STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

(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 05/24/2021 through 05/27/2021. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LXLX11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/24/2021 through 05/27/2021. Six of the 6 complaint allegations were not substantiated. Event ID# LXLX11	F 000		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		6/4/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/11/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

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PRODIGY TRANSITIONAL REHAB	**911 WESTERN BOULEVARD TARBORO, NC 27886**

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F 693	Continued From page 1 by: Based on observation and staff interviews the facility failed to administer medications through a peg tube by gravity for 1 of 5 residents (Resident #45) reviewed for medication administration. Findings included: The facility policy version 6/2020 for administration of oral medications through a nasogastric tube or gastrostomy tube (peg tube) under procedure number 15 revealed pour the diluted medication into the syringe barrel. To prevent air from entering the resident's stomach, hold the tube slightly higher to increase the flow rate. Slowly add more diluted medication to the syringe until the entire dose has been given. Further review of the policy revealed there was no instructions for when the medications did not flow into the tube by gravity. Resident #45 was admitted to the facility on 4/21/2020 with diagnoses which included unspecified intracranial injury. The quarterly Minimum Data Set (MDS) dated 3/22/2021 indicated Resident #45's cognitive status was unable to be assessed. It revealed Resident #45 received total care for all activities of daily living and received nutrition via a peg tube. An observation on 5/26/2021 at 9:45 am of Resident #45's medication administration revealed Nurse #5 pulled the plunger out of a 60 milliliters (ml) syringe and attached the syringe to the peg tube port. She poured 30 ml of water in the attached syringe barrel. The water did not infuse through the peg tube port by gravity. While the syringe with water was attached to the port	F 693	Submission of the response to The Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required. F 693 Tube Feeding Mgmt/Restore Eating Skills Criteria #1 Resident #45 had medication administration via gravity through gastrostomy tube completed on 5/26/21. Criteria #2 All residents that receive their medications through gastrostomy tube have the potential to be affected by this alleged deficient practice, therefore, 100% of all residents with a gastrostomy tube were observed for compliance with gravity administration of meds. Criteria #3 100% of all staff were educated by the Director of Nursing and the Staff Development Coordinator on medication administration via gastrostomy tubes. All new employee Nurses will be educated on hire. Criteria # 4 Medication administration through Gastrostomy Tubes will be audited by the Director of Nursing, Staff Development	

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	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

(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 693	Continued From page 2 Nurse #5 placed the plunger inside of the syringe barrel and applied pressure to push the water through the port. Each of Resident #45's medications which included phenobarbital, baclofen, vitamin D3, multivitamin liquid, and lactulose liquid were administrated with Nurse #5 pushing it through the peg tube. She ended the medication administration by flushing the peg tube with 200 ml of water using the syringe and plunger. During an interview with Nurse #5 on 5/26/2021 at 9:55 am she stated she had to push the medications through the peg tube because Resident #45 was pushing back against the tube. She said that was why the medications could not go through the tube. Nurse #5 stated she would normally push the medication through the tube when it did not flow by gravity. She stated the physician had not been informed that medications had to be pushed through Resident #45's feeding tube. During an interview with the Director of Nursing (DON) on 5/27/2021 at 8:40 am she stated Nurse #5 should have crushed and dissolved the medications in water and administered the medications through the tube by gravity.	F 693	Coordinator , Clinical Compliance Nurse, RN Weekend Supervisor or designee weekly times 4 weeks, then every 2 weeks x 1 month, then monthly x one month. then as determined by the QAA team. The results will be recorded on the Gastrostomy/Medication audit tool. The Director of Nursing will incorporate the POC into the facility□s monthly QAA and report any significant findings from the follow-up to the QA team. 6/4/21	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 761 Continued From page 3

§483.45(h) Storage of Drugs and Biologicals

§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 6 medication carts observed (200 West hall medication cart).

Findings included:

During an observation on 5/25/2021 at 3:50 pm the 200 West hall medication cart was observed to be unlocked and unattended on the West 200 hall. The cart was located to the left side of a resident's open door with the back of the cart against the wall. The cart ' s lock was observed not to be engaged. At 3:52 pm Nurse #4 was observed to leave from the resident's room to go to the medication cart which contained medications and confirmed the medication cart was not locked. There were no other staff

F 761

F761 Label/Store Drugs and Biologics
Criteria #1 Medication cart was locked by Nurse on 5/25/2021

Criteria # 2 A 100% audit was conducted by the Director of Nursing to ensure that all medication carts and Treatment carts were locked on 5/26/21

Criteria #3 100% of all Nurses and Med Aides were educated by the Director of Nursing and the Staff Development Coordinator on keeping all Medication and Treatment carts locked. All new employee Nurses and Med Aides will be educated upon hire, in orientation. 05/27/21

