STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pettigrew Rehabilitation Center	1515 W Pettigrew Street Durham, NC 27705

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38077 Based on records review, and staff interviews, the facility failed to obtain and verify Advance Directives (code status) in the residents' records (Resident #191) and failed to clarify code status in the residents' record (Resident # 75) for 2 of 2 residents reviewed for Advance Directives. Findings included: 1. Review of Resident #191's hospital discharge summary dated [DATE] revealed the resident was coded as Full Code. Resident #191 was admitted to the facility on [DATE]. Resident's admission Minimum Data Set (MDS) dated [DATE] was in progress. At the time of review on [DATE], there was no active order for code status in Resident #191's medical record {electronic health record (EHR)}. The facility did not use any hard copy chart. During an interview on [DATE] 9:28 AM, Nurse #1 stated she would look in the EHR for a resident's code status. The code status was usually displayed next to the resident's picture or would be in the physician's orders. Nurse #1 reviewed Resident #191's electronic medical record and stated the resident did not have a code status. Nurse #1 explained if there was no code status then the hospital discharge summary would be reviewed. Nurse #1 stated the Unit Manager, was responsible to review the discharge summary and notify the physician about the discharge medications and code status. Once verbal and/or written orders were received this was entered in the resident's EHR by the Unit Manager. During an interview on [DATE] at 10:45 AM, Unit Manager #1 stated when any resident was newly admitted or readmitted , the Unit Managers would verify the code status with the admission / medical record staff. Once the code status was verified, the Unit Managers would send/ notify the physician about the resident's discharge medications and the code status for approval. The orders would be approved verbally or written. Once the orders were approved by the physician, the residents code status would be entered in the resident's EHR. Unit Manager stated the resident's code status was missed. The Unit Manager stated the code status should be entered within 24 hours after admission or readmission. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 1:14 PM, Nurse Practitioner #1 stated that the staff would discuss with the resident and/or resident representative about Advance Directives and code status. This information was notified to her, and the order was signed. The staff would then enter the information in the resident's record. The Director of Nursing was unavailable for interview at the time of the survey. During an interview on [DATE] at 4:32 PM, the Administrator stated the resident's code status should be entered in the resident's EHR at admission. the Administrator indicated all residents should have code status orders and they should be care planned based on their code status. The Administrator further stated the Unit Managers were responsible for verifying the code status of residents upon admission or readmit admission and entering them in their EHR. 41579 2. Resident #75 was admitted to the facility on [DATE] and had diagnoses that included chronic obstructive pulmonary disease, chronic congestive heart failure, and chronic kidney disease. A review of Resident #75's electronic medical record (EMR) and an order dated [DATE] revealed Resident's #75's code status was do not resuscitate (DNR). A review of Resident # 75's care plan last revised [DATE] revealed the Resident had an advance directive in place for full code. The goal was the advance directive would be honored by staff. The interventions included advance directive acknowledgement signed on admission on consent to treat, advance directive in medical record, CPR (cardiopulmonary resuscitation) will be provided in the event of cardiac arrest and ensure provider's order is in place. On [DATE] at 11:57 am an interview with Nurse #6 was conducted. She indicated she checked the EMR for resident's code status when a resident's health declined. Nurse #6 opened Resident # 75's EMR and the information indicated Resident was a DNR. She then checked Resident #75's care plan and it indicated Resident had an advance directive in place for full code. Nurse #6 then checked Resident #75's physician orders and read an order dated [DATE] for DNR and checked the code status book located at the Nurses station and it had a DNR form with an effective date of [DATE] for Resident # 75. An interview was conducted on [DATE] at 12:15 pm with Unit Manager #2 and she indicated all the interdisciplinary team had portions of the care plan they were responsible to update on the care plan, and she was not sure why Resident 75's care plan was not updated. She stated, maybe he went to the hospital, but I will update it now. The MDS Nurse was unavailable for interview. During an interview on [DATE] at 4:32 pm, the Administrator stated all residents should have a code status order and they should be care planned based on their code status. She indicated the code status, and the care plan should match, and the Unit Managers should ensure that the care plan reflected the correct and current code status of the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on record review and staff interviews, the facility failed to complete the Interview for Activity Preferences of the comprehensive Minimum Data Set (MDS) for 2 of 2 cognitively impaired residents reviewed for activities (Resident #12 and Resident #81). The findings included: 1. Resident #12 was admitted to the facility on [DATE] with diagnoses including cognitive impairment. The admission MDS dated [DATE] noted Resident #12 had cognitive impairment and required assistance with activities. The MDS did not include the Interview for Activity Preferences. Resident #12's care plan dated 3/12/24 included an area of focus: Resident #12 has impaired cognitive function/impaired thought process related to encephalopathy. The goal included: The resident would communicate with family/caregivers regarding resident's capabilities and needs. The interventions included: the resident would engage in simple, structured activities that avoid overly demanding tasks. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director (AD). The AD stated that one-on-one in room activities were Resident# 12's preference which included story time, music, sensory stimulation of hand rubs, television programs of her choice, and family visits. The AD confirmed while completing the Preferences for Customary Routine and Activities assessment she did not conduct the Interview for Activity Preferences which would include Resident #12's specific activity interests. The AD indicated she was not formerly trained on the completion of the MDS assessment. 2. Resident #81 was admitted on [DATE] with diagnoses including cognitive impairment. The admission MDS dated [DATE] noted Resident #81 had cognitive impairment and required assistance with activities. The MDS did not include the Interview for Activity Preferences. An admission activity assessment dated [DATE], revealed no information was included about Resident 81's preferences or interests in activities. A focus area on the care plan dated 12/29/23 revealed Resident #81 enjoyed participating in favorite activities and spending time outdoors. There was no further information provided on the care plan regarding Resident# 81's activity interests. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director (AD). The AD confirmed while completing the Preferences for Customary Routine and Activities assessment she did not conduct the Interview for Activity Preferences which would include Resident #81's specific activity interests. The AD indicated she was not formerly trained on the completion of the MDS assessment. An interview was conducted on 4/17/24 at 4:30 PM with the Administrator and the Regional Director of Operations. Both stated the activity section on the MDS for both Resident #12 and Resident #81 were incomplete, and they were unable to provide any further information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20906 Based on observations, resident and staff interviews and record reviews, the facility failed to provide an on-going activity program that met the individual interests and needs for 2 of 2 cognitively impaired residents reviewed for activities (Resident #12 and Resident #81). The findings included: The activity calendar was posted and offered the following scheduled activities: 4/15/24 at 10:00 AM morning stretch, 10:15 AM current events, 10:30 AM creative corner, 2:00 PM, movies and popcorn, 4:00 music and sensory. 4/16/24 at 10:00 AM news and views, 10:15 AM puzzles and coloring, 10:30 AM music and manicures, 2:00 PM arts and crafts, 2:45 PM bingo with friends and 4:00 PM music and reminiscing. 4/17/24 10:00 AM coffee and chat, 10:30 AM arts and crafts, 11:00 AM music and sensory, 2:00 PM, Bible study, 3:15 PM Bible study social and 4:00 PM create club. 1. Resident #12 was admitted to the facility on [DATE], with a diagnosis of encephalopathy. Resident #12 was coded on the admission Minimum Data Set (MDS) assessment dated [DATE] as having moderate cognitive impairment and she needed assistance with activities of daily living and assistance to attend activities. The MDS also did not code any of Resident #12's activity interests. The resident was coded for total assistance with transfers and locomotion. A focus area of the care plan dated 3/12/24 revealed Resident #12 had impaired cognitive function/impaired thought process. The goal included the resident would communicate with family/caregivers regarding resident's capabilities and needs. The intervention included the resident would engage in simple, structured activities that avoid overly demanding tasks. Record review revealed there were no activity notes available after the 3/12/24 assessment for Resident #12. There were no preferences listed. There were no documented notes or activity participation records for Resident #12. A continuous observation of Resident #12 was conducted on 4/16/24 from 10:00 AM to 11:30 AM. Resident #12 was in her room sitting in her wheelchair with no television on or any other form of social stimulation. The scheduled activities were held in the activity room during the time of the observation were news and views at 10:00 AM, 10:15 AM puzzles and coloring, and 10:30 AM music and manicures. An observation was conducted on 4/16/24 at 2:16 PM. Resident #12 was observed in bed with television on low volume and the remote control was across the room on the counter. There were no other stimulatory items in the room or within reach of the resident. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse Aide # 8 on 4/16/24 at 2: 16 PM, who stated she had not seen Resident #12 involved in group activities or provided with One-to-One (1:1) activities by the activity staff. Nurse Aide #8 further stated the aides try to assist with getting residents to activities, but if they were providing care to other residents, they were unable take residents to activities. An interview was conducted on 4/17/24 at 10:57 AM with Resident #12 during which she stated she enjoyed religious services, sports, gospel music and food events. Resident #12 further stated she had limited physical mobility and was unable to go to activities herself. Resident #12 reported she was not provided with in-room activities or offered to attend group activities. A continuous observation was conducted 4/17/24 from 3:15 PM to 3: 30 PM of Resident #12 seated in her room. The observation revealed she was not provided with any form of activity or stimulation while in her room. The television and the radio were off. The scheduled activity during the time of the observation was Bible study social at 3:15 PM. An interview was conducted on 4/17/24 at 4:00 PM with the Activity Director who stated that one to one (1:1) in room activities were Resident# 12's preference which included story time, music, sensory stimulation of hand rubs, television of her choice and family visits. The Activity Director confirmed the Minimum Data Set (MDS) assessment, or activity assessment completed on 3/12/24 did not include Resident #12's specific activity interest. The Activity Director further stated documentation of the resident's response would be in the activities note. The Activity Director could not confirm Resident #12 received any 1:1 activity or been offered any group activities of preferences based on the activities that were being provided. The Activity Director further stated she did not have a specific 1:1 schedule that was consistent with residents who needed 1:1 activity or that assistance was provided for residents to participate in small group activities. An interview was conducted on 4/17/24 at 9:15 AM with the Administrator who stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would document participation and refusal of activities in notes. An interview was conducted on 4/17/24 at 4:30 PM with the Regional Director of Operations and the Administrator. Both stated they were unable to provide documentation of the resident activity assessment for Resident #12, that included preference list or any actual participation records for group activity or 1:1 record of the resident's involvement. 2. Resident #81 was admitted to the facility on [DATE]. The diagnoses included both hemiparesis, hemiplegia, and cerebral infarction. Resident #81 was coded on the admission MDS assessment dated [DATE] as having severely impaired cognition and he needed assistance with activities. The MDS coded Resident #81 needed assistance with ADLs and assistance to recreational activity. The MDS also did not code any of Resident #81's activity interests. The resident was coded for total assistance with transfers and locomotion. A focus area on the care plan dated 12/29/23 revealed Resident #81 enjoys participating in favorite activities spending time outdoors. There was no further information provided on the care plan regarding Resident# 81's activity interests. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review revealed there were no activity notes available after 3/21/24. Observation was conducted on 4/15/24 at 10:30 AM of Resident #81 who sat in his wheelchair in the doorway of his room and there was no social stimulation. The Activity Director was in a group activity (creative corner) with 6 other residents in the activity room. The resident indicated he wanted to go the activity but did not know what activity was happening. Observation and interview were conducted on 4/15/24 at 2:00 PM with Resident #81 who sat in his wheelchair in the doorway of his room without staff interaction or any other sensory stimulation. The activity being offered was a movie and popcorn. Resident #81 asked staff what's going on. Staff briefly spoke with the resident and walked away. Resident #81 stated he had limited physical mobility and was unable to go to activities himself. Resident #81 reported he was not provided with in-room activities, offered to go to activities. There was no other stimulation in the room. An interview on 4/17/24 at 2:45 PM, of Resident #81 revealed he was in bed with the ability to communicate his social interest. Resident#81 stated he enjoyed cooking, electronics, sports movies, cards and wanted to go to activities. Resident #81 further stated no one asked him to go to anything, so he did not know what was offered. An interview was conducted on 4/17/24 at 10:16 AM, with the Activity Director who stated she did not have any documentation of the actual group or one to one activity that the resident participated in or a complete activity assessment of the resident's activity preference. The Activity Director stated she did not have time to do a lot of the one-to-one activities because she was the only person who provided the activities for the entire building. Staff had not consistently brought residents to activities, therefore she had to go around the facility to get those who wanted to go and escort them to the activity. An interview was conducted on 4/17/24 at 4:30 PM with the Regional Director of Operations and the Administrator. Both stated they were unable to provide documentation of the resident activity assessment for Resident #81, that included preference list or any actual participation records for group activity or 1:1 record of the resident's involvement. An interview was conducted on 4/17/24 at 9:15 AM with the Administrator who stated the expectation was for the activities team to develop a program, to include residents in small group activities and develop a system to ensure residents received 1:1 activity. The activities staff would document participation and refusal of activities in notes.

