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 10/28/2021

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
E 000	Initial Comments An unannounced recertification and compliant investigation survey was conducted on 10/25/21 through 10/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # CXNG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/25/21 through 10/28/21. Event ID# CXNG11 5 of the 5 complaint allegations were unsubstantiated	F 000		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observations, resident interview, staff	F 688	This plan of Correction constitutes the	11/25/21

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

Electronically Signed | 11/19/2021

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 10/28/2021

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 688	Continued From page 1 interviews and record review, the facility failed to apply splints for 1 of 2 residents (Resident #13) reviewed for contractures. The findings included: Resident #13 admitted to the facility on 8/5/21. The diagnoses included spinal cord, hypertension, hyperlipidemia, contracture, and muscle weakness. The Minimum Data Set (MDS) dated 8/11/2021, indicated Resident #13 cognition was intact and he required total assistance from staff for activities of daily living. The MDS coded Resident #13 with contracture of right hand and spinal cord injury(neck). Physician orders dated 8/30/21, documented Resident #13 would wear right resting hand splint at all time except bathing and exercise. Staff to monitor pressure areas for redness and/or skin breakdown. Resident #13 would wear the neck collar when out of bed. Review of care plan dated 10/25/21, identified the problem as Resident #13 was at risk for skin impairment/pressure wound development related to mobility impairments and incontinence. Resident #13 admitted posterior neck surgical wound. The goal included Resident #13 would show signs of healing and remain free from complications. The interventions included assist Resident #13 with turning and repositioning as needed. Put on neck collar before attempting to get OOB. Resident #13 would wear right resting hand splint at all time except bathing and exercise. Staff to monitor pressure areas for redness and/or skin breakdown. An observation and interview on 10/25/21 02:49	F 688	facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. An acceptable plan of correction must: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 11/1/2021, order for resident # 13 was updated. There was no negative outcome. On 10/29/2021, reeducation was provided to Rehabilitation Manager and OT by the DON regarding treatment orders populating in the ETAR in PCC. On 10/29/2021, therapy staff was reeducated by Rehabilitation Manager regarding writing treatment orders and training nursing staff on assistive devices, this was completed by 11/3/2021. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 10/28/2021, Therapy Manager and DON completed an audit of residents requiring splints to ensure accuracy of the care plan, the ETAR, and training documentation in place. Care plans and orders of residents noted to be affected were updated as deemed necessary by the audit results. Therapy Manager reeducated therapy staff on 10/29/2021 regarding the treatment order process and the process of training nursing staff on assistive devices, this was completed by	

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 10/28/2021

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 688	Continued From page 2 PM, revealed Resident #13 was lying in bed without hand splint. The blue splint and neck collar was located on the side table. Resident #13 stated he had been told he did not need to wear the splint while in bed. Observation on 10/25/21 at 3:30 PM, Resident #13 was in bed and the blue splint was located on the side table under a stack of clothing. Resident #13 stated he had no ability to put on or remove splint. Resident #13 stated he had limited mobility in left hand and dependent upon staff to apply splint. Observation on 10/26/21 at 9:20 AM, Resident #13 was in bed without right splint in place, the blue splint was located under batch of clothing and other supplies. Observation on 10/26/21 at 1:22PM, Resident #13 was in bed without the splint in place. The splint was located on the side table under clothing. NA #6 stated the splint would be placed on at night after the resident had taken his bath and removed in the morning. An interview on 10/28/21 at 9:13 AM, the Physical Therapy Director (PTD) confirmed the splint orders dated 8/30/21, revealed the right-hand resting splint should be worn daily. The PTD stated the staff had been provided with education and training on when to apply the hand splint. A follow-up interview on 10/28/21 at 9:27 PM, the NA #6 stated she was unaware the resident ' s right hand splint should have been applied daily. She stated she was informed by the resident and therapy assistant the splint was to be applied at night. NA #6 reviewed the orders for the	F 688	11/3/2021. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; Therapists will in-service nursing staff on residents that receive a new device. DON will review orders from therapy in daily clinical meeting. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Administrator or designee will audit the review of splint orders daily times 4 weeks, weekly times 1 month, and monthly times 1 month. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator/designee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance	

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 10/28/2021

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 688	Continued From page 3	F 688		

application of the splint and stated, "I have never seen the orders or was told any different than what the resident was told by therapy." She indicated she had not received any direct training regarding the application of the splint for the specific resident. She further stated she performed the resident's ADL care on the days she works and only applied the neck collar when the resident was out of bed, she had not been applying the splint during the day.
An interview on 10/28/21 at 9: 32 AM, Nurse #5 stated she was unaware of Resident #13 wore a right-hand splint or the frequency of the splint use. The Nurse stated she was only aware the resident wore the neck collar when he was out of bed.

