	-	D HUMAN SERVICES			FC	RM APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) D/	NO. 0938-0391 ATE SURVEY DMPLETED
		345053	B. WING			04/08/2020
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD		
PETTIGRE	W REHABILITATION CE	NTER		1515 W PETTIGREW STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Survey was conducte Medicare & Medicaid 7-8, 2020. The facility compliance with 42 C	Services (CMS) on April was found to be in FR §483.73 related to rt-B-Requirements for Long The census was 69.	F 00	00		
	was conducted by the Medicaid Services (C facility was not in sub CFR §483.80 (Infection Subpart-B-Requirement Facilities. The facility control safety practice recommended by CM Disease Control and COVID-19 pandemic. COVID-19 is a Coron disease caused by a been determined by t through contact with a they cough, sneeze, t that the viruses may be their eyes, nose and the	ents for Long Term Care was not following infection es and guidance S and the Centers for Prevention (CDC), during a The census was 69. avirus disease, an infectious new virus. This disease has he CDC to spread primarily an infected person, when ouch a surface or object be present on, then touch mouth, etc.				
	with one or more requ	provider's non-compliance lirements of participation kely to cause, serious injury,				
LABORATORY	L DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E	TITLE		(X6) DATE

Electronically Signed

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.

04/27/2020

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	(X3) DAT	O. 0938-03
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CON	IPLETED
		345053	B. WING		04	4/08/2020
NAME OF PI	ROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP COD	E	
PETTIGRE	EW REHABILITATION C	ENTER		515 W PETTIGREW STREET URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DN SHOULD BE COMPLET IE APPROPRIATE DATE	
F 000	Continued From pag	e 1	F 000			
	-	death to residents. The				
		was related to 480.80				
		ne facility failed to ensure 1) performed hand hygiene prior				
		'1's room, who was on				
	droplet precautions,	and before proceeding to				
		rooms, 2) Nursing care staff				
		/es and perform hand ming incontinence care for				
F f		ursing care staff proceeded				
	from Resident #1's re	oom with the same gloves				
	-	re to Resident #6, who was,				
		allway, and 3) failed to stancing was maintained for				
		s 2, 3, 4, and 6), and 4)				
		onal protective equipment				
		and accessible (masks), for				
	staff to use for Resid occurred during a CO	lent #1. These failures OVID-19 pandemic.				
	The Administrator, D	irector of Nursing, Staff				
		nator, Regional Clinical				
		ility's Vice President, were				
	April 7, 2020 at 5:52	nediate Jeopardy existed on p.m.				
		was removed on April 8,				
		fter an acceptable removal				
	action plan was rece observations, staff in	iterviews, policy review and				
		o verify the immediate				
		en. The facility remained out				
	of compliance at a lo "E" at F880.	ower scope and severity of				
F 557		ht to have Prsnl Property	F 557			4/30/20
SS=D	CFR(s): 483.10(e)(2					
						1

If continuation sheet Page 2 of 19

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		ATE SURVEY OMPLETED
		345053	B. WING			04/08/2020	
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
PETTIGRE	W REHABILITATION CE	INTER	1515 W PETTIGREW STREET				
				D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 557	Continued From page	e 2	E 4	557			
		ght to be treated with respect					
	possessions, includir as space permits, un upon the rights or hea- residents. This REQUIREMENT by: Based on medical re- and facility policy, en Personal Privacy," th resident was not expo- provision of care for of (Resident #1). This was six (6) residents. The findings include: On 04/07/2020 at 2:5 Assistant (CNA) #1 was to Resident #6. From was observed positio back to feet able to b	 the retain and use personal ag furnishings, and clothing, less to do so would infringe alth and safety of other T is not met as evidenced cord review, staff interviews, titled, "Resident Dignity & e facility failed to ensure, a cosed to public view, during one (1) of one (1) resident was from a total sample of 3 p.m., Certified Nursing vas observed providing care in the hallway, the resident ned on the left side, with the e seen. The CNA checked mence depends or brief, and 			This Plan of Correction is the center' credible allegation of compliance. Preparation and/or execution of this p of correction does not constitute admission or agreement by provider of the truth of the forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely beca it is required by the provisions of state and federal law. On 4/7/20 a certified nursing assistant was observed providing ADL to Resid #6. From the hallway, Resident #6 w	lan r the ause d t ent as	
	accompanied by the should have maintain	-			observed positioned on the left side, we the back of feet able to be seen. At the time the certified nursing assistant checked the resident's incontinence be and reposition the resident, then pulled the sheet/linens back up on the resident	nat orief od	
	expected the curtain door closed.	to have been pulled or the ssessment details provided			Criteria 1 Resident #6 was not noted to be affect by the deficient practices of the Certif Nursing Assistant (C.N.A.) The certified nursing assistant (C.N.A	ied	

