| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| **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 |
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| E 001 SS=F | Establishment of the Emergency Program (EP)<br>CFR(s): 483.73<br><br>§403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12<br><br>The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements:<br><br>* (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.)<br><br>*[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements:<br><br>*[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The | E 001 | | 12/8/23 |

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

Electronically Signed | 12/01/2023

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| E 001 | Continued From page 1<br>CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to establish policies and procedures. The Emergency Preparedness Plan also did not provide subsistence needed for staff and residents, list staff and their responsibilities, provide an alternate means of communication, share information with residents or family members, complete a tabletop or full-scale exercise and EP education.<br><br>Findings included:<br><br>A review of the facility's Emergency Preparedness plan dated October 2022 revealed:<br><br>a. The EP plan did not have policies and procedures for the following:<br>" establishing an Emergency Preparedness Plan.<br>" Risk assessment and communication plan<br>" Provision of subsistence and alternate sources of energy to maintain the following: temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection/extinguishing/alarm systems, and sewage and waste disposal.<br>" Evacuation<br>" Sheltering in place<br>" Medical documents | E 001 | Corrective Action<br>The facilities Emergency Preparedness Plan was updated on 12/4/23 to include policies and procedures for establishing an Emergency Plan, risk assessment and communication plan, provision of subsistence and alternate energy, evacuation, sheltering in place, and medical documents. The EP plan was also updated to include provisions needed for staff and residents, a list of direct care staff responsibilities, alternate means of communication, and how information will be shared with residents families (VoiceFriend). Documentation including analysis of the facility's response to a completed tabletop training was updated.<br>A copy of the EP will be placed at each Nurse Station. All staff who work at Prodigy to include Prodigy Employees and Contract Employees will be educated on the Emergency Preparedness Plan by the Administrator and SDC by 12/8/2023.<br>The EP training will be included in the facility's annual competency training each April and will be conducted by the Administrator and SDC.<br>The EP will be covered in the facility's orientation program and is included on the orientation checklist.<br>The facilities Safety Committee met to review the updated EP on 12/5/23. | |

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| E 001 | Continued From page 2<br><br>b. The EP plan did not include a list of substances provisions needed for staff and residents.<br><br>c. The EP plan failed to list direct staff responsibilities.<br><br>d. The plan did not provide an alternate means of communication.<br><br>e. The plan did not address how information was going to be shared with residents' families.<br><br>f. The EP plan did not include an analysis of the facility's response to their completed tabletop and/or community-based training and there was no evidence of staff completing the required yearly EP training.<br><br>The Administrator was interviewed on 11-16-23 at 11:18am. The Administrator stated the plan he had provided for the EP plan was the completed EP plan for the facility. Upon attempting to review the EP plan, the Administrator said, "This is all I have." | E 001 | Quality Assurance<br>The facility Quality Assurance Performance Improvement committee will review changes/updates to the EP at their December 2023 meeting.<br>The Emergency Preparedness Plan will be reviewed annually by the Facility Safety Committee and the QAPI team. | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 11-13-23 through 11-16-23. Event ID# 7G9911. The following intakes were investigated NC00202686 and NC00203103.<br><br>4 of the 11 complaint allegations resulted in deficiency. | F 000 | | |
| F 568 | Accounting and Records of Personal Funds | F 568 | | 12/7/23 |

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| F 568 SS=B | Continued From page 3<br>CFR(s): 483.10(f)(10)(iii)<br><br>§483.10(f)(10)(iii) Accounting and Records.<br>(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br>(C)The individual financial record must be available to the resident through quarterly statements and upon request.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff and Responsible Party (RP) interviews the facility failed to provide the resident or their RP quarterly statements for their personal trust fund account managed by the facility for 1 of 1 resident (Resident #85) reviewed for personal funds.<br><br>Findings included:<br><br>Resident #85 was admitted to the facility on 6/28/22 with a diagnosis of dementia.<br><br>A review of the quarterly Minimum Data Set (MDS) assessment for Resident #85 dated 10/23/23 revealed she was severely cognitively impaired.<br><br>On 11/13/23 at 11:39 AM a telephone interview with Resident #85's RP indicated Resident #85 had a personal trust fund account with the facility. The RP stated Resident#85 used this account to pay for things like beauty shop appointments at | F 568 | Corrective Action for the Resident Affected and those Potentially Affected Resident Trust statements were sent out on 11/17/23.<br><br>Systemic Changes<br>The Business Office Manager was educated on Resident Trust statement policy and procedure.<br>The Job Description for Business Office Manager was reviewed by the Administrator to ensure it includes sending resident statements in the duties and responsibilities section.<br>Resident Trust Statements will next be sent out in January 2024. At that time 10 percent of residents with resident trust accounts will be audited to make sure they did receive their statements.<br><br>Quality Assurance<br>The results of the audit will be submitted | |