An interview on 10/28/21 at 9: 38, AM, the Nurse #1 stated all splint orders should be on the medication administration record (MAR). She further stated she was unaware the resident should be wearing the right-hand splint daily. She was aware the neck collar should be worn when the resident was out of bed. The nurse confirmed there was no documentation of the right-hand splint application on the MAR.

An interview on 10/28/21 at 9:45 AM, the DON stated residents with orders for splints should be worn as order. Therapy was responsible for ensuring staff were trained and educated on the splint application and the frequency they should be worn.

An interview on 10/28/21 at 10:31 AM, the NA #4 stated she was unaware of when Resident #13 should wear the right-hand splint. She was only aware the resident should wear the neck collar when he was out of bed.

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 10/28/2021

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 688	Continued From page 4 An interview 10/28/21 at 10:33 AM, NA#8 stated she was unaware Resident #13 should be wearing a right-hand splint. A follow-up interview on 10/28/21 at 10:48 AM, the Physical Therapy Director stated he did not complete the requirements for training of staff or updated resident on the frequency of Resident #13 ' s splint application.	F 688		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews and review of resident council minutes, the facility failed to offer and deliver daily and	F 809	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However,	11/25/21

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 10/28/2021

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 809	Continued From page 5 bedtime snacks for 3 of 3 sampled residents (Resident #13, #30 and #42). The findings included: Observations on 10/25/21 at 10:00 AM and 2:00 PM, there were no snacks available on the cart or in the nourishment room to offer the residents. Observations on 10/26/21 at 10:00 AM and 2:00 PM, there were no snacks available on the cart or the nourishment room to offer the residents. Observation and interview on 10/26/21 at 10:15 AM, the nourishment refrigerator (station 1) only contained 2 pudding cups. NA#4 stated the dietary department usually provided snacks at 10 AM/2 PM and 8 PM, and the residents would have been offered snacks at this time. The dietary staff had not sent out snack for past few days at 10 AM and 2 PM. An interview on 10/26/21 at 3:05 PM, Nurse Aide #5 confirmed she did not offer snacks to residents at 10:00 AM and 2:00 PM because they were not available. NA#5 stated the dietary department did not send any snacks to be offered to the residents. Observations on 10/27/21 at 10:00 to 11:00 AM, 2:00 PM to 2:45 PM, there were 6 residents in the small dining room and the blue snack cart was located across the from the day room against the wall. There were no snacks on the cart. Several staff were observed entering and exiting the room and did not offer the residents snacks or fluids. An Interview on 10/27/21 at 11:05 AM, Resident #13 stated he was not offered snacks on a routine basis, he would have to ask for a snack.	F 809	submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. What residents were affected in/by the alleged deficient practice and how was the same corrected? Residents were offered snacks during the next available time on 10/28/2021. No negative outcome was noted. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? On 10/28/2021, an audit was conducted by the Administrator of snacks provided on each unit. No other residents were noted to be affected as snacks were in place as expected. What measures will be put into place or systematic changes will be made to ensure that the deficient practice will not reoccur? Education/In-service to nursing and dietary staff by Administrator and DON regarding providing and offering snacks, this will be complete by 11/3/2021. Dietary aides will obtain signature from floor nurse that snacks have been prepared and delivered to be available for the residents on each unit. How will the corrective action be monitored to assure that the deficient practice will not reoccur? DON/ Designee will monitor for compliance by verifying documentation. Administrator will randomly audit 4 days	

