PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345510	B. WING			1	C <b>08/10/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER	0.00.0			FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010	
PRODIGY	TRANSITIONAL REHAB	<b>,</b>			1 WESTERN BOULEVARD			
				T/	ARBORO, NC 27886		I	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F	000				
	A recertification and conducted from 8/06/ Immediate Jeopardy	•						
	CFR 483.25 at tag F6	689 at a scope and severity J						
	The tag F689 constitu Care.	uted Substandard Quality of						
	Immediate Jeopardy removed on 8/9/18.	began on 7/22/18 and was						
	An extended survey v	was also conducted.						
	complaint investigation							
F 636 SS=E	l ·	<u> </u>	F 6	636			9/5/18	
	a comprehensive, ac	duct initially and periodically						
	A facility must make a assessment of a resident assessment resident assessment	ent Assessment Instrument. a comprehensive dent's needs, strengths, I preferences, using the instrument (RAI) specified						
	the following:	sment must include at least  demographic information						
	(iii) Cognitive patterns (iv) Communication.							
LABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE	

Electronically Signed 08/24/2018

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.

AND DI AN OF CORRECTION IN IMPRED.		` ′	PLE CONSTRUCTION  G	COMPLETED	
		345510	B. WING		C 08/10/2018
	ROVIDER OR SUPPLIER  TRANSITIONAL REHA	В		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	1 33/10/23/13
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 636	(ix) Continence.  (x) Disease diagnos (xi) Dental and nutrit (xii) Skin Conditions (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatme (xvi) Discharge plan (xvii) Documentation regarding the addition on the care areas trithe Minimum Data S (xviii) Documentation assessment. The assinclude direct observed with the resident, as licensed and nonlice members on all shift §483.20(b)(2) When timeframes prescribed chapter, a facility musassessment of a restimeframes specified through (iii) of this seprescribed in §413.3 apply to CAHs. (i) Within 14 calendal excluding readmission significant change in mental condition. (For readmission" means.	vior patterns. rell-being. roning and structural problems. ris and health conditions. ris and procedures. ring. ron of summary information ronal assessment performed riggered by the completion of riet (MDS). ron of participation in rissessment process must ration and communication rissessment process must ration and communication rissed direct care staff riss. required. Subject to the red in §413.343(b) of this rist conduct a comprehensive rident in accordance with the right in paragraphs (b)(2)(i) rection. The timeframes right in days after admission, rons in which there is no right the resident's physical or ror purposes of this section, rist a return to the facility ry absence for hospitalization	F 63	36	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
	345510	B. WING _			C 08/10/2018	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COI	•	30/10/2010	
			911 WESTERN BOULEVARD			
PRODIGY TRANSITIONAL REHAE			TARBORO, NC 27886			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
by: Based on record rev facility failed to condu assessment for 6 of 2 Resident Compreher (Residents #18, #3, # Findings included:  1. Resident # 18 was 6/17/13. Active diag fibrillation, malignant prostate and Alzheim Minimum Data Set (N completed for Reside assessment complete assessment complete assessment with an A (ARD, the last day of of 6/20/18 was obser record as "open" and incomplete sections of Speech and Vision, S Section H-Bladder ar Diagnosis, Section J- L-Oral/Dental Status, Section N-Medication and Alarms.  An interview was cor on 8/8/18 at 4:19 PM late in completing Re	iews and staff interviews, the act an annual comprehensive 29 residents reviewed for asive Assessments 435, #20, #37, and # 24).  Is admitted to the facility moses included atrial neoplasm (tumor) of the er's disease. A review of the MDS) assessments and #18 revealed the last ed was a quarterly ed on 3/27/18.  It is annual comprehensive Assessment Reference Date the 7-day lookback period) ved in the electronic medical not completed. The were Section B-Hearing, Section G-Functional Status, and Bowel, Section I-Active Health Conditions, Section Section M-Skin Conditions, as, and Section P- Restraints and work was sident #18's annual MDS een completed in June 2018.	F 6	Submission of the response The Statement of Deficiencie The undersigned does not Constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is require  F 636 – Comprehensive Ass Timing  Criteria #1: It was identified t failed to do 6 of 29 resident Comprehensive Assessments timely. All affect resident's MDS Assessment were completed 8/21/2018.  Criteria # 2: A 100% audit wat on 8/21/2018 to ensure all late at were identified. All assessm up to date by 09/05/18.  Criteria #3: The MDS team on timeliness of assessments on 8/14/2018.  Criteria #4: The Administrato the MDS calendar due dates with the daily, Monday through Friday the weekends being reviewee	d. essments & hat the facility cted d by as completed assessments ents will be was educated or will review MDS team y with		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345510	B. WING_				C <b>10/2018</b>
NAME OF P	ROVIDER OR SUPPLIER	2.22.2		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2016
					1 WESTERN BOULEVARD		
PRODIGY	TRANSITIONAL REHAB				ARBORO, NC 27886		
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F 636	Continued From page	÷ 3	F6	36			
F 636	absent from the facility assessments became MDS Nurse indicated complete assessments became reported the facility rest to complete assessments of complete assessments of the incompletion of the incompleted on time.  An interview was contact and the incompleted as required the incompletion of the incomplet	y. She reported be behind at that time. The there was no one to ts during her leave. She ecently hired additional staff ents.  ducted with the Director of 4:59 PM who stated she was ete assessments. She ectation that assessments  ducted with the 18 at 5:05 PM. He stated it essments would be d.  admitted to the facility noses included pneumonia, kidney disease and diabetes the Minimum Data Set completed for Resident #3 essment completed was a completed on 3/12/18.  3's annual comprehensive assessment Reference Date wed in the electronic medical not completed. The were Section I-Active Health Conditions, and	F	336	for timely completion daily x 1 month, weekly x 2 months, and monthly x 3 months. In the Administrator's absence, the DON or ADON will assume the responsibility of the POC. Director of Nursing will incorporate the POC into the facility's monthly QAA meeting evaluate the effectiveness and compliance of the regulatory requirements. 09/05/18	The	
		en completed in June 2018. d had a family emergency					