Facility ID: 923266

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STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
		345053	B. WING		04/08/2020		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PETTIGRI	EW REHABILITATION CE	INTER		1515 W PETTIGREW STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE		
F 557	residents appropriate exposure and embar resident privacy durir other activities of per		F 55	 re-educated and disciplined 4.7.20 a which time he resigned. Criteria 2 All residents who were cared for by C.N.A would be at risk for the same deficient practices. Criteria 3 The DON and or the SDC provided education regarding providing privad during Activities of Daily Living (ADL or by 4.25.20 and will be included as of the certified nursing assistant orientation. Criteria #4 Random daily audits will be conduct the Administrator, Director of Nursin (DON), Staff Development Coordina (SDC), and other clinical team mem to ensure compliance with the center dignity and hand hygiene protocols. Criteria #5 This information will be tracked and trended by the DON and or designed presented to the QAPI committee at time will determine the need for continentation. 	this 2y .) on s part ed by g tor bers r's e and which		
F 880 SS=K	Infection Prevention CFR(s): 483.80(a)(1)		F 88		4/30/20		
	§483.80 Infection Co The facility must esta infection prevention a designed to provide a	ıblish and maintain an and control program					

Facility ID: 923266

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/14/2020 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMPI	SURVEY
		345053	B. WING			04/	08/2020
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
PETTIGRE	EW REHABILITATION CE	NTER		515 W PETTIGREW STRE URHAM, NC 27705	ET		
0(0)15		ATEMENT OF DEFICIENCIES	I	,	S PLAN OF CORRECTION		(//5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	e 4	F 880				
		nent and to help prevent the nsmission of communicable ns.					
	program. The facility must estat	prevention and control blish an infection prevention (IPCP) that must include, at ving elements:					
	reporting, investigating and communicable dis staff, volunteers, visito providing services und arrangement based u	ipon the facility assessment to §483.70(e) and following					
	procedures for the pro- but are not limited to: (i) A system of surveil possible communicab infections before they persons in the facility; (ii) When and to whom communicable diseas reported; (iii) Standard and tran to be followed to prev- (iv)When and how iso resident; including but (A) The type and dura depending upon the ir involved, and (B) A requirement that	Ilance designed to identify ole diseases or can spread to other ; m possible incidents of se or infections should be nsmission-based precautions vent spread of infections; olation should be used for a it not limited to:					

Facility ID: 923266

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		D HUMAN SERVICES				FORM	M APPROVED
STATEMENT O	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	D. 0938-0391 SURVEY PLETED
			A. BUILDI	NG _			
		345053	B. WING			04/	/08/2020
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
DETTIODE		NTED		1	1515 W PETTIGREW STREET		
PETTIGRE	EW REHABILITATION CE	NIER		1	DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 880	must prohibit employed disease or infected sk contact with residents contact will transmit th (vi)The hand hygiene by staff involved in dir §483.80(a)(4) A syster identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update thei This REQUIREMENT by: Based on medical re- and review of the "Ou Diseases," "Suspecte Precautions Guideline failed to ensure 1) Ho performed hand hygie #1's room, who was co before proceeding to rooms, 2) Certified Nu failed to remove glove hygiene, after perform Resident #1. CNA #1 #1's room with the sa care to Resident #6, v	s under which the facility ees with a communicable in lesions from direct a or their food, if direct he disease; and procedures to be followed rect resident contact. Immodeling incidents heatility's IPCP and the en by the facility. Ite, store, process, and to prevent the spread of view. Ite an annual review of its r program, as necessary. T is not met as evidenced cord review, staff interviews, tbreak of Communicable d COVID-19 Isolation es," policies, the facility busekeeping staff (HKS) #1 ene prior to exiting Resident on droplet precautions, and enter other residents' ursing Assistant (CNA) #1 es and perform hand hing incontinence care for proceeded from Resident me gloves on, and provided who was, located across the	F	880		he	
	care to Resident #6, when the second se				Criteria #1 No residents were noted to be affected	by	