Criteria #4 Medication carts will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 4 members on the hall. During an interview at 3:53 pm Nurse #4 stated she was aware the medication cart was supposed to be locked when it was unattended. The nurse concluded she should have locked the medication cart before she went into the resident ' s room. During an interview with the Director of Nursing on 5/27/2021 at 8:40 am she stated medication carts should always be locked when left unattended by staff.	F 761	audited by the Director of Nursing, Staff Development Coordinator , Clinical Compliance Nurse, RN Weekend Supervisor or designee to ensure they are locked two times weekly x 4 weeks, then every 2 weeks x 1 month, then monthly x one month then as determined by the QAA team. The results will be recorded on the Med Storage tool. The Director of Nursing will incorporate the POC into the facility□s monthly QAA and report any significant findings from the follow-up to the QAA team. 6/4/21	
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, 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.	F 812		6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 812	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to label and date personal food items and remove personal food items with signs of spoilage in 2 of 3 nourishment refrigerators observed. (100 West Hall Nourishment Refrigerator, 100 East Hall Nourishment Refrigerator) Findings included: 1. During observation on 5/25/21 at 8:08 AM a sign on the 100 west hall nourishment refrigerator read in part, "[i]tems placed in the refrigerator need to be dated and have to be discarded in 3 days." During observation on 5/25/21 at 8:09 AM a fast food cup half filled with liquid was observed in the 100 west hall nourishment refrigerator with no labeled date or name, a bottle half full of red liquid was observed in the 100 west hall nourishment refrigerator with no labeled date or name, and a container wrapped in aluminum foil which held strawberries was observed in the 100 west hall nourishment refrigerator with no labeled date or name. During an interview on 5/25/21 at 8:12 AM Nurse #1 stated the nourishment refrigerator was for resident food storage. She stated items placed in the refrigerator should be labeled and dated. Upon observing the items in the nourishment refrigerator she stated they should have been labeled and dated. The nurse stated she did not know who's items they were. She stated the reason items were dated and labeled in the nourishment refrigerators was in order to know	F 812	F812 Food Procurement, Store/Prepare/ Serve Sanitary Criteria #1 All personal food products were removed from 100 East & 100 West refrigerators and discarded on 05/25/21. Criteria #2 A 100% audit of all refrigerators was conducted by the Director of Nursing to ensure that all contents in refrigerators were labeled and dated appropriately. All items were discarded if found to be Inappropriate. 5/25/21 Criteria #3 100% of all staff were educated On the policy for food procurement from visitors. All new employees will be educated upon hire, in orientation. Criteria #4 Refrigerators will be audited by the Director of Nursing, Staff Development Coordinator , Clinical Compliance Nurse,	

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	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	**911 WESTERN BOULEVARD TARBORO, NC 27886**

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F 812

Continued From page 6

how long the items had been in the refrigerator to discard them after 3 days and know who the item is for. She stated her understanding was that housekeeping was responsible for checking the nourishment refrigerators.

During an interview on 5/25/21 at 8:32 AM Nurse #2 stated it was all staff's responsibility to check the nourishment refrigerators and ensure they labeled and dated items that went into the 100 west hall nourishment refrigerator. She stated the 100 west hall nourishment refrigerator was for residents. She stated labeling and dating the items ensured they would be discarded after 3 days and would tell the staff who the items were for. Upon observing the 100 west hall nourishment refrigerator the nurse stated the items did not have names or dates written on them and the strawberries looked very wilted and should have been discarded before then. She concluded the items should have had names and been dated when placed in the 100 west hall nourishment refrigerator and they were not.

During an interview on 5/25/21 at 9:12 AM Housekeeper #1 stated she was responsible for the 100 west hall housekeeping. She further stated nursing was responsible for checking the nourishment refrigerators for labels and dates on the food items.

During an interview on 5/25/21 at 10:31 AM the Director of Nursing stated items should be labeled with the name of the individual they were for and the date they were placed in nourishment refrigerators. She further stated it was the responsibility of the staff member who placed the item in the refrigerator to ensure it was labeled properly. She concluded staff should have labeled

F 812

RN Weekend Supervisor or
designee
to ensure compliance of food
item contents
have name, date and are
discarded
according to policy. Weekly x 4
weeks,
then every 2 weeks x 1 month,
then
monthly x one month then as
determined
by the QAA team. The results
will be
recorded on the Food Storage
tool. The
Director of Nursing will
incorporate the
POC into the facility□s monthly
QAA and
report any significant findings
from the
follow-up to the QA team.
6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 812		F 812		

Continued From page 7
and dated the items prior to placing them in the 100 west hall refrigerator.

