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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 complaint investigation survey was conducted on 03/03/25 through 03/07/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #KK4D11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/03/25 through 03/07/25. Event ID# KK4D11. The following intakes were investigated NC00225057, NC00225384, NC00225805, NC00225961 and NC00228084. 7 of the 7 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		

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

Electronically Signed | 03/28/2025

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F 578	Continued From page 1 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and Physician interviews, the facility failed to ensure an effective system was in place in order that a resident's advance directive to not be resuscitated was honored when she was discovered unconscious and without pulse or respirations. This was for 1 of 22 residents reviewed for advanced directive (Resident #80). The findings included: Resident #80 was admitted to the facility on 1/18/24. Resident 80's diagnoses included diabetes mellitus, congestive heart failure, stroke, end-stage renal disease (ESRD), tube feeding status, and dementia.	F 578	Past noncompliance: no plan of correction required.	

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Review of Resident 80's quarterly Minimum Data Set assessment, dated 1/3/25, revealed the resident was severely cognitively impaired.

Review of physician orders, dated 9/4/24, revealed Resident #80 had an order for DNR (Do Not Resuscitate).

Review of Resident 80's plan of care, dated 9/16/24, revealed the resident had an Advance Directive of Do Not Resuscitate Order. Honor Residents Advance Choices.

Record review of the nurses' notes, dated 2/15/25 at 3:28 AM, indicated that at 12:25 AM, Nurse #1 assessed Resident #80 as less responsive than usual, with her blood sugar significantly above normal level (484 milligrams in deciliter, mg/dL, when normal blood sugar level is 100 mg/dL or below). Nurse #1 reported it to the Physician Assistant on call and received an order to send the resident to the hospital. Nurse #1 called Emergency Medical Service (EMS), checked the transfer binder, and could not find the DNR paper. Upon returning to the Resident 80's room, the resident was non-responsive and not breathing. Nurse #1 initiated the Code Blue (emergency code for cardiac or respiratory arrest), Nurse #2 confirmed no DNR paper, and together with Nurse #1 began CPR (cardiopulmonary resuscitation). After a few chest compressions, the EMS arrived and took over the situation. The EMS team pronounced Resident 80's death at 1:50 AM.

Record review of the EMS report, dated 2/15/25, indicated that at 12:52 AM, EMS was dispatched for hospital transfer. The EMS team arrived at

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1:01 AM, and the staff reported they just witnessed the cardiac arrest of Resident #80 with absent respirations and pulse, and initiated CPR due to no Advanced Directive in place. The EMS team determined the initial asystole rhythm, and continued the CPR, including chest compressions, non-mechanical ventilation, and medications. For thirty minutes, CPR had no effect; the resident remained asystole, and the resuscitation was terminated at 1:50 AM.

On 3/4/25 at 3:30 PM, during the phone interview, Nurse #1 indicated that on 2/15/25, during 7 PM-7 AM shift, she was assigned to Resident #80. At the beginning of her shift, the resident had normal vital signs and rested in bed with her eyes closed. At 12:15 AM, Nurse #1 went to check the resident's blood sugar and found the resident less responsive, with blood sugar 484 mg/dL. She reported the situation to the Physician Assistant on call and received an order for hospital evaluation. Nurse #1 called EMS and prepared the resident's documents for hospital transport. There was no DNR paper in the transport binder. She returned to the resident's room and found Resident #80 unresponsive with no breathing or pulse. Nurse #1 initiated the Code Blue. Nurse #2 confirmed no DNR paper, and both nurses began CPR. When chest compressions started, the EMS team arrived and took over the situation. The resident passed with unsuccessful CPR.

On 3/5/25 at 9:40 AM, during the phone interview, Nurse #2 (agency nurse) indicated that after midnight on 2/15/25, Nurse #1 stated she could not find the DNR paper in the transfer binder for Resident 80's hospital transfer. Nurse #2 double-checked the binder and did not find DNR

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paper. Nurse #1 found Resident #80 with no pulse, not breathing, and initiated the Code Blue. In response to Code Blue, Nurse #2 entered Resident 80's room, confirmed to Nurse #1 that there was no DNR paper, started chest compressions, and Nurse #1 provided bag valve ventilation when the EMS team arrived and took over the situation. In approximately thirty minutes, the EMS team pronounced resident's death. After the incident, the facility provided mandatory education for all licensed employees, including agency staff. In the case of emergency, the nurses were educated to check electronic medical records for Avance Directive/Code status verification.

