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 06/15/2017

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID 4HKJ11 - 06/15/17	F 000		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		7/13/17

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

Electronically Signed | 07/06/2017

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 06/15/2017

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 329	Continued From page 1 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to a) respond to letters to the physician from the pharmacist for gradual dose reductions (GDR) of antipsychotic medication (Zyprexa), and b) to reassess the need for Prozac for 1 of 5 sampled residents (Resident # 55) reviewed for unnecessary medications. Findings included: Resident # 55 was admitted on 4/16/13 with documented diagnoses of Alzheimer ' s disease, Depression, Paranoid personality disorder and Psychotic disorder. Review of the Annual Minimum Data Set (MDS) assessment, dated 9/7/16 revealed Resident # 55 was coded as moderately cognitively impaired with a BIMS score of 10, having clear speech and minimal difficulty hearing. Resident #55 was coded as not having any psychosis or behavioral issues. Resident was coded as needing limited one person assist for activities of daily living (ADL ' s). Resident received antidepressant and antipsychotic medications 7 out of 7 days. Review of Resident 55 ' s Psychiatry consultation note, dated 9/22/16, read in part: Problem - with Psychotic features - Prozac - 20 mg (milligrams) every day [QD]; Continue Zyprexa 5 mg once every night (QHS).	F 329	Pettigrew Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that this summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care for the residents. The plan of correction is submitted as a written allegation of compliance. Pettigrew Rehabilitation Center's response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. A) Interventions for affected resident: Resident #55 pharmacy recommendation was addressed by the Director of Nursing and physician on 06/16/17. B) Interventions for residents identified as having the potential to be affected: An audit of physician pharmacy recommendations for the months of May and June 2017 was completed by Director of Nursing and/or Unit Managers on 7/12/17 to ensure completion and	

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 06/15/2017

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 329	Continued From page 2 Review of Resident 55 ' s Psychiatry consultation note, dated 11/03/16, read in part: Problem - with Psychotic features - Prozac 20 mg QD; Continue Zyprexa 5 mg once QHS (every night.) Review of the Quarterly Minimum Data Set (MDS) assessment, dated 11/30/16 revealed resident was coded as moderately cognitively impaired with a BIMS score of 9, having clear speech and minimal difficulty hearing. Resident was coded as not having any psychosis or behavioral issues. Resident was coded as needing extensive one person assist for activities of daily living (ADL ' s). Resident received antidepressant and antipsychotic medications 7 out of 7 days and Antibiotics 5 out of 7 days. a) Review of Resident 55 ' s Pharmacy progress notes, dated 1/14/17, revealed recommendation for Zyprexa Gradual dose reduction (GDR). Review of Resident 55 ' s Consultation Report from the consultant pharmacist to the physician, dated 1/14/17, read in part: (Resident # 55) receives an antipsychotic medication, Zyprexa 5 mg QD (every day) for paranoia/delusion. Please consider reducing the dose of Zyprexa if possible. The Pharmacy consultation report dated 1/14/17 was not signed by the physician and had no response accepting or declining the recommendation noted on the report. Review of a Physician ' s order, dated 1/24/17, revealed orders to fax pharmacy recommendation to possibly decrease Zyprexa for GDR to the outpatient Psychiatrist. No physician or Psychiatric progress note related to this request was noted in the chart.	F 329	physician response to all physician pharmacy recommendations were addressed as appropriate. C) Systematic Change: To enhance currently compliant operations and under the direction of the Director of Nursing and Staff Development Coordinator, all nurses were in-serviced (from 07/06/17 - 07/12/17) on the following updated process: 1) Upon receipt of any pharmacy recommendations from the facility pharmacy consultant, the Director of Nursing (DON) or Unit Manager will forward all pharmacy recommendations to the physician for review and response. 2) The Unit Manager(s) will follow-up with the physician in one week to ensure pharmacy recommendations have been acted upon. 3) After the physician has completed and determined response to pharmacy recommendation(s), the Unit Manager and/or Licensed Nurse will process orders written in response to pharmacy recommendations. 4) The completed pharmacy recommendation with physician response will be placed in the resident medical record by the Medical Records Clerk or Unit Manager. 5) The Unit Manager(s) will forward a	