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 10/28/2021

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 809	Continued From page 6 An interview on 10/27/21 at 1:30 PM, Resident #30 stated he was not offered snacks on a routine basis. An interview on 10/27/21 at 2:00 PM, the Dietary Manager acknowledged that it was an error on his and the dietary staff that snacks were not sent out for past few days. An interview on 10/28/21 at 11:00 AM, the Director of Nursing (DON) indicated the restorative aides and nurse aides should contact the dietary department, if the snacks were not received on the unit. All residents should be offered snacks at 10 AM/ 2 PM and 8 PM. An interview with the on 10/28/21 at 11:17 AM, the Administrator indicated all residents should be receiving and offered snacks at 10 AM, 2 PM and 8 PM. The dietary department should be stocking the nourishment refrigerator (station 1) with snacks and juices, so that the nursing staff can offer residents snacks as needed. During an interview with Resident #42 on 10/25/21 at 2:55pm; Resident #42 stated she had not received snacks in about 2-weeks. Resident #42 further stated she would like snacks at bedtime and relied on a friend to provide snacks. During observations on 10/26/21 at 10:00am and 2:00pm revealed snacks not being offered to residents. During observations on 10/27/21 at 10:00am revealed staff providing water to residents, but snacks were not being offered to residents.	F 809	times 4 weeks, 10 days times 1 month, and once a month for 1 month. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator/designee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance	

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 10/28/2021

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 809	Continued From page 7 During an observation and interview on 10/26/21 at 10:15 AM, the nourishment refrigerator (station 1) was observed to be contain only 2 pudding cups. Nurse Aide (NA) #4 stated the dietary department usually provides snacks at 10 AM/2 PM and 8 PM and the residents were offered snacks at this time. The dietary staff had not send out snack for past few days at 10 AM and 2 PM. During an interview on 10/26/21 at 3:05 PM, NA#5 stated she did not offer snacks to the residents as the dietary department had not sent out any snacks that could be offered to the residents. She confirmed she did not offer residents snacks during her shift at 10 AM and 2 PM. During an interview on 10/27/21 at 2:00 PM, the Dietary Manager acknowledged that it was an error on his part and the dietary staff had not sent out snacks the past few days. During an interview with the Director of Nursing (DON) on 10/28/21 at 11:00 AM; the DON indicated the Restorative Aides and NAs should contact the dietary department if the snacks were not received. All residents should be offered snacks at 10 AM/ 2 PM and 8 PM. During an interview with the Administrator on 10/28/21 at 11:17 AM, he indicated all residents should be receiving/offered snacks at 10, 2 and 8 PM. The dietary department should be stocking the nourishment refrigerator (station 1) with snacks and juices, so that the nursing staff can offer residents snacks as needed.	F 809		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		11/25/21

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 10/28/2021

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 812	Continued From page 8 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to label leftovers and discard expired food from their walk- in refrigerator and failed to maintain the walk-in freezer in a safe operating condition. The kitchen's walk-in freezer had accumulated ice on the freezer floor. The facility failed to ensure the commercial dishwasher was maintaining wash and rinse temperatures according to the manufacturer's recommendations, failed to use clean lids to cover food on the steam table, failed to ensure the glasses and cups stacked on the drying rack were clean and failed to ensure the sanitization solution strength used on the kitchen counter tops was within manufacturer's recommendation. The facility failed to keep the nourishment refrigerators clean, failed to label	F 812	This plan of Correction constitutes the facilities written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that deficiencies exist or that one was cited correctly. This plan of correction is submitted to meet requirements established by federal and state law. What residents were affected in/by the alleged deficient practice and how was the same corrected? Dishwasher in Kitchen was repaired on 10/28/2021. Administrator ensured nourishment refrigerator was cleaned and printed correct temperature logs for refrigerator	