Facility ID: 923266

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/14/202 FORM APPROVE OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345053	B. WING		04/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·	
PETTIGRE	EW REHABILITATION CE	NTER	1515 W PETTIGREW STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 880	Continued From page	a 6	F 880			
	and 5), and 4) failed t	to ensure personal protective s readily available and	1 000	the alleged deficient practice.		
	accessible (masks), f Resident #1. These COVID-19 pandemic	-		The housekeeper observed leavir room of resident #1 by the survey re-educated by the Director of Nu (DON) and or his/her designee or /07/2020 at approximately regard	or was rsing n 04	
	with one or more req had caused, or was li harm, impairment or	e provider's non-compliance uirements of participation kely to cause, serious injury, death to residents. The was related to 480.80		infection control practices/procedu relates to the COVID-19 Pandemi education included review of how identify residents on droplet and c contact precautions, handwashing	ures as it ic. This to or	
	Infection Control scop Administrator, Directo Development Coordin Director, and the faci	pe and severity of "K." The		requirements and expectations will cleaning and going in and out of r rooms, and performing hand hygin to and after applying gloves for re presumed to be positive for COVI	hen esident ene prior sidents	
	2020 at 8:01 p.m., af	was removed on April 8, ter an acceptable removal		Criteria #2 All residents receiving housekeep services would be at risk for the s	-	
	review of training's to	terviews, policy review and		alleged deficient practice. Criteria #3		
	"E" (no actual harm w	wer scope and severity of vith potential for more than not immediate jeopardy) at		Housekeepers were re-educated DON and or his or her designee of 04/07/2020. This education include review of how to identify residents	on or by led s on	
	The findings include:			droplet and or contact precautions handwashing requirements and		
	the resident was 82 y	1's medical record revealed, rears old. Diagnoses history Isy, Peripheral Vascular		expectations when cleaning and g and out of resident rooms, and per hand hygiene prior to and after ap gloves for residents presumed to	erforming oplying	
	Chronic Pain, Disorde	ated cholesterol). Review of		positive for COVID-19. This educa be added to the housekeeping ge orientation as well. Staff not educ 04/07/2020 will not be allowed to	neral cated on	

Facility ID: 923266

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TATENCE T						NO. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			ATE SURVEY	
		345053	B. WING			04/08/2020	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
PETTIGRE	W REHABILITATION CE	NTER		1515 W PETTIGREW STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOUL		N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 880	Continued From page	97	F 88	0			
	facility's "Warnings" th	nreshhold of "99.0" revealed, 20 03:54 (3:54 AM)99.4		until the education has been	provided.		
	(oral) 03/20/2020 014 (temporal) 04/05/2020	9 (1:49 AM)99.8		Criteria #4			
		5 AM). Further review of		Random daily audits will be on the Administrator, Director of	-		
		, "Droplet precautions r/t		(DON), Staff Development C	•		
		every shift for 7 days."		(SDC), and other clinical tear			
	, , ,	m (mg) tablets by mouth		to ensure compliance with th			
	was ordered on 04/05			infection control program as			
t	treatment," for "Fever			hand hygiene when cleaning			
	-	s, "Based on experience		room to the next, identification			
	the Taber's medical d	fic principles," according to ictionary. The nurse's notes /ealed, "Elevated temp		on isolation, and performing for residents with presumed			
	102.5 this shiftreche	-		Criteria #4			
		lenol 650 mg given" and		The results of the audits will	be presented		
	-	nt (PA) was notified. The		by the Staff Development Co			
	temperature decrease			and/or the Director of Nursing	g to the QA		
				committee for further review			
	Further review of the			recommendations monthly for			
		, the PA ordered Resident		months and as deemed nece	essary		
	#1 to be sent to the e			thereafter.			
		when emergency medical e facility, the emergency		Criteria #5			
		uestioned the facility staff,		Date of compliance 4/30/202	0		
		should be treated at the			.0		
		of contracting something					
	-	/ID-19 pandemic. The PA		Criteria #1			
		ursing staff and the PA		No residents were noted to b	e affected by		
		o remain at the facility. In		the alleged deficient practice			
	addition to the orders			The certified nursing assistar			
		acute findingschest is		#1 is no longer employed by	the center.		
		linical indication: fever,					
		nd culture sensitivity (UA		Criteria #2	- h		
		blood count with differential		All residents cared for by the			
		cility was awaiting the final specimen (collected on		C.N.A had the potential to be the alleged deficient practice	-		
	04/06/2020) and UA (continued monitoring of resid			

