334		

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F 334	Continued From page 9 (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, facility failed to offer pneumococcal vaccine to 2 of 5 sampled residents (Residents #11 and 20). Findings included: Resident #11 was admitted on 4/22/15 (discharged on 5/11/15) with diagnoses including heart failure and diabetes mellitus. Review of the recent minimum data set (MDS), dated 5/11/15, revealed that the resident was cognitively intact with long and short term memory. The MDS also	F 334	F334 Director of Nursing immediately corrected the documentation for residents 11 and 20 and offered the vaccine when applicable. Director of Nursing, Staff Development Coordinator, and Resident Care Specialist completed a 100% audit of MDS and MARs to ensure compliance in this area. All nursing staff were in-serviced on ensuring pneumococcal vaccination	

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F 334	Continued From page 10 indicated that the resident ' s pneumococcal vaccination was up to date. Record review of resident 11 ' s medication administration record (MAR) for April and May of 2015 revealed that pneumococcal vaccination was not given or scheduled for administration. Review of resident 11 ' s chart revealed that the resident ' s pneumococcal vaccination was marked as " not in last 5 years " . During an interview on 8/12/15 at 10:00 AM, nurse #1, who completed the immunization record for the resident #11, clarified that " not in last 5 years " meant that the resident did not receive a pneumococcal vaccination within the last 5 years. He added that according to policy, if the resident did not receive pneumococcal vaccination within the last 5 years, it should be offered during the first month from the day of admission. During an interview on 8/12/15 at 10:05 AM, the infection control nurse stated that she could not provide the documentation of the pneumococcal vaccination for resident #11. Resident #20 was admitted on 6/9/15 with diagnoses, including schizophrenia and dementia. Review of the MDS, dated 6/23/15, revealed that the resident was moderately cognitively impaired. The MDS also revealed that resident 20 ' s pneumococcal vaccination was documented as not up to date and not offered. Review of the resident 20 ' s chart revealed in the immunization record section that pneumococcal vaccination was " current " . Record review of the resident 20 ' s MAR for June and July of 2015 revealed that pneumococcal vaccination was not given or scheduled for	F 334	documentation is consistent between MDS sheets and MARs. Director of Nursing, Staff Development Coordinator, and Resident Care Specialist will audit 24 residents charts a week for twelve weeks. The Administrator and/or Director of Nursing will review the QI audit tool weekly for 12 weeks to assure the system is working and the facility is in compliance. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	

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F 334	Continued From page 11 administration. On 8/12/15 at 10:25 AM, during an interview, the infection control nurse stated that she had no documentation for resident #20 ' s pneumococcal vaccination. During an interview on 8/12/15 at 10:15 AM, the director of nursing (DON) stated that her expectation of the staff was to offer pneumococcal vaccination according to immunization policy for all of the new admitted residents.	F 334		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain sanitary conditions in the kitchen by not, (1) ensuring that foods were properly sealed and dated in 1 of 1 walk in dry food storage, (2) Clean and remove dried residue from top of the lid covering the thickened liquids and (3) 2 of 2 dessert trays containing lemon cake were left uncovered on the rack. The findings included	F 371	F371 Dietary Manager immediately did a 100% audit of kitchen ensuring the items cited in the 2567 are in compliance. Dietary Manager in-serviced all dietary staff to ensure 100% compliance in the items cited in the 2567. Dietary Manager will complete a 100%	9/10/15

