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 05/19/2022

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 000	INITIAL COMMENTS An unannounced complaint investigation was conducted 5/16/22 - 5/19/22. Additional information was obtained offsite on 5/19/22. Therefore, the exit date was 5/19/22. Event ID# L9OZ11. The following intakes were investigated NC00184474, NC00185866, NC00186974, NC00187427, and NC00188966. 3 of the 25 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, family interview, and physician interview, the facility failed to protect a resident's right to be free from employee to resident abuse for 1 of 3 residents (Resident #1) reviewed for abuse. Nurse Aide (NA) #7 mocked and intimidated Resident #1 when she refused his assistance and Resident #1 expressed NA #7 inappropriately touched her	F 600	Preparation and/or execution of this plan of correction does not constitute 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	6/16/22

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

Electronically Signed | 06/10/2022

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F 600	Continued From page 1 breast. The findings included: Resident #1 was admitted to the facility on 1/24/22 with diagnoses that included cerebral infarction and aphasia. The care plan dated 1/25/22 revealed a focus area for impaired communication related to aphasia. Interventions included allowed ample time to respond and ensured a safe environment. The quarterly Minimum Data Set dated 4/18/22 revealed Resident #1 was independent with bed mobility and toileting. The standardized cognition test revealed she was cognitively impaired. A progress note by Nurse #11 dated 3/8/22 revealed Resident #1 was alert and able to communicate needs to staff. A progress note by Physician's Assistant (PA) #1 dated 3/16/22 revealed Resident #1 had expressive aphasia and she responded consistently to yes and no questions. She was noted to be pleasant and cooperative. Review of the Initial Allegation Report revealed the facility became aware of Resident #1's accusation of sexual abuse on 3/8/22 at 10:45 PM. The resident's roommate told Administrator #3 and staff that Resident #1 expressed NA #7 had touched her breast. The details of mental harm section stated the resident was teary eyed and very upset, stating "no, no, no." The police department was notified on 3/8/22 at 11:40 PM. On 3/9/22 Administrator #3 and Regional Nurse	F 600	and state law. F600 Freedom from Abuse, Neglect, and Exploitation 1. Resident #1 was discharged home with family on 4/26/2022. 2. All alert and oriented residents were interviewed by Social Worker/Activity Director regarding abuse, to include but not limited to; humiliation, threats of punishment, intimidation. Interviews were completed by 6/9/2022. Any concerns were addressed immediately. All other residents were evaluated by the DON/Unit Manager/Designated nurse for any signs of physical abuse or mental anguish (unusual/new tearfulness, anxiety, etc.). The evaluations were completed by 6/10/2022. Any concerns were addressed immediately. 3. Facility staff were re-educated by SDC/Designee on abuse, neglect and exploitation. Staff re-education will be completed by 6/16/2022. The facility administrator who was involved in the investigation is no longer employed at the facility.	

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F 600	Continued From page 2 Consultant #1 reviewed camera and audio recordings of the interaction between Resident #1 and NA #7 on 3/8/22. The video recording was dated 3/8/22 and a narrative described the details of the interaction. The narrative stated Resident #1 was observed to become upset when she saw NA #7 at the nurse's station. Resident #1 continued to say "no" and gestured with her hands at NA #7. The NA was noted to mock her movement and said "no" back to the resident. Other staff present at the nurse's station informed NA #7 to stay away from the resident. NA #7 was observed going into Resident #1's room and the audio recording revealed Resident #1 continued to say "no" to NA #7. The narrative further revealed NA #7 was not assigned to Resident #1 on 3/8/22. After review of the video encounter, NA #7 was terminated for inappropriate interaction with Resident #1. A request to view the video footage was made on 5/18/22 at 1:30 PM. Video footage of the incident was not available to review. A recording of the interaction was not saved. The facility investigation report revealed the investigation ended on 3/11/22. NA #7 was terminated from employment on 3/14/22 for rude behavior at the nurse's station as well as aggressive comments made to multiple staff members on 3/8/22. The report indicated mental anguish was observed for Resident #1 and her emotional response and behavior was crying and saying "no, no, no." Resident #1 was referred to psychiatric services. Review of NA #7's disciplinary action record dated 3/14/22 revealed they had expressed rude behavior at the nurse's station as well as made	F 600	The current administrator and the regional nurse were re-educated on 6/8/2022 by Vice President of Operations regarding preventing, recognizing, and reporting abuse. 4. Random interviews with alert and oriented residents regarding abuse will be conducted by the SDC/DON/ Unit Manager/ Designee daily for 2 weeks, weekly for 4 weeks and monthly for 3 months. Any negative responses will be addressed by the Administrator and DON for follow up/investigation. The audit results will be reviewed in the monthly QAPI meeting for a minimum of 3 months. The QAPI committee will determine the need for further monitoring beyond 3 months.	