Facility ID: 923266

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	S FOR MEDICARE &				
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345053	B. WING		04/08/2020
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
PETTIGRE	W REHABILITATION CE	INTER		1515 W PETTIGREW STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)		JLD BE COMPLETIO
F 880	Continued From page	e 8	F 880		
	04/07/2020), at the tin	me of the survey findings.		signs and symptoms of presumptive COVID-19 remain in place.	/e
	 1. On 04/07/2020 at 11:24 a.m., accompanied by the Director of Nursing (DON), HSK #1 was observed in Resident #1's room, with a mask and gloves on, sweeping the floor. HSK #1 cleaned in close proximity to, around, and underneath the resident's bed. HSK #1 exited the resident's room with the same mask and gloves on and proceed down the hallway, where several residents' rooms were located. Upon inquiry, HSK #1 confirmed that he was in route to other residents' rooms. He stated, that he only performed hand hygiene, when he entered and exited the facility, for his work shift. He further clarified, that he only washed his hands with soap and water, upon entering and exiting the facility. He said, he did not perform hand hygiene, when he completed housekeeping duties, between residents' rooms. HSK #1 acknowledged that he was aware of the COVID-19 pandemic. He also 			Criteria #3 Licensed and non-licensed nursing were re-educated on infection con practices and procedures as it rela the COVID-19 Pandemic. The edu was specific to identification of res on isolation precautions for dropler contact precautions, handwashing requirements and expectations be after providing care, before doffing donning of gloves, and when enter exiting resident rooms identified as on precautions due to presumed COVID-19 infections. This education provided by the Director of Nursing his/her designee. This education w added to the general orientation.	trol ttes to ication idents t and fore and j and ring and s being on was g and or
	on the resident's door During an interview of the DON stated, she hand hygiene before and follow the facility' precautions. Review of the "Hand Return Demonstration 03/27/2020, revealed importance of hand h Review of the "COVII	n 04/07/2020 at 11:36 a.m., expected HSK #1 to perform exiting the resident's room, s policy related to droplet Hygiene Competencies with n," dated and signed on , HSK #1 was aware of the ygiene.		Random daily audits will be condu- the DON/designee to ensure prope- identification of residents on isolat precautions (droplet and contact), hygiene requirements and expecta- before and after providing care, be doffing and donning of gloves, and entering and exiting resident room identified as being on precautions presumed COVID-19 infections an focus on proper infection control procedures.	er ion hand ations ofore 1 when s due to id with a

Event ID: YBGE11

Facility ID: 923266

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		MEDICAID SERVICES				<u>VO. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		345053	B. WING		04/08/2020	
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
PETTIGRE	EW REHABILITATION CE	NTER		1515 W PETTIGREW STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Continued From page	9	F 88	30		
	Review of the "Drople posted on Resident #	et "Precautions," signage 1's door read, "Perform entering and before leaving		committee for further review ar recommendations monthly for months and as deemed necess thereafter.	three	
D 03 st	Review of the "Outbreak of Communicable Disease," infection control policy, revised on 03/13/2020, revealed, "11. All employees should: a. Practice good hand hygiene and			Criteria #5 Date of compliance 4/30/20		
	handwashing techniq			Criteria #1		
	Precautions Guideling revealed, "1. If a res (99.6 or higher) or res determine if the resid health conditions or ir answer to #1 is yes, i on droplet/contact pre face masks, eye prote	sident develops acute fever		Resident #1 PPE droplet preca which included masks and star precautions of gloves, were rep with masks immediately at the reported to the DON. The facili CDC recommendations/guideli droplet precautions. Resident # noted to be affected by the alle deficient practice.	ndard blenished time it was ty uses the nes for ‡1 was not	
	room on isolation to n to discard PPE" 2. On 04/07/2020 at 2 Resident #1's room w and proceeded into R	2:53 p.m., CNA #1 exited /ith gloves and a mask on, Resident #6's room. The he door, physically touched		Criteria #2 There is only (1) resident that i precautions that requires PPE. residents were noted to be affe alleged deficient practice.	No other	
	the resident, and che incontinence depends resident, and touched			All staff received education on on the process for reporting an replenishing of personal protect equipment (PPE) as well as ho identify what personal protectiv	d tive w to ve	
	accompanied by the I to entering Resident a incontinence care to I	DON, CNA #1 stated, prior #6's room, he provided Resident #1 with the same was aware that Resident #1		equipment (PPE) is required for precautions. This information on the isolation sign noted on t the affected person(s) room. T educated by 04/07/2020 will no	r droplet s provided he door of hose not	