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| F 568 | Continued From page 4<br>the facility. The RP went on to say she was not receiving quarterly statements from the facility for Resident #85's personal trust fund account.<br><br>On 11/16/23 at 10:06 AM an interview with the Business Office Manager confirmed Resident #85 had a personal trust fund account with the facility. She stated she had been in her position as the Business Office Manager since February 2023. She went on to say she had not been sending quarterly statements for resident trust fund accounts to residents or their RPs. The Business Office manager stated she would provide one if a resident or RP asked, but she was not aware she was supposed to be providing them quarterly.<br><br>On 11/16/23 at 11:16 AM an interview with the Administrator indicated the facility resident trust fund account policy specified that quarterly statements for resident trust fund accounts would be given to the resident or their responsible party. He stated the Business Office Manager should be providing these in accordance with the facility's policy. | F 568 | to the Quality Assurance Performance Improvement Committee for review. | |
| F 584 SS=D | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. | F 584 | | 12/5/23 |

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| F 584 | Continued From page 5<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff and resident interviews the facility failed to clean blood from a floor surface for 1 of 1 room reviewed for environment (Room 241).<br><br>Findings included:<br><br>During observation of Room 241 on 11/13/23 at 10:24 AM an approximately 3.0 inch by 0.5 inch | F 584 | Corrective Action for the Resident Affected<br>Room 241 was sanitized and cleaned on 11/14/23.<br><br>Corrective Action for Residents Potentially Affected<br>All rooms were audited by assigned department heads on 11/15/23. | |

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| F 584 | Continued From page 6<br>area of dried blood was observed on the floor between the window and bed.<br><br>During observation on 11/13/23 at 3:05 PM the dried blood was observed still on the floor in Room 241. Resident #12 stated the blood on floor was from his toenail which had bled that morning.<br><br>During observation on 11/14/23 at 8:13 AM, the same dried dried blood was again observed on the floor of Room 241.<br><br>During an interview on 11/14/23 at 8:14 AM Nurse Aide #1 stated she did not notice the dried blood on the floor in Room 241 and did not know how she had missed seeing it.<br><br>During an interview on 11/14/23 at 8:17 AM Nurse #5 stated she saw him in the morning when giving his medicine and did not note the blood.<br><br>During an interview on 11/14/23 at 8:23 AM the Director of Nursing stated around 8:30 AM she entered Room 241 and Resident #12 informed the Director of Nursing of the blood on his toe but did not mention any blood on the floor. Where his wheelchair was at the time blocked her view of that area of the floor. She concluded blood should be cleaned from surfaces for infection control concerns.<br><br>During an interview on 11/14/23 at 8:31 AM the Contracted Housekeeping Account Manager stated Housekeeper #1 should visualize the entirety of the floor while cleaning and Housekeeper #1 was the staff member responsible for Room 241. If housekeepers noted any blood, which they should have noted in Room 241, they should have reported the area to | F 584 | Systemic Changes<br>All housekeeping employees were in-serviced by 12/4/23 by the Housekeeping Supervisor on proper room cleaning procedures. Any housekeeping employee what did not receive the education will not be allowed to work until the training is complete.<br>Rooms will be inspected at least twice a week by an assigned department head for room rounds. Rounds sheets will be given to the administrator for review.<br>Rooms will be audited by the housekeeping manager weekly x 6 weeks, then monthly x 3 months to ensure compliance.<br><br>Quality Assurance<br>Results of room rounds/audits will be submitted to the Quality Assurance Performance Improvement Committee for review monthly | |

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| F 584 | Continued From page 7<br>nursing who would clean the blood and then come back and sanitized the area after.<br><br>Housekeeper #1 was unavailable for interview. | F 584 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for | F 656 | | 11/30/23 |