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 06/15/2017

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 329	Continued From page 3 Resident 55 ' s Pharmacy progress notes, dated 2/15/17, revealed a request for Zyprexa GDR. The pharmacy note also indicated that the request was faxed to outpatient psychiatric services on 1/24/17. No physician or Psychiatric progress note related to this request was noted in the chart. Review of Resident 55 ' s Pharmacy progress notes, dated 3/9/17, revealed recommendations for a Zyprexa GDR. Review of Resident 55 ' s Consultation Report from consultant pharmacist to the physician, dated 5/11/17, read in part: repeated recommendation from 3/9/17 and 1/14/17. (Resident # 55) received an antipsychotic medication, Zyprexa 5 mg QD for paranoia/delusion. Please consider reducing the dose of Zyprexa if possible. Review of Resident 55 ' s Psychiatry consultation note, dated 5/18/17, read in part: - Paranoia regarding facility staff doing something to her and her family. Problem - with Psychotic features - Prozac 20 mg QD; Increase Zyprexa to 2.5mg daily morning in addition to 5 mg once QHS (every night.) Problem - Anxiety - Prozac 20 mg QD. Continue to encourage early morning routine and non-pharmacological intervention. Continue Zyprexa 5 mg once QHS. A review of the Physician response to the pharmacy ' s recommendations revealed the Physician refused recommendations based on Psychiatric evaluation on 5/18/17. During an interview with Director of Nursing [DON] on 06/14/2017 at 2:30 PM related to	F 329	copy of the completed pharmacy recommendation(s) to the DON for review to ensure all pharmacy recommendations have been acted upon. D) Monitoring of the change to sustain ongoing system compliance: Effective 7/6/17, a quality assurance tool was implemented by the Director of Nursing to ensure all pharmacy recommendations are acted upon. The Director of Nursing or Unit Manager will conduct the quality assurance audit weekly for 12 weeks. Any deficiencies will be immediately corrected. The Director of Nursing will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter.	

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 06/15/2017

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 329	Continued From page 4	F 329		

Pharmacy request for Gradual Dose Reductions and Clarification of antipsychotic medication, the DON indicated that Resident #55 received outpatient psychiatric treatment on an as needed basis.

During an interview with the facility Physician Assistant (PA) via phone on 6/15/17 at 1:15 PM she indicated that it was her expectation that if a resident was seen by outpatient psychiatric services, the recommendations from the psychiatrist were reviewed by the facility medical doctor or PA, and that the medications are were ordered as needed. She further stated that if the Pharmacy requested a medication GDR, she would expect for the resident to be referred to psychiatric services and that a medication recommendation would be made based on the pharmacy recommendation.

During an interview with the DON on 06/15/2017 3:15 PM , DON stated that if the pharmacy had requested the nursing staff to contact the doctor, then nursing should forward the pharmacy request to the Physician to see if the Physician want to implement or decline pharmacy request.

b) Review of Resident 55 ' s Psychiatry consultation note, dated 7/21/16, read in part: problem - with Psychotic features - Plan continue Cymbalta twice a day. Problem - Anxiety - Plan to switch Cymbalta to Prozac, continue to encourage early morning routine and non-pharmacological interventions.

Review of the Physician orders revealed Prozac 10 milligrams (mg) 2 tablets every morning. Physician orders also revealed that Prozac order was initiated on 8/18/16.