Facility ID: 923266

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		MEDICAID SERVICES			OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345053	B. WING		04/08/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE
PETTIGRI	EW REHABILITATION CE	INTER		1515 W PETTIGREW STREET DURHAM, NC 27705	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE COMPLETIO TO THE APPROPRIATE DATE
F 880	Continued From page	e 10	F 88	30	
	acknowledged that he COVID-19 pandemic			allowed to work until the been provided.	education has
	and after resident car another resident.	re, and before proceeding to et "Precautions," signage		Criteria #4 PPE needs for residents precautions will be chec and or designee at the b	ked by the DON
		1's door read, "Perform entering and before leaving		day shift (7a-3p) and pri the day. Also PPE supp the medication rooms so rationed under the supe	blies will be kept in o that it can be
	Disease," infection co 03/13/2020, revealed	eak of Communicable ontrol policy, revised on I, "11. All employees ood hand hygiene and jue"		nurse. Staff have been the nurse know if PPE s be replenished. If PPE s medication room are run nurse is to notify the Dir and or the Administrator	supplies need to supplies in the nning low the ector of Nursing
	Licensed Practical Nu 2, 3, 4 and 5 were loc room area. The telev some residents were confirmed that all res than four (4) to five (5	12:00 noon, accompanied by urse (LPN) #1, Resident #s cated in the common day vision (TV) was loud and watching the TV. LPN #1 idents present were less 5) feet from each other. At Development Coordinator		(initiated 04.07.2020). The DON/designee will weekly audits through d of droplet isolation room appropriate PPE supplie gowns).	irect observation ns for the
	(SDC) confirmed the #1 and the SDC ackr COVID-19 pandemic maintaining social dis	aforementioned. Both LPN nowledged awareness of the , and the importance of stancing.		The results of the audits by the Staff Development and/or the Director of N committee for further re recommendations mont	nt Coordinator ursing to the QA view and hly for three
	the DON stated, she monitor and maintain the residents. The D residents should not proximity to each othe	be grouped in close er, due to the COVID-19		months and as deemed thereafter. Criteria #5 Date of compliance 4/30	
	facility confirmed pos	d, although there were no itive COVID-19 residents, to expected social distancing		Criteria #1 All residents (#2, #3, #4	, and #5) were

Facility ID: 923266

If continuation sheet Page 11 of 19

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		O. 0938-03	
		IDENTIFICATION NUMBER:	· · /		CONSTRUCTION	1 Y /	E SURVEY IPLETED	
		345053	B. WING			04/08/2020		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
PETTIGRE	EW REHABILITATION CE	INTER		1515 W PETTIGREW STREET DURHAM, NC 27705				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIC	
F 880	Continued From page	e 11	F 8	80				
	amongst residents.				redirected to their rooms on 4.7.20 by	а		
					facility certified nursing assistant (C.N.			
	Review of an in-servi	ce report dated 03/18/2020,			immediately when made aware of the	-		
		COVID-19 and Social			noncompliance observation of social			
	•	ducated regarding the			distancing reported by the surveyor.			
	COVID-19 pandemic				Resident # 5 who is alert and oriented			
					was re-educated during the survey by			
		11:24 a.m., accompanied by			Director of Nursing on social distancing			
		ecautions" signage was ht #1's door. The isolation			6 feet from all persons as it relates to t			
		ontain any masks. On			COVID-19 Pandemic. Residents #2, 3 and 4 were not able to be educated or			
		.m., the DON explained that			social distancing due to their cognitive			
	-	sponsible for ensuring the			status. None of the residents were			
	isolation caddy was r				affected by the alleged deficient practic	ce		
	appropriate PPE. Sh							
		aff, to notify the nurse on the			Criteria #2			
	hallway, when PPE s				No other residents were identified to b	е		
	•	l said, the hall nurse had			affected by the alleged deficient praction	ce.		
	access to additional F	PPE in the med-room. The						
	DON proceeded to th	ne med-room located on the			Criteria #3			
	same hallway as Res	sident #1, and confirmed			Staff were re-educated by the Director	of		
		nal masks, that were readily			Nursing and or his/her designee on			
		le for the staff to use. The			monitoring and observing residents an			
		ected nursing staff to have			for social distancing of at least 6 feet a			
		the Administrator, so that			relates to the possible transmission of			
		d have been provided.			COVID-19. Staff were educated and	tina		
	Administrator's office	e confirmed located in the			instructed on redirecting and re-educa residents when the behavior of social	ung		
		vledged they needed to			distancing of less than 6 feet is observ	ba		
		, to ensure PPE was readily			amongst residents. Employees not	cu		
	available for the staff	-			educated by 04/07/2020 will be educated	ted		
					prior to being allowed to clock in for the			
	During a telephone in	nterview on 04/08/2020 at			next scheduled shift.			
	7:42 p.m., accompan							
	Administrator, the Me				Criteria #4			
		ecautions, to be the same			All staff are responsible for maintaining			
		omeone with the flu. He			and enforcing of social distancing of 6			
	stated as part of diag				between residents. Compliance of this			
	determine the source	of the fever for Resident #1,			directive will be monitored via the facili	ity		

