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 07/11/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 07/08/19 through 07/11/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # FCFV11.	E 000		
F 000	INITIAL COMMENTS A recert with complaint investigation survey was conducted from 07/08/19 through 07/11/19. 6 of the 6-complaint allegation(s) were not substantiated.	F 000		
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, staff interviews, and observations, the facility failed to accurately code the MDS (Minimum Data Set-a tool used for resident assessment) in the area of active diagnoses for 1 out of 18 residents (Resident #5) reviewed. Findings included: Resident #5 was admitted to the facility 2/7/14 with the last date of re-entry on 4/8/17. A review of a quarterly MDS dated 4/10/19 revealed Resident #5 had adequate hearing, vision and clear speech, and was cognitively intact. Active diagnoses included, but were not limited to, diabetes mellitus, cerebral vascular accident and gastrostomy status (an opening into the stomach from the abdominal wall, made surgically for the	F 641	F641 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. 1. A modification of the quarterly MDS dated 4/10/19 to remove the coding for the gastrostomy tube from the active diagnoses was completed by the Clinical Reimbursement Director (CRD on	8/6/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/28/2019

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 641 Continued From page 1

introduction of food). The MDS also revealed Resident #5 was assessed as having received no enteral or tube feeds.

An observation was conducted on 7/9/19 at 10:10AM of Resident #5 during morning care. No gastrostomy was observed. The resident denied having a feeding tube. There was a colostomy present, which appeared without concern.
An interview was conducted on 7/9/19 at 10:20AM with Nurse #2. She stated Resident #5 had not had a gastrostomy (feeding tube) throughout the 2 years she had been employed at the facility.

An interview was conducted with Nurse #1 on 7/9/19 at 2:50PM. She stated Resident #5 never had a gastrostomy but does have a colostomy.

An interview was conducted with the MDS Coordinator on 7/10/19 at 9:50AM. She stated she gathered information for MDS completion from the medical record, physician notes, hospital records, nursing assessments, and face to face resident assessments. She also stated a gastrostomy was, "an opening in the stomach made surgically for the introduction of food. It sounds like a feeding tube. I get active diagnoses from physician documentation and face to face resident interviews and assessments. I think something needs to be documented in the last 90 days by the physician for it to be an active diagnosis. (Resident #5) has gastrostomy status coded under the active diagnosis tab in the last quarterly MDS dated 4/10/19."

An interview was conducted with MDS Nurse #2 on 7/10/19 at 10:00AM. She stated active diagnoses are coded based on hospital discharge

F 641 (Plan of correction)

7/10/19).

2. An audit of active diagnoses of all MDSs completed in the last 90 days was completed by the CRD on 7/12/19 to ensure the MDSs correctly reflected their active diagnoses s status. If the MDS did not correctly reflect the active diagnoses status, a modification assessment was completed and submitted to remain in compliance with the Resident Assessment Instrument (RAI) Manual.

3. The Clinical Reimbursement Director (CRD) and the Clinical Reimbursement Staff (CRS) were in-serviced by the Regional Clinical Director on 7/23/19 regarding accurately coding of the MDS. The active diagnoses of MDSs in progress will be reviewed the Interdisciplinary Team in the Daily Clinical Meeting prior to the Assessment Reference Date (ARD) to ensure the active diagnoses are accurately reflected on the MDS.

The accuracy of the active diagnoses of 10% of MDSs completed, will be audited by the CRD for the next two months, or until 100% compliance is achieved for two consecutive months, to ensure the MDSs are accurately coded.

Outcomes related to those audits will be reviewed at the weekly QAPI meeting and with the steering QAPI committee monthly.
The steering committee will direct further analysis and interventions

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F 641	Continued From page 2 summaries and face to face assessments. Active diagnoses were what was being treated during the look back period. She also stated a gastrostomy was a feeding tube and gastrostomy was coded if the resident had a feeding tube regardless if it was being used or not. She stated, "If Section I was coded as gastrostomy status it meant the resident had a feeding tube." An interview was conducted with the Director of Nursing (DON) on 7/10/19 at 10:10AM. She stated, "I'm familiar with (Resident #5). She had a feeding tube back in 2014, but it has long since been removed. I expect MDS nurses to complete an MDS assessment face to face, and the MDS should be accurate." An interview was conducted with the Administrator on 7/10/19 at 10:15AM. She stated her expectations was for the MDS to be completed accurately the first time. She also stated she expected the MDS nurse to complete her own actual physical assessment. An interview was conducted with the Regional Clinical Director on 7/10/19 at 10:20AM. She stated she believed the MDS Active Diagnosis section 'pulled' gastrostomy from the admission records diagnoses. She also stated a correction would be made to the 4/10/19 MDS.	F 641	based on reported outcomes and direct further investigations.	
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		8/6/19