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| F 656 | Continued From page 8<br>future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, resident, and staff interviews, the facility failed to develop an individualized person-centered comprehensive care plan related to tracheostomy care which included an intervention for suctioning for a resident who required suctioning daily and as needed. This occurred for 1 of 13 residents (Resident #73) reviewed for comprehensive care plans.<br><br>Findings included:<br><br>Resident #73 was admitted to the facility on 4-2-22 with multiple diagnoses that included encounter for tracheostomy and chronic respiratory failure.<br><br>The quarterly Minimum Data Set (MDS) dated 9-25-23 revealed Resident #73 was severely cognitively impaired. The MDS documented Resident #73's tracheostomy care but not suctioning.<br><br>Resident #73's care plan dated 9-25-23 revealed | F 656 | Corrective Action for the Resident Affected<br>On 11/15/23 a telephone order for tracheal suctioning as needed was written for resident #73. The intervention of tracheal suctioning as needed was added to Resident #73's comprehensive care plan on 11/15/23 by the MDS Nurse.<br><br>Corrective Action for the Residents Potentially Affected<br>DON and MDS Nurse were educated on Trach Care, Suctioning and Coding on 11/15/2023 by the Administrator.<br>On 11/15/23 a comprehensive care plan audit was conducted by the MDS Nurse. 100% of residents with a tracheostomy were reviewed on 11/15/23. Comprehensive care plans for each resident with tracheostomies were found to have suctioning and trach care identified as interventions.<br><br>Quality Assurance | |

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| F 656 | Continued From page 9<br>goals and interventions for his tracheostomy but no goals and interventions related to as needed suctioning.<br><br>Resident #73 was interviewed on 11-13-23 at 12:11pm. The resident used a communication board to state that he was suctioned at least once a day by nursing staff. Resident #73 communicated there were no issues with his suctioning.<br><br>During an interview with Nurse #1 on 11-14-23 at 11:35am, Nurse #1 discussed Resident #73 having a tracheostomy. She explained the resident required to be suctioned at least once a shift but sometimes more. Nurse #1 stated she knew Resident #73 had a care plan for the care of his tracheostomy but said she did not recall ever seeing any goals or interventions for suctioning. The nurse explained when an order was written for "trach care daily" that it was understood by nursing staff that suctioning was part of daily trach care. Nurse #1 explained she would provide suctioning for Resident #73 "when he had an increase in congestion."<br><br>The MDS Nurse was interviewed on 11-14-23 at 11:41am. The MDS Nurse confirmed there were not any goals or interventions for Resident #73 to be suctioned. She explained the resident did not need a separate goal or intervention for suctioning because the task was part of his routine trach care.<br><br>An interview with the Director of nursing (DON) occurred on 11-14-23 at 12:17pm. The DON discussed care plans for tracheostomy residents and stated she expected the residents to have goals and interventions for routine trach care and | F 656 | Comprehensive Care Plans for all residents with a tracheostomy will be completed weekly for 4 weeks then monthly for 4 months to ensure all care plans are correct and implemented. The results of these reviews will be submitted to the Quality Assurance Performance Improvement (QAPI) committee for review monthly. | |

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| F 656 | Continued From page 10<br>possibly suctioning. She explained not all their tracheostomy residents needed routine suctioning. The DON stated for Resident #73, she would expect to see interventions on his care plan for as needed suctioning. She said Resident #73 had not required routine suctioning but was aware he required suctioning at times. The DON stated she was not aware that there were not any goals or interventions for Resident #73's suctioning.<br><br>The Administrator was interviewed on 11-16-23 at 11:18am. The Administrator discussed not knowing enough about tracheostomy care to say if Resident #73 should have goals and interventions on his care plan for suctioning. | F 656 | | |
| F 688 SS=D | Increase/Prevent Decrease in ROM/Mobility<br>CFR(s): 483.25(c)(1)-(3)<br><br>§483.25(c) Mobility.<br>§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and<br><br>§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.<br>This REQUIREMENT is not met as evidenced | F 688 | | 12/8/23 |