On 3/5/25 at 9:50 AM, during an interview, the Interim Director of Nursing indicated that at the nurses' station, there was a transport binder for all the residents with the current code status. At the same time, the Advanced Directive information was located in every resident's electronic record. The original DNR paper documents from the transport binder must be sent to the hospital with the resident. Upon the resident's return to the facility, the nurses should check for the DNR paper, and if it is missing, reach out to the provider to make a new code status order.

On 3/5/25 at 12:05 PM, during the phone interview, Resident 80's Emergency Contact #1 indicated that she was aware of Resident 80's DNR status and thought it was not necessary to resuscitate the resident.

On 3/5/25 at 1:40 PM, during an interview, the Regional Vice President of Operations indicated that the code status should be checked when a

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resident is found without pulse or breathing. Nurse # 1 could not find the DNR order and started the resuscitation. The Regional Vice President of Operations expected the electronic medical records to reflect the transport binder code status.

On 3/5/25 at 2:30 PM, during an interview, the Medical Director indicated that Resident #80 was admitted to the facility with DNR order. On 2/15/25, when Resident #80 was found unresponsive with no pulse or breathing, Nurse #1 could not find the DNR order and, per the facility's protocol, initiated the Code Blue. The Medical Director mentioned that every time the resident returned from an outside appointment, the staff had to ensure the DNR order was in place. If it was missing, the nurse should contact the physician to order a new code status. The Medical Director expected the staff to verify the residents' code status before resuscitation.

The facility implemented the following Corrective Action Plan with a completion date of 2/22/25.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

On 2/15/25 at approximately 12:25 am Nurse #1 was in Resident #1 room to obtain blood glucose reading, blood glucose noted to be 484. Nurse #1 gave 5 units insulin per order and notified the on-call provider who gave order to send Resident #1 to the Emergency Room for evaluation related to elevated blood sugar and reports from Nurse #1 that Resident #1 was not responding per baseline. Nurse #1 activated 911 and returned to Resident #1 room to prepare for transfer to

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emergency department. Upon return Nurse #1 noted that Resident #1 was non-responsive without respirations. Nurse # 1, called Code Blue, checked the Electronic Medical Record (EMR) which noted Resident #1 to be a Do Not Resuscitate (DNR). Nurse #1 checked the transport binder along with Nurse #2 for Golden Rod and there was not one present. At that time Nurse #1 and Nurse #2 initiated Cardio Pulmonary Resuscitation (CPR). Upon arrival of Emergency Medical Services (EMS) they took over CPR efforts until 1:50 am at which time EMS called time of death. Family and Center Provider was notified. Nurse #1 obtained order to release body to funeral home of choice.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 2/15/25 Interim Director of Nursing/Designee began Center audit of all residents' code status provider orders in electronic medical record versus Golden Rod/MOST forms and care plan. Any discrepancies identified were reviewed with resident and resident representative for clarification. Audit completed on 2/17/25.

On 2/15/2025 Interim Director of Nursing/Designee began Center audit with all residents/ resident's representative to confirm that their current providers orders in the electronic medical record remained their desired wishes. Discussion of code status review was documented in the electronic medical record. Audit completed on 2/17/25.

3. Address what measures will be put into place or systemic changes made to ensure that the

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deficient practice will not recur:

The Interim Director of Nursing/Designee began education with all licensed nursing staff on provider orders for Advance Directives , validating code status per the provider order in the electronic medical record, location of the transport binder that contains Golden Rods/MOST Forms (Medical Order Scope of Treatment) and that CPR will be initiated unless: A valid provider order for DNR is in place or resident presents with obvious signs of irreversible death. Additionally, upon admission, re-admission, or significant change Code Status will be reviewed and discussed with resident/resident's representative and provider order obtained and placed in the EMR at which time nursing will obtain Golden Rod/Most form as applicable and place in the transport binder and update care plan for resident/resident's representative wishes. Education completed 2/19/25. Any nurse not educated by 2/19/25 will complete education prior to next shift worked. Interim Director of Nursing/Designee will monitor schedule to ensure that no nurse works after 2/19/25 without receiving the education.

The Licensed Nursing Home Administrator educated the Social Services Director on periodic (care connect conference, quarterly care plans, significant, and as needed) review to validate advance directives with resident/resident's representatives to ensure there is no change to their advance directive wishes. Additionally, if resident/resident's representative wishes to make changes, then Social Services will notify licensed nursing staff so that the appropriate provider order may be obtained per resident/resident's representative wishes, care plan updated and

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golden rod form completed, if applicable. Education completed on 2/18/25.

Newly hired RN/LPN will be educated on advance directives procedure during orientation by the Staff Development Coordinator/Designee. The SDC was notified of this responsibility on 2/15/2025 by the Licensed Nursing Home Administrator.