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F 0687

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate foot care.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 20906

Based on observations, resident interview, staff interview and record reviews, the facility failed to provide foot care and arrange podiatry services for 2 of 2 dependent residents reviewed for foot care. Resident #4 was discovered to have a buildup of skin between her toes and had curled toenails which extended 1.5 inches beyond the base of the nail. Resident #81 was discovered to have thick layers of skin between the toes, thick, dry patches on the bottoms of his feet and long toenails beyond the base of the nail growing into the next toe. (Resident #4 and Resident #81).

The findings included:

1. Resident #4 was admitted on [DATE] and readmitted [DATE]. The diagnoses included cognitive impairment, Parkinson's disease, chronic pulmonary obstructive disease, and diabetes.

The significant change Minimum Data Set (MDS) dated [DATE] coded Resident #4 as having moderate cognitive impairment and he needed assistance with activities of daily living.

A care plan focus area dated 2/4/24 revealed Resident #4 was at risk for impairment to skin integrity related to incontinent of bowel and bladder. The goal included risk for injury would be minimized. The interventions included Resident #4 would avoid mechanical trauma of constrictive shoes and cutting/trimming corns/callouses.

Review of the podiatry schedule from January 2024 and April 2024 revealed no consultation report or notation was made in Resident #4's chart that she had been seen by the podiatrist or had been scheduled to be seen.

Review of Resident #4's skin assessments done by nursing dated 3/13/2024, 3/17/24, 3/28/24 and 3/30/24. There was no information documented about the condition of Resident #4's feet.

An observation was conducted on 4/15/24 at 10:15 AM with Resident #4. The resident was in her room seated in a wheelchair pulling her socks off, the big toenails and 2nd toes on both feet were discovered to have a buildup of skin between her toes and had curled toenails which extended 1.5 inches beyond the base of the nail. Resident #4's toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, dry patches on the bottoms of her feet.