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 06/15/2017

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 329	Continued From page 5	F 329		

Review of Resident 55 ' s Psychiatry consultation note, dated 11/03/16, read in part: Problem - with Psychotic features - Prozac 20 mg QD. Problem - Anxiety - Prozac 20 mg QD. Continue to encourage early morning routine and non-pharmacological intervention.
Review of Resident 55 ' s Pharmacy progress notes, dated 12/12/16, revealed a request for Prozac clarification.

Review of Resident #55 ' s Consultation Report from consultant pharmacist, dated 12/12/16, read in part: Repeated recommendation from 10/10/16, Cymbalta changed to Prozac on 8/18/16, appears to experiencing the following side effect- insomnia as evidence by start of Melatonin on 9/12/16. Please send to Psychiatric Medical Doctor [MD] for evaluation and documentation. Please reassess use of Prozac and consider an alternative agent if possible to minimize adverse effect.

The Pharmacy consultation report to the physician dated 12/12/16 was not signed by the Physician and no response accepting or declining the recommendation was noted on the report. No Physician or Psychiatric note related to this request was noted in the chart.

Review of Resident 55 ' s Pharmacy progress notes, dated 2/15/17, revealed a second request for Prozac clarification after the 12/12/16 request.

Review of Resident 55 ' s Consultation Report from the consultant pharmacist, dated 2/15/17, read in part: Repeated recommendation from 12/12/16 and 10/10/16. Cymbalta changed to Prozac on 8/18/16, appears to experiencing

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 06/15/2017

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 329	Continued From page 6	F 329		

following side effect- insomnia as evidence by start of Melatonin on 9/12/16. Please send to Psychiatric MD for evaluation. Please reassess use of Prozac and consider an alternative agent if possible to minimize adverse effect.

The Pharmacy consultation report dated 2/15/17 was not signed by the physician and no response accepting or declining the recommendation was noted on the report.

Review of a Physician ' s order, dated 3/2/17, revealed orders to fax the pharmacy recommendation regarding reassessing Prozac to the Psychiatrist. No physician or Psychiatric progress note related to this request was noted in the chart.

Review of Resident 55 ' s Pharmacy progress notes, dated 4/7/17, revealed a third Prozac clarification request after the 12/12/16 request date.

Review of Resident 55 ' s Psychiatry consultation note, dated 5/18/17, read in part: Paranoia regarding facility staff doing something to her and her family. Problem - with Psychotic features - Prozac 20 mg QD. Problem - Anxiety - Prozac 20 mg QD. Continue to encourage early morning routine and non-pharmacological intervention.

Review of the Quarterly Minimum Data Set (MDS) assessment, dated 5/23/17 revealed the resident was coded as moderately cognitively impaired with a BIMS score of 9, having clear speech and minimal difficulty hearing. Resident was coded as not having any psychosis or behavioral issues. Resident was coded as needing extensive one person assist for activities

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 06/15/2017

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 329	Continued From page 7	F 329		

of daily living (ADL ' s.) Resident received antidepressant and antipsychotic medications 7 out of 7 days.

Review of the Physician orders for the month of June 2017 revealed Prozac 10 mg 2 tablets every morning.
Review of Resident 55 ' s Medication Administration Record [MAR] for month of June 2017 revealed Prozac 10 mg, 2 tablets by mouth every morning for depression. MAR ancillary orders included Psychiatry consultation as needed for behavior or psychotropic medication management.

Review of Resident 55 ' Care Plan, revised on 6/13/17, revealed goals for use of antidepressant medications [Cymbalta/ Prozac], and related to depression. Interventions included observation and reporting of behavioral symptoms to Physician, Monitor / document and report side effects to Physician and Psychiatrist follow up per physician order.

During an interview with the facility Physician Assistant (PA) via phone on 6/15/17 at 1:15 PM she indicated that it was her expectation that if a resident was seen by outpatient psychiatric services, the recommendations were reviewed by the facility medical doctor or PA in-charge for the resident and medications are ordered as needed. She further stated that if the Pharmacy requested a medication GDR, she would expect for the resident to be referred to psychiatric services and that a medication recommendation would be made based on the pharmacy recommendation.