Facility ID: 923266

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DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· /		(X3) DAT	E SURVEY
		A. BUILDIN	G		
	345053	B. WING		04	4/08/2020
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DDE	
REHABILITATION CE	NTER		1515 W PETTIGREW STREET DURHAM, NC 27705		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
he aforementioned of The MD indicated that being asked about CC optential presumptive letermined otherwise 11 had a history of pu- bandemic. He also are of the importance of the fraction control pract bandemic. The DON confirmed Resident # 10 and UA C&S had r ime of the survey. The facility provided a faction plan on April 8, ead: Housekeeping staff fa- bygiene prior to exitin COVID 19 resident#1 The housekeeper ob e-educated by the Di or his/her designee or upproximately 2:30 Pl or contact precautions equirements and exp and going in and out of performing hand hygie polying gloves for re- positive for COVID-19 All Housekeepers we	rders were implemented. t he did not understand DVID-19 or recognizing signs and symptoms, until . The MD stated Resident almonary edema. He ness of the COVID-19 cknowledged understanding he facility staff following safe ices, during the COVID-19 and Administrator 1's final test results, for the not been received, at the an acceptable removal , 2020 at 5:12 p.m., that ailed to provide hand g room of presumptive : pserved by the surveyor was rector of Nursing (DON) and n 04.07.2020 at M regarding infection control as it relates to the . This education included tify residents on droplet and s, handwashing bectations when cleaning of resident rooms, and ene prior to and after sidents presumed to be ere re-educated by the DON	F 84	rounds (angel rounds) that a daily by the department hea assigned support staff. Any observations of non-complia addressed immediately by th member completing the faci observation round. Any find non-compliance will be discu morning meetings along with corrective action(s) that was Those with continued nonco be addressed through the fa disciplinary action. The results of the audits will by the Staff Development Co and/or the Director of Nursir committee for further review recommendations monthly f	ds and other of ance should be he staff lity lings of ussed in the h the simplemented. ompliance will acility's be presented oordinator ng to the QA or and or three	
	FOR MEDICARE & I DEFICIENCIES DRRECTION VIDER OR SUPPLIER REHABILITATION CE SUMMARY STI (EACH DEFICIENC' REGULATORY OR L Continued From page the aforementioned o the MD indicated that eing asked about CC otential presumptive etermined otherwise 1 had a history of pu- cknowledged aware andemic. He also a f the importance of t infection control pract andemic. The DON onfirmed Resident # u and UA C&S had r me of the survey. The facility provided a ction plan on April 8, ead: Housekeeping staff f ygiene prior to exitin COVID 19 resident#1 The housekeeper of e-educated by the Di r his/her designee of proximately 2:30 P ractices/procedures COVID-19 Pandemic. eview of how to iden r contact precautions equirements and exp nd going in and out o erforming hand hygi- polying gloves for re ositive for COVID-15 All Housekeepers w	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345053 VIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 12 ne aforementioned orders were implemented. he model about COVID-19 or recognizing otential presumptive signs and symptoms, until etermined otherwise. The MD stated Resident 1 had a history of pulmonary edema. He cknowledged awareness of the COVID-19 andemic. He also acknowledged understanding f the importance of the facility staff following safe infection control practices, during the COVID-19 andemic. The DON and Administrator onfirmed Resident #1's final test results, for the u and UA C&S had not been received, at the me of the survey. he facility provided an	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIA JORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIA JUDER OR SUPPLIER 345053 B. WING	FOR MEDICARE & MEDICAID SERVICES DEFICIENCIES (X1) PROVIDERSUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING VIDER OR SUPPLIER 345053 8. WING IREMABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP OC 1515 W PETTIGREW STREET DURHAM, NC 27705 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIS BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PB READILATORY OR LSC IDENTIFYING INFORMATION; (EACH DEFICIENCY MISS BE PRECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PB Continued From page 12 ne aforementioned orders were implemented. the MD indicated that he did not understand eing asked about CVUID-19 or recognizing otential presound CVUID-19 or recognizing otential presond for COVID-19 andemic. He also acknowledged understanding frection control practices, during the COVID-19 andemic. The DON and Administrator onfirmed Resident #1's final test results, for the u and UA C&S had not been received, at the me of the survey. F 880 Housekeeping staff failed to provide hand ygiene prior to exiting room of presumptive iSOVID 19 resident#11: Those with continued nonco be addressed through the fa disciplinary action. The housekeeper observed by the surveyor was e-educated by the Director of Nursing (DON) and r hisher designee on 04.07.2020 at pproximately 2:30 PM regarding infection control ractices/procedures as it relates to the COVID-19 Pandemic. This education included eview of how to identify residents on dropielt and r contact precautions, handwashing aquirements and expectations when cleaning ind going in and out of resident rooms, and er	FOR MEDICARE & MEDICAID SERVICES ONE N PRECENCE (X) MULTIPLE CONSTRUCTION (X) MULTIPLE