During an interview on 5/25/21 at 11:00 AM the District Dietary Manager stated it was nursing's responsibility to ensure the items in the 100 west hall nourishment refrigerators were labeled appropriately.

2. During observation on 5/25/21 at 10:11 AM a sign on the 100 east hall nourishment refrigerator read in part, "[i]tems placed in the refrigerator need to be dated and have to be discarded in 3 days."

During observation of the 100 east hall nourishment refrigerator on 5/25/21 at 10:12 AM a can of whipped cream was observed in the 100 east hall nourishment refrigerator with no labeled date or name, an opened roll of crackers was observed in the 100 east hall nourishment refrigerator with no labeled date or name, a cup of cottage cheese was observed in the 100 east hall nourishment refrigerator with no labeled date or name, a can of unopened vegetable juice was observed in the 100 east hall nourishment refrigerator with no labeled date or name, a bag of grapes was observed in the 100 east hall nourishment refrigerator with no labeled date or name, and a cup of mixed fruit was observed in the 100 east hall nourishment refrigerator with no labeled date or name.

During an interview on 5/25/21 at 10:18 AM Nurse #3 stated the 100 east hall nourishment refrigerator needed to have items labeled and dated prior to being stored. The person who put the items in the refrigerator was responsible for ensuring this was done. She concluded she did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 812	Continued From page 8 not know if there was anyone who checked to see what was in the refrigerator. During an interview on 5/25/21 at 10:31 AM the Director of Nursing stated the items should be labeled with the name of the individual they were for and the date they were placed in the refrigerators. She further stated it was the responsibility of the staff member who placed the item in the refrigerator to ensure it was labeled properly. Upon observing the items in the 100 east hall nourishment refrigerator, the Director of Nursing stated she did not know who the items belonged to and they should have been labeled with a name and date. During an interview on 5/25/21 at 11:00 AM the District Dietary Manager stated it was nursing's responsibility to ensure the items in the 100 east hall nourishment refrigerators were labeled appropriately.	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep the dumpster area free of debris for 1 of 3 dumpsters. Findings included: Observations of the facility's dumpster area on 5/25/21 at 10:41 AM with the Dietary District Manager and the Maintenance Director revealed a pile of debris covered with leaves behind a	F 814	1. The area around the dumpster was cleaned on 5/25/2021. 2. Maintenance Director in-serviced on keeping area around the dumpsters free from debris. 5/25/2021 3. The Maintenance Director, Dietary Manager, Administrator, Housekeeping Manager, or designee will inspect the	6/4/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRODIGY TRANSITIONAL REHAB	911 WESTERN BOULEVARD TARBORO, NC 27886

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F 814	Continued From page 9 dumpster. Items in this debris included a 2"x 6"x 8' board, 2 4"x6"x8' boards, a 1"x6"x8' board, a 2'x4' table top, a 4'x4' table top and part of a small wood round table top. An interview on 5/25/21 at 10:41 AM with the Maintenance Director during this observation revealed this debris had been behind the dumpster 'for a while'. He also stated it should have been thrown away before but had just not been done and he didn't really know why it was placed behind the dumpster. An interview on 5/26/21 at 10:49 AM with the Administrator revealed the debris behind the dumpster should not have been there and he did not know why it had been left there.	F 814	dumpster area daily and record findings daily x 1 week, weekly x 2 weeks, and monthly x 1 month. All findings will be reported to the QA committee for evaluation and will be incorporated into the facilities monthly QAA meeting. 6/4/21	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		6/7/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 10	F 880		

providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure residents were offered or provided hand hygiene and staff failed to perform hand hygiene before and after residents or surface contact when 2 of 2 Nursing Assistants (NA #1 and NA#2) delivered meal trays to 6 of 6 residents (Residents #78, #9, #57, #80, #20, and #8).These failures occurred during the COVID-19 pandemic. Findings included: 1a. A continuous observation was made on 5/24/21 from 12:17 PM to 12:32 PM of the facility's 100 hallway. NA #1 was observed to remove a resident's meal tray from the meal cart located in the hallway, deliver the tray to Resident #78, and exit the room. She did not offer the resident hand hygiene and did not perform hand hygiene after exiting the resident's room. NA #1 was observed to remove a resident's meal tray from the meal cart and deliver it to Resident #9, exit the resident's room, obtain a plastic cup from the medication cart, fill the cup with water from the medication cart, and take it to Resident #9's room where she placed it on his meal tray. She did not offer the resident hand hygiene and did not perform hand hygiene before entering or after exiting the resident's room. NA #1 then proceeded to remove another meal tray from the	F 880	F880 Infection Prevention & Control Criteria #1 Residents #8, #9, #20, #57, # 78, #80 were all provided hand hygiene after staff had performed hand hygiene on themselves before and after each individual resident contact. 05/24/21 Criteria #2 A 100% audit was conducted at the next meal time by the Director of Nursing, Staff Development Coordinator, Clinical Compliance Nurse and Administrator to ensure that all residents were offered and performed. 05/24/21 Criteria #3 100 % of staff Nurses and CNAs were educated on hand hygiene. Prior to passing meal trays, all staff will preform hand hygiene before and after passing a meal tray before passing the next resident a meal tray. All residents will have hand hygiene offered and performed prior to	