During an interview with the DON on 06/15/2017 3:15 PM , DON indicated that it was her

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 06/15/2017

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 329	Continued From page 8 expectation that when residents returned from an outpatient psychiatric consultation with recommendations, nursing staff would forward the recommendations and orders to the facility Physician for review, and that new medications orders and recommendations would be implemented as needed. She further stated that if pharmacy had requested the nursing staff to contact the doctor, then nursing should forward the pharmacy request to the Physician to see if Physician want to implement or decline pharmacy request.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage,	F 371		7/13/17

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 06/15/2017

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 371	Continued From page 9 handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to properly label food in the walk in refrigerator, failed to store food under sanitary conditions in the walk- in freezer, and serve food under sanitary conditions in the dining hall. The facility also failed to maintain a clean ice machine. Findings include: 1. An observation of walk in refrigerator on 6/12/17 at 9:25 AM, revealed a container half filled with creamy mushy food, which was labelled as apple sauce. No opened date or use by date was noted on the container. 2. An observation of the dry storage room on 6/12/17 at 9:30 AM, revealed a bag containing 4 bread like products labeled "English Muffins" placed underneath a bag of Hamburger buns on the bread rack. The label on the bag indicated "Keep Frozen". The dietary manager indicated that the English muffins were used for breakfast and staff should have placed the leftover in the freezer. 3a. An observation of the walk in freezer on 6/12/17 at 9:40 AM, revealed ice and a thick block of icicles on food stored on the top rack underneath the freezer compressor. The rack contained 3 bags of hoagie rolls; 1 bag of cake, 1 bag of spinach wraps, 2 and half bags of English muffin and 1 bag of frozen bread sticks. The Dietary Manager indicated that the water must have dripped out of the compressor.	F 371	F371: The Dietary Manager immediately addressed the food without proper labeling in the walk in refrigerator, the English muffins in the dry storage room, food stored on the top rack underneath the freezer compressor of the walk-in freezer and the unlabeled frozen dough on the side rack of the walk-in freezer,by discarding it on 6/12/17. The ice noted in the freezer was scraped on 6/12/17 and freezer was repaired on 6/13/17 by a technician. The Dietary Manager removed the cup from the ice cooler in the dining room and placed a proper ice scoop outside the ice cooler on 6/12/17 and the Maintenance Assistant powered off the ice machine, emptied, and cleaned it on 6/14/17. An audit was completed by the Dietary Manager and/or Maintenance Department to ensure compliance with proper food storage of frozen items, labeling items, ice in freezer, proper ice scoop being utilized, and ice machine clean of debris on 7/6/17. Staff Development Coordinator completed an in-service of proper food storage of frozen items, properly labeling items, no noted ice in freezer, proper ice scoop being utilized, and ice machine clean of debris to all staff on 7/6/17.	

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 06/15/2017

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 371	Continued From page 10 3b. Observation also revealed, 2 bags of opened frozen dough cut in squares with no label, on the side rack in the walk-in freezer. The Dietary Manager indicated that the dough was biscuits that was used in the morning for breakfast. 4. During lunch observation in the main dining hall on 06/12/2017 at 12:00 PM, staff #1 assisting in the dining hall was observed dipping an empty cup into a jar containing ice. No ice scoop was noted near the ice pitcher. During an interview with the staff #1 on 06/12/2017 at 12:03 PM, staff # 1 indicated that a resident requested ice for the tea served. Staff # 1 stated that as the ice pitcher had some water at the bottom and to avoid that water in the ice tea, a cup was used to scoop ice. 5. During an observation of the ice machine in the activity room on 06/14/2017 at 11:35 AM, a few of the ice cubes in the ice machine had black matter on them. The floor around the ice machine was not clean and ice machine had black - uncleansed areas outside the machine. During an interview with the Dietary Manager on 06/14/2017 at 11:37 AM, Dietary Manager indicated that the facility maintenance staff was responsible for cleaning and maintaining the ice machine. Dietary manager was unsure who and how the ice scoop was washed. During an interview with facility maintenance assistance on 06/14/2017 at 11:40 AM, staff indicated that ice machine was cleaned every 2 weeks and the scoop and scoop bin was sent to the kitchen when machine was cleaned.	F 371	Administrator and/or Designee will conduct random weekly audits of proper food storage of frozen items, proper labeling of items, no noted ice in freezer, proper ice scoop being utilized, and ice machine clean of debris for twelve weeks. Re-education will be provided to staff that do not follow proper procedure. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter.	