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/14/2020 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE	
		345053	B. WING			_	04/	08/2020
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PETTIGRE	W REHABILITATION CE	NTER			1515 W PETTIGREW STRE DURHAM, NC 27705	ET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	residents on droplet a handwashing requirer when cleaning and go rooms, and performin after applying gloves be positive for COVID 04/07/2020 will not be education has been p - All residents in the fa evaluated on-going, b (DON), Staff Develop and other clinical tear identify any possible s COVID-19. The signs COVID-19 that the sta and continue to be ed with elevated tempera respiratory signs sym breath, cough, and or as it relates to signs a prevention of COVID- information is commu via Centers for Diseas and State organizatio identified will be discu- recommendations. If i physician that a reside COVID-19, the facility and Federal regulatio of the Department of I regulatory agency.	ed review of how to identify nd or contact precautions, ments and expectations ong in and out of resident g hand hygiene prior to and for residents presumed to -19. Those not educated on a allowed to work until the rovided. acility will be observed and y the Director of Nursing ment Coordinator (SDC), n members every shift to signs and symptoms of and symptoms of affs have been educated ucated on are residents atures and or any other ptoms such as shortness of sore throat. Staff education and symptoms and 19 is ongoing as new nicated to our organization se Control (CDC), Federal ns. Those residents ussed with the MD for further t is determined by the ent requires to be tested for will follow the CDC, State ns in regards to notification Health and any other	F	880				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	05/14/2020 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		345053	B. WING			04/	08/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
DETTION	W REHABILITATION CE	NTED		1515 W PETTIGREW STRE	EET		
PETTIGRE		NIER	1	DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page	9 14	F 880				
	care to resident #1 an care to resident #6.	nd then going onto providing					
	the survey was re-edu practices and procedu COVID-19 Pandemic. to identification of res precautions for drople handwashing requirer before and after provi and donning of gloves exiting resident rooms precautions due to pro- infections. This educa Director of Nursing and (completed 04.07.202 - All direct care staff of re-educated by the Di- her designee related to	et and contact precautions, ments and expectations ding care, before doffing s, and when entering and s identified as being on esumed COVID-19 ation was provided by the nd or his/her designee. 20) currently in the facility will be frector of nursing and his or to infection control practices					
	Pandemic. The education of resider for droplet and contact requirements and exp providing care, before gloves when entering identified as being on presumed COVID-19 educated by 04/07/20	ents on isolation precautions of precautions, handwashing pectations before and after e doffing and donning of and exiting resident rooms precautions due to					
	the deficient practice. the facility will be observed Director of Nursing (D Coordinator (SDC), and	potential to be affected by Therefore, all residents in erved and evaluated by the OON), Staff Development nd all staff every shift to signs and symptoms of					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SURVE' COMPLETED NAME OF PROVIDER OR SUPPLIER 345053 B. WING 04/08/202 PETTIGREW REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 04/08/202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 04/08/202 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 04/08/202 F 880 Continued From page 15 COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further F		RTMENT OF HEALTH AN ERS FOR MEDICARE & I					FORM): 05/14/2020 APPROVED 0. 0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE PETTIGREW REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE Image: stress of the stress of t	STATEMENT (IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` <i>`</i>			(X3) DATE	SURVEY
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) 0 F 880 Continued From page 15 COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further 1515 W PETTIGREW STREET DURHAM, NC 27705			345053	B. WING			04/	08/2020
PETTIGREW REHABILITATION CENTER 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) 0 00000000000000000000000000000000000	NAME OF PI	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY	, STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMP DV F 880 Continued From page 15 COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further F 880 Each constraint Constraint Composition the approximation is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further PREFIX TAG PREFIX TAG CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	PETTIGRE	REW REHABILITATION CE	NTER					
COVID-19. The signs and symptoms of COVID-19 that the staffs have been educated and continue to be educated on are residents with elevated temperatures and or any other respiratory signs symptoms such as shortness of breath, cough, and sore throat. Staff education as it relates to signs and symptoms and prevention of COVID-19 is ongoing as new information is communicated to our organization via Centers for Disease Control (CDC), as well as Federal and State organizations. Those residents identified will be discussed by the nurse with the attending physician and or medical director for further	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH COF	RRECTIVE ACTION SHOULD B ERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
recommendations. If it is determined by the physician that a resident requires to be tested for COVID-19 the facility will follow the CDC, State and Federal regulations and guidelines in regards to notification of the Department of Health. - Those resident identified as having signs and symptoms will be considered presumed COVID-19 positive and will be placed on Droplet precautions. Personal Protective Equipment (PPE) required for droplet precautions will be identified on the isolation sign noted on the outside of the door of the affected person/persons. The attending physician/medical director will be notified for further recommendations/orders. If it is determined by the physician that a resident requires to be tested for COVID-19 the facility will follow the CDC, State and Federal regulations and guidelines in regards to notification of the Department of Health. - All education will be provided by the Director of Nursing and or his/her designee. Facility failed to ensure PPE on resident #1 was	F 880	COVID-19. The signs COVID-19 that the sta and continue to be ed with elevated tempera respiratory signs sym breath, cough, and so it relates to signs and of COVID-19 is ongoi communicated to our Disease Control (CDO State organizations. will be discussed by ti physician and or med recommendations. If i physician that a reside COVID-19 the facility and Federal regulatio to notification of the D - Those resident idem symptoms will be con COVID-19 positive ar precautions. Persona (PPE) required for dro identified on the isolar outside of the door of person/persons. The director will be notified recommendations/ord the physician that a reg for COVID-19 the faci State and Federal reg regards to notification Health. - All education will be Nursing and or his/he	and symptoms of affs have been educated lucated on are residents atures and or any other ptoms such as shortness of ore throat. Staff education as symptoms and prevention ng as new information is organization via Centers for C), as well as Federal and Those residents identified he nurse with the attending lical director for further it is determined by the ent requires to be tested for will follow the CDC, State ns and guidelines in regards Department of Health. tified as having signs and sidered presumed nd will be placed on Droplet I Protective Equipment oplet precautions will be tion sign noted on the the affected attending physician/medical d for further ders. If it is determined by esident requires to be tested ility will follow the CDC, gulations and guidelines in of the Department of	F 8	80			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/14/2020 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345053	B. WING _			04/	08/2020
NAME OF PF	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PETTIGRE	W REHABILITATION CE	NTER		15	515 W PETTIGREW STREET		
				D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Continued From page readily accessible:	9 16	F 8	80			
	 Resident #1 PPE draincluded masks and sigloves, were replenish at the time it was report facility uses the CDC recommendations/guil precaustions. There is only (1) resprecautions that required ucated on 4/7/2020 reporting and replenish equipment (PPE) as we personal protective early for droplet precautions provided on the isolation of the affected person educated by 04/07/20 work until the educated on 4/7/2020 work until the educated by 04/07/20 work until the educated to let the supplies need to be referent the medication roor is to notify the Director Administrator for replet 04.07.2020). 	idelines for droplet ident that is on droplet ires PPE. All staff were) on the process for shing of personal protective well as how to identify what quipment (PPE) is required s. This information is ion sign noted on the door n(s) room. Those not 020 will not be allowed to on has been provided. dents placed on droplet ecked by the DON and or the beginning of the day shift eaving for the day. Also PPE in the medication rooms to of the nurse. Staff have the nurse know if PPE eplenished. If PPE supplies m are running low the nurse or of Nursing and or the					
	The facility failed to e	nsure social distancing was					