Newly hired Social Services Employees will be educated on advance directives procedures during orientation by the Licensed Nursing Home Administrator. The Licensed Nursing Home Administrator was notified of this responsibility on 2/18/25 by the Vice President of Operations.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:
The Director of Nursing /designee will review during daily clinical morning meeting (Monday - Friday) new admission orders and order listing report for provider order for advance directives to ensure accuracy of provider order and that there is supporting documentation of discussion with resident/resident's representative wishes in the EMR. Additionally, the Director of Nursing/Designee will validate at the nurse's station that there is a Golden Rod/Most form complete and in the transport binder as applicable. Audit will be completed x 12 weeks.

The decision was made to begin monitoring on 2/19/25 when the Performance Improvement Plan was reviewed by the Interdisciplinary Team.

Beginning on 2/22/25, data obtained during the audit process will be analyzed for patterns and

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F 578	Continued From page 9 trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Director of Nursing monthly x 3 or until substantial compliance is obtained. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance: 2/22/25 The Corrective Action plan was validated onsite on 3/11/25 when staff interviews revealed they had recently received education on Advanced Directive/Code Status verification. In-service reports and sign-in sheets were used to verify this information. The Audit tools for the Advanced Directive in electronic medical records and transport binders were completed by the Interim Director of Nursing and Unit Managers and reviewed by the Interdisciplinary Team according to the monitoring plan. No concerns were identified. Multiple staff interviews revealed they could verbalize education training provided in reference to the Advance Directive and Code status verification process. The facility's completion date of 2/22/25 for the Corrective Action plan was validated on 3/11/25.	F 578		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews, the facility failed to accurately code the Minimum	F 641	Preparation and/or execution of this plan of correction does not constitute	4/1/25

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F 641	Continued From page 10 Data Set (MDS) assessment in the area of Preadmission Screening and Resident Review (PASRR) Level II status for 1 of 3 residents (Resident #4) reviewed who were determined to have a PASRR Level II status. The findings included: Resident #4 was admitted to the facility on 3/16/23 with a cumulative diagnosis which included anxiety disorder, bipolar disorder, and residual schizophrenia. Residual schizophrenia is a phase where the acute psychotic symptoms of schizophrenia (such as hallucinations and delusions) have subsided, while some persistent symptoms remain. The resident's electronic medical record (EMR) included a PASRR Level II Determination Notification letter dated 4/14/23. This letter noted Resident #4 had a PASRR number ending with the letter "B," which was indicative of a PASRR Level II determination with no expiration date. The results of the evaluation, including the determination of a PASRR Level II status, were used for formulating a determination of need, an appropriate care setting, and a set of recommendations for services to help develop an individual's plan of care. The resident's care plan included the following area of focus: Resident #4 has PASRR Level II with intellectual disability / mental condition and has been diagnosed with paranoid schizophrenia / schizoaffective disorder, bipolar depression, and anxiety (Initiated 3/17/23; Revised 4/10/24). Resident #4's most recent comprehensive Minimum Data Set (MDS) was an annual	F 641	admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of corrections is prepared and/or executed solely because it is required by the provisions of federal and state law. F641 Accuracy of Assessment 1. Center failed to accurately code a Preadmission Screening and Resident Review (PASRR) Level II on Minimum Data Set (MDS) dated 2/4/25 for Resident # 4. MDS was corrected by Resident Care Specialist #1 on 3/6/25. 2. An audit of current Residents with a Level II PASRR was completed by the Social Services Director to ensure accuracy of MDS coding. Any discrepancies identified corrected immediately. Audit completed by 3/28/25. 3. Senior Resident Care Specialist to provide education to the RCS on accurately coding of PASRR Level II in section A of the Minimum Data Set. Education completed on 3/20/25. Newly hired RCS will be educated during department orientation on completion/accuracy of coding for Section A PASRR by the Senior Resident Care Specialist/Designee. Audit will be completed by the Administrator/Designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks, then 1 time a week for 4 weeks to ensure that Section A for PASRR is accurately coded for all	

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F 641	Continued From page 11 assessment dated 2/4/25. The "Identification Information" section of this MDS assessment did not report Resident #4 had a PASRR Level II determination. An interview was conducted on 3/6/25 at 1:57 PM with the facility's Interim MDS Coordinator related to Resident #4's annual assessment dated 2/4/25. Upon review of Resident #4's 2/4/25 MDS, the MDS Coordinator confirmed her assessment inaccurately indicated this resident had a PASRR Level I status when it should have noted she had a PASRR Level II status due to serious mental illness. An interview was conducted on 3/6/25 at 4:23 PM with the facility's Administrator. During the interview, the concern identified during the review of Resident #4's annual MDS assessment was discussed. Upon inquiry, the Administrator reported she would expect the residents' PASRR Level to be coded accurately on the MDS assessments.	F 641	comprehensive MDS assessments. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		4/1/25

