

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2017
NAME OF PROVIDER OR SUPPLIER PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the Complaint investigation conducted on 7/20/17. Event ID#DKZY11. Complaint Intake# NC00129918.	F 000			
F 161 SS=C	483.10(f)(10)(vi) SURETY BOND - SECURITY OF PERSONAL FUNDS (10)(vi) Assurance of Financial Security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to ensure that a surety bond which protects the resident's funds held in trust, was secured by a bond that named the residents of the facility as the obligee instead of the Department of Human Resources. The findings include: A review of the facility surety bond, which was effective 2/21/17, revealed the amount of the surety bond was for \$120,000.00, and the Department of Human Resources, Division of Facility Services was named as the obligee for funds entrusted to the facility. The Department of Human Resources, Division of Facility Services does not have any provisions for distributing funds to individuals in long term care facilities. During an interview on 07/20/2017 at 12:18:18 PM, the Business Office Manager stated she did not know who the surety bond was supposed to	F 161	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. 1. The surety bond was updated to read that the residents of the facility are the obligee. 7/20/17 2. The administrator will review the surety bond annually to ensure that it is still worded correctly and report the results to the QA committee.	7/20/17	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

08/14/2017

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: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2017
NAME OF PROVIDER OR SUPPLIER PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 161	Continued From page 1 be made out to. During an interview on 07/20/2017 at 12:23PM, the Administrator stated he did not know anything had changed with the surety bond. He said it had been the same information since he had been in facility. He revealed the facility had a surety company in 2009 and they changed companies in 2011 and they (surety bond company) must have gotten the wording wrong.	F 161			
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (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. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced	F 371		8/1/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2017
NAME OF PROVIDER OR SUPPLIER PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	<p>Continued From page 2</p> <p>by: Based on observations, staff interviews the facility failed to maintain kitchen equipment clean and in a sanitary condition to prevent cross contamination by failing to clean the steam table under shelf for one of one steam tables observed. The findings included:</p> <p>Review of the undated Area and Equipment Cleaning Frequency Kitchen Area schedule, Steam Tables under Equipment reads as: "Steam Tables, Wells as outside, overhead shelf and overhead heat lamps. The Frequency of cleaning the wells and overhead shelf were to be cleaned & sanitize, after each use."</p> <p>Review of the daily cleaning matrix under "Task" the steam table was initialed on 7/15/17 indicating the steam table had been cleaned on that date.</p> <p>During an observation on 7/19/17 at 8:37 AM the 5 well steam table was observed. The 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles.</p> <p>A second observation on 7/19/17 at 3:14 PM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles.</p> <p>On 7/20/17 at 9:39 AM the 5 ½ foot underside of the steam table shelf was observed to be covered with dark dried food particles and was sticky to touch.</p> <p>In an interview with the Certified Dietary Manager (CDM) on 7/20/17 at 9:39 AM she stated the steam table was on the bi weekly cleaning schedule and would be cleaned immediately.</p>	F 371	<p>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.</p> <ol style="list-style-type: none"> 1. The steam table was deep cleaned on 7-20-17. 2. All dietary staff were in-serviced on proper cleaning procedures on 7/21/17. 3. The cleaning list with all equipment on a daily and weekly schedule was updated and posted on 7-21-17. 4. A steam table cleaning form with daily checks after each meal was started on 7-21-17. 5. Monitoring will be done daily x 1 month, weekly x 2 months, and a monthly x 3 months. Results will be reported to the QAA committee monthly. 		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345510	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/20/2017
NAME OF PROVIDER OR SUPPLIER PRODIGY TRANSITIONAL REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 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 371	Continued From page 3 In an interview with the Registered Dietitian on 7/20/17 at 9:48 AM she stated the steam table had been cleaned but not the under shelf and staff would clean under shelf immediately. In an interview on 7/19/17 at 11:02 AM the Administrator stated he would expect the steam table under shelf to be clean.	F 371		