(X3) DATE SURVEY COMPLETED		
C 08/10/2018		
00/10/2010		
(X5) COMPLETION DATE		

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED		
		345510	B. WING		C 08/10/2018	
	ROVIDER OR SUPPLIER TRANSITIONAL REHAE			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 636	An interview was coron 8/8/18 at 4:19 PM late in completing Rewhich should have by The MDS Nurse state emergency in April, wabsent from the facility assessments became MDS Nurse indicated complete assessment reported the facility reported the incomplicated it is her expectation as completed on time. An interview was coronal Administrator on 8/8/18 at aware of the incomplicated it is her expectation as completed as required. Resident #20 was 5/9/16. Active diagnosystemic inflammato. A review of the Mining assessments completed the last assequarterly assessment. On 8/8/18 Resident #20 was 5/9/16 assessment with an anoing 7/2/18 was observed as "open". The management of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open". The management was coronal factors of 7/2/18 was observed as "open".	and Setting.  Inducted with the MDS Nurse I. She confirmed she was esident #35's annual MDS een completed in July 2018. The seed she had a family which required her to be ty. She reported ee behind at that time. The district the three was no one to the during her leave. She eccently hired additional staffments.  Inducted with the Director of 4:59 PM who stated she was ete assessments. She ecctation that assessments eccentrictly the sessments would be ed.  Inducted with the 18 at 5:05 PM. He stated it seessments would be ed.  It admitted to the facility on poses included sepsis, by response and dementia. The sessment seed the set of the sessment that the sessment that as the sessment that	F 63	6		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345510	B. WING		C 08/10/2018
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	1 00/10/2010
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F 636	C-Cognitive Patterns E-Behavior, Section Routine and Activitie Status, Section H-BI I-Active Diagnoses, Section L-Oral/Denta Conditions, Section O-Special Treatmen Programs, Section F Section Q-Participat Setting.  An interview was coron 8/8/18 at 4:19 PN late in completing Re which should have b The MDS Nurse statemergency in April, absent from the facil assessments becam MDS Nurse indicate complete assessment reported the facility r to complete assessment An interview was con Nursing on 8/8/18 at aware of the incomp indicated it is her exp completed on time.  An interview was con Administrator on 8/8 is his expectation as completed as require  5. Resident #37 was 8/31/17. Active diag	F-Preferences for Customary s, Section G-Functional adder and Bowel, Section Section J-Health Conditions, al Status, Section M-Skin N-Medications, Section is, Procedures and r-Restraints and Alarms and on in Assessment and Goal and the Confirmed she was resident #20's annual MDS reen completed in July 2018. The determinant of the behind at that time. The dithere was no one to the dity. She reported recently hired additional staffments.  Inducted with the Director of 4:59 PM who stated she was recently hired additional staffments.  Inducted with the Director of 4:59 PM who stated she was recently hired additional staffments.  Inducted with the Director of 4:59 PM who stated she was recently hired assessments be recently hired sessments would be	F 63		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE : COMPI		
		345510	B. WING _				C 10/2018
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAE	<b>.</b>		STREET ADDRESS, CITY, STATE, ZIF 911 WESTERN BOULEVARD TARBORO, NC 27886	CODE	1 001	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIE	CTION SHOULD BI O THE APPROPRIA		(X5) COMPLETION DATE
F 636	affecting the right dor Minimum Data Set (Month Completed for Reside assessment complete assessment dated 4/4  On 8/8/18 Resident # assessment with an # of 7/3/18 was observed as "open". The Section C-Cognitive In Section E-Behavior, Section H-Bladder are Diagnoses, Section JL-Oral/Dental Status, Section P-Restraints Q-Participation in Assembly An interview was conton 8/8/18 at 4:19 PM late in completing Rewhich should have be the MDS Nurse state emergency in April, wabsent from the facility assessments became MDS Nurse indicated complete assessments	nemiplegia (paralysis) minant side. A review of the MDS) assessments ant #37 revealed the last ed was a quarterly 4/18.  37's annual comprehensive Assessment Reference Date ed in the electronic medical e incomplete sections were Patterns, Section D-Mood, Section G-Functional Status, ad Bowel, Section I-Active -Health Conditions, Section Section N-Medications, and Alarms and Section sessment and Goal Setting.  ducted with the MDS Nurse . She confirmed she was sident #37's annual MDS een completed in July 2018. ed she had a family which required her to be ty. She reported e behind at that time. The I there was no one to ts during her leave. She ecently hired additional staff	F 6		NCY)		
	Nursing on 8/8/18 at aware of the incompl	ducted with the Director of 4:59 PM who stated she was ete assessments. She ectation assessments be ducted with the					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER  TRANSITIONAL REHAE	3		STREET ADDRESS, CITY, STATE, ZIP COI 911 WESTERN BOULEVARD TARBORO, NC 27886	DE	00/10/2010
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F 636	is his expectation assocompleted as required to complete as required to the complete and dementia. A reversible of the comprehensive assessments are comprehensive assessments are comprehensive assessments are comprehensive assessments. The comprehensive assessments are comprehensive assessments and Vision, and Section D-Mood, Sectio	admitted 6/3/17. Active sychosis, cerebral infarction iew of the Minimum Data Set completed for Resident #24 essment completed was a t dated 4/5/18.  #24's annual ssment with an Assessment 5/18 was observed in the cord as "open". The were Section B-Hearing, Section C-Cognitive Patterns, ction E-Preferences for and Activities, Section Section H-Bladder and ve Diagnoses, Section Section L-Oral/Dental in Conditions, Section on O-Special Treatments, grams, Section P-Restraints ion Q-Participation in oal Setting.  Inducted with the MDS Nurse as Section #24's annual MDS even completed in July 2018. Seed she had a family which required her to be	F	636		
	MDS Nurse indicated complete assessmen	e behind at that time. The If there was no one to Its during her leave. She Its during her leave. She				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345510	B. WING				C 10/2018
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB			91	TREET ADDRESS, CITY, STATE, ZIP CODE  11 WESTERN BOULEVARD  ARBORO, NC 27886	1 00/	10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 638 SS=E	Nursing on 8/8/18 at a aware of the incomple indicated it is her exp be completed on time. An interview was con Administrator on 8/8/is his expectation ass completed as require. Qrtly Assessment at LCFR(s): 483.20(c)  §483.20(c) Quarterly A facility must assess quarterly review instruand approved by CM3 once every 3 months. This REQUIREMENT by:  Based on record revifacility failed to conduct (MDS) assessmereviewed for Residen #13, #11, #17, #19, #16, #20, and #4).  Findings included:  1. Resident # 13 was 2/2/17. Active diagnomellitus, major depresa A review of the (Mininassessments complete revealed the last asset	ducted with the Director of 4:59 PM who stated she was ete assessments. She ectation that assessments ducted with the 18 at 5:05 PM. He stated it essments would be d. Least Every 3 Months  Review Assessment a resident using the ument specified by the State S not less frequently than is not met as evidenced ews and staff interviews, the ct a quarterly Minimum Data nt for 13 of 29 residents the Assessments (Residents 14, #39, #34, #36, #8, #38, and staff included diabetes sive disorder, and sepsis. In the state of the service o		636	F 638 – Quarterly Assessment at least every 3 months  Criteria # 1: It was identified that the facility failed to complete quarterly MDS assessmentimely.  All affected resident's MDS Assessmenwere complete by 8/21/2018.  Criteria # 2: A 100% audit was completed on 8/21/2018 to ensure all late assessments were identified.  all assessments will be completed and to	ts nts red	9/5/18

NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   911 WESTERN BOULEVARD   TARBORO, NC 27886   TARBORO,	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
PRODIGY TRANSITIONAL REHAB    SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   PREPIX   TAGS   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY WILST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY) MUST BE PRECEDED BY FULL (EACH DEFICIENCY)    F 638			345510	B. WING _					
PRODIGY TRANSITIONAL REHAB    Manual Complete the MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments diditional staff to complete the MDS Nurse indicated there was no one to complete the MDS Nurse indicated the reverse indicated the reverse indicated it is her expectation that assessments.   PROPRIATE   PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	NAME OF P	ROVIDER OR SUPPLIER		1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010	
C(A)   D   SUMMARY STATEMENT OF DEFICIENCIES   (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   COMPLETION (CACH COMPLETION)   COMPLETION (CACH COMPLETION)   CACH COMPLETION (CACH COMPLETION)									
F 638  Continued From page 10  On 8/8/18 Resident #13's quarterly assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 6/13/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section I-Active Diagnoses, Section J-Health Conditions and Section N-Medications.  An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #13's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete the MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments. She indicated it is her expectation that assessments.	PRODIGY	TRANSITIONAL REHAB							
On 8/8/18 Resident #13's quarterly assessment with an Assessment Reference Date (ARD, the last day of the 7-day lookback period) of 6/13/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section I-Active Diagnoses, Section J-Health Conditions and Section N-Medications.  An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #13's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete the MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.  An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.  2.Resident # 11 was admitted to the facility 3/9/18. Active diagnoses included contracted left knee, dysphagia (difficulty swallowing) and diabetes mellitus. A review of the Minimum Data Set (MDS) assessments completed for Resident	F 638	On 8/8/18 Resident # with an Assessment F last day of the 7-day I was observed in the 6 "open" and not compl sections were Section Section I-Active Diagr Conditions and Section An interview was con on 8/8/18 at 4:19 PM late in completing Res which should have be The MDS Nurse state emergency in April, w absent from the facilit assessments became MDS Nurse indicated complete the MDS as leave. She reported to additional staff to com An interview was con Nursing on 8/8/18 at 4 aware of the incomple indicated it is her exp be completed on time An interview was con Administrator on 8/8/1 is his expectation ass completed as required 2.Resident # 11 was a 3/9/18. Active diagnic knee, dysphagia (diffit diabetes mellitus. A	13's quarterly assessment Reference Date (ARD, the ookback period) of 6/13/18 electronic medical record as eted. The incomplete of G-Functional Status, noses, Section J-Health on N-Medications.  ducted with the MDS Nurse She confirmed she was sident #13's quarterly MDS en completed in June 2018. ed she had a family thich required her to be y. She reported e behind at that time. The there was no one to sessments during her the facility recently hired aplete assessments.  ducted with the Director of 4:59 PM who stated she was ete assessments. She ectation that assessments  ducted with the 18 at 5:05 PM. He stated it essments would be d.  admitted to the facility oses included contracted left culty swallowing) and review of the Minimum Data	F 6	538	Criteria # 3: The MDS team was education the timeliness of assessments on 08/14/18.  Criteria # 4: The Administrator will revite MDS calendar due dates with the MDS team daily, Monday through Friday with the weekends being reviewed on Frida The Administrator will monitor for timely completion daily x 1 month, weekly x 2 months, and monthly x 3 months. In the Administrator's absence, the DON or ADON will assume the responsibility of the POC. Director of Nursing will incorporate the POC into the facility's monthly QAA meeting evaluate the effectiveness and compliance of the regulatory requirements.	iew n y. n		

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		345510	B. WING _			C 08/10/2018	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODI 911 WESTERN BOULEVARD TARBORO, NC 27886	<b>_</b> _	33/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COI  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 638	an admission assess On 8/8/18 Resident with an Assessment was observed in the "open" and not compsections were Section Section J-Health Con L-Oral/Dental Status Section P-Restraints An interview was coron 8/8/18 at 4:19 PM late in completing Rewhich should have both the MDS Nurse statemergency in April, wabsent from the facil assessments became MDS Nurse indicated complete MDS assess She reported that facts aff to complete assessments was con Nursing on 8/8/18 at aware of the incompindicated it is her expectation as completed as required.	assessment completed was sment completed on 3/16/18.  #11's quarterly assessment Reference Date of 6/14/18 electronic medical record as pleted. The incomplete in I-Active Diagnoses, inditions, Section in I-Active Diagnoses, inditions, inditions, Section in I-Active Diagnoses, inditions, indition	F	538			
	11/6/17. Active diag	s admitted to the facility noses included: chronic ry disease, diabetes mellitus,					