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F 727	Continued From page 12 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage at least 8 consecutive hours per day, 7 days per week for 1 of of 32 days reviewed for staffing (03/03/25). The findings included: Review of the facility's daily staffing sheet indicated there was no RN coverage for eight consecutive hours on 03/03/25. An interview was conducted on 03/06/25 at 3:45 PM with the facility scheduler and she indicated she was unable to assign an RN for 8 hours on 03/03/25 due to the RN being off. She indicated usually she would be able to get RN coverage from the agency, however, she was unable to do so on 03/03/25. The scheduler indicated she thought it was ok for the Minimum Data Set (MDS) Nurse who was an RN to count as coverage. The scheduler verified she was aware there was supposed to be RN coverage for 8 consecutive hours daily. On 03/06/25 at 4:06 PM an interview was conducted with the Administrator, and she indicated due to the survey activities the scheduler most likely was not able to get RN cover. The Administrator stated, "We had the MDS Coordinator, Nurse Consultant and the Interim Director of Nursing (DON) here and she probably thought that was ok." The Administrator also stated, "Our interim DON was in all the rooms providing care to residents, I thought we	F 727	F727 1. Center failed to have 8 hours of consecutive Registered Nurse Coverage on 3/3/2025. Administrator and Staffing Scheduler received immediate in-service by the Vice President of Operations on 3/5/25. 2. No residents were affected. 3. The Administrator, Staffing Coordinator, and Clinical leadership team were educated on 3/19/25 by the Regional Clinical Director on the requirement to have 8 hours of consecutive RN coverage each day 7 days per week. Newly hired Administrators, Staffing Coordinators and Clinical Leadership team members will be educated during Department Orientation on the requirement of 8 hours of consecutive RN coverage each day 7 days per week by the Staff Development Coordinator/Designee. Audit will be conducted by the Administrator/Designee 7 days per week x 4 weeks, then 5 x per week x 4 weeks, then 3x per week x 4 weeks to ensure that the facility has the required 8 hours of consecutive RN coverage each day. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A/QAPI) Committee	

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	345053	A. BUILDING _____ B. WING _____	C 03/07/2025

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F 727	Continued From page 13 could use leadership as coverage."	F 727	by the Administrator monthly x 3 months. At that time, the QA & A/QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to	F 732		4/1/25

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F 732	Continued From page 14 exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to post daily nurse staffing data for 3 of 3 days reviewed (03/01/25, 03/02/25, 03/03/25). The findings included: An observation of the nurse staffing data occurred on 03/03/25 at 10:41 AM. The observation revealed a daily staffing sheet dated 02/28/25 and it was posted in the case on the wall near the lobby area. An interview with the Scheduler occurred on 03/06/25 at 10:42 AM. The Scheduler indicated she was responsible for posting the daily staffing sheets and typically she printed out the sheets for the weekend on Friday. She indicated she placed the sheets for the weekend behind the current sheet. The Scheduler stated, "I must have forgotten to remind the Weekend Supervisor to change the sheets on the weekends. An interview was conducted with the Administrator on 03/06/25 at 4:06 PM. She indicated the nurse staffing data should be posted daily.	F 732	F732 1. Center failed to post accurate daily staffing data for the 3/1/2025, 3/2/2025, and 3/3/2025. Nurse Staff posting was updated on 3/3/2025 by the Staffing Coordinator. 2. No residents were affected. 3. The Administrator, Staffing Coordinator, Clinical leadership were educated by the Regional Clinical Director on 3/19/25 on the requirement to post accurate daily nurse staffing data at the beginning of each shift. Licensed Nursing staff were educated on the requirement to post accurate daily nurse staffing data at the beginning of each shift by the Staff Development Coordinator/Designee. Education to be completed by 3/28/2025. Newly hired Administrators, Staffing Coordinators, Clinical Leadership team members and Licensed Nurses will be educated during Department Orientation by the Staff Development Coordinator/Designee. An audit of the staff posting will be reviewed 7 days per week x 4 weeks, then 5x per week x 4	

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F 732	Continued From page 15	F 732	weeks, then 3x per week x 4 weeks by the Administrator/Designee to ensure accurate daily staffing is reflected on the daily staffing posting. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		4/1/25