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aggressive comments to multiple people on 3/8/22. Actions were validated with witness statements and camera footage.

Multiple attempts to reach NA #7 by telephone were unsuccessful. In his written statement dated 3/8/22 NA #7 indicated Resident #1 presented with an angry disposition toward him on 3/8/22. He felt this was strange and asked her several times why she was angry. He explained, in his dealings with her, he never touched or said anything disrespectful or demeaning. The last two times he worked with her involved him assisting her back to bed after she rolled to the floor, and "night before last" when he assisted her to the bathroom then back to bed.

An interview was conducted with Resident #10 on 5/17/22 at 10:30 AM. Resident #10 was cognitively intact. She recalled Resident #1 stating they were roommates on 3/8/22. Resident #10 stated she heard Resident #1 hollering, "no, no, no" in the hallway outside of their room. Resident #1 came into the room and was visibly upset. Her face was red, she was breathing heavy, upset, and crying. Resident #10 had nursing staff come check her. After the nursing staff left the room, NA #7 came into the room and Resident #1 pointed at NA #7, crying, and said, "no, no, no." Resident #10 stated she had not seen Resident #1 upset before with male or female staff. Resident #10 asked Resident #1 a series of yes and no questions and determined NA #7 had touched Resident #1 inappropriately. Resident #1 gestured NA #7 had touched her breasts. Resident #10 felt certain unwanted inappropriate touching had occurred and believed it was mentally painful to Resident #1.

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An interview was conducted with NA #6 on 5/17/22 at 3:00 PM. She stated she was at the nurse's station on 3/8/22 with NA #7 when Resident #1 came to ask for ice. NA #7 told Resident #1 to give him her cup. Resident #1 stated "no, no, no" and became visibly upset and was tearful. NA #7 reportedly asked Resident #1 why she was acting like that stating he would tell her dad. NA #6 believed this was done in an intimidating manner. Resident #1 went to her room and was tensed up and crying. NA #6 went with Resident #1 to her room and the resident stated, "him no good." NA #7 came into the resident's room stating, "don't be in here telling lies." NA #6 stated Resident #1 had motioned that NA #7 touched her breast. Nurse #9 and Administrator #3 were notified. When NA #7 was at the nurse's station, he was angry and cursing about Resident #1 stating he didn't do anything to her, and she should find the other side of her brain. NA #6 explained staff were able to communicate with Resident #1 as she answered yes and no questions and used gestures. Resident #1 did not express confusion but was sometimes frustrated when trying to communicate with her aphasia. NA #6 felt something had happened to Resident #1 and NA #7 was the one who did it.

In an interview with the Social Worker (SW) on 5/17/22 at 3:28 PM, she stated she remembered an investigation was completed when Resident #1 told staff NA #7 had touched her inappropriately. During the interview, Resident #1 expressed NA #7 had touched her breast and she cried. The SW felt Resident #1 was telling what happened from her perspective and there was no reason to think she was lying. The resident was consistent in her interviews with other staff.

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Resident #1's family member was contacted and stated he was appreciative of the investigation.

An interview was conducted with Administrator #3 on 5/17/22 at 4:25 PM. He stated he was called to the facility when Resident #1 accused NA #7 of touching her inappropriately. The facility unsubstantiated the allegation because they couldn't prove anything happened. When Administrator #3 reviewed video footage of the interaction between NA #7 and Resident #1 at the nurse's station, he stated NA #7 had mocked Resident #1 saying, "no, no, no" and bobbed his head from side to side. Administrator #3 believed this was done in a negative way. NA #7 was heard saying he would call her dad. The police and family were notified of the allegation. It was evident Resident #1 did not want NA #7 to help her. Administrator #3 believed Resident #1's reaction to NA #7 had been strong. Resident #1 was observed saying, "no, no, no" when NA #7 approached her. Administrator #3 believed there was an issue with customer service and NA #7 was suspended pending investigation and then terminated. The administrator believed Resident #1 was credible and consistent in her account of what happened. Administrator #3 felt something had happened to her.