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F 812	Continued From page 3 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 store food under sanitary conditions in the walk-in freezer and failed to label and date food items in 2 of 2 nourishment refrigerators and label opened loaves of bread stored on the bread rack in the kitchen. Findings included: 1a. An observation of the walk-in freezer on Monday 07/08/19 at 10:34 AM, revealed water from ceiling leaking onto the boxes of frozen meat stored in the freezer. Observation also revealed ice on a box of chicken, a box of meat balls, and a box diced beef and a box beef patties. There was ice buildup on the floor and black matter built up in the openings of the floor mat. During an interview on 07/08/19 at 10:36 AM the Dietary Manager (DM) stated that there was a leak on the outside roof that was coming into the freezer, she reported it to the Maintenance	F 812	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were identified to be affected by the food storage in the freezer and the nourishment refrigerators. The freezer was cleaned, and the ice was removed from the boxes of chicken, meat balls, diced beef and beef patties; as the Dietary Manager showed the surveyor, the inside of the boxes were not wet, however the boxes were moved to another area of the freezer away from the area that was leaking on 7/8/19. The ice build-up on the floor was cleaned by the Dietary Manager on 7/8/19. The ice fragments on the floor and under the shelves was cleaned up by	

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F 812

Continued From page 4

Director (MD) on Friday 7/5/19 and he repaired it. She indicated they had just received a food shipment and would get the area cleaned up.

An observation of the walk-in freezer on 7/10/19 at 12:23 PM, revealed ice fragments on the floor and under the shelves. A buildup of black matter was also observed in the openings on the floor. An aluminum pan was observed on the shelf under the compressor fans. Observations also revealed, below the aluminum pan were a brown cardboard box labelled "sweet potato pies ", a brown cardboard box labelled "skin on potato cubes 36 pounds (lbs.) ", and 2 brown boxes labeled "crinkle cut potato 6/ 5 lb. bags" that were wet and had ice on them.

During an interview 7/10/19 at 12:24 PM the DM indicated the pan on the top shelf was used by maintenance to collect fluid while he hosed off the ice from the fans. The ice on the floor was from maintenance hosing off the fans.

During interview 07/10/19 02:30, Maintenance Director (MD) indicated that the freezer coils get a buildup of ice and to defrost the freezer he used a hose and placed an aluminum pan under the compressor coils to catch the water. Defrosting was part of weekly preventive maintenance and checked weekly. This prevented the temperature from rising in the freezer. He stated he did notify the DM prior to defrosting and had moved the food forward in the freezer to prevent it from getting wet.

2 a. An observation of the bread rack on 07/10/19 at 12:23 PM, revealed an opened bag of hamburger buns with 4 buns in them, an opened

F 812

the Dietary Manager when it was brought to her attention by the surveyor on 7/10/19. The aluminum pan was removed, the floor mat was cleaned, and the ice was removed from the boxes labeled “sweet potato pies, skin on potato cubes, and crinkle cut potatoes” on 7/10/19. The Dietary Manager showed the surveyor, the inside of the boxes were not wet, however the boxes were moved to another area of the freezer away from the area that was leaking. The open bags of hamburger buns, hot dog rolls and Texas Toast were discarded by the Dietary manager on 7/10/19. The plastic container of tomato and lettuce salad, the plastic container of the small amount of pale brown food, and the partial bottle of clear liquid were removed from nourishment refrigerator #1 by the Dietary Manager when they were brought to by attention by the surveyor on 7/10/19. The partial bottle of clear liquid was removed from the refrigerator, and the vanilla ice cream was removed from the freezer in nourishment #2 by the Dietary Manager when they were brought to by attention by the surveyor on 7/10/19.

The Dietary Manager will complete and document daily walk through of the kitchen, freezer, refrigerators, dry storage and nourishment refrigerator to ensure the food is dated and stored properly. The Dietary Staff was in-serviced by the Dietitian on 7/19/19 regarding the proper labeling and storage of food, the importance of checking the equipment on

