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 ______	07/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PETTIGREW REHABILITATION CENTER	**1515 W PETTIGREW STREET DURHAM, NC 27705**

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F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident interviews and	F 565	Pettigrew Rehabilitation Center	8/9/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/03/2018

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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F 565 Continued From page 1

staff interviews, the facility failed to resolve grievance that were reported in resident council meetings for 3 of 3 consecutive months.

The findings included:

During the resident council meeting 8 residents were identified as alert and oriented on 7/10/18 at 2:00 PM. The residents revealed an issue with the resolution of group grievances.

The residents in the meeting reported not all grievances were acted upon promptly by the facility and there was no reasonable or satisfiable resolution for the group. The residents reported the on-going group concern included not receiving meal of the month, choice or preferable foods such as chicken on the bone, hot dogs and foods or snacks with peanut butter. The residents added each month the discussion comes up and if the meal of the month included chicken on the bone the group was told another selection had to be made, not sure why foods of choice like hot dogs or food with peanut butter had to been taken from everyone. The resident further stated the food items were removed from the facility menus and food selection of choices by dietary manager and administrator due to a policy and safety per administrator. The residents stated their rights to foods of choice was being violated and if they wanted the designated food items the family had to bring in these items for them. Residents did not feel the family should have to bring in food items the facility was able to provide.

Review of the resident council concerns dated 4/17/18, revealed the residents requested chicken on the bone as part of the meal of the month.

F 565

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. 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.

F565

Education was provided to Activity Director on 8/1/18 by the Administrator regarding follow-up and resolution of grievances revealed in resident council. Root Cause: Facility did not escalate resident council concern beyond facility level due to misunderstanding of the facility’s ability to amend/change the current standard.

The Administrator held a meeting with Resident Council on 7/25/18 to review

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F 565	Continued From page 2 Review of the resident council concern dated 5/2/18 resident requested fried chicken on the bone for meal of choice. Emergency resident council meeting held on 5/4/18, revealed the residents were asked to switch meat request of chicken on the bone to fried salmon cakes. The Dietary Manager(DM) was asked why they could not have the chicken on the bone. The DM and Administrator went over the policies for Southern Healthcare regarding food choices and indicated it was a facility policy and choking hazard. The Administrator further reported to the group that food items such as hot dogs and peanut butter products in addition to chicken on the bone would no longer be provided by the facility and if resident would like these food items. The family would have to provide these food items for them. Review of the resident council meeting dated 6/5/18, revealed further discussion regarding the foods of choice for the residents and no resolutions for the resident concerns for the past 3 meetings. The concern continued to be the provision of food choices for meal of the month and as individuals and the expectation for family to provide foods the facility was able to provide. During an interview on 7/11/18 at 2:20 PM, the Administrator stated there was no policy for the resident's not receiving the chicken on the bone and he misspoke when he told the resident this information in group. He further stated the chicken on the bone was not served because it was not part of the facility menu. He added that in the resident council meeting he also informed the residents of the discontinuation of foods such as	F 565	with the residents bone in chicken, hot dogs, and items with peanut butter are now available upon resident request. The Administrator in-serviced staff on 8/1/18 to make them aware the facility is now offering bone in chicken, hot dogs, and peanut butter per resident's request. Administrator was educated by Regional Clinical Director regrading escalating resident grievances/concerns above the facility's level when related to facility's policies on 8/3/18. The Activity's Director and/or Designee will have a resident council meeting weekly for 4 weeks to ensure that grievances reported in resident council are followed up on and resolved. The Activity's Director 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. Administrator will be responsible for implementation of this plan of correction.	

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F 565	Continued From page 3 hot dogs and peanut butter products effective 6/1/18 per policy and choking hazards. The administrator indicated there was no system in place to assess residents for choking hazards or inform families of the removal of the food items of choice. During an interview on 7/11/18 at 2:50 PM, the Registered Dietician (RD) stated the previous Dietary Manager(DM) had spoken with the residents regarding the facility choking hazards for the supply of cylindrical items with casings (hot dogs, sausage), peanut and choking hazards. The policy went into effect 6/1/18. Southern Healthcare management implemented the policy not to provide these items to residents. If resident family wanted to bring these food items that were removed from the food selection it would be fine.	F 565		
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 record review and staff interviews, the facility failed to code the discharge Minimum Data Set (MDS) assessment to reflect accurately the discharge status for 1 of 8 residents, reviewed for assessment accuracy (Resident #78). Findings included: Resident #78 was admitted to the facility on 4/20/18 with diagnoses included ESRD (renal insufficiency), epilepsy, diabetes mellitus and	F 641	F641 The Minimal Data Set nurse corrected the incorrect coding for resident #78 on 7/11/18. Root Cause: The MDS nurse based the discharge status of the resident on prior knowledge of the expected discharge location not the actual discharge location. Education was provided to the Minimal	8/9/18

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F 641	Continued From page 4 cerebral infraction. Record review of the Discharge MDS assessment, dated 5/23/18, revealed Resident #78 was discharged to acute hospital. Record review of Resident 78 ' s plan of care, dated 4/23/18, revealed resident ' s wishes to be discharged to home with the spouse. Review of the physician ' s orders for Resident #78 revealed the order, dated 5/11/18, indicated that resident "will discharge home" on 5/23/18. Record review of the nurses ' notes, dated 5/23/2018, revealed that Resident #78 was discharged home. On 7/11/18 at 3:35 PM, during an interview, Nurse #4 indicted that she was responsible for MDS assessment of Resident # 78. The resident was scheduled for sleep study in the hospital on the night of 5/23/18 but went home with his wife on 5/23/18. The nurse stated that she put incorrect discharge coding for Resident #78. On 7/12/18 at 10:15 AM, during an interview, the Director of Nursing indicated that her expectation the MDS nurses to provide accurate coding, reflecting actual resident ' s status.	F 641	Data Set nurses on 8/1/18 by the Corporate Clinical Process Analyst regarding accurately coding discharges. A 100% audit of the last 30 days was completed on 8/2/18 by the Minimal Data Set nurses to ensure discharge MDS assessments have accurate coding of where the resident was discharged. The Director of Nursing will audit the discharge assessments for accuracy weekly for 12 weeks. 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. Director of Nursing will be responsible for implementation of this plan of correction.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812		8/9/18