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

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| F 688 | Continued From page 11<br>by:<br>Based on observations, record review, and staff and family interviews, the facility failed to place a splint on 1 of 1 resident reviewed for range of motion (Resident #88).<br><br>Findings included:<br><br>Resident #88 was admitted to the facility on 1/12/23. Her active diagnoses included cancer, hypertension, cerebrovascular accident [(CVA), TIA, or stroke], depression, and secondary malignant neoplasm of bone. She received hospice services.<br><br>Resident #88's minimum data set assessment dated 10/9/23 revealed the resident was assessed as severely cognitively impaired. She had impairment to the upper and lower extremity of one side. She was dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, and chair/bed-to-chair transfer. She was always incontinent of bowel and bladder.<br><br>Resident #88's care plan dated 10/9/23 revealed she was care planned for impaired mobility related to diagnoses of history of cerebrovascular accident, cancer with metastasis to bones and is on hospice services. The interventions included placing her left hand splint as ordered by Hospice 4 to 6 hours daily.<br><br>During observation on 11/13/23 at 9:47 AM Resident #88 was observed in her room and had no splint applied to her left hand.<br><br>During an interview on 11/13/23 at 11:02 AM | F 688 | Corrective Action for the Resident Affected<br>On 11/15/23, the Director of Nursing (DON) observed Resident # 88 to ensure that the left hand splint had been placed per MD order.<br><br>Corrective Action for the Residents Potentially Affected<br>On 11/27/2023, the Director of Nursing (DON) and Administrative Nursing reviewed residents with order for splints. Out of 90 residents in house, there 34 residents with splints. There are 13 residents assigned to the Restorative program, 19 residents in therapy and 2 assigned to nursing. The 2 that are assigned to nursing have orders to apply splints to their extremities. The DON and Administrative Nurses observed resident with splints and all were applied as ordered.<br><br>Systemic Changes<br>On ¬¬ 11/27/23, the Staff Development Coordinator initiated an in-service with the licensed nurses and certified nursing assistants on placing splints on resident with orders and to document. Any Licensed nurse and or Certified Nursing Assistant that did not received the in-service by 12/4/23 will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses and Certified Nursing Assistants, as well as include Agency staff. | |

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| F 688 | Continued From page 12<br>Nurse Aide #2 stated at one time, Resident #88 had a splint for one of her hands. She had not put Resident #88's splint on because she did not know where it was or if she still needed it.<br><br>During observation on 11/13/23 at 11:34 AM Resident #88 was observed in her room and had no splint applied to her left hand.<br><br>During observation on 11/14/23 at 11:32 AM Resident #88 was observed in her room and had no splint applied to her left hand.<br><br>During a follow-up interview on 11/14/23 at 12:14 AM Nurse Aide #2 stated she was not putting splints on Resident #88 because she did not know where it was, and splints were not on the care guide in the closet, so she did not know the resident was to get splints.<br><br>During observation on 11/14/23 at 12:14 AM the care guide in the closet was observed to not have splint use documented on the closet door care guide.<br><br>During an interview on 11/13/23 at 12:22 Nurse #5 stated the daughter had splints on the resident prior to coming to the facility and the splint was placed on Resident #88 by staff including herself at times. She stated she believed it was to be put on daily and she had put the hand splint on Resident #88 in the mornings. She stated if she put the splint on, she would document it in the chart. Since she did not put the splint on yesterday or today, the MAR was blank. She concluded she did not put the splints on Resident #88 yesterday or today as she was busy and had forgotten. | F 688 | The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with orders for splints have the splints on, by utilizing the QA monitoring tool for applying splints.<br><br>Quality Assurance (QA)<br>The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. | |

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| F 688 | Continued From page 13<br>During an interview on 11/14/23 at 12:29 the Medical Director, after reviewing the order, stated that the order was for the splint to be placed for 4 to 6 hours each day. He stated he did not remember any discussion with the family about the splint but would expect the orders to be followed. As the Medication Administration Record (MAR) was blank, either it was not documented, or the splint was not put on.<br><br>During an interview on 11/14/23 at 1:22 PM the Director of Nursing stated most of the time hospice would bathe the resident in the morning and put the hand splint on the resident and if not, their staff should place the splint on Resident #88. She concluded, based on the MAR, the splint was not placed on the resident 11/1/23 through 11/13/23 and it should have been placed per physician's orders. | F 688 | | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, and physician interviews, the facility failed to obtain a physician's order to suction a resident who was trach dependent. This occurred for 1 of 1 resident (Resident #73) reviewed for tracheostomy care. | F 695 | Corrective Action for the Resident Affected<br>On 11/15/2023, an order was obtained from the Medical Director to suction resident # 73 who is trach dependent. | 12/8/23 |

