| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345053 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **08/09/2016** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **PETTIGREW REHABILITATION CENTER** | **1515 W PETTIGREW STREET**<br>**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 |
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| K 000 | INITIAL COMMENTS<br><br>A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. The facility is utilizing speical locking systems. In the exit conference all deficiencies noted were discussed and acknowledged with administration.<br><br>Stories: One (with basement )<br>Construction Type: II (111)<br>Constructed: 6/6/1969<br>Fully Sprinkled - Yes<br>At time of survey the:<br>Total Certified Bed Count = 96<br>Census = 94<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: | K 000 | | |
| K 012<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following:<br>19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70 (a)<br><br>Based on observations, and documentation review on 8/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted:<br><br>The facility maintenance and inspection of room walls was non-compliant, specific findings include:<br>The facility has holes in the medication room walls at the medication room servicing the nurses station number one. That room is on the egress | K 012 | 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.<br><br>Pettigrew Rehabilitation Center's | 9/23/16 |

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

Electronically Signed | 08/26/2016

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.

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| K 012 | Continued From page 1<br>corridor and is not currently smoke tight.<br><br>Ref: 2000 NFPA 101 Section 19.1.6.2; 8.2.3.1.4.2*<br><br>This deficiency affected one smoke of approximately six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke | K 012 | response to the Statement of Deficiencies and the Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Pettigrew Rehabilitation Center reserves the right to submit documentation to refute any of the stated deficiencies on the statement of Deficiencies through informal dispute resolution, formal appeal procedure, and/or other administrative or legal proceedings.<br><br>K012<br><br>The Maintenance Director corrected the holes in the medication room wall at nurse station one on 8/10/16.<br><br>The Maintenance Director completed a 100% audit to check all facility corridors/walls to ensure smoke tight on 8/26/16.<br><br>The Administrator in-serviced the Maintenance Department on ensuring that all facility corridors/walls are smoke tight and in proper repair.<br><br>The Administrator and/or Maintenance Department will monitor facility corridors/walls weekly for four weeks utilizing a QI audit tool.<br><br>The Administrator will review the QI audit tool weekly for fours weeks to assure the system is working and the facility is in compliance. | |

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| K 012 | Continued From page 2 | K 012 | The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area. | |
| K 025 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames.<br>8.3, 19.3.7.3, 19.3.7.5<br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70 (a)<br><br>Based on observations, and documentation review on 8/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted:<br><br>The facility maintenance and inspection of smoke / fire barriers was non-compliant, specific findings include:<br>The facility has unsealed penetrations in the rated smoke wall above the cross corridor smoke doors near the beauty shop where the sprinkler piping is penetrating the rated wall. The smoke barrier at that location shall be constructed to provide at least a one half hours fire resistance rating and constructed in accordance with regulations.<br><br>Ref: 2000 NFPA 101 Section 19.3.7.3; 8.3.2<br><br>This deficiency affected two smoke of approximately six smoke compartments. | K 025 | K025<br><br>The Maintenance Director corrected the smoke/fire barriers noted to be unsealed in the corridor near the beauty shop on 8/10/16.<br><br>The Maintenance Director completed a 100% audit to check all facility smoke/fire barriers to ensure all are sealed and in good repair on 8/26/16.<br><br>The Administrator in-serviced the Maintenance Department on ensuring that all facility smoke/fire barriers are sealed properly.<br><br>The Administrator and/or Maintenance Department will monitor facility smoke/fire barriers weekly for four weeks utilizing a QI audit tool. | 9/23/16 |

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| K 025 | Continued From page 3<br>Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke | K 025 | The Administrator will review the QI audit tool weekly for fours weeks to assure the system is working and the facility is in compliance.<br><br>The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area. | |
| K 029<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70 (a)<br><br>Based on observations, and documentation review on 8/9/2016, at approximately 9:15 AM onward, the following deficiencies were noted:<br><br>The facility maintenance and inspection of the hazardous areas was non-compliant, specific findings include:<br>The facility has unsealed penetrations in the rated ceiling where conduit is penetrating the ceiling in the mechanical space near the overhead electrical box in the basement area. | K 029 | K029<br><br>The Maintenance Director corrected the unsealed penetration in the rated ceiling where conduit is penetrating the ceiling in the mechanical space near the overhead electrical box on 8/10/16.<br><br>The Maintenance Director completed a 100% audit to check all facility hazardous areas to ensure no unsealed penetrations were noted on 8/26/16. | 9/23/16 |

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| K 029 | Continued From page 4<br><br>Ref: 2000 NFPA 101 Section 19.3.2.1; 8.4.1.1*<br><br>This deficiency affected one smoke of approximately six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke | K 029 | The Administrator in-serviced the Maintenance Department on ensuring all hazardous areas must have a one hour fired rated construction, to include sealed penetrations.<br><br>The Administrator and/or Maintenance Department will monitor facility hazardous areas weekly for four weeks utilizing a QI audit tool.<br><br>The Administrator will review the QI audit tool weekly for fours weeks to assure the system is working and the facility is in compliance.<br><br>The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area. | |
| K 076 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.<br>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4<br>This STANDARD is not met as evidenced by:<br>42 CFR 482.41(a)<br><br>Based on the observations, and staff interviews | K 076 | K076<br><br>The Maintenance Director corrected the | 9/23/16 |

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| K 076 | Continued From page 5<br>on 8/9/2016 at approximately 9:15 AM onward, the following deficiencies were noted:<br>The facility inspection of the storage of oxygen cylinders was non-compliant the specific items include:<br>1. The E type oxygen cylinders in the oxygen storage room were not properly secured. The full cylinders are stored in a smaller rack was not designed to hold E size cylinders securely.<br>2. Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly.<br><br>Ref: 2000 NFPA 101 Section 19.3.2.4; NFPA 99 Section 4-3.5.2.1b (27);<br>NFPA 99 4-3.5.2.2b(2)<br><br>This deficiency affected one smoke of approximately six smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke | K 076 | cylinder storage rack and designated full/empty areas for the cylinders on 8/26/16.<br><br>The Maintenance Director completed a 100% audit to check all facility oxygen storage areas to ensure proper storage racks and designated full/empty areas for cylinders on 8/26/16.<br><br>The Administrator in-serviced the Maintenance Department on ensuring that all facility oxygen storage areas must have designated areas for full/empty cylinders and the appropriate racks.<br><br>The Administrator and/or Maintenance Department will monitor facility oxygen storage weekly for four weeks utilizing a QI audit tool.<br><br>The Administrator will review the QI audit tool weekly for fours weeks to assure the system is working and the facility is in compliance.<br><br>The Administrator will submit results of the audits to the Quality Improvement Executive Committee Meeting monthly for review, recommendations, and monitoring of continued compliance in this area. | |