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F 812	Continued From page 5 bag of hot dog rolls, one opened bag of half loaf of Texas toast and one of bag of half loaf opened white bread with no label or date on them. On 07/10/19 12:23 PM, during an interview, DM indicated the bread was delivered two days before. DM stated the bread should be labelled by the dietary staff. 2b. An observation of the nourishment refrigerator #1 on 7/10/19 at 11:40 AM, revealed a plastic container of tomato and lettuce salad, without a label. Observation also revealed a plastic container containing small amount of pale brown food with no label. A partial bottle of clear liquid with no label. An observation of the nourishment refrigerator #2 on 7/10/19 at 11:44 AM, revealed a partial bottle of clear liquid with no label and in the freezer vanilla ice cream partially used with no label. During an interview on 7/10/19 at 11:45 AM, DM stated the dietary staff were responsible for checking the nourishment refrigerators and to inform the nurse to label and/ or discard the food brought to resident from family or visitors that was stored in the nourishment refrigerator. During an interview on 7/11/19 at 11:45 AM, the Administrator stated it was her expectation that the foods were labelled prior to be placed in the nourishment refrigerator. She indicated she expected the Maintenance Director to communicate with dietary staff prior to conducting any maintenance in the freezer so that the appropriate action could be taken by the dietary staff.	F 812	a daily basis for need of repair, and what to do if leaking and/or ice build-up is noted in the freezer. They were also in-serviced regarding the process for inspecting and labeling food in the nourishment refrigerators. The nursing staff were also in-serviced by the Director of Nursing regarding the policy for labeling food in the nourishment refrigerators. The Dietary Manager and Maintenance Director inspected all food storage areas to include the kitchen, dry storage and the refrigerator to ensure there was no leakage from the roof on 7/10/19. The Maintenance Director was in-serviced by the Administrator on 7/23/19 regarding preventative maintenance for food storage area to include weekly inspections to identify any issues that may affect the proper storage of food, inspection of the freezer coils for ice buildup and proper defrosting of the freezer coils. The education also included communication with the Dietary Department so food may be moved and stored properly while repairs are being completed. The Maintenance Director will report in the Daily Stand Up Meeting any projects, including defrosting of the freezer coils scheduled for that day to inform department heads of scheduled projects, so food may be moved and stored properly while repairs/defrosting is being completed. In addition, the Maintenance Director will document all preventative maintenance on the preventative maintenance logs to ensure	

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F 812	Continued From page 6	F 812	preventative maintenance is completed and documented. The Administrator will audit by conducting random sanitation inspections in the kitchen and nourishment rooms at least 3 times weekly until 100% compliance regarding freezer and food labeling is maintained for at least two consecutive months. In addition, the Administrator or designee will review the Preventative Maintenance Log to ensure preventative maintenance is being completed as scheduled weekly until 100% compliance is maintained for 2 consecutive months. Results of those audits will be reported to QAPI committee monthly for three months and the quality monitoring schedule will be modified based on findings.	
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: (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 July of 2018. This was for one deficiency, which were originally cited on 6/15/17	F 867	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared	8/6/19

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	345053	A. BUILDING ______ B. WING ______	C 07/11/2019

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F 867	Continued From page 7	F 867		

and 7/12/18 during the recertification survey and on the current recertification and complaint survey. The repeated deficiency was in the area of food procurement store/prepare/serve foods under sanitary conditions (F371 which is now F812). Two deficiencies were originally cited on 7/12/18 during the recertification and during the current recertification and complaint survey. The repeated deficiencies were in the area of accuracy of assessment (F641) and Quality Assurance and Performance improvement (QAPI)/ QAA improvement activities (F 867) The continued failure of the facility during three 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. During the recertification survey dated 7/11/19 F-812 food procurement store/prepare/serve foods under sanitary conditions was cited. Based on observations, staff interviews, and record review the facility failed to store food under sanitary conditions in the walk-in freezer and failed to label and date food items in 2 of 2 nourishment refrigerators and open packages of bread were stored on the bread rack in the kitchen.

During the recertification survey in July 2018 the facility was cited for failure 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 also cited during the 6/15/17

Provider's Plan of Correction (F 867):

and / or executed solely because it is required by both Federal and State laws.

The facility held and ad hoc QAPI meeting on 7/23/19 to review the previous citations and regarding assuring professional standards of practice are followed in regards to having an effective QAPI program.

The QAPI team members were in-serviced by the Regional Clinical Director on 7/23/19. The education included the QAPI program, review of the previous survey citations, and the inclusion of on-going monitoring to maintain compliance.

The QAPI meeting has been revised and changes are being made so that previous citations will be reviewed and outcomes of the associated audits analyzed for effectiveness, need for revision and potential for cessation with documentation being recorded in the QAPI minutes. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.

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F 867	Continued From page 8	F 867		

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.

2. During the recertification survey dated 7/11/19 F 641 Accuracy of assessment was cited. Based on record review, staff interviews, and observations, the facility failed to accurately code the MDS (Minimum Data Set-a tool used for resident assessment) in the area of active diagnoses for 1 out of 18 residents (Resident #5) reviewed.

