

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/11/2026
NAME OF PROVIDER OR SUPPLIER Pettigrew Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews, the facility failed to maintain a clean and homelike environment in 5 of 32 resident rooms on 2 of 3 halls which affected nine (9) residents reviewed for a safe, comfortable, and homelike environment (Resident #11, Resident #84, Resident #23, Resident #16, Resident #6, Resident #66, Resident #51, Resident #61, and Resident #71). The findings included: a. An observation of Resident #6/Resident #66's room on 6/8/26 at 10:17 AM revealed all corners and baseboards of the bathroom had a heavy buildup of dirt, hair, and food particles. The base of the tube feeding pole of Resident #6 was covered with dried feeding formula. Dried feeding formula was observed on the wall behind the tube feeding pole, floor at the base of the pole, the telephone on the overbed table, the power strip, the electrical cord of the tube feeding pump, the feeding pump, and the oxygen concentrator. An observation of Resident #6/Resident #66's room on 6/9/26 at 3:01 PM revealed all corners and baseboards of the bathroom had a heavy buildup of dirt, hair, and food particles. The base of the tube feeding pole of Resident #6 was covered with dried feeding formula. Dried feeding formula was observed on the wall behind the tube feeding pole, floor at the base of the pole, the telephone on the overbed table, the power strip, the electrical cord of the tube feeding pump, the feeding pump, and the oxygen concentrator. The two residents were unable to be interviewed. b. An observation of Resident #23/Resident #16's room on 6/8/26 at 10:21 AM revealed a heavy layer of dirt, hair, and dust along the baseboards throughout the room, particularly in each corner. On the wall to the left side of Bed B a large area of raised brown matter was observed on the wall just above the baseboard. Fall mats were present on either side of Bed B and both were covered with residue sticky to touch, food particles, and white granules. An empty plastic top was observed under the foot of the bed. On the floor behind the headboard were pepper and salt packets, a clear plastic wrapper, and food particles. On the floor behind the headboard of Bed A was large dust/hair ball, a black twine closure, and a cloth napkin. An observation of Resident #23/Resident #16's room on 6/9/26 at 3:15 PM revealed a heavy layer of dirt, hair, and dust along the baseboards throughout the room, particularly in each corner. On the wall to the left side of Bed B a large area of raised brown matter was observed on the wall just above the baseboard. Fall mats were present on either side of Bed B and both were covered with residue sticky to touch, food particles, and white granules. An empty plastic top was observed under the foot of the bed. On the floor behind the headboard were pepper and salt packets, a clear plastic wrapper, and food particles. On the floor behind the headboard of Bed A was large dust/hair ball, a black twine closure, and a cloth napkin. The two residents were unable to be interviewed. c. An observation of Resident #71's room on 6/8/26 at 10:34 AM revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and all corners of the bathroom had heavy, raised dirt and hair buildup. A portable fan was observed on a bureau blowing towards Resident #71; the grills of the fan were covered with thick, gray material. The blades of the fan were covered with thick gray material that hung down from the blades. An observation of Resident #71's room on 6/9/26 at 3:20 PM revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and all corners of the bathroom had heavy, raised dirt and hair buildup. A portable fan was observed on a bureau blowing towards Resident #71; the grills of the fan were (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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	covered with thick, gray material. The blades of the fan were covered with thick gray material that hung down from the blades. The resident was unable to be interviewed. d. An observation of Resident #11 and Resident #84's room on 6/8/26 at 10:42 AM revealed a heavy layer of dirt and dust along the baseboards throughout the room and food particles and a plastic orange bead in the corner. An observation of Resident #11 and Resident #84's room on 6/9/26 at 3:23 PM revealed a heavy layer of dirt and dust along the baseboards throughout the room and food particles and a plastic orange bead in the corner. The two residents were unable to be interviewed. e. An observation of Resident #51 and Resident #61's room on 6/8/26 at 10:56 AM revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and around the bureau. The metal base of Resident #6's overbed table was covered with rust and sticky, white residue. The quarterly Minimum Data Set (MDS) for Resident #5 dated 3/19/26 revealed he was cognitively intact. During the observation on 6/8/26 at 10:56 AM Resident #51 stated a housekeeper had cleaned the room earlier in the morning and he did not like a dirty room. An observation of Resident #51 and Resident #61's room on 6/9/26 at 3:31 PM revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and around the bureau. The metal base of Resident #6's overbed table was covered with rust and sticky, white residue. An interview was conducted with Housekeeper #1 on 6/9/26 at 9:46 AM. She stated that her shift was 8:00 AM to 4:00 PM, three days a week with a responsibility of approximately 25-30 rooms to clean daily. Housekeeper #1 shared that after a room was cleaned, she