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 10/28/2021

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 812	Continued From page 9 and discard food from 2 of 2 nourishment refrigerator/freezers and failed to maintain one of two nourishment refrigerator/ freezer (Station # 2) in safe temperature zone. The nourishment refrigerator temperature was above 40 degrees and the freezer must keep frozen foods frozen solid reviewed for food storage. Finding included: 1. Observation of the walk-in refrigerator on 10/25/21 at 9:20 AM, revealed the floor of the refrigerator had a puddle of water under the food storage rack. A plastic bag containing 4 red bell peppers placed on the vegetable rack, had spots of white colored mold on them. The rack used for thawing meat contained a big square aluminum pan with an opened blue plastic bag dated 10/1/21. The blue plastic bag contained raw chicken in light pink colored fluids. The raw chicken had an odor. There was a one-gallon plastic jug half filled with orange colored liquid with no label on it. An opened 46 fluid ounce package containing thickened water with an opened date 10/19/21. During an interview on 10/25/21 at 9:23 AM, the dietary cook #1 indicated all foods placed in the walk-in refrigerator were to be labeled and to be used within 3 days. The dietary cook#1 stated the chicken should have been discarded. Someone had pushed it to the back of the rack and was not discarded. The dietary cook #1 indicated the orange-colored liquid in the jar was orange juice. She further indicated the jar should be labeled with a use by date. During an interview on 10/27/21 at 1:20 PM, the dietary manager stated all dietary staff should be	F 812	for Nursing Station 2 on 10/25/2021. Food that wasn□t labeled and expired was discarded 10/25/2021. Maintenance corrected the accumulated ice in freezer floor on 10/25/2021. Maintenance Director called plumber to investigate hot water issue and was resolved on 10/27/2021. Dietitian in-serviced 100% dietary staff including CDM on 10/25/2021 regarding labeling and discarding expired food, using clean dishes to serve food, ensuring glasses and cups stacked on the drying rack when cleaned, using sanitization solution strength according to manufacturer□s recommendation. Administrator reeducated dietary staff and nursing staff on 10/25/2021 and 11/15/2021 regarding the importance of ensuring the nourishment refrigerators are clean and labeling and/or discarding food when appropriate. Administrator updated the nourishment refrigerator (Station #2) temperature log on 10/25/2021 in order to allow the identification of when refrigerator temperatures are out of range and what to do when temperatures are out of range. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Maintenance Director conducted an audit on 11/1/2021 of dietary equipment to ensure proper function. As a result, equipment was working properly, but dishwasher and hot water heater needed additional service follow up that was corrected 11/12/2021.	

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 10/28/2021

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 812	Continued From page 10 labeling all foods when opened and left-over food should be used within 3 days or discarded after 3 days date. The dietary manager further stated it was an error that the chicken was not discarded. The pan had been moved to the back of the rack and must have been missed by the staff. 2. An observation of the walk-in freezer on 10/25/21 at 9:30 AM revealed a thin layer of ice on the freezer's floor and along the freezer door frame. The walk-in freezer strip door curtain had a layer of ice on it. There were blocks of ice approximately 3-4 inches under the freezer compressor. During an interview on 10/25/21 at 9:30 AM, Dietary Cook# 1 indicated she had noticed the freezer door was not closed well and ice was formed along the door frame and curtain when she came in the morning to work. She further stated ice on the floor and on the strip door curtain may be due to the freezer door frequently being opened by staff. Dietary Cook #1 stated she was unaware if the maintenance staff was notified, or work order was placed. Observation of the walk-in freezer on 10/27/21 at 11:50 AM, revealed ice on the curtain of the freezer. ice on the floor and walls of the freezer. No boxes placed in the freezer had ice on them. During an interview on 10/27/21 at 1:20 PM, the Dietary Manager stated the freezer was usually locked during the night and unsure why there was ice formation on the floor. The Dietary Manager indicated a work order for maintenance was placed earlier that day. During an interview on 10/26/21 at 10:40 AM, the	F 812	Administrator conducted an audit on 10/26/2021 of Nourishment Room refrigerators to ensure compliance with food labeling, cleaning, and temperature monitoring. As a result of the of the audit, the refrigerators were clean but the nourishment refrigerator on station 2 had the wrong temperature log, Administrator immediately corrected with correct temperature log. What measures will be put into place or systematic changes will be made to ensure that the deficient practice will not reoccur? On 11/2/2021, Dietary staff was educated by Administrator regarding the Maintenance log procedures and when to notify CDM. CDM will complete daily kitchen audits and report findings to the Administrator in stand down. Dietary staff and nursing staff will monitor for Nourishment refrigerators temperature daily. Housekeeping will deep clean nourishment refrigerators weekly. Maintenance Department will check equipment weekly to ensure proper function and repair as needed. How will the corrective action be monitored to assure that the deficient practice will not reoccur? Administrator/ Designee will monitor for compliance completing kitchen audit weekly times 1 month, bi-weekly times 1 month and monthly times one month. Administrator/Designee will randomly	