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345510	B. WING			C 08/10/2018			
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB			911	EET ADDRESS, CITY, STATE, ZIP CODE WESTERN BOULEVARD RBORO, NC 27886	1 00/	10/2010		
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F 638	(artificial opening in the Minimum Data Set (M	paralysis), and gastrostomy ne stomach). A review of the MDS) assessments nt #17 revealed the last ed was an annual	F	538					
	with an Assessment I was observed in the component and not component sections were Section Speech, Section G-F H-Bladder and Bower Diagnoses, Section J	-Health Conditions, Section Section N-Medications and							
	on 8/8/18 at 4:19 PM late in completing Re which should have be The MDS Nurse state emergency in April, wabsent from the facility assessments became MDS Nurse indicated complete MDS assess She reported the facility staff to complete assess An interview was con Nursing on 8/8/18 at aware of the incomplete.	which required her to be ty. She reported the behind at that time. The there was no one to the sments during her leave. It precently hired additional the essments.  It is a second to the second to t							
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NAME OF PROVIDER OR SUPPLIER  PRODIGY TRANSITIONAL REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  911 WESTERN BOULEVARD  TARBORO, NC 27886   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CRESS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AGE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLY AT A COMPLY AT A COMPLY ACTION SHOULD BE COMPLY AT A COMPLY			345510	B. WING _			C 08/10/2018	
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DEFICIENCY)	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	X (EACH CORRECTIVE ACTIC	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
is his expectation assessments would be completed as required.  4. Resident #19 was admitted 4/17/17. Active diagnoses included: gastrointestinal hemorrhage, chronic kidney disease, and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessments completed for Resident #19 revealed the last assessment completed was an annual assessment on 3/29/18.  On 8/8/18 Resident #19's quarterly assessment with an Assessment Reference Date of 6/18/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section J-Health Conditions, Section L-Oral/Pental Status, Section N-Medications and Section P-Restraints and Alarms.  An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #19's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be absent from the facility. She reported assessments became behind at that time. The MDS Nurse indicated there was no one to complete MDS assessments during her leave. She reported the facility recently hired additional staff to complete assessments.  An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments.	F 638	is his expectation as completed as required.  4. Resident #19 was diagnoses included: chronic kidney diseased A review of the Minit assessments complete evealed the last assannual assessment.  On 8/8/18 Resident with an Assessment was observed in the "open" and not complete in the "open" and not complete in Section H-Bladder and Diagnoses, Section L-Oral/Dental Status Section P-Restraints.  An interview was coon 8/8/18 at 4:19 PM late in completing R which should have be the MDS Nurse state emergency in April, absent from the faci assessments became MDS Nurse indicate complete MDS assessments assessments became MDS nurse indicate complete MDS assessments assessments became MDS nurse indicate complete MDS assessments and nurse more more more more more more more mor	sessments would be ed.  s admitted 4/17/17. Active gastrointestinal hemorrhage, use, and Alzheimer's disease. Inum Data Set (MDS) eted for Resident #19 sessment completed was an on 3/29/18.  #19's quarterly assessment Reference Date of 6/18/18 electronic medical record as oleted. The incomplete on G-Functional Status, and Bowel, Section I-Active J-Health Conditions, Section S, Section N-Medications and s and Alarms.  Inducted with the MDS Nurse of M. She confirmed she was esident #19's quarterly MDS of the end o	F	638			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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				911 WE	STERN BOULEVARD		
PRODIGY	TRANSITIONAL REHAB			TARBO	DRO, NC 27886		
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F 638	F 638 Continued From page 14		F 6	38			
	An interview was con Administrator on 8/8/ is his expectation ass completed as required	18 at 5:05 PM. He stated it sessments would be					
	10/23/15. Active diag kidney failure, diabete leukemia, bilateral be and peripheral vascul Minimum Data Set (M	low the knee amputation, lar disease. A review of the IDS) assessments nt #14 revealed the last ed was a re-entry					
	with an Assessment F was observed in the e "open" and not compl sections were Section Section J-Health Con	ditions, Section Section N-Medications, and					
	on 8/8/18 at 4:19 PM. late in completing Rewhich should have be The MDS Nurse state emergency in April, wabsent from the facilit assessments became MDS Nurse indicated complete MDS asses	which required her to be ty. She reported the behind at that time. The there was no one to sments during her leave. lity recently hired additional					
	An interview was con	ducted with the Director of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				COMPLETED		
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DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	00/10/2010		
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rsing on 8/8/18 a are of the incomplicated it is her excompleted on time interview was coministrator on 8/8 his expectation as impleted as required. Resident #39 was 1/15. Active diagramment of the Minimum Data in the Minimum	t 4:59 PM who stated she was plete assessments. She pectation that assessments he.  Inducted with the 13/18 at 5:05 PM. He stated it issessments would be ed.  Inducted with the 13/18 at 5:05 PM. He stated it issessments would be ed.  Inducted with the 13/18 at 5:05 PM. He stated it issessments would be ed.  Inducted with the facility gnoses included: diabetes and atrial fibrillation. A review at Set (MDS) assessments lent #39 revealed the last sted was a quarterly widely.  Inducted was a quarterly assessment at Reference Date of 6/21/18 at electronic medical record as pleted. The incomplete on G-Functional Status, and Bowel, Section I-Active J-Health Conditions, Section is, Section N-Medications and is and Alarms.  Inducted with the MDS Nurse induc	F 63	38			
	SUMMARY S (EACH DEFICIEN REGULATORY OF  Intinued From page rsing on 8/8/18 at are of the incomplicated it is her ex completed on time interview was completed as required. Resident #39 was interview diagonal expectation as impleted as required. Resident #39 was interview diagonal expectation as impleted for Resident expectation as impleted for Resident expectation as impleted for Resident expectation. Seessment complete expectation expectation as interview diagonal expectation. Interview diagonal expectation in the interview was considered as an expectation. Interview was considered as interview was considered. Interview was considered as interview was considered as interview was considered. Interview was considered as interview was considered in the interview was considered in the interview was considered. Interview was considered in the interview wa	DER OR SUPPLIER  NSITIONAL REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	DER OR SUPPLIER  INSITIONAL REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Intinued From page 15  rsing on 8/8/18 at 4:59 PM who stated she was are of the incomplete assessments. She icated it is her expectation that assessments completed on time.  interview was conducted with the ministrator on 8/8/18 at 5:05 PM. He stated it his expectation assessments would be mpleted as required.  Resident #39 was admitted to the facility 1/115. Active diagnoses included: diabetes shillius, dementia, and atrial fibrillation. A review the Minimum Data Set (MDS) assessments mpleted for Resident #39 revealed the last sessment completed was a quarterly sessment dated 4/4/18.  