A follow-up observation in conjunction with an interview on 04/16/24 at 10:38 AM revealed Resident #4 's bilateral toenails were long and sharp on the big and second toes. Resident #4 reported her feet were hurting due to the long toenails and has reported the need to see the podiatrist several times to the aides and nursing , but no-one responded. The resident stated her feet had been in this condition since admission. Resident #4 stated staff were not washing her feet regularly.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation was conducted of Resident #4 on 4/17/24 at 9:47 AM, in conjunction with an interview with the Director of Nursing from another facility (the current Director was out due to illness) revealed the condition of Resident #4's feet. The Director of Nursing confirmed Resident #4's feet needed to be cleaned and the toenails needed to be cut/trimmed. The Director of Nursing further stated it was the responsibility of the nurse aides to report to nursing when the toenails needed to be cut for all residents, especially diabetic residents. She explained nursing staff were responsible for doing a full head to toe assessment and document on the weekly skin assessment for any changes of the resident's body including the condition of the toenails. An interview was conducted on 4/17/24 at 9:54 AM, Nurse #7 stated the nursing staff were responsible for doing a head-to-toe assessment of the resident and document any change of condition including the condition of the resident's feet. She was unaware of the condition of Resident #4's feet or the need to see a podiatrist. The last skin assessment was on 3/30/24 done by Nurse #7. An interview was conducted on 4/17/24 at 10:15 AM with the Social Work Director who stated the podiatrist visited the facility every three months and any diabetic resident would be added to the schedule when nursing reported a resident needed podiatry services. The Social Work Director confirmed Resident #4 had not been on the podiatry list for the April visit on 4/11/24. She was unaware the resident needed to be seen by the podiatrist. She further stated nursing was responsible for letting the social work department know when podiatry services were needed. An interview was conducted on 4/17/24 on 10:30 AM with the Administrator who stated Nurse Aides and nursing were responsible for ensuring residents skin/toenails were being checked and cleaned during personal care and Nurse Aides should report to nursing any resident that needed podiatry services. He explained Nurse Aides could cut resident toenails that were not diabetic and should be cleaned. Nurse Aides should clean and check between toes to ensure the area was thoroughly clean. The Administrator added residents' feet should be checked on all residents when skin assessments were being completed and the condition of the resident's feet/toenails should be reflected on the assessment. The Administrator stated nursing should be notifying the social workers to let them know when a resident needed to be seen by an outside service. In addition, the Administrator added nursing should be cutting residents' toenails in between appointments until the resident could be scheduled. An interview was conducted on 4/18/24 at 11:20 AM, Nurse #8 stated she did the weekly skin checks but did not document the condition of the resident's feet or toenails. She explained that unless there was an impairment documented, the form does not advance to document any other condition. The nurse stated if a skin impairment was checked then the full body diagram would come up and nursing would then document what they observed. Nurse #8 confirmed a complete assessment of head-to-toe findings would include the condition of a resident's feet and/or need for podiatry services. 2. Resident #81 was admitted to the facility on [DATE]. The diagnoses included cognitive impairment, diabetes, hemiparesis, hemiplegia, and cerebral infarction. Resident #81 was coded on the admission Minimum Data Set (MDS) dated [DATE] as having severe cognitive impairment and he needed assistance with activities of daily living. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A focus area on the care plan dated 3/29/23 [NAME] is at risk for impairment to skin integrity related to decreased mobility. The goal included the resident's risk for injury would be minimized. The interventions included avoid scratching and keep hands and body parts from excessive moisture; encourage good nutrition and hydration to promote healthier skin; and identify potential causative factors and eliminate/resolve where possible. Review of the podiatry schedule from January 2024 and April 2024 revealed no consultation report or notation was made in Resident #81's chart that he had been seen by the podiatrist or had been scheduled to be seen. Review of 81's head-to-toe skin assessments done by nursing dated 3/4/2024, 3/11/2024, 3/12/2024, 3/18/2024, 3/25/2024, 4/1/2024, 4/6/2024 and 4/8/2024 revealed no documentation of the condition of Resident #81's toenails from either foot, or other concerns regarding the resident's feet. An observation was conducted on 4/17/24 at 2:45 PM of Resident #81. The resident was lying in bed with their feet exposed from under the covers a strong foul odor was detected near his feet as he moved them around in the bed. Resident #81's toenails on both feet were observed to have visible thick layers of what appeared to be dirt and thick layers of skin between the toes, thick, calcified, dry patches on the bottoms of his feet. The toenails were several inches beyond the base of the nail growing into the next toe. An observation was conducted 4/17/24 03:28 PM with the Unit Manager #2 of Resident #81's feet. Unit Manager #2 confirmed the condition of the resident's feet had visible thick layers of what appeared to be dirt and thick layers of skin between the toes, and thick, calcified, dry patches on the bottoms of his feet. The toenails were dirty, and a strong foul odor was detected near his feet as he moved them around in the bed. An interview with Resident #81 was conducted during the observation with Unit Manager #2. Resident #81 stated that he needed his feet checked and cleaned. During an interview on 4/17/24 at 3:28 PM Unit Manager #2 stated the nurse aides were expected to provide foot care during baths/showers, report any change of condition of the resident's feet, and notify the nurse if the resident's toenails needed to be cut/trimmed. She further stated the charge nurse would do a weekly full body assessment on the residents and document any changes, including the condition of the resident's feet, so appropriate referrals could be made. She explained the charge nurse would then provide the social workers with the names of the residents who would need to be seen for podiatry. She indicated the nurses would also document in the physician/nurse practitioner notebook to inform them of the change in the resident foot condition as they would for other concerns. Unit Manager #2 stated she had also done skin checks on Resident #81 but did not document the condition of the resident's feet. The current skin check form only asked 2 questions. She explained, if there was not an impairment with the skin, the form did not allow for other documentation. During an interview on 4/17/24 at 4:25 PM the Social Worker stated based on her podiatry schedule and list of residents seen in January 2024 and April 2024, Resident #81 was not seen by podiatry. The Social Worker further stated she had not received notification from nursing that Resident #81 needed to be scheduled. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 4/17/24 at 4:45 PM, in conjunction with a record review with the Regional Clinical Nurse the current head-to-toe skin assessment form was reviewed. She confirmed the 2 questions on the form did not include the condition of the resident's feet. She stated unless the nurse checked an impairment was observed there was no way of nursing documenting foot care or other concerns. The Regional Clinical Nurse further stated if a skin impairment was checked then the full body diagram would come up and nursing would then document what they observed. She indicated it would be expected that nursing checks the condition of resident feet for further evaluation and treatment and do a referral for podiatry care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345053	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Pettigrew Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 W Pettigrew Street Durham, NC 27705	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 38077 Based on record reviews and staff interviews, the facility failed to complete a performance review every 12 months to provide in-service education based on the outcome of the performance reviews for 3 of 5 nursing assistants (NAs) reviewed (NA # 1, #2, and #3). The findings included: 1a. Review of NA #1's employee file revealed a date of hire of 2/3/2016. The employee file for NA #1 did not include annual performance review documents based on the date of hire including February 2023 and February 2024. b. Review of NA #2's employee file revealed a date of hire of 12/23/2021. The employee file for NA #2 did not include annual performance review documents based on the date of hire including December 2022 and December 2023. c. Review of NA #3's employee file revealed a date of hire of 5/1/2014. The employee file for NA #3 did not include annual performance review documents based on the date of hire including for May 2022 and May 2023. During an interview on 4/18/24 at 3:30 PM, the Staff Development Coordinator (SDC) stated she was hired 2 months ago by the facility and was in-training for the past month. She indicated she was currently doing new employee orientation in-services and competencies. She stated she had not been in the role of SDC for very long and she had not started to review employee training files or started training nursing staff to have started completing annual performance evaluation or review. During an interview on 4/18/24 at 4:25 PM, the Administrator stated Nurse Aides' skills assessment /competencies should be completed at hire and annually. The facility should also have a performance review completed annually to address the needs of staff. The Administrator stated at this time the facility was unable to provide documentation to indicate Nurse Aides' annual performance reviews were completed. The Administrator indicated the skill competencies evaluation and annual performance review should be completed and signed by Staff Development Coordinator (SDC) or her designee. The Administrator stated the facility had some turnover in the SDC position, resulting in not knowing if they were completed as no documentation was available. During an interview on 4/18/24 at 4:30 PM, the Regional Clinical Director stated she expected staff competencies and performance review of NA's to be completed annually. She indicated there had been some changes in SDC staffing and currently only new hire competency skills assessments were available. She explained there was an online education program which consisted of learning modules allowing the NAs to receive their 12 hours yearly education. The NA's education was not based on their annual performance review. She indicated the annual skill assessment and performance review documentations were not available at this time.