An interview was conducted with the detective on 5/18/22 at 8:57 AM. The detective had spoken with Administrator #3 and was informed NA #7 had a casual way of speaking with the residents that Administrator #3 felt warranted termination. The detective explained there were no direct witnesses to sexual abuse and Resident #1's roommate had initially determined NA #7 had touched the resident's breast.

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In an interview on 5/18/22 at 10:45 AM, Regional Nurse Consultant #1 stated she reviewed the video footage with Administrator #3. In the video, Resident #1 shook her head "no" at NA #7. The NA bobbed his head at Resident #1, and it appeared aggressive. Audio revealed Resident #1 had asked for a cup of water and she pulled away when NA #7 went to get the cup from her. Resident #1 was saying "no." NA #7 grabbed the cup despite Resident #1 saying "no" repeatedly. The interaction showed NA #7 was mocking Resident #1 with his head and saying, "no, no, no." The nurse consultant stated the interaction was inappropriate. Resident #1 went to her room and NA #7 went into the room afterwards. The audio revealed the resident was saying, "no, no, no" when NA #7 entered the room. The mocking NA #7 did to Resident #1 was insulting and rude. Resident #1 had not reacted this way with other staff members and she would become frustrated when trying to communicate. The nurse consultant revealed the facility determined there was no harm intent and no threatening. NA #7 cursed to staff at the nurse's station when he learned of the allegation and was removed from resident care. The nurse consultant described NA #7's response as odd.

An interview was conducted with Resident #1's family member on 5/18/22 at 11:07 AM. The family had been notified NA #7 was fired for being disrespectful. The family believed something happened to Resident #1 due to her change in behavior. Resident #1 was ultimately discharged home to live with family. Resident #1's family member stated Resident #1 was not the type to make accusations. He visited Resident #1 most days and stated during one visit, she took his hand and put it on her chest. He didn't

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understand what she was doing at the time but thought Resident #1 was trying to tell him something happened. The family member revealed Resident #1 knew what was going on and had difficulty expressing things at times. He believed she was groped.

An interview was conducted with the Psychiatric Nurse Practitioner (PNP) on 5/18/22 at 2:38 PM. The PNP assessed Resident #1 with a test specific for persons with aphasia and determined her cognition was wholly intact. The resident was pleasant and smiling during the interview and became very tearful and crying when asked about inappropriate touching. Resident #1 had pointed to her breasts and to the bathroom. The PNP indicated Resident #1 had been abused and molestation occurred in the facility. She was unable to determine the details due to challenges with communication. The PNP stated some type of abuse had occurred and Resident #1 was credible. The PNP stated mental abuse would include mocking a resident. When the video was described as documented to the PNP, she stated the NA was mocking the resident to discredit her and show her that she was disabled, and no one would believe her.

In an interview with the Physician on 5/18/22 at 3:05 PM, he stated he had been notified a resident's breast was fondled. He was aware the video was reviewed, but he did not see it. The physician stated the facility handled the situation promptly.

In an interview with Nurse #9 on 5/18/22 at 3:22 PM, she stated she was notified NA #7 had inappropriately touched Resident #1. Nurse #9 assessed Resident #1 who indicated NA #7 had

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F 600	Continued From page 8 touched her breasts. She assured Resident #1 of her safety and notified Administrator #3. Nurse #9 was asked to keep NA #7 from entering resident rooms until the administrator arrived. Nurse #9 recalled Resident #1 was upset. An interview was conducted with Nurse #7 on 5/18/22 at 3:35 PM. Nurse #7 stated Administrator #3 arrived at the facility after being notified of the sexual abuse allegation. He asked Nurse #7 to come with him to the resident's room. Resident #1 was crying and upset during the interview. Resident #1 pointed to her breasts and indicated NA #7 had inappropriately touched her there. Resident #1 agreed the police should be notified. Resident #1 was normally pleasant and was independent in doing things for herself. The only bathroom assistance she needed was for safety and to ensure she wore her helmet. In an interview with Administrator #1 on 5/18/22 at 5:15 PM, she stated she was not working at the facility at the time of the incident or investigation. Administrator #1 stated mocking and insulting a resident would be considered abuse.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	F 607		6/16/22