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 06/15/2017

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 371	Continued From page 11 Maintenance assistance further stated that, he was unsure if a cleaning schedule log was kept. Facility Administrator on 06/14/2017 at 11:42 AM indicated that the ice machine would be shut down and cleaned. During an interview with administrator on 06/14/2017 at 12:25 PM, administrator indicated that the ice machine was last cleaned on 6/2/17. Administrator further stated that the dietary helps in washing the ice scoop and bin. During an interview with the Dietary Manager on 06/15/2017 at 1:50 PM, Dietary Manager indicated that she was unaware about staff using a cup to scoop ice from the ice jar. She further stated that the ice machine was cleaned and the freezer was repaired by an outside maintenance service. Dietary Manager indicated that it was her expectation that staff serve residents food under sanitary conditions. During an interview with the facility administrator on 6/15/17 at 3:07 PM, administrator indicated that it was his expectations that equipment be kept in good working conditions and equipment be repaired as needed. He further stated that ice machine should be cleaned on routine basis and on as needed basis.	F 371		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 441		7/13/17

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 06/15/2017

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 441	Continued From page 12 (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility	F 441		

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 06/15/2017

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 441	Continued From page 13 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility staff failed to wash hands between tasks while assisting 1 out of 6 residents [Resident #2] during lunch observed for dining in the facility's dining hall. Finding included During lunch observation in main dining hall on 06/12/2017 at 12:10 PM, observed Nurse #1 removed a dirty plate from the table, with the aid of a paper napkin scooped the leftover food from the plate into the thrash trash can and placed the plate in the dirty dish bin. Nurse #1 walked over to Resident # 2 and started feeding the resident. No hand hygiene washing was observed before Nurse #1 started feeding the resident. During an interview with Nurse #1 on 06/12/2017	F 441	F441: Administrator re-educated Nurse #1 regarding hand hygiene on 6/12/17. Administrator completed an audit of hand hygiene during meal service in the dining room on 7/6/17. Staff Development Coordinator in-serviced all staff regarding hand hygiene technique during meal service in the dining room on 7/6/17. Administrator and/or Designee will randomly audit hand hygiene technique in the dining room weekly for twelve weeks. Re-education will be provided to staff that	

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 06/15/2017

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 441	Continued From page 14 at 12:13 PM, Nurse #1 indicated that she usually does not help in the dining hall. Nurse #1 also stated that she had washed her hands before coming to the dining hall, however had not washed her hand after cleaning the dirty plate and before assisting another resident. Nurse #1 indicated that she was aware that hand washing was essential, however failed to follow it. During an interview with the Dietary Manager on 06/15/2017 at 1:50 PM, Dietary Manager indicated that she was unaware that staff was not following proper hand washing. Dietary Manager indicated that it was her expectation that staff wash their hands between tasks and serve food under sanitary conditions. During an interview with the facility administrator on 6/15/17 at 3:07 PM, administrator indicated that it was his expectations that all staff assisting in the dining hall properly wash their hands before and after assisting any resident with feeding, and between tasks in the dining hall.	F 441	do not follow the proper procedure. The Administrator will report the results of the audits to the Quality Assurance and Performance Improvement Committee for further review and recommendations monthly for three months, and as needed thereafter.	