did not go back to through again as she had too many rooms assigned daily. The housekeeper explained her daily responsibilities for each room included pulling trash from rooms and replacing the liner, cleaning the floors of the room and bathroom, scrubbing the toilet, and wiping down surface areas in the room to include the blinds, overbed tables, nightstands, doorknobs, and light switches. She shared that floor cleaning included sweeping first followed by mopping under the beds. Housekeeper #1 stated each room received a deep cleaning monthly and the Housekeeping Director checked completed work after the deep clean and did daily, random work audits. An interview was conducted on 6/9/26 at 10:03 AM with the Housekeeping Director who explained daily room cleaning responsibilities included wiping down the bedside table, tabletops, sweeping and mopping room and bathroom floors, cleaning toilets, emptying trashcans and replacing the trashcan liner. She confirmed each housekeeper was assigned approximately 30 rooms for daily cleaning and 2 rooms on each hallway were scheduled weekly for a deep cleaning. The Housekeeping Director shared she audited each room at least weekly and if issues were observed she followed up with the assigned housekeeper. The Housekeeping Director stated she and her regional supervisor did facility rounds weekly. On 6/9/26 from 3:52 PM to 3:59 PM observations of Resident #11/Resident #84, Resident #23/Resident #16, Resident #6/Resident #66, Resident #51/Resident #61, and Resident #71's rooms were conducted with the Housekeeping Director. The Housekeeper Director confirmed Housekeeper #1 had completed the daily cleaning for all 5 rooms. Resident #6/Resident #66's room revealed all corners and baseboards of the bathroom had a heavy buildup of dirt, hair, and food particles. The base of the tube feeding pole of Resident #6 was covered with dried feeding formula. Dried feeding formula was observed on the wall behind the tube feeding pole, floor at the base of the pole, the telephone on the overbed table, the power strip, the electrical cord of the tube feeding pump, the feeding pump, and the oxygen concentrator. The Housekeeping Director stepped out of Resident #6/Resident #66's room at 3:55 PM and retrieved Housekeeper #1 to participate in the remaining room observations. Resident #23/Resident #16's room was observed to a heavy layer of dirt, hair, and dust along the baseboards throughout the room, particularly in each corner. On the wall to the left side of Bed B a large area of raised brown matter was observed on the wall just above the baseboard. Fall mats were present on either side of Bed B and both were covered with residue sticky to touch, food particles, and white granules. An empty plastic top was observed under the foot of the bed. On the floor behind the headboard were pepper and salt packets, a clear plastic wrapper, and food particles. On the floor behind the headboard of Bed A was large dust/hair ball, a black twine closure, and a cloth napkin. of (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #71's room revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and all corners of the bathroom had heavy, raised dirt and hair buildup. A portable fan was observed on a bureau blowing towards Resident #71; the grills of the fan were covered with thick, gray material. The blades of the fan were covered with thick gray material that hung down from the blades. Resident #11 and Resident #84's room revealed a heavy layer of dirt and dust along the baseboards throughout the room and food particles and a plastic orange bead in the corner. Resident #51 and Resident #61's room on revealed a heavy layer of dirt and dust along the baseboards and corners throughout the room and around the bureau. The metal base of Resident #6's overbed table was covered with rust and sticky, white residue. When the housekeeping Director was asked about the rust she simply stated, That is just rust. The Housekeeping Director asked Housekeeper #1 to please take care of any identified issues right away and the Director stated she did not know why the rooms had not been properly cleaned. The Housekeeping Director indicated Housekeeper #1 was responsible for all the observed issues except for the dirty portable fan, which was the responsibility of the Maintenance Department. On 6/9/26 at 4:00 PM an observation of the portable fan in Resident #71's room was completed with the Maintenance Director who stated his department was responsible for maintenance and cleaning of portable fans. He acknowledged it was a facility fan and was brand new. He stated he did not know why the fan would be covered with heavy debris since it was new and that dirty equipment was unacceptable. An interview and observations of Resident #11/Resident #84, Resident #23/Resident #16, Resident #6/Resident #66, Resident #51/Resident #61, and Resident #71's rooms were conducted with the Administrator on 6/9/26 PM from 4:10 PM to 4:21 PM. The Administrator shared she was not aware of the cleaning issues as she did not conduct monthly room inspections but relied on reports from the Housekeeping Director. During the observations of Resident #11/Resident #84, Resident #23/Resident #16, Resident #6/Resident #66, Resident #51/Resident #61, and Resident #71's rooms Administrator stated the cleanliness did not meet the facility standards and dirty rooms were unacceptable. The Administrator stated she did not know why the Housekeeping Director was unaware. She further stated the Housekeeping Department had experienced turnover which may have been a factor.		