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F 371	Continued From page 12 During observation of the kitchen ' s dry food storage area on 8/10/15 at 10:30 am, two packs of dry breakfast cereal and one pack of dry cocoa mix were opened and not resealed correctly; the package tops were rolled over and the packages were not dated. Further observation on 8/10/15 at 10:35 am, revealed the lid covering the thickened liquid container had moderate amount of dried residue on top of it. Also 2 of 2 trays containing lemon cake were left uncovered while three dietary aides (DA) continued with their various tasks. During an interview on 8/10/15 at 11:00 am with the DA #2, the surveyor inquired why the dessert was left uncovered. She confirmed that the cakes should have been covered. During observation of the kitchen on 8/12/15 at 7:50 am, during breakfast preparation, the same 1 pack of dry cocoa mix remained on the shelf in the dry food storage area, opened and not resealed correctly; the package top was rolled over and was not dated. Both dry cereal packages were opened on the serving counter for use. An interview with the Dietary Manager (DM) on 8/12/15 at 7:55 am, she stated new staff were working in the kitchen and she acknowledged that any dietary staff that opened a product should properly seal and date the item before it was returned to the storage area. She also mentioned that at the end of the shift the DA ' s were responsible for cleaning down all surfaces ensuring that the kitchen remained sanitary.	F 371	audit of the kitchen/dry storage area weekly for 12 weeks to ensure compliance. The Administrator and/or Director of Nursing will review the QI audit tool weekly for 12 weeks to assure the system is working and the facility is in compliance. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	

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 _____	C 08/13/2015

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F 441	Continued From page 13	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		9/10/15

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F 441	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews, the facility staff failed to follow infection control policy by not wearing a gown before entering a room of 1 of 1 resident on contact precaution for Clostridium difficile (C. diff.) infection (Resident # 102). Findings included: Review of Medical Waste Handling Policy/housekeeping in-service, revised in 2012, revealed a section on cleaning contaminated isolation room with C. Diff. spores. The policy revealed that before entering the room, employees had to scrub hands and arms for three minutes with disinfectant soap, put on personal protective equipment (PPE), including mask, gown and gloves. On 8/11/15 at 3:37 PM, during an interview, the infection control nurse stated that all of the employees, including housekeepers, had to follow the infection control policy. Resident # 102 was admitted on 7/7/15 with a diagnosis of Clostridium difficile (C. diff.), a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon. C. diff. can spread by person to person contact. Review of the physician order dated 8/6/15 revealed an order to put the resident on contact precaution for C. diff. infection. Contact precaution required the use of gloves and gown before entering the resident ' s room. On 8/10/15 at 12:25 PM, during an observation of resident ' s # 102 room, there was " contact	F 441	F441 Housekeeper #1 was immediately re-educated on the infection control policy including the use of personal protective equipment (PPE). Housekeeping manager re-educated all housekeeping staff on infection control policy including the use of PPE. Housekeeping manager will monitor 4 housekeepers on PEE using an QI monitoring tool weekly for twelve weeks. The Administrator and/or DON will review the QI audit tool weekly for 12 weeks to assure the system is working and the facility is in compliance. The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area.	

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F 441	Continued From page 15	F 441		

precaution " sign mounted on the door and a plastic cart with personal protective equipment was located outside of the room. Contact precaution required the use of gloves and gown before entering the resident ' s room.
On 8/10/15 at 12:30 PM, during an observation, housekeeper #1 came into resident ' s # 102 room to clean. She was wearing housekeeping fabric uniform, shoes and gloves. She had not put on any personal protective equipment (PPE), other than gloves. The housekeeper #1 entered the room, removed the plastic bag from the trash can near the resident ' s bed and took it out of the resident ' s room.
On 8/10/15 at 12:32 PM, during an interview, resident # 102, indicated that she was moved to this room specifically to maintain contact precaution, related to some type of infection " in her stool " . She added that the nurses used PPE often, but housekeepers and aides had not. She stated that she reminded the staff to use PPE many times.
On 8/10/15 at 12:40 PM, during an interview, housekeeper #1 stated that she was aware that contact precaution was implemented in resident ' s # 102 room. She was wearing gloves when she entered the room to quickly empty the trash can and failed to put on the gown.
On 8/11/15 at 6:00 AM, during an interview, the housekeeper supervisor indicated that according to policy, housekeepers should use PPE all the time when entering rooms with contact precaution.