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F 607	Continued From page 9 §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of misappropriation of resident property within 24 hours to the State agency and failed to complete a thorough investigation for 1 of 2 residents (Resident #3) reviewed for misappropriation of resident property. Resident# 3's food stamp card (EBT) was reported missing on 4/23/22. The facility filed the 24-hour report on 5/3/22. Findings included: Review of the abuse & neglect prohibition policy revised date 5/23/17 read in part "the facility will report all allegations and substantiated occurrence of abuse, neglect and misappropriation of property to the state/ federal agency and law enforcement officials as designated by state/ federal law." The policy also included that the facility would investigate any alleged abuse/neglect and misappropriation of resident's property in accordance with the State and Federal law. Review of the initial Report dated 5/3/22 revealed the incident occurred on 4/30/22. Allegation details indicated Resident#3 had alleged that Nurse aide (NA)#1 had taken her food stamp card to purchase her a sandwich. NA #1 had not returned with the sandwich or the food stamp card on 4/30/22. Law enforcement was notified on 5/3/22. Review of the Investigation report dated 5/5/22 revealed the incident occurred on 4/30/22. The	F 607	Preparation and/or execution of this plan of correction does not constitute 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. F607 Develop/Implement Abuse/Neglect Policies 1. Resident #3 remains at the facility with no current concerns. 2. Alert and oriented residents were interviewed by Social Worker from 5/20/2022-5/27/2022 regarding abuse/neglect/misappropriation. No new negative findings. Interviews with responsible parties of residents unable to be interviewed were conducted by the Staff Development Coordinator on 5/19/2022-5/31/2022 to identify any concerns regarding abuse/neglect/misappropriation. No new negative findings. 3. 1:1 Re-education/counseling of mandatory reporting guidelines for abuse/neglect/misappropriation was	

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F 607	Continued From page 10 facility was made aware of the incident on 5/2/22. The allegation details revealed Resident#3 alleged NA#1 had taken the resident's food stamp card to purchase a sandwich for the resident. NA #1 had not returned with the sandwich or food stamp card on 4/30/22. Summary of the investigation revealed NA #1 was interviewed and had denied the allegation. Resident #3's daughter was contacted who indicated the food stamp card was last seen in the resident's room, inside the bedside table drawer. The room was searched, and card was not found. North Carolina food stamp office was notified. The allegation was unsubstantiated due to lack of adequate information. Corrective Action indicated the NA #1 was educated to not shop for any residents and notify social worker if the residents had needs regarding procuring items from the community. Review of Nurse #2 statement dated 5/4/22, revealed the incident had occurred approximately 2 weeks from the date the statement was written. The statement indicated Resident #3 verbalized that her food stamp card was missing. The resident had given the food stamp card to one of the NA to purchase her something from the store. Nurse #2 indicated that she had reported it to Manager on Duty on that weekend. Review of Manager on Duty (MOD) documentation dated 4/23/22, revealed on 4/22/22, Resident #3 complained that a NA has used her food stamp card. The card was not returned on 4/23/22. The documentation further indicated that the Administrator would be alerted if the card was not returned by 4/25/22. The document also indicates that the resident was suffering side effects of Urinary Tract infection	F 607	completed with the Business Office Coordinator, Business Office Manager, and the Receptionist on 5/23/2022 by the Administrator. NA #1 was relieved of employment from the facility on 5/23/22. Staff re-education of mandatory reporting guidelines for abuse/neglect/misappropriation was started on 5/17/2022 and will be completed by 6/16/2022. Re-education included: every staff member is a mandatory reporter and the time sensitive nature of reporting. An audit was conducted of the last 3 months of Complaint Intake and Health Care Personnel Investigations for compliance with reporting requirements. No new negative findings. 4. Random interviews will be conducted with alert and oriented residents and/or staff regarding abuse/neglect/misappropriation weekly for 4 weeks, then monthly for 3 months. QAPI committee will review audits during monthly QAPI meetings and make recommendations for ongoing compliance. QAPI committee will determine need for further audits beyond 3 months.	

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and the claims may not be true.