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 10/28/2021

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 812	Continued From page 11 Maintenance Director stated he was unaware that the freezer had ice accumulation on the floor, along the door and under the compressor. He stated he did not receive any work order from the dietary department. During an interview on 10/27/21 at 2:45 PM, the Administrator stated it was his expectation that the walk -in freezer was maintained in good working condition and food was stored at appropriate temperatures. The Administrator indicated that there was a work order folder in kitchen for any maintenance concerns in the kitchen. Dietary staff should be writing work order and notify the maintenance person if they had any issues. 3. The Installation and Operation Manual for the dishwasher was reviewed. It stated the water requirements (low temperature machine) were wash temperature 120 degrees Fahrenheit (F) and rinse temperature 120 degrees F with a note that temperatures listed were minimums. An observation on 10/27/21 at 1:54 PM was made of the dish machine in the kitchen. The wash and rinse cycle gauge read 100 degrees F during use with the Dietary Cook #1 present. During an interview on 10/27/21 at 1:54 PM, the Dietary Cook#1 stated the dishwasher temperature was usually between 100 - 120 degrees F for both wash and rinse cycle. The Dietary Cook #1 further stated the dietary staff had made the Dietary Manager aware of this issue. The Dietary Manager had informed the dietary staff that it was safe to run the dishwasher (both wash and rinse cycle) between 100-120 degrees F.	F 812	select two staff members a week to test knowledge on kitchen procedures and regulations until 4 weeks of 100% compliance. Administrator will randomly audit the dishwasher machine 4 days times 4 weeks, 10 days times 1 month, and once a month time 1 month. Data obtained during the audit process will be analyzed for patterns and trends and reported to QAPI by the Administrator/designee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance	

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 10/28/2021

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 812	Continued From page 12	F 812		

During an interview on 10/27/21 at 1:58 PM, the Dietary Manager stated he had informed the previous administrator about the dishwasher running between 100 -120 degrees F and was informed it was safe to do so. The Dietary Manager further stated the maintenance staff was not notified about the issue and no work order was placed.

During an interview on 10/27/21 at 2:45 PM, the Administrator stated he had recently joined the facility and was not aware that the dish-machine was not working at appropriate temperature. The Administrator acknowledged the dishwasher was not operating at the recommended temperature. The Administrator stated the Dietary Manager should notify the Maintenance staff if the temperature was not within manufacturing recommendations.

4. Observation of the steam table on 10/27/21 at 12:00 PM, revealed the hot food pans were covered with aluminum foil on the steam table. These food pans were covered with 5 steam table lids that were dirty and had dried foods on them. The Dietary Manager was observed placing clean scoops over them.

During an interview on 10/27/21 at 12:03 PM, the Dietary Manager stated he was in a hurry and did not bring clean steam lids from the clean rack, instead used the lids that were used during the earlier meal. He stated clean lids should be used to cover foods placed on the steam table.

5. Observation of the drying rack on 10/27/21 at 12:05 PM revealed one tray containing 15, eight-ounce glasses with dried foods and stains

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 10/28/2021

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 812	Continued From page 13	F 812		

on them. Another tray containing 12 soup cups with dried foods in them.

During an interview on 10/27/21 at 12:07 PM, the Dietary Manager indicated the two trays containing glasses and cups should be rewashed. The staff should check the glasses and cups after running through the dishwasher and before placing them on the drying rack.

6. On 10/27/21 at 12:10 PM, two red colored buckets containing sanitization solution used to sanitize the kitchen countertops were tested using test strips. The test strips did not change color as indicated on the box of the test strips.

During an interview on 10/27/21 at 12:10 PM, the dietary cook #2 stated the red bucket contained sanitization solution. The cook indicated that the sanitizer solution in the bucket needed to be changed at least twice between meal preparation. He confirmed the sanitization bucket was not changed since morning and was using the same one.

During an interview on 10/27/21 at 12:12 PM, dietary aide stated the solution in the bucket was not changed or refilled after the breakfast meal. The sanitization solution in the bucket needed to be changed after each meal and should test 200 parts per million (ppm) when tested with the testing strip.

During an interview on 10/27/21 at 1:15 PM, the dietary manager stated the "146 Multi Quat" sanitizer solution in the red buckets should test 200 ppm or greater per manufacturer's recommendations. The solution should be discarded as needed or at least once or twice

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 10/28/2021

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 812	Continued From page 14	F 812		

between meal. The dietary manager indicated the test strip used by staff have expired and may not be showing correct reading.

7a. Review of the "Food from outside sources use and storage policy" read in part: "Resident's personal food items that are brought in should be consumed immediately or labeled and stored according to Food Storage Principle. Perishable foods are discarded after 72 hours of the date placed in the refrigerator. The facility will designate who will be responsible to clean the refrigerator and who will discard outdated or uneaten foods."