8/8/18 Resident #39's quarterly assessment han Assessment Reference Date of 6/21/18 sobserved in the electronic medical record as ben'' and not completed. The incomplete citions were Section G-Functional Status, cition H-Bladder and Bowel, Section I-Active agnoses, Section J-Health Conditions, Section Dral/Dental Status, Section N-Medications and cition P-Restraints and Alarms.  interview was conducted with the MDS Nurse 8/8/18 at 4:19 PM. She confirmed she was e in completing Resident #39's quarterly MDS ich should have been completed in June 2018. The incomplete of the facility. She reported sessments became behind at that time. The Sis Nurse indicated there was no one to mplete MDS assessments during her leave.	DER OR SUPPLIER  INSTITIONAL REHAB  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFIYM INFORMATION)  Trace of the incomplete assessments. She icated it is her expectation that assessments completed on time.  Interview was conducted with the ministrator on 8/8/18 at 4:50 F PM. He stated it his expectation assessments would be impleted as required.  Resident #39 was admitted to the facility 11/15. Active diagnoses included: diabetes illitus, dementia, and atrial fibrillation. A review the Minimum Data Set (MDS) assessments minimum Data Set (MDS) assessments morpleted was a quarterly sessment dated 4/4/18.  8/8/18 Resident #39 vealed the last sessment and to complete dus a required.  8/8/18 Resident #39 vealed the last sessment dated 4/4/18.  8/8/18 Resident #39's quarterly assessment in the electronic medical record as pens" and not completed. The incomplete citions were Section G-Functional Status, ection H-Bladder and Bowel, Section I-Active gignoses, Section J-Health Conditions, Section Dra/Dental Status, Section J-Health Conditions, Section Dra/Dental Status, Section I-Active gignoses, Section J-Health Conditions, Section Dra/Dental Status, Section P-Restraints and Alarms.  Interview was conducted with the MDS Nurse 8/8/18 at 4:19 PM. She confirmed she was a in completing Resident #39's quarterly MDS ich should have been completed in June 2018. Be MDS Nurse stated she had a family ergency in April, which required her to be sent from the facility. She reported sessments became behind at that time. The DS Nurse indicated there was no one to mplete MDS assessments burning her leave.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED			
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staff to complete ass  An interview was con Nursing on 8/8/18 at aware of the incompindicated it is her exibe completed on time.  An interview was con Administrator on 8/8 is his expectation as completed as require.  7. Resident #34 was 9/20/17. Active diagnature with tubular in Minimum Data Set (completed for Residiassessment complete assessment dated 4.  On 8/8/18 Resident with an Assessment was observed in the "open" and not compisections were Section Section H-Bladder and Diagnoses, Section L-Oral/Dental Status Section P-Restraints.  An interview was considered and the section of	nducted with the Director of 4:59 PM who stated she was elete assessments. She pectation that assessments i.e.  Inducted with the pectation that assessments i.e.  Inducted with the //18 at 5:05 PM. He stated it issessments would be ed.  Is admitted to the facility on proses included acute kidney ecrosis. A review of the MDS) assessments ent #34 revealed the last ted was a quarterly //2/18.  #34's quarterly assessment Reference Date of 6/22/18 electronic medical record as oleted. The incomplete on G-Functional Status, and Bowel, Section I-Active J-Health Conditions, Section Section N-Medications and as and Alarms.	F 63	,				
sections were Section Section H-Bladder a Diagnoses, Section L-Oral/Dental Status Section P-Restraints  An interview was coon 8/8/18 at 4:19 PM late in completing Rowhich should have be The MDS Nurse state.	on G-Functional Status, and Bowel, Section I-Active J-Health Conditions, Section s, Section N-Medications and s and Alarms.  Inducted with the MDS Nurse M. She confirmed she was esident #34's quarterly MDS been completed in June 2018. Ited she had a family						
	ROVIDER OR SUPPLIER  TRANSITIONAL REHA  SUMMARY S (EACH DEFICIEN REGULATORY OF STATE	ROVIDER OR SUPPLIER TRANSITIONAL REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL	A BUILDING  345510  B. WING  BOVIDER OR SUPPLIER  TRANSITIONAL REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16 staff to complete assessments.  An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.  An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.  7. Resident #34 was admitted to the facility on 9/20/17. Active diagnoses included acute kidney failure with tubular necrosis. A review of the Minimum Data Set (MDS) assessments completed for Resident #34 revealed the last assessment completed was a quarterly assessment atded 4/2/18.  On 8/8/18 Resident #34's quarterly assessment with an Assessment Reference Date of 6/22/18 was observed in the electronic medical record as "open" and not completed. The incomplete sections were Section G-Functional Status, Section H-Bladder and Bowel, Section I-Active Diagnoses, Section J-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.  An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #34's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be	A BUILDING  345510  A BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  911 WESTERN BOULEVARD  TARBORO, NC 27886  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  staff to complete assessments.  An interview was conducted with the Director of Nursing on 8/8/18 at 4:59 PM who stated she was aware of the incomplete assessments. She indicated it is her expectation that assessments be completed on time.  An interview was conducted with the Administrator on 8/8/18 at 5:05 PM. He stated it is his expectation assessments would be completed as required.  7. Resident #34 was admitted to the facility on 9/20/17. Active diagnoses included acute kidney failure with tubular necrosis. A review of the Minimum Data Set (MDS) assessments completed for Resident #34's quarterly assessment tompleted was a quarterly assessment completed. The incomplete sections were Section 6-Incutional Status, Section 1-Bladder and Bowel, Section 1-Active Diagnoses, Section 3-Health Conditions, Section L-Oral/Dental Status, Section N-Medications and Section P-Restraints and Alarms.  An interview was conducted with the MDS Nurse on 8/8/18 at 4:19 PM. She confirmed she was late in completing Resident #34's quarterly MDS which should have been completed in June 2018. The MDS Nurse stated she had a family emergency in April, which required her to be	A BUILDING		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER  TRANSITIONAL REHA	В		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	· · · · · · · · · · · · · · · · · · ·	33/13/2313	
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F 638	complete MDS asses She reported the fact staff to complete ass.  An interview was concentrated in the incomplete in the	d there was no one to ssments during her leave cility recently hired additional sessments.  Inducted with the Director of 4:59 PM who stated she was lete assessments. She pectation that assessments e.  Inducted with the pectation that assessments would be ed.  Inducted with the sessments would be ed.  Inducted 4/21/00. Active neurotraumatic intracerebral anial injury and dysphagia enial injury an	F 6	38			
	"open" and not comp sections were Section Section H-Bladder a Diagnoses, Section L-Oral/Dental Status Section P-Restraints An interview was con on 8/8/18 at 4:19 PM late in completing Re	electronic medical record as obleted. The incomplete on G-Functional Status, and Bowel, Section I-Active J-Health Conditions, Section is, Section N-Medications, and is and Alarms.  Inducted with the MDS Nurse of M. She confirmed she was desident #36's quarterly MDS deen completed in June 2018.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345510	B. WING		C	
	ROVIDER OR SUPPLIER  TRANSITIONAL REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	08/10/2018	