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F 761	Continued From page 16 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, manufacturer's literature review, the facility failed to date opened multi-dose vials of insulin medication in 2 of 5 medication administration carts (Long and Short halls), failed to discard expired insulin pens in 1 of 5 medication administration carts (Short hall) and discard loose pills in the medication cart drawers for 3 of 5 medication administration carts (Rehabilitation, Long and Short halls). Findings Included: a. On 3/3/25 at 10:00 AM, an observation of the medication administration cart of Rehabilitation Hall with Nurse #6 revealed in the second drawer of the medication cart, which contained over-the-counter medications, there were noted three white loose pills and two yellow round-shaped loose pills and one blue oval shape loose pill. On 3/3/25 at 10:05 AM, during an interview, Nurse #6 indicated that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #6 did not clean the medication cart before her shift. b. On 3/3/25 at 10:20 AM, an observation of the medication administration cart of the Long Hall	F 761	F761 1. Center failed to date opened multi-dose vials of insulin on medication carts for the Long and Short Hall, remove expired insulin pens on medication cart for short hall, and remove loose pills on medication carts for the Rehab, Long and Short Halls. All items were removed from the carts and full medication cart audits were completed by the Wound Care Nurse and the Infection Prevention Control Officer on 3/3/2025. 2. All medication carts were audited daily 3/3/2025 to 3/7/2025 by the Clinical Leadership Team (Infection Prevention Control Officer and Wound Care Nurse) to ensure that Drugs/Biologicals were labeled and stored properly. No additional observations of incorrectly labeled or stored medications/biologicals were identified. 3. Licensed nurses will be educated on properly storing/labeling of Drug and Biologicals by the Staff Development Coordinator/Designee. The education will be completed by 3/28/25.Newly hired Licensed nurses will receive education on proper labeling/storage of Drugs and Biologicals during department orientation	

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F 761	Continued From page 17 with Nurse #3 revealed one opened and undated multi-dose vial of Lispro insulin. Review of the manufacturer's literature indicated to discard Lispro multi-dose vial 28 days after opening. In the second drawer of the medication cart containing over-the-counter medications, two dark red loose pills and two white round shaped loose pills were noted. On 3/3/25 at 10:25 AM, during an interview, Nurse #3 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medication vials. The nurse stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. Nurse #3 stated she had not administered expired medication this shift. The nurse continued that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #3 did not clean the medication cart before her shift. c. On 3/3/25 at 10:45 AM, an observation of the medication administration cart of the Short Hall with Nurse #5 revealed one opened and undated Novolog Flex Pen (insulin), two opened and undated Glargine pens (insulin), three opened and undated Lantus pens (insulin), one opened Novolin pen (insulin), marked as expired on 1/25/25, and one opened Novolog Flex Pen (insulin), marked as expired on 1/30/25. A review of the manufacturer's literature indicated to discard Novolog, Glargine, and Lantus multi-dose insulin pens 28 days after opening. In the second	F 761	by the Staff Development Coordinator/Designee. The Director of Nursing/Designee will complete audit of all medication carts to ensure that medication /biologicals are labeled and stored properly. The Audit will be completed 3x per week x 4 weeks, then 2 times per week x 4 weeks, then one time per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Director of Nursing monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance.	

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F 761	Continued From page 18 drawer of the medication cart containing over-the-counter medications, two yellow round shape loose pills and two white round shape loose pills were noted. On 3/3/25 at 10:55 AM, during an interview, Nurse #5 indicated that the nurses, who worked on the medication carts, were responsible for discarding opened and undated or expired multi-dose vials. She mentioned that per training/competency, every nurse should put the date of opening on multi-dose medication vials. Nurse #5 stated that she had not checked the date of opening on insulin vials in her medication administration cart at the beginning of her shift. The nurse stated she had not administered expired medication this shift. The nurse continued that she could not identify what each of the pills were but stated the nurses were responsible for checking and cleaning their medication administration carts each shift. Nurse #5 did not clean the cart before her shift. On 3/4/25 at 11:00 AM, during an interview, the Director of Nursing indicated that the nurses were responsible for checking for loose pills, the date of opening, and the expiration date of the medication at the beginning of the shift. On 3/4/25 at 11:10 AM, during an interview, the Administrator expected no loose pills or expired medications to be left in the medication carts.	F 761		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812		4/1/25