Printed: 08/01/2024
Form Approved OMB
No. 0938-0391

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41579 Based on observations, record review, and staff interview the facility failed to secure medications stored in the room/bathroom for 1 of 1 resident (Resident #62) reviewed for medication storage. The findings included: Resident #62 was admitted to the facility on [DATE] with diagnoses that included osteoarthritis, hypertension, chronic pain, and spinal stenosis. Review of Resident #62's physician orders sheet dated April 2024 revealed an order dated 04/11/24 for Nystatin External Powder (Topical)) Apply to skin folds topically two times a day for yeast. On 04/17/24 at 9:53 am an observation of activities of daily living (ADL) care was conducted. After ADL care was provided by NA #3, the NA applied Nystatin powder (used to treat fungal infections of the skin) under Resident # 62's bilateral breast, under abdomen (panniculus), inner thigh creases and between legs. During an interview with NA#3 on 04/17/24 at 10:01am it was indicated she had applied the Nystatin powder to the same areas on Resident #62 after ADL care last week. On 04/17/24 at 12:17 pm an observation was conducted in Resident #62 room with Unit Manager #2. Two bottles of Nystatin powder were observed in Resident #62's bathroom, one bottle on her bedside table and 2 bottles in Resident's drawer. During an interview with the Administrator on 04/18/24 at 4:38 pm she indicated it was her expectation medications would not be at beside without physician orders.