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	345510	A. BUILDING ______ B. WING ______	C 05/27/2021

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F 880	Continued From page 12 cart and deliver it to Resident #57. She opened Resident #57's bread pouch, opened butter and pepper which she stirred into the mashed potatoes. She also opened the resident's mighty shake and ice cream containers. She did not offer the resident hand hygiene and did not perform hand hygiene before entering or after exiting the resident's room. NA #1 then proceeded to remove another meal tray from the cart and deliver it to Resident #80. She opened Resident #80's dessert container, opened butter, salt and pepper which she stirred into the mashed potatoes. She also opened sugar packets and stirred them in the resident's tea. She did not offer the resident hand hygiene and did not perform hand hygiene before entering or after exiting the resident's room. An interview on 5/24/21 at 1:03 PM with NA #1 revealed she did not offer the residents any hand hygiene because she thought they had been provided a wipe at snack time and she could see that their hands were still clean. She also stated she was taught she did not have to perform her own hand hygiene if she was only touching the tray and she did not realize she had touched multiple bedside tables and other surfaces such as the medication cart. An interview on 5/24/21 at 1:15 PM with the Director of Nursing (DON) revealed all residents should be offered or have performed hand hygiene before meals. She also stated staff should perform hand hygiene before entering and upon exiting the resident's room. She also stated that staff have been taught to perform hand hygiene before and after each resident's tray. An interview on 5/26/21 at 10:49 AM with the	F 880	eating their meal. 6/7/21 Criteria #4 Meal passes will be audited by the Director of Nursing, Staff Development Coordinator , Clinical Compliance Nurse, RN Weekend Supervisor or designee to ensure that staff passing trays are performing hand hygiene before and after passing each meal tray. All residents will have hand hygiene offered and performed prior to eating their meal. Audits will be done on alternating halls at alternating meals, weekly x 4 weeks then every 2 weeks x 1 month, then monthly x one month then as determined by the QAA team. The results will be recorded on the Hand Hygiene Tool. The Director of Nursing will incorporate the POC into the facility□s monthly QAA and report any significant findings from the follow-up to the QA team. 6/7/21	

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F 880	Continued From page 13	F 880		

Administrator revealed all staff should perform hand hygiene when delivering meal trays. And all residents should be offered or have performed hand hygiene before meals.

1b. A continuous observation was made on 5/24/21 from 12:32 PM to 12:38 PM of the facility's 100 hallway. NA #2 was observed to remove a resident's meal tray from the meal cart located in the hallway, deliver the tray to Resident #20. She was observed to open the butter pack and stir the butter into the potatoes. She cut up the resident's meat loaf and mixed it with the mashed potatoes. She opened the bread pouch and placed it on the tray beside the plate. She positioned the plate and took the resident's hand to show him where his food was located before exiting the room. She did not offer the resident hand hygiene and did not perform hand hygiene after exiting the resident's room. NA #2 then proceeded to remove a resident's meal tray from the cart and deliver the tray to Resident #8. She was observed to open the residents butter pack, salt and pepper packs and stir them into the mashed potatoes. She then opened a straw and touched both ends with her hands prior to placing the straw into the resident's tea.

An interview on 5/24/21 at 12:56 PM with NA #2 revealed she usually offered the resident's hand wipes but had not done so during this meal due to the wipes not being on the meal cart. She stated she did not perform her own hand hygiene due to being nervous about being observed during the meal tray pass.

An interview on 5/24/21 at 1:15 PM with the Director of Nursing (DON) revealed all residents should be offered or have performed hand

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F 880	Continued From page 14 hygiene before meals. She also stated staff should perform hand hygiene before entering and upon exiting the resident's room. She also stated that staff have been taught to perform hand hygiene before and after each resident's tray. An interview on 5/26/21 at 10:49 AM with the Administrator revealed all staff should perform hand hygiene when delivering meal trays. And all residents should be offered or have performed hand hygiene before meals.	F 880		