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		MEDICAID SERVICES	(¥2) MI II TI	PLE CONSTRUCTION		10. 0938-039
	PLAN OF CORRECTION IDENTIFICATION NUMBER:			G	· · ·	MPLETED
		345053	B. WING		0	4/08/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PETTIGRE	EW REHABILITATION CE	ENTER		1515 W PETTIGREW STREET DURHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 880	Continued From page	e 17	F 88	30		
	maintained in the res #2, #3, #4, and #5:	ident setting for residents				
	nursing assistant (C.I made aware of the no social distancing repo to their cognitive state	oms by a facility certified N.A) immediately when oncompliance observation of orted by the surveyor. Due us these residents are not				
	able to be educated o (04.07.2020).					
	re-educated during th Nursing on social dis persons as it relates Staff were also re-ed Nursing and or his/he	alert and oriented, was ne survey by the Director of tancing of 6 feet from all to the COVID-19 Pandemic. ucated by the Director of er designee on monitoring				
	of at least 6 feet as it transmission of COV and instructed on red residents when the b	nts and for social distancing relates to the possible ID-19. Staff were educated lirecting and re-educating ehavior of social distancing				
	Employees not educa	observed amongst residents. ated by 04/07/2020 will be ng allowed to clock in for shift.				
	enforcing of social dis residents. Compliand monitored via the fac that are completed da and other assigned s	sible for maintaining and stancing of 6 feet between ce of this directive will be sility rounds (angel rounds) aily by the department heads support staff. Any of compliance should be				
	addressed immediate completing the facility findings of non-comp	ely by the staff member y observation round. Any liance will be discussed in s along with the corrective				

Facility ID: 923266

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 05/14/2020 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		345053	B. WING		_	04/08/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	
PETTIGRE	EW REHABILITATION CE	NTER		1515 W PETTIGREW STRE DURHAM, NC 27705	ET	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
F 880	Continued From page	<u></u> 18	F 88	30		
	1.0	blemented. This process will				
		d to social distancing will be and or his/her designee.				
	presented by the DOI	nding of findings with be N in QAPI committee for or 60 days, unless the QAPI s otherwise."				
	April 8, 2020 at 8:01 p verified corrective act been implemented. T staff interviews, policy	oval plan was completed on o.m., after the survey team ions taken by the facility had This included observations, y review and review of immediate corrective				

Facility ID: 923266

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