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| F 695 | Continued From page 14<br><br>Findings included:<br><br>Resident #73 was admitted to the facility on 4-2-22 with multiple diagnoses that included encounter for tracheostomy.<br><br>The quarterly Minimum Data Set (MDS) dated 9-25-23 revealed Resident #73 was severely cognitively impaired.<br><br>Review of the Physician's standing orders dated 11-7-23 read trach care every shift.<br><br>During an interview with Nurse #1 on 11-14-23 at 11:35am, Nurse #1 explained when a resident received tracheostomy care, the care was documented on the resident's Medication Administration Record (MAR). She further explained if the resident required suctioning, that would also be documented on the resident's MAR. Nurse #1 discussed Resident #73 not having suctioning on his MAR and stated, "that is because there is not an order to suction the resident." The nurse explained that suctioning was part of Resident #73's routine trach care and she was not aware there needed to be an order.<br><br>An interview with the Director of Nursing (DON) occurred on 11-14-23 at 12:17pm. The DON discussed if a resident required routine suctioning, there was a physician order for suctioning but if a resident required suctioning on an as needed basis, then the order for routine daily trach care would include suctioning. She explained that Resident #73 required suctioning on an as needed basis and stated she was not aware a separate order should be written. | F 695 | Corrective Action for the Residents Potentially Affected<br>On 11/15/2023, the Director of Nursing (DON) and Administrative Nursing reviewed resident's charts and identified 3 other residents with tracheostomies. The DON and or Administrative Nurse's will check orders to ensure orders were written separately for trach care and suctioning. Out of 3 residents that have tracheostomies, 3 residents have order written for tracheostomy care and order for suctioning.<br><br>Systemic Changes<br>On 11/27/202, the Staff Development Coordinator initiated an in-service with the licensed nurses on Tracheostomy care and suctioning and documentation. Any Licensed nurse that did not received the in-service by 12/4/23 will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as include Agency staff.<br>The DON and or Administrative Nurses will conduct random assessments 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure residents with a tracheostomy will have a MD order for trach care and order for suctioning, by utilizing the QA monitoring tool for trach care and suctioning.<br><br>Quality Assurance (QA)<br>The results of these reviews to be submitted to the Quality Assurance | |

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| F 695 | Continued From page 15<br>The Medical Director was interviewed on 11-14-23 at 1:59pm. The Medical Director explained he did not write orders for trach care because there were standing orders for trach care. He further explained it was understood by nursing that the standing order for trach care would include suctioning when needed. The Medical Director discussed Resident #73 and stated there should be a physician's order for as needed suctioning for the resident. He said he was not aware that there was not an order in place for Resident #73's suctioning.<br><br>The Administrator was interviewed on 11-16-23 at 11:18am. The Administrator stated he was not familiar enough about tracheostomy care and would defer to what the DON and Medical Director discussed. | F 695 | Performance Improvement (QAPI) Committee by the DON for review by the IDT members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident | F 726 | | 12/8/23 |

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| F 726 | Continued From page 16<br>assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff, and Physician interviews, the facility failed to educate 3 of 3 nurses (Nurse #2, Nurse #3, and Nurse #4) to ensure competency and demonstrate skills in providing care to 1 of 1 resident (Resident #73) reviewed for tracheostomy care.<br><br>Findings included:<br><br>Resident #73 was admitted to the facility on 4-2-22 with multiple diagnoses that included encounter for tracheostomy.<br><br>A telephone interview occurred with Nurse #2 on 11-15-23 at 9:41am. Nurse #2 explained she began working at the facility in May 2023 and had been assigned to Resident #73 "sometimes." She stated when she had worked with Resident #73, she remembered having to provide trach care and having to suction Resident #73 once during her shift. The nurse discussed not receiving trach training or having to show competency in providing trach care and/or suctioning to Resident #73. | F 726 | Corrective Action for the Resident Affected<br>On 11/27/23, the Staff Development Coordinator, (SDC), reviewed the competencies of the licensed nursing staff scheduled to work with resident #73 and if they had not received training for tracheostomy care and suctioning, they did receive training prior to working with resident #73.<br><br>Corrective Action for the Residents Potentially Affected<br>On 11/27/23, SDC received the schedules of the licensed nurses working with residents with Tracheostomies. Any Licensed Nurse that had not received training for tracheostomy care and suctioning, will receive training prior to working with the residents with tracheostomies.<br><br>Systemic Changes<br>On 11/27/2023, the Staff Development | |