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F 638	emergency in April, absent from the fact assessments becard MDS Nurse indicated complete MDS assess the reported the fastaff to complete assess aware of the incomplimities of the incomplete on time. An interview was concluded it is her explored to the completed on time. An interview was concluded as required in the completed as required as required in the complete of the incompleted as required in the complete of the incompleted as required in the complete of the incomplete o	which required her to be ility. She reported me behind at that time. The ed there was no one to essments during her leave. cility recently hired additional sessments.  Inducted with the Director of at 4:59 PM who stated she was plete assessments. She expectation that assessments me.  Inducted with the B/18 at 5:05 PM. He stated it essessments would be red.  It is admitted to the facility on gnoses included: sepsis, an, prostate cancer and a review of the Minimum Data ments completed for Resident assessment completed was ent dated 4/2/18.  #8's quarterly assessment the Reference Date of 7/2/18 are electronic medical record as appleted. The incomplete on B-Hearing, Speech and ognitive Patterns, Section	F 63	8		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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F 638	An interview was corron 8/8/18 at 4:19 PM late in completing Rewhich should have be The MDS Nurse state emergency in April, vabsent from the faciliassessments became MDS Nurse indicated complete MDS assess the reported the facistaff to complete ass.  An interview was corn Nursing on 8/8/18 at aware of the incomplindicated it is her expibe completed on time. An interview was corn Administrator on 8/8/is his expectation assecompleted as required 10. Resident #38 was 3/5/12. Active diagnovascular disease, de disorder. A review of (MDS) assessments revealed the last assequarterly assessment.	rms and Section sessment and Goal Setting.  Inducted with the MDS Nurse I. She confirmed she was esident #8's quarterly MDS een completed in July 2018. It she had a family which required her to be ty. She reported the behind at that time. The the there was no one to esments during her leave. If there was no one to esments during her leave. If there was no one to esments.  Inducted with the Director of 4:59 PM who stated she was ete assessments. She exectation that assessments e.  Inducted with the It sat 5:05 PM. He stated it esesments would be etd.  It is admitted to the facility on coses included peripheral mentia, and psychotic for the Minimum Data Set completed for Resident #38 essment completed was a t dated 4/4/18.  #38's quarterly assessment	F6	538			
	was observed in the	Reference Date of 7/3/18 electronic medical record as leted. The incomplete					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345510	B. WING		C 08/10/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 638	An interview was cor on 8/8/18 at 4:19 PM late in completing Re which should have be the MDS Nurse state emergency in April, wabsent from the facility assessments became MDS Nurse indicated complete MDS assessments the facts as the reported the facts staff to complete assessments was concluded in the complete on time. An interview was concluded it is her expected on time. An interview was concluded as required the last assessments as completed as required the last assequanterly dated 3/23/10 On 8/8/18 Resident and the last assequanterly dat	In C-Cognitive Patterns, discretion E-Behavior.  Inducted with the MDS Nurse II. She confirmed she was esident #38's quarterly MDS een completed in July 2018. It is seen to be seen the discretion of the behind at that time. The discretion discretion of the behind at that time. The discretion of the	F 63	38		
	with an Assessment was observed in the	Reference Date of 6/12/18 electronic medical record as eleted. The incomplete				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 00/	10/2010
PRODIGY	TRANSITIONAL REHAB			911 WESTERN BOULEVARD TARBORO, NC 27886			
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF C  (EACH CORRECTIVE ACTIC  CROSS-REFERENCED TO TH  DEFICIENCY	ON SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 638	Section H-Bladder an Diagnoses, Section J L-Oral/Dental Status, Section P-Restraints  An interview was con on 8/8/18 at 4:19 PM late in completing Rewhich should have be The MDS Nurse state emergency in April, wabsent from the facilit assessments became MDS Nurse indicated complete MDS asses She reported the facilistaff to complete asses An interview was con Nursing on 8/8/18 at a aware of the incomplet indicated it is her exp be completed on time An interview was con Administrator on 8/8/1 is his expectation asses completed as required 12. Resident #20 wa 6/24/14. Active diagridisease, diabetes medisorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder. A review of (MDS) assessments of the incomplete disorder.	d G-Functional Status, d Bowel, Section I-Active -Health Conditions, Section Section N-Medications and and Alarms.  ducted with the MDS Nurse . She confirmed she was sident #16's quarterly MDS been completed in June 2018. Seen that a family which required her to be say. She reported to behind at that time. The there was no one to sments during her leave. Lity recently hired additional dessments.  ducted with the Director of 4:59 PM who stated she was set assessments. She ectation that assessments are estation that assessments and the sessments would be d.  s admitted to the facility noses included Alzheimer's lilitus, psychosis and sleep of the Minimum Data Set completed for Resident #20 essment completed was an	F	538			
	On 8/8/18 Resident #	20's quarterly assessment					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345510	B. WING _		C 08/10/2018		
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAE	3		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	'	00/10/2010	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 638	was observed in the and not completed. were Section C-Cogr D-Mood, Section E-E G-Functional Status, Bowel, Section I-Acti J-Health Conditions, Status, Section N-Me P-Restraints and Ala Q-Participation in Ass. An interview was cor on 8/8/18 at 4:19 PM late in completing Rewhich should have bore The MDS Nurse state emergency in April, vabsent from the faciliassessments became MDS Nurse indicated complete MDS assess She reported the facistaff to complete ass. An interview was cor Nursing on 8/8/18 at aware of the incomplindicated it is her expibe completed on time. An interview was cor Administrator on 8/8/is his expectation assecompleted as required 13. Resident #4 was	Reference Date of 7/6/18 medical record as "open" The incomplete sections nitive Patterns, Section Section H-Bladder and ve Diagnoses, Section Section L-Oral/Dental edications, Section rms, and Section seesment and Goal Setting.  Inducted with the MDS Nurse and Section H-Bladder and Section seesment and Goal Setting.  Inducted with the MDS Nurse and Section H-Bladder and Section seesment and Goal Setting.  Inducted with the MDS Nurse and Section H-Bladder and Section seesment and Goal Setting.  Inducted with the MDS Nurse and Section H-Bladder and Section seesment and Goal Setting.  Inducted with the MDS Nurse and Section H-Bladder and Section H-Bladde	F 6	38			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345510	B. WING			C 08/10/2018	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		00/10/2010	
(X4) ID PREFIX TAG	(-, -, -, -, -, -, -, -, -, -, -, -, -, -		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 638	disorder. A review of (MDS) assessments revealed the last assessment of the last assessment	f the Minimum Data Set completed for Resident #4 essment completed was an dated 4/17/18.  #4's quarterly assessment Reference Date of 7/9/18 medical record as "open" The incomplete sections nitive Patterns, Section Section H-Bladder and ve Diagnoses, Section Section L-Oral/Dental edications, Section rms and Section rms and Section sessment and Goal Setting.  aducted with the MDS Nurse begin the Moder of the Moder of the Moder completed in July 2018. The Moder of the Mo	F 6:				
	assessments becam MDS Nurse indicated complete MDS asses She reported the fac staff to complete ass  An interview was cor Nursing on 8/8/18 at aware of the incomp indicated it is her exp be completed on tim  An interview was cor	e behind at that time. The d there was no one to esments during her leave. ility recently hired additional essments.  Inducted with the Director of 4:59 PM who stated she was ete assessments. She exectation that assessments e.					