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F 812	Continued From page 19 §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 and staff interviews, the facility failed to: 1) Maintain the chemical sanitizing solution of the dish machine at the correct concentration according to the manufacturer's recommendations; 2) Change gloves/wash hands between handling soiled and clean dishes to prevent cross-contamination of the clean dishes and failed to allow all clean dishware to air dry; 3) Dispose of expired food items and seal, label, and/or date opened food items observed in food storage areas; 4) Cover facial hair for 4 of 4 Dietary staff observed with facial hair and working in food preparation (Cook #1, Cook #2, Dietary Aide #1 and Dietary Aide #2); and 5) Keep the kitchen food service equipment and vents clean within the Dietary Department. These practices had the potential to affect food served and distributed to 74 of 79 residents who received an oral diet. The findings included:	F 812	F 812 1. Center failed to maintain chemical sanitizing solution of the dish machine at the correct concentration, perform hand hygiene between task, to allow dishware to airdry, dispose of expired food items and seal, label, date open food items in food storage areas, cover facial hair, and keep the kitchen food service equipment and vents clean. On 3/5/25 Maintenance Director and a Technician from Ecolab assessed and fixed the intake tube to appropriately dispense chlorine to the dish machine per manufacturer guidelines. On 3/5/2025 Dietetic Technician (DTR) educated Dietary Aide #1 on changing gloves/washing hands between handling soiled and clean dishes to prevent cross□contamination of the clean	

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F 812	Continued From page 20 1. Accompanied by the Dietetic Technician (DTR), an observation was initiated within the Dietary Department on 3/5/25 at 1:37 PM to observe the dishwashing process using the facility's dish machine. At that time, the DTR reported the dishwasher was a low temperature dishwasher. The required temperatures for this machine were 120-125 degrees Fahrenheit (o F) for both the wash and rinse cycles with a chlorine solution used for sanitizing the dishes. When asked, the DTR reported the recommended level for the chlorine concentration was 50-100 parts per million (ppm). Upon request, the DTR tested the concentration of the dish machine's sanitizing solution by using chlorine test strips. The vial containing the test strips indicated the strips detected the concentration of chlorine by undergoing a color change. The DTR tested the sanitizing solution of the machine four times using four test strips. None of the test strips changed color (indicative of low or no levels of chlorine in the solution). Since she could not determine whether there was an acceptable concentration of chlorine in the sanitizing solution, the DTR told the Dietary Aides who were currently using the dishwasher to hold off on washing dishes until the sanitizing solution could be fixed. She stated she would need to ask the Maintenance Director to come and fix the dishwasher so that the correct concentration of chlorine would be dispensed to sanitize the dishes. The DTR reported she had checked the dish machine's sanitizing solution with a test strip at breakfast time on the previous day (3/4/25) and the chlorine in the sanitizing solution was at the correct concentration when she conducted that test. Upon request and accompanied by the DTR,	F 812	dishes.On 3/4/2025 the DTR educated Dietary Aide #1 on proper placement of wet dishes to allow them to air dry.On 3/3/2025 the Dietary Manager removed and discarded undated, opened, and expired items. On 3/4/2025 Cook #1, Cook #2, Dietary Aide #1, and Dietary Aide #2 were educated on wearing beard guard during food preparation activities by DTR. On 3/3/2025 the kitchen and equipment were cleaned by dietary staff. 2. All residents that receive a diet by mouth have the potential to be affected by the alleged deficient practice. 3. Dietary staff will be educated by the Regional Director of Culinary Services on maintaining chlorine sanitation levels per manufacturer guidelines in the dish machine, performing hand hygiene between tasks, allowing clean dishes to air dry, disposing of expired food items, sealing, labelling, and dated open food items, covering facial hair, and maintaining clean kitchen equipment and vents. Education will be completed by 3/28/25. Newly hired dietary staff will receive education regarding food procurement and storage as well as maintaining cleanliness and sanitation in the kitchen. Education will be completed by the Dietary Manager/Designee. The Administrator/Designee will complete audits of Dietary for use of hair coverings to include beard guards when performing food preparation activities 3 x per week x	