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| F 726 | Continued From page 17<br><br>An interview with Nurse #3 occurred by telephone on 11-15-23 at 10:21am. Nurse #3 explained she had begun working at the facility in the middle of October 2023 and stated she had provided trach care and suctioning to Resident #73. She discussed not receiving training or skills competency on trach care and/or suctioning since she was hired.<br><br>During an interview with Nurse #4 on 11-15-23 at 4:11pm, Nurse #4 discussed working for an agency and often being assigned to Resident #73 where she stated she had performed trach care and suctioning. She said she had not been provided training and/or skills competency on trach care and/or suctioning to Resident #73.<br><br>The Medical Director was interviewed on 11-14-23 at 1:59pm. The Medical Director discussed not being aware the nurses had not received competency education or demonstrated their competency to provide trach care to Resident #73. He stated all nursing staff should have competency training and be able to demonstrate their competency in providing trach care.<br><br>The Staff Development Coordinator (SDC) was interviewed on 11-15-23 at 12:24pm. The SDC explained when there was a new nurse hired, the new nurse would be paired with a seasoned nurse who would be responsible for completing the competency skills check list with the new hire. He stated trach care and suctioning was part of the new hire competency check list, however when reviewing the document, the SDC realized trach care and suctioning was not part of the new hire competency check list. The SDC discussed | F 726 | Coordinator began in-servicing the Licensed Nursing staff on Tracheostomy care and Suctioning. Any Licensed nurse, including agency that did not received the in-service by 12/4/23 will not work until they have received the in-service. This in-service will be a part of the facilities orientation process for training of new licensed nurses, as well as agency nurses.<br>On 11/27/23, the Staff Development Coordinator included Tracheostomy care and Suctioning on the RN/LPN orientation checklist for new hires.<br>On 11/27/23, the Staff Development Coordinator included Tracheostomy care and Suctioning on the RN/LPN annual checklist.<br>The DON and or Administrative Nurses will review Licensed competencies 3 times a week for 6 weeks, then weekly for 6 weeks, then monthly to ensure all licensed nurses including agency have been trained by using the QA monitoring tool for Competent Nursing Staff.<br><br>Quality Assurance<br>The results of these reviews to be submitted to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review by the Interdisciplinary Team members monthly or until compliance is sustained. Quality monitoring schedule modified based on findings. The QAPI Committee to evaluate and modify monitoring as needed. | |

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| F 726 | Continued From page 18<br>not being aware that trach care and suctioning was not part of the new hire competency check list but stated all new nursing staff should be trained and show competency prior to performing trach care and/or suctioning.<br><br>The Director of Nursing (DON) was interviewed on 11-14-23 at 12:17pm. The DON discussed not being aware that all the new nurses hired had not had trach care and/or suctioning training and competencies completed. She stated all nurses should be trained and show competency in trach care and/or suctioning prior to working with trach residents. | F 726 | | |
| F 838 SS=F | Facility Assessment<br>CFR(s): 483.70(e)(1)-(3)<br><br>§483.70(e) Facility assessment.<br>The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:<br><br>§483.70(e)(1) The facility's resident population, including, but not limited to,<br>(i) Both the number of residents and the facility's resident capacity;<br>(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, | F 838 | | 12/8/23 |

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| F 838 | Continued From page 19 | F 838 | | |

and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

§483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.
This REQUIREMENT is not met as evidenced by:

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| F 838 | Continued From page 20<br>Based on record review and staff interviews the facility failed to review and annually update the Facility Assessment and to ensure the Facility Assessment identified and addressed the care required for the population of residents with a tracheostomy and to address the staff training necessary to competently provide tracheostomy care.<br><br>Findings included:<br><br>Review of the Facility Assessment revealed the assessment was last updated in November 2022. The document indicated the facility had completed education/training/competencies with staff specific to resident care needs, however, the facility lacked training/competencies to care for residents who required a trach. The Facility Assessment also indicated the facility had an Emergency Preparedness Plan that was up to date, however the Emergency Preparedness Plan that was present was not complete.<br><br>The Administrator was interviewed on 11-16-23 at 11:18am. The Administrator confirmed that the facility had 2 residents that were trach dependent and discussed that the Facility Assessment was a collaboration effort with management. He indicated he was unaware that tracheostomy care and training was not addressed in the Facility Assessment. The Administrator also stated he was not aware that some of the staff had not received education/competencies in providing trach care/suctioning. He also stated he believed the Emergency Preparedness Plan was complete and accurate. | F 838 | Corrective Action for the Resident Affected and those Potentially Affected<br>The Facility Assessment was reviewed and updated by the QAPI committee on 11/28/23. Tracheostomy care was added to the trainings necessary to competently provide tracheostomy care.<br>Updates to the Emergency Preparedness plan were completed on 12/5/2023 and the Facility Assessment reviewed and updated to reflect completion.<br><br>Quality Assurance<br>The Facility Assessment will be reviewed by the Quality Assurance Performance Improvement annually as required. | |
| F 867 SS=F | QAPI/QAA Improvement Activities<br>CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) | F 867 | | 12/8/23 |