During a telephone interview on 5/17/22 at 11:53 PM, Nurse #2 stated she was assigned to Resident #3 on 4/23/22 and 4/24/22. Nurse #2 further stated on 4/23/22, Resident #3 had reported to her that the resident had given her food stamp card to NA #1. Resident had requested NA #1 to buy her a sub and other things from the store. Nurse #2 further indicated the resident was upset that the staff member had not returned with her card or her food. Nurse #2 stated this was reported to the MOD. The MOD spoke with Resident #3 and took the report.

During an interview on 5/17/22 at 10:57 AM, the facility business office coordinator indicated she was Manager of Duty (MOD) on the weekend of 4/23/22 - 4/24/22. The business office coordinator stated on 4/23/22, an agency nurse (name unknown) had reported to her that Resident #3 was upset that a NA had taken her food stamp card and had not returned it. The business office coordinator indicated the resident was assured that her food and card would be returned to her when the NA#1 returned to work that day. NA #1 was scheduled to work on 4/23/22 from 3 PM- 11 PM. The Business office coordinator stated on 4/24/22 she followed up with Resident #3. The resident had indicated to her that the staff had not returned the card and was ignoring the resident. The Business office coordinator stated she was informed by the nurse (name unknown) that the resident had Urinary Tract Infection (UTI) and was confused. The Business office coordinator stated on 4/25/22, she did not report to the administrator as there was a new administrator, who was in training. The Business office coordinator stated she reported it to the

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 05/19/2022

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
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administrator on 4/26/22. The Business office coordinator confirmed she did not report to the administrator on 4/23/22 or 4/24/22 about resident's missing Food stamp card.

During a telephone interview on 5/17/22 at 2:41 PM, the Business Office Manager (BOM) confirmed that the resident received a food stamp card (EBT) via mail. This was delivered to the resident personally by the BOM. The BOM stated few weeks ago (date unknown), her assistant had reported to her that the resident's food stamp card was missing. The BOM further indicated the resident was reassured by her that the requested food and food stamp card would be returned to the resident when NA #1 returned to work that day. The BOM stated she does not recollect the exact details but remembers speaking with the Resident #3 family member and reassuring family member that the food stamp card would be returned to the resident when NA#1 returned to work that day. The BOM indicated NA #1 was confronted and NA #1 acknowledged that the resident wanted a sandwich, and she was going to bring the food for her. The BOM stated she was not aware that the food stamp card was lost, that a grievance report was filed, and facility had conducted the investigation. The BOM stated she was not interviewed by the administrator or anyone investigating it. The BOM indicated she thought the card was returned to the resident.

During an interview on 5/17/22 at 1:11 PM, the Social Worker (SW) stated she did speak with the BOM, who confirmed that Resident #3 had received her food stamp card via mail two months ago. The SW further stated the BOM had not shared any other information with her.

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During a telephone interview on 5/19/22 at 11 AM, the previous interim administrator indicated she was working at the facility as an Administrator from 4/4/22 to 4/25/22. The Administrator stated she did not receive any report regarding any missing food stamp card over the weekend of 4/23/22 from the facility.

During an interview on 5/18/22 at 5:00 PM, the administrator stated she was the chief investigating officer. The administrator stated on 5/2/22 the residence's family member had reported to the social worker that the resident's food stamp card was missing. The grievance was forwarded to the administrator and an investigation was immediately started. The initial report was sent to DHSR on 5/2/22. The administrator stated during the investigation, the MOD documentation dated 4/23/22 revealed the incident had occurred on 4/23/22. The Administrator confirmed that the incident was not reported to the previous administrator or to her by the MOD on 4/23/22. The facility was made aware when Resident #3's family member had reported it on 5/2/22. During the investigation the NA was suspended, and the food stamp card was searched. The administrator further stated Resident #3 was confused and treated for Urinary Tract Infection when the allegation was initially made by the resident. The investigation was completed on 5/5/22. The administrator stated the facility could not substantiate the allegation due to lack of sufficient evidence. The administrator indicated the BOM was interviewed during the investigation. The BOM did not reveal the information that she had spoken with the resident, resident family member and NA #1. The administrator stated the staff had withheld some of the information. The facility became aware of

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F 607	Continued From page 14 this information on 5/17/22. The facility submitted a new initial report to State agency on 5/17/22.	F 607		