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING		C 08/10/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	1 00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 638	Continued From pag		F 63	8		
F 641 SS=D	completed as require Accuracy of Assessn	ed.	F 64	1	8/10/18	
	resident's status. This REQUIREMEN' by: Based on record revolutions, the fact a Quarterly Minimum resident assessment (Resident #68) review Findings included: Resident #68 was re 7/19/18. A gastrostory place on re-admission Minimum Data Set (I Resident #68 was set had no behaviors or Activities of Daily Livextensive to total assessed for a fectube) feedings.  Review of the physic through 7/31/18 reveguence of the status of the physic through 7/31/18 reveguence of the status of the physic through 7/31/18 reveguence of the status of the physic through 7/31/18 reveguence of the status of the physic through 7/31/18 reveguence of the status of the physic through 7/31/18 reveguence of the p	ast accurately reflect the  T is not met as evidenced  riew, staff interviews, and  cility failed to accurately code in Data Set (a tool used for is) for 1 of 63 residents  wed.  -admitted to the facility on my (feeding) tube was in in. Review of the Quarterly  MDS) dated 7/20/18 revealed  everely cognitively impaired, rejection of care, and ing (ADLs) required sistance to be completed. Inded diabetes mellitus (DM), inentia, malnutrition, and int #68 received a in, therapeutic diet and was beeding tube or parenteral  cian orders dated 7/1/18 isaled an order to "Cleanse tube) /c (with) NS (Normal ind drag (dressing) QOD (every		F641 – Accuracy of Assessments  Criteria #1: The facility failed to code a feeding tube on a Quarterly MDS accurately for 1 of 63 residents. The affected resident's MDS was corrected on 8/10/2018.  Criteria # 2: A 100% audit was done or residents with Feeding tubes to ensure Section K of the MDS was coded correctly on 08/09/18.  Criteria # 3: The Dietary Manager was educated on 8/9/2018 regarding coding accuracy.  Criteria # 4: All closed MDS assessme will be audited for accuracy daily x 4 weeks, weekly x months, and monthly x 3 months. The Director of Nursing will incorporate the POC into the facility's monthly QAA meeting evaluate the effectiveness and compliance of the regulatory requirements.	n all nne ents	