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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** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of PASRR (Preadmission Screening and Resident Review) (Resident #4 and Resident #8), and medications (Resident #1 and Resident #7) for 4 of 6 residents whose MDS assessments were reviewed. Findings included: 1. Resident #4 was admitted to the facility on [DATE] which included anxiety disorder, bipolar disorder, residual schizophrenia, and depression. Review of Resident #4's PASRR screening (a mandatory federal Medicaid program used to identify individuals with, or suspected of having, a serious mental illness (SMI), intellectual or developmental disability (I/DD), or related condition prior to being admitted to or residing in a nursing facility) revealed the resident received a Level II PASRR determination on 04/14/23 with no expiration for this determination. Review of Resident #4's annual Minimum Data Set (MDS) assessment dated [DATE] revealed it was coded no for if the resident was currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview conducted with the MDS Coordinator on 06/10/26 at 12:00 PM revealed she was not aware that Resident #4 was not coded for having a Level II PASRR. The MDS Coordinator further revealed she normally looked back at previous MDS assessments, PASRR screenings, and resident care plans to determine a resident's PASRR status. The MDS Coordinator indicated she had coded the MDS assessment dated [DATE] wrong by mistake. An interview conducted with the Administrator and Director of Nursing (DON) on 06/11/26 at 10:30 AM revealed they were not aware Resident #4 had not been coded appropriately for PASRR. The interview further revealed they expected the MDS assessments to be coded accurately. 2. Resident #8 was admitted to the facility on [DATE] with diagnoses which included anxiety, bipolar disorder, recurrent depressive disorder, and post-traumatic stress disorder. Review of Resident #4's PASRR screening (a mandatory federal Medicaid program used to identify individuals with, or suspected of having, a serious mental illness (SMI), intellectual or developmental disability (I/DD), or related condition prior to being admitted to or residing in a nursing facility) revealed the resident received a Level II PASRR determination on 03/10/23 with no expiration for this determination. Review of Resident #8's annual Minimum Data Sets (MDS) dated [DATE] revealed it was coded no for if the resident was currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. An interview conducted with the MDS Coordinator on 06/10/26 at 12:00 PM revealed she was not aware that Resident #8 was not coded for having a Level II PASRR. The MDS Coordinator further revealed she normally looked back at previous MDS assessments, PASRR screenings, and resident (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans to determine a resident's PASRR status. The MDS Coordinator indicated she had coded the MDS assessment dated [DATE] wrong by mistake. An interview conducted with the Administrator and Director of Nursing (DON) on 06/11/26 at 10:30 AM revealed they were not aware Resident #8 had not been coded appropriately for PASRR. The interview further revealed they expected the MDS assessments to be coded accurately. 3. Resident #7 was admitted to the facility on [DATE] with diagnoses which included hypertension and atherosclerotic heart disease. A physician order dated 12/16/25 for enteric coated aspirin (an antiplatelet medication) 81 milligram (mg) give one tablet by mouth daily was observed in Resident #7's record. No anticoagulant medication had been ordered. Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #7 received enteric coated aspirin 81 mg daily as ordered. No anticoagulant medication had been received. The annual Minimum Data Set (MDS) assessment dated [DATE] noted Resident #7 had been taking anticoagulant medication during the assessment period. The MDS did not include antiplatelet medication use during the assessment period. An interview was conducted with the MDS Nurse on 4/9/26 at 11:43 AM. The MDS nurse confirmed the annual MDS assessment should have been coded for the use of antiplatelet medication instead of anticoagulant medication. The MDS Nurse stated coding the anticoagulant medication was an error on her part. An interview was conducted with the Administrator on 4/10/26 at 2:15 PM. The Administrator stated she expected that the antiplatelet medication would have been coded correctly in Resident #7's MDS assessment. 