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| F 867 | Continued From page 21<br><br>§483.75(c) Program feedback, data systems and monitoring.<br>A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:<br><br>§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.<br><br>§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.<br><br>§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.<br><br>§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. | F 867 | | |

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|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | C 11/16/2023 |

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

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| F 867 | Continued From page 22<br><br>§483.75(d) Program systematic analysis and systemic action.<br><br>§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.<br><br>§483.75(d)(2) The facility will develop and implement policies addressing:<br>(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;<br>(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and<br>(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.<br><br>§483.75(e) Program activities.<br><br>§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.<br><br>§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the | F 867 | | |

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| F 867 | Continued From page 23<br>facility.<br><br>§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).<br>Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.<br><br>§483.75(g) Quality assessment and assurance.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br><br>(ii) Develop and implement appropriate plans of action to correct identified quality deficiencies;<br>(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observations, staff, and resident interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously | F 867 | The QAPI team was educated by the Administrator on the Facility Policies, Procedures, and Requirements for the Quality Assessment and Assurance Committee on 12/8/2023. | |

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| F 867 | Continued From page 24<br>put in place following the recertification and complaint investigation surveys of 10-13-22. This was for 4 recited deficiencies in the areas of Emergency Preparedness (E001), Safe/Clean/Comfortable/Homelike Environment (F584), Respiratory/Tracheostomy care and Suctioning (F695), and Facility Assessment (F838). The continued failure during 2 federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program.<br><br>Findings included:<br><br>This tag was cross referenced to:<br><br>E001: Based on record review and staff interviews, the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to establish policies and procedures, provide subsistence needed for staff and residents, list staff and their responsibilities, provide an alternate means of communication, review and update the communication plan, share information with residents or family members, complete a tabletop or full-scale exercise and EP education.<br><br>During the recertification and complaint investigation survey of 10-13-22 the facility was cited for failing to include/document facility based and community-based risk assessment, address persons at risk, establish policies and procedures, develop a system to track residents' and staff, maintain/ update current contacts, review and update the communication plan, update names and contact information, share information with residents or family members and | F 867 | The noted 4 recited deficiencies will be included as agenda items for QAPI review for the next 12 months.<br>The QAPI policy will be included in the facility's annual Education Fair and will be conducted by the Administrator. | |

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| F 867 | Continued From page 25 | F 867 | | |

to complete a tabletop or full-scale exercise and EP education.

F584: Based on observations and staff and resident interviews the facility failed to clean blood from a floor surface for 1 of 1 room reviewed for environment (Room 241).

During the recertification and complaint investigation survey of 10-13-22 the facility was cited for not maintaining resident walls and heating/air units in good repair and maintaining a clean-living environment.

F695: Based on record review, staff, and physician interviews, the facility failed to obtain a physician's order to suction a resident who was trach dependent. This occurred for 1 of 1 resident (Resident #73) reviewed for tracheostomy care. During the recertification and complaint investigation survey of 10-13-22 the facility was cited for failing to provide tracheostomy care following sterile technique and set oxygen as ordered.

F838: Based on record review and staff interviews the facility failed to review and annually update the Facility Assessment and to ensure the Facility Assessment identified and addressed the care required for the population of residents with a tracheostomy and to address the staff training necessary to competently provide tracheostomy care.
During the recertification and complaint investigation survey of 10-13-22 the facility failed to review and annually update the Facility Assessment.

The Administrator was interviewed on 11-16-23 at

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| F 867 | Continued From page 26<br>11:18am. The Administrator discussed trying not to have repeat citations and stated, "but it happens." | F 867 | | |