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F 812	Continued From page 21 another observation was conducted on 3/5/25 at 2:23 PM as the concentration of chlorine in the rinse cycle of the dish machine was again tested. This test confirmed the chlorine concentration was within the recommended range of 50-100 ppm. The DTR reported the facility's Maintenance Director had fixed the dish machine, so the chlorine solution was appropriately dispensed during the rinse cycle. A follow-up interview was conducted with the DTR on 3/5/25 at 2:55 PM. At that time, the DTR also reported a service technician came out that afternoon (3/5/25) to check the dish machine. The DTR stated the technician fixed the intake tube that went into the sanitizer container to ensure the problem with the sanitizing solution for the dish machine would no longer be a problem. No additional concerns were identified at that time. 2-a. Accompanied by the Dietetic Technician (DTR), an observation and interview was conducted on 3/5/25 at 1:15 PM of the facility's dish washing process using the facility's low temperature dish machine. Dietary Aide (DA) #1 was observed to be the sole staff member working at the dishwasher. While wearing a pair of disposable gloves, DA #1 was observed as he loaded dirty insulated domes (covers for the plate bases) and plate bases onto dish racks located on the left side of the dish machine (the dirty side). He then slid the dish rack containing the dirty service ware into the dish machine and activated the machine. The DA did not change gloves or perform hand hygiene. When the dish machine was finished with the wash and rinse cycles, DA #1 moved to the right side of the dish machine (the clean side). While there, he unloaded and stacked the clean domes and plate bases from the dish rack and loaded them onto a	F 812	4 weeks, then 2x per week x 4 weeks, then 1x per week x 4 weeks. The Administrator/Designee will complete audits of the chlorine concentration in the dish machine to ensure proper sanitation 3 x per week x 4 weeks, then 2x per week x 4 weeks, then 1x per week x 4 weeks. The Administrator/Designee will complete audits to ensure that food items are dated, labeled, and sealed 3 x per week x 4 weeks, then 2x per week x 4 weeks, then 1x per week x 4 weeks.The Administrator/Designee will complete audits to ensure that equipment and vents are clean 3 x per week x 4 weeks, then 2x per week x 4 weeks, then 1x per week x 4 weeks.The Administrator/Designee will complete audits to ensure that dietary staff perform hand hygiene between tasks when ware washing and allow clean dishes to air dry 3 x per week x 4 weeks, then 2x per week x 4 weeks, then 1x per week x 4 weeks. 4. Data obtained during the audit process will be analyzed for patterns and trends and reported to The Quality Assessment and Assurance (QA & A) Committee by the Administrator monthly x 3 months. At that time, the QA & A committee will evaluate the effectiveness of the interventions to determine if continued auditing is necessary to maintain compliance. Date of Compliance Tuesday April 1, 2025	

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clean drying rack. He then returned to the dirty side of the dish machine to begin the process over again. Upon observing this practice, DA #1 was requested to stop. When asked if he should be moving from the dirty side of the dishwasher to the clean side without his washing hands and changing his gloves, he didn't respond. The DTR then instructed DA #1 to wash his hands if he was going to move from the dirty to the clean side of the dish machine. She told him that alternatively, he should enlist the help of a second Dietary Aide to assist him so that one Dietary Aide could work on the dirty side while a second DA worked on the clean side of the dish machine. At that time, the dishwashing process was suspended.

2-b. An observation of the facility's lunch tray line meal service was conducted on 3/4/25 at 12:14 PM. As the tray line began, the divided plates were observed to be placed in a vertical position on a rack behind the steam table. Upon review, the divided plates were noted to have water pooled in the corners of the divided sections. This was brought to the attention of the Dietetic Technician (DTR). An inspection of 24 divided plates revealed 3 of the plates were dirty, 16 of the divided plates were visibly wet where water dripped off the plates when they were tipped over, and only 5 of the divided plates were both clean and dry. The DTR instructed Dietary Aide (DA) #1 to run the divided plates back through the dish machine. He proceeded to do so. On 3/4/25 at 12:25 PM, DA #1 was observed as he pulled a rack of clean divided plates out of the dish machine and used a paper towel to wipe them dry. When the DTR was asked what she thought of that practice, she intervened and stopped DA #1 from wiping the divided plates. Instead, she instructed the DA to position the divided plates on

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PETTIGREW REHABILITATION CENTER	1515 W PETTIGREW STREET DURHAM, NC 27705

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the clean drying rack, so they were slightly tipped downward, allowing the water to drain as the plates air dried.

3. An initial tour of the facility's Dietary Department was conducted on 3/3/25 at 10:00 AM. An observation of the contents of the walk-in freezer revealed the following concerns were identified:
--One cardboard box containing an unsealed plastic liner with approximately 40 frozen waffles was open to air as it was stored in the freezer. Neither the box nor the plastic liner was dated as to when it had been opened.
--One stack of lunch meat was observed to have been opened and wrapped in cellophane. The stack consisted of approximately 10 slices of meat. The cellophane-wrapped meat was not labeled or dated.

Joined by Dietary Manager #1 on 3/3/25 at 10:06 AM, the initial tour of the Dietary Department continued. An observation of the contents of the facility's walk-in cooler revealed the following concerns were identified:
--A clear plastic bag containing approximately 3 pounds (#) of chicken salad was opened and not sealed (open to air). The bag was dated 2/24/25.
--Seven (7) and ½ quart cartons of half and half cream with a "use by" date of 3/2/25 were stored on a shelf, along with other dairy products.
--A one-gallon container of honey mustard dressing (with approximately 1/3 remaining in the container) was not dated as to when it was opened or when it expired.