Observation of the nourishment refrigerator #1 (station 1) on 10/26/21 at 10:15 AM revealed 2 plastic containers of home cooked food that was not labeled, one 12-ounce disposable cup with no lid, half-filled with brown colored fluids, five 8.45 fluid ounce of nutrition supplement with use by date 8/31/21. There was no label indicating whom the supplements belonged to. An opened 15 fluid ounce salad dressing bottle with no label.

During an interview on 10/26/21 at 10:18 AM, the Nurse Aide (NA) #4 indicated the nutritional supplement brand was not distributed by the facility but was brought in by a family member for one of their residents. NA# 4 stated the nourishment refrigerator was usually cleaned by the dietary department. The staff accepting the food should label all food brought in by resident's family members with resident's name and date before placing them in the nourishment refrigerator.

7b. Observation of the nourishment refrigerator #2 (station 2) on 10/26/21 at 10:21 AM revealed 4

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 10/28/2021

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 812	Continued From page 15	F 812		

plastic containers of homemade food with no label or date. An empty plastic cup lying in the back. A Styrofoam cup labeled "fruit cup - 10/5/21", a plastic bag containing a 5.3 ounce of yogurt that was not labeled. The floor of the refrigerator had brownish/yellowish liquid. The refrigerator had condiments packets all over the shelves. The shelves were stained and dirty. The temperature of the refrigerator was 43 degrees Fahrenheit (F). Observation of the freezer revealed a 16-ounce soda bottle and a pan sized pizza that was not labeled. The pizza was store-brought and had no label or expiration date. Both products were not frozen, and the temperature of the freezer was 10 degrees F.

Review of the temperature record log placed on the outside of the nourishment refrigerator revealed the temperature was check marked as 44 degrees from 10/16/21 through 10/28/21. The log also indicated the temperature was marked 39 to 40 degrees from 10/16/21 through 10/26/21. The record log did not differentiate between freezer and refrigerator temperature.

During an interview on 10/26/21 at 10:25 AM, NA#4 stated the refrigerator should be cleaned by the dietary department. The nurses or staff accepting food from family members should label and date the foods. NA#4 indicated all foods were stored for 72 hours and should be discarded after that. Nurse Aide # 4 further indicated the nursing staff check the refrigerator temperature daily. Any issue with the refrigerator should be reported to the maintenance department. Nurse Aide#4 stated the work order could be written in the book over the refrigerator or the maintenance staff could be notified any time.

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 10/28/2021

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 812	Continued From page 16	F 812		

During an interview on 10/26/21 at 10:40 AM, The Maintenance Director indicated he did not receive any work order that indicated the refrigerator was not maintaining safe temperatures. The Maintenance Director stated he occasionally checks the nourishment refrigerator. He added he does not check the thermometer reading on the thermometer placed in the refrigerator and freezer but would touch the food in the refrigerator to see if the food was cold. He indicated he does not check the temperature record log on the refrigerator

During an interview on 10/28/21 11:01 AM, the Director of Nursing (DON) stated the dietary staff were responsible for cleaning and checking the nourishment refrigerators daily prior to placing snacks in the refrigerator. DON further stated the nurses were responsible to label all foods brought in by resident's family. All perishable foods should be discarded within 72 hours. The Director of Nursing stated the third shift nurses were responsible to check the temperature of the nourishment refrigerators. Any issue with the nourishment refrigerators, should be reported to both the maintenance staff and dietary department and a maintenance work order should be written by staff.

During an interview on 10/28/21 at 11:20 AM, the dietary manager indicated he was unsure who was responsible for cleaning the nourishment refrigerator. The dietary manager further indicated it was only recently when he was made aware that the dietary department was responsible for cleaning them.

During an interview on 10/28/21 at 12:05 PM, the Administrator stated food brought in by the

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 10/28/2021

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 812	Continued From page 17 residents' families should be labeled and discarded within 3 days. The dietary department was responsible for cleaning the nourishment refrigerators. the Administrator stated the third shift nurses were responsible to record the temperatures and put in a work order if the nourishment refrigerator temperature was not within range. He was unsure why the temperature log was marked with different temperatures and completed till 10/28/21. The Administrator indicated the staff were using the incorrect temperature log to record the nourishment refrigerator and freezer temperatures.	F 812		