During the recertification survey on 7/12/18 , the facility was cited for failure 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).

3. During the recertification survey dated 7/11/19 F867 QAPI/QAA improvement activities was cited. 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 July of 2018.

During the recertification survey dated 7/12/18 the facility was cited for failing to effectively maintain implemented procedures and effectively monitor these interventions that the committee put into place in June of 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 07/11/2019

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F 867	Continued From page 9 During an interview on 7/11/19 at 12:49 PM, the Administrator acknowledged understanding of the reciting of F 641, F 812 and F 867 during the recent recertification and complaint survey in July 2019. The administrator indicated she had recently accepted this position in the facility. She stated 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. Administrator indicated QAA meets monthly, quarterly and no as needed basis, and discusses the identified concerns, goals met, and improvement needed. The Administrator stated it was her expectation that the foods were labelled prior to be placed in the nourishment refrigerator. She further stated that the resident's assessments should be completed accurately and in a timely manner. The Administrator indicated QAA was a work in progress.	F 867		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain one of one walk-in freezer in safe operating conditions. The freezer leaked from the ceiling and did not defrost automatically resulting in ice build-up on the shelves and on the floor. Findings included: Review of the maintenance order request dated	F 908	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. No residents were noted to be affected by	8/6/19

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F 908 Continued From page 10

7/7/19 completed by the Dietary Manager read in part "Freezer leaks on roof and around seals when raining". The document also indicated Maintenance had completed the work order on 7/7/19 at 6:15 PM. Maintenance note read "patch roof with cool seel" (sic).

An observation of the kitchen's walk- in freezer on 07/08/19 at 10:34 AM, revealed the ceiling leaking clear liquid onto the boxes of frozen meat and onto the floor. An ice buildup was observed on the floor and on the shelves of the walk-in freezer.

During an interview on 07/08/19 at 10:36 AM the Dietary Manager (DM) stated that there was a leak on the roof that was coming into the freezer. The DM indicated a work order was generated and the Maintenance Director (MD) had repaired it. DM further stated the ice on the floor was due to the leak from the roof.

The roof contractor invoice dated 7/10/19, read in part "Item description," To seal voids in termination bar flashing and to seal open wall flashing material on 7/8/19.

Observation of the walk-in freezer on 7/10/19 at 12:23 PM, revealed ice fragments on the floor and accumulation of ice under the shelf. Observation also revealed an aluminum pan placed on the shelf under the compressor fans of the freezer.

During an interview on 7/10/19 at 12:24 PM, the DM indicated the aluminum pan on the top shelf was used by maintenance to collect fluid while he hosed off the ice from the fans. DM stated the ice on the floor was from maintenance hosing off the fans.

During interview on 7/10/19 at 2:30 PM, MD

F 908

the roof leak and ice buildup on the coils in the freezer. The area of determined to be leaking in the freezer was repaired by an outside contractor on 7/10/19 and there is no longer any leakage from the roof into the freezer.

The Dietary Manager and Maintenance Director inspected all food storage areas to include the kitchen, dry storage and the refrigerator to ensure there was no leakage from the roof on 7/10/19.

The Maintenance Director was in-serviced by the Administrator on 7/23/19 regarding preventative maintenance for food storage area to include weekly inspections to identify any issues that may affect the proper storage of food, inspection of the freezer coils for ice buildup and proper defrosting of the freezer coils.

The education also included communication with the Dietary Department so food may be moved and stored properly while repairs are being completed. The Maintenance Director will report in the Daily Stand Up Meeting any projects scheduled for that day to inform department heads of scheduled projects. In addition, the Maintenance Director will document all preventative maintenance on the preventative maintenance logs to ensure preventative maintenance is completed and documented.

The Administrator or designee will review the Preventative Maintenance Log to ensure preventative maintenance is being completed as scheduled weekly until

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 07/11/2019

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 908	Continued From page 11 indicated the freezer coils got a build-up of ice and to defrost the freezer he used a hose. An aluminum pan was placed under the coils to catch the water. MD stated the defrosting was part of weekly preventive maintenance. MD further stated this prevented the temperature from rising in the walk-in freezer. MD indicated he was notified about the roof leak on 7/7/19 and had put a patch on the roof. He added a roofing company was contacted to put flashing on the roof.	F 908	100% compliance is maintained for 2 consecutive months. Outcomes of those reviews will be presented to the steering QAPI committee monthly. The steering committee will direct further analysis and interventions based on reported outcomes and direct further investigations.	