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F 812	Continued From page 5	F 812		

state or local authorities.
(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review, the facility failed to label properly food stored in walk-in freezer and walk-in cooler, failed to discard expired food from walk-in cooler in the kitchen.

Findings included:

1a. On 7/9/18 at 9:15 AM, an observation in the kitchen of foods, stored in the walk-in freezer revealed one opened paper box of Chicken Tenders, one opened paper box of Breaded Shrimps, one opened paper box of Homestyle Cookie Dough, one opened paper box of Frozen Fish and one opened paper box of Veggie Burgers with no expiration date on them.

1b. On 7/9/18 at 9:20 AM, an observation in the kitchen of foods, stored in the walk-in freezer revealed one opened box of French Fries, two plastic containers of Strawberry Cream Pies and three plastic bags of Frozen Bread without labels on them.

F812

The Dietary Manager immediately addressed the food without proper labeling in the walk in freezer and refrigerator and the expired food noted in the walk in refrigerator. Root Cause: In the time period of 5/8/2018 to present, there was a transition in the dietary department which led to the facility's inability to perform quality monitoring and comprehensive review in order to ensure compliance.

An audit was completed by the Consultant Dietitian to ensure compliance with labeling items and ensuring expired items were discarded on 07/9/18.

The Administrator completed an in-service of properly labeling items and discarding expired food items to dietary staff on 8/2/18.

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F 812	Continued From page 6 2a. On 7/9/18 at 9:30 AM, an observation in the kitchen of foods, stored in the walk-in refrigerator revealed two unopened plastic bags of Whipped Toppings with no expiration date on them. 2b. On 7/9/18 at 9:35 AM, an observation in the kitchen of foods, stored in the walk-in refrigerator revealed one opened plastic bag of Parmesan Cheese, expired on 7/4/18. On 7/9/18 at 9:25 AM, during an interview, the Dietary Manager indicated that all food packages should be properly labeled and expired food discarded appropriately. On 7/9/18 at 9:45 AM, during an interview, the Cook indicated that all the kitchen staff was responsible for labeling food in the walk-in freezer and cooler, check the expiration date and discard expired food. On 7/9/18 at 10:50 AM, during an interview, the Administrator indicated it was his expectation that staff labeled food appropriately and discard expired food. Review of Receiving Food and Supplies policy, dated 9/27/16, revealed the described procedure for food delivery, inspection, distribution, labeling and appropriate storage.	F 812	Administrator and/or Designee will conduct random weekly audits of proper labeling of items and having expired food discarded for twelve weeks. 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. Administrator will be responsible for implementation of this plan of correction.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must:	F 867		8/9/18

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F 867	Continued From page 7 (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in June of 2017. This was for a recited deficiency, which were originally cited on 6/15/17 during the recertification survey and on the current recertification survey. The repeated deficiency was in the area of food procurement store/prepare/serve foods under sanitary conditions (F371 which is now F812). The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective quality assurance Program. The Findings included: This tag is cross-referred to: 1.F-812: Based on observations, staff interviews and record review, the facility failed to properly label food stored in walk-in freezer and walk-in cooler, failed to discard expired food from walk-in cooler in the kitchen. The facility was cited during the 6/15/17 recertification survey for failure to properly label food in the walk-in refrigerator, failure to store food under sanitary conditions in the walk- in freezer and serve food under sanitary conditions in the dining hall. The facility also cited for failure to maintain a clean ice machine.	F 867	F867 The facility held an ad hoc QAPI meeting on 8/3/18 to review previous citations regarding the second citation of food labeling to assure professional standards of practice are followed and having an ineffective QA program. Root Cause: In the time period of 5/8/2018 to present, there was a transition in the dietary department which led to the facility's inability to perform quality monitoring and comprehensive review of previously cited deficiencies. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. QAPI team members were in-serviced by the Administrator on 8/2/2018. The education included the QA program review of previous survey citations and the inclusion of on-going monitoring to maintain compliance. The QA meeting has been revised and changes are being made so that previous citations will be reviewed as needed and followed up on with documentation being recorded in the QA minutes. The Administrator will document in the QA minutes the monthly review of on-going	

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F 867	Continued From page 8 During an interview on 07/12/18 04:56 PM , the Administrator indicated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits and monitors that plan and 4) discusses the outcome. The Administrator indicated QAA was a work in progress. He indicated QAA meets monthly, quarterly and no as needed basis, and discusses the identified concerns, goals met, and improvement needed. Administrator stated that it was his expectation that staff use proper labeling and discard expired products immediately and appropriately. He further stated that facility had some issues with recruiting dietary managers and were unable to have consistent dietary manager for past few months which was a factor in the facility's continued noncompliance with this tag.	F 867	QAPI plans with the QA team for three months and as needed. The Administrator will be responsible for implementing the plan of correction. QAPI committee will review the results of the audits monthly for three months and as needed thereafter. Administrator will be responsible for implementation of this plan of correction.	