4. Resident #1 was admitted to the facility on [DATE] with diagnoses which included Type 2 Diabetes mellitus. A physician order dated 1/4/26 for Humulin R (an insulin) 100 unit/milliliter (mL): inject as per sliding scale for elevated blood sugar was observed in Resident #1's record. Review of the Medication Administration Record (MAR) for February 2026 revealed Resident #1 received an insulin injection as ordered for elevated blood sugar 30 times. Review of Resident #1's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed no use of hypoglycemic, including insulin during the assessment period. An interview was conducted with the MDS Nurse on 4/9/26 at 11:45 AM. The MDS nurse confirmed the quarterly MDS assessment should have been coded for the use of insulin. The MDS Nurse stated coding the MDS as no insulin was an error on her part. An interview was conducted with the Administrator on 4/10/26 at 2:17 PM. The Administrator stated she expected that the insulin to be coded correctly in Resident #1's MDS assessment.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and resident and staff interviews, the facility failed to store a plastic syringe used for enteral water flushes (water flushes are essential to maintain gastrostomy/feeding tube patency, prevent clogging and support hydration), dry and with the plunger separated from the syringe and free from moisture for 1 of 3 residents reviewed for tube feeding (Resident #5). This practice had the potential for bacterial growth and contamination. Findings included: Resident #5 was admitted to the facility on [DATE] with diagnoses of muscle weakness, malnutrition, gastrostomy status (indicates the presence of a gastrostomy tube/feeding tube, which is surgically placed to provide direct access to the stomach for nutrition and hydration when oral intake is insufficient or unsafe), and dysphagia. Review of admission Minimum Data Set (MDS) dated [DATE] revealed Resident #5 was moderately cognitively impaired and was coded for tube feeding. The MDS confirmed Resident #5's average fluid intake per day by IV fluids or tube feeding was 501 cc/day or more per day. Review of Resident #5's physician order dated 05/19/26 revealed the resident was ordered to receive water flush of 100 milliliters (ml) three times a day (every shift). During observation of Resident #5 on 06/08/26 at 11:50 AM the syringe used for enteral water flushes was observed with the plunger in the syringe which was wet with clear condensation and brown substance. The syringe was stored in a plastic bag hanging on the feeding pump pole undated. Review of Resident #5's Medication Administration Record (MAR) dated 06/08/26 revealed Nurse #1 had signed off Resident #5's water flush during first shift. Review of Resident #5's Medication Administration Record (MAR) dated 06/09/26 revealed Nurse #1 had signed off Resident #5's water flush during first shift. During an observation and interview with Nurse #1 06/09/26 at 9:00 AM the syringe used for enteral water flushes was observed with the plunger in the syringe which was wet with clear condensation. The syringe was stored in a plastic bag hanging on the feeding pump pole dated 06/09/26. Nurse #1 revealed she had completed Resident #5's water flushes in the morning of 06/08/26 and 06/09/26. Nurse #1 further revealed she was aware the plastic syringe and plunger should be washed if residue was left in the syringe and the plunger should be separated to air dry to prevent any bacterial growth in the syringe. Nurse #1 indicated she was not aware that she had missed those steps and must have got in a hurry to care for other residents. An interview with the Director of Nursing on 06/11/26 at 10:30 AM stated Nurse #1 should have washed the plastic syringe and plunger and allowed them to dry completely to prevent any bacterial growth.		