An interview was conducted with Dietary Manager #1 during the tour of the walk-in cooler conducted on 3/3/25 at 10:06 AM. At that time, the Manager

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reported all food items identified in the walk-in freezer and walk-in cooler needed to be covered, labeled, and dated. She stated both the undated food items and expired foods needed to be discarded. Dietary Manager #1 was observed as she removed and discarded the undated and expired foods.

4. Accompanied by the Dietetic Technician (DTR) and joined by the Regional Vice President of Operations, a follow-up observation was conducted on 3/4/25 at 11:20 AM of the Dietary Department to observe the completion of meal preparation for the noon meal and tray line meal service. Upon entering the department, Cook #1, Cook #2, Dietary Aide #1 and Dietary Aide #2 were observed to be involved in food preparation activities. Each of these Dietary staff members were wearing hairnets or hair coverings. However, each of these four Dietary staff members had facial hair (at least ½ inch long) but were not wearing a beard cover. After watching the meal preparation activities for approximately 5 minutes, the four staff members with facial hair were observed as they each donned a beard cover.

5. Accompanied by Dietary Manager #1, observations of the kitchen equipment were made during the initial tour of the Dietary Department conducted on 3/3/25 at 10:27 AM as follows:
--The hood located above the range top, oven, and convention oven had brown/black build up on its outside surface.
--The outside surfaces of the oven and gas stove top had a brown/black grease buildup.
--The lowerator (an appliance that stores and heats plates) had food debris on its top, sides,

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and on the platform where the clean plates were stored.
--The sneeze guard on the steam table had multiple dried splashes and droplets of food and fluids on it.
--The ice machine was empty with multiple black particles observed on the bottom and sides of the storage bin.
--Three (3) vents on the side wall of the kitchen appeared to have a black substance built up on the frame and louvers of the vents.

An interview was conducted with Dietary Manager #1 during the initial tour of the Dietary Department conducted on 3/3/25 at 10:27 AM (with the focus on the cleanliness of the kitchen equipment). At that time, the Dietary Manager stated the brown/black build up observed on the outside surfaces of the hood, oven, and gas stove top appeared to be "grease." The Dietary Manager was shown the lowerator, steam table sneeze guard, and inside of the ice machine. She reported each needed to be cleaned. Dietary Manager #1 reported she was not sure whether the ice machine was in working order but noted it would need to be cleaned before it was put into service. When Dietary staff members were asked if the ice machine was working, the staff reported they were not sure. Upon inquiry, Dietary Manager #1 reported the Maintenance Department was responsible for cleaning the vents.

An interview was conducted with the Dietetic Technician (DTR) on 3/6/25 at 2:06 PM. During this interview, the concerns identified within the Dietary Department were discussed. The DTR reported that although she had not been at the facility during the initial tour on 3/3/25, she saw

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pictures of the equipment that required cleaning. She reported that "a crew" came in the evening of 3/3/25 to concentrate on cleaning in the Dietary Department. She stated that most (if not all) of the Dietary Department staff were relatively new and required ongoing education on the topics of appropriate dish washing practices, sanitation, cleaning duties, labeling/dating of opened food items, and the use of beard covers for Dietary staff with facial hair.

An interview was conducted on 3/6/25 at 2:35 PM with the Maintenance Assistant. During the interview, the Assistant reported there is a Maintenance book at each of the two nursing stations where work orders were kept. If staff preferred, they could call the Maintenance Department to put in a verbal request for work to be done (and write it in the Maintenance book afterwards).

An interview was conducted on 3/6/25 at 3:10 PM with the facility's Maintenance Director. The Maintenance Director stated he started working at the facility about two weeks ago. During the interview, the following issues were discussed:
--When asked about the ice machine, the Director reported he fixed the ice maker on Monday morning (3/3/25) after it was identified as not working. He stated that upon inspection, the water to the ice maker had been turned off and just needed to be turned back on.
--With regards to the dish machine not dispensing the chlorine solution to sanitize the dishes, the Maintenance Director reported the tubing which went from the container of chlorine solution to the machine needed to be primed. On 3/5/25, he educated the Dietary staff on how to prime the tubing so the appropriate amount of the chlorine

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solution would be dispensed.
--Upon inquiry, the Director confirmed the Maintenance Department was responsible for cleaning the air vents in the kitchen. He reported he just hadn't gotten to take care of that task yet, but confirmed it needed to be done.

An interview was conducted with the facility's Administrator on 3/6/25 at 4:03 PM. During the interview, the Administrator was asked what her expectation would be with regards to the concerns identified in the Dietary Department. In response, the Administrator stated her expectation would be for the Dietary Department to always maintain cleanliness and sanitation in the kitchen.