Facility ID: 923550

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345510	B. WING		08/	C 10/2018
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB	L	,	STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	1 00/	10/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	have pleasure foods." "Jevity 1.5 tube feedin hour."  A physician's progres in part, "physical exartube is in place." The feeding will be continued an interview was con Coordinator on 8/9/18 information for MDS of from resident interview electronic and paper physician notes, physician notes, physician notes. She is feeding tube and it has re-admission in Octob Quarterly MDS was in feeding or a feeding to	"Dietary consult: ing due to low albumin. May 'An additional order read, ng at 55ml (milliliter)/ (per)  s note dated 7/20/18 read, m-Abdomen: PEG (feeding) e plan read, in part, "Tube ued."  ducted with the MDS at 3:40 PM. She stated completion was gathered ws, observations, the	F 641	09/05/18		
F 689 SS=J	with the Director of N #68 had a feeding tube expectations included coded and accurately clinical picture. She a MDS dated 7/20/18 s feeding tube, but was Free of Accident Hazar	I the MDS was accurately reflected the patients' lso stated the Quarterly hould have been coded for a not.  ards/Supervision/Devices (2)	F 689			8/10/18

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE : COMPI	
		345510	B. WING			00/	) 10/2018
NAME OF P	ROVIDER OR SUPPLIER	0.00.0	1	9	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2018
TO THE OT THE	TO VIDER OR OUT FEILER				11 WESTERN BOULEVARD		
PRODIGY	TRANSITIONAL REHAB				ARBORO, NC 27886		
()(1) ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	Continued From page	e 26	F6	689			
		sident environment remains izards as is possible; and					
	supervision and assist accidents. This REQUIREMENT by: Based on record revinterviews, and obser provide supervision to cognitively impaired right displayed wandering facility unsupervised for accidents. The restacility only after a statement of the supervision	is ident receives adequate stance devices to prevent is not met as evidenced iew, resident and staff vations the facility failed to prevent a severely esident (Resident #274) who behaviors from exiting the for 1 of 3 residents reviewed sident was returned to the aff member was alerted by resident that Resident #274			F689 Free of Accident Hazards/ Supervision/ Devices  Criteria #1: Resident #274 was observe outside in her wheelchair without supervision in the facility parking lot. She was brought back into the facility be a Staff Nurse. She was without injury.	ne	
	was observed in an a injuries were reported	djoining parking lot. No			A Wanderguard was placed on 7/22/18 A new Elopement Risk Assessment was completed on 7/22/18 and 07/24/18 th care plan was updated on 7/22/18.	s	
	without supervision in parking lot. The resid #1 and returned to the injuries. Immediate je 8/8/18 when the facili implemented an accellimediate Jeopardy remains out of compliseverity of "D" (no ha more than minimal har jeopardy) to ensure in place are effective.	ptable allegation of removal. The facility sance at a lower scope and rm with the potential for arm that is not immediate nonitoring systems put in			Criteria # 2: On 7/24/18, a 100% audit was completed on all residents regarding the risk for elopement by the DON and ADON.  An audit was conducted for all doors and Wanderguard bracelets and units on 7/23/18 to assess proper function by the Administrator and ADON.  On 7/23/18, a staff member was assign to monitor the door after the receptionis leaves (from 4:30 pm-8:00 pm.)  Effective 08/20/18, The facility doors remained locked at all times requiring visitors to be buzzed in or out of the facility.		
FORM CMS-256	7(02-99) Previous Versions Obs	-	<u> </u> 1	Fac	•	ation sheet	Page 27 of 44

PRINTED: 09/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			C 08/10/2018	
NAME OF PR	ROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	00/10/2010	
				911 WESTERN BOULEVARD			
PRODIGY	TRANSITIONAL REHAE			TARBORO, NC 27886			
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F 689	Continued From page	e 27	F 6	89			
F 689	schizophrenia, musch walking, cognitive co dementia with behave anxiety disorder.  Review of Resident # (MDS) assessment of was assessed as seen the seen seen seen seen seen seen seen se	e weakness, difficulty mmunication deficit, foral disturbances, and \$274's minimum data set ated 7/6/18 revealed she verely cognitively impaired. In have behaviors not directed adays of the previous 7 days. The vereit assistance by one staffility, transfers, and the had no impairment to the er upper and lower a wheelchair as a mobility	F 6	Criteria # 3: On 8/8/18 staff (nurses, nurse aides, physical therap occupational therapist, spee therapists, therapy assistan department managers, dieta housekeeping and laundry) in-serviced on appropriate r to exit seeking behavior, no administration, and assignm monitoring of door from 4:30 All nurses were in-serviced completion of the Elopemer Assessment.  No staff member will be per return to work until they have beer All new Nurses will be educ orientation regarding the completeness of the elopement assessment. The QAA Committee and M met on 7/24/18 and 8/8/18 and a Allegation of Compliance.  Criteria # 4 : The DON will r admission's, readmission as	pist, ech language tts, ary, were response respo		
	interventions include	d to monitor for any changes e status. There were no care		change Elopement Risk Ass for accuracy weekly x 8, mo and quarterly x3. The ADON responsibility of this POC in absence.	sessments onthly x 2, N will assume		
	Risk Assessment, for form instructions read or per facility policy. I	d and unsigned Elopement Resident #274 revealed the d "Complete upon admission For each question under Factors, check yes/no as		The Elopement Audit Tool w completed monthly x3 and t x 3. The Director of Nursing will the POC	then quarterly		

Facility ID: 923550

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345510	B. WING _				C /10/2018
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB			91	TREET ADDRESS, CITY, STATE, ZIP CODE  11 WESTERN BOULEVARD  ARBORO, NC 27886	1 00/	10/2010
(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 689	summarize findings, or recommendations in Resident #274 was a intervention put in plat bracelets. The interverplan were left blank. In the summarization/conclusection of the assess Assessment did not strisk for elopement or Review of Resident #revealed no nurse's regards to an attempt the facility by Resider 7/22/18. This attempt the surveyor per intervaled #1, and Resider Review of a nurse's repm, signed by the Hornesident #274 made facility. Resident #274 made facility. Resident #274 made facility and was documented was punotified. No further in Review of an undated Risk Assessment review.	Il interventions used then conclusions and the space provided." ssessed, and the ace was identification entions to be on the care There was no documentation usions/recommendations ment. The Elopement Risk specify if the resident was at not.  274's nurse's notes acted was were written with ted unsupervised exit from an #274 around 2 PM on acted exit was made known to eviews with Nurse #1, Nurse at #110.  Inote dated 7/22/18 at 7:11 acuse Supervisor, revealed one unassisted exit from the 4 was assisted back in to the mented to be unharmed. A ut in place and the family was formation was documented.  If and unsigned Elopement ealed the form instructions	F	689	into the facility's monthly QAA meeting evaluate the effectiveness and compliance of the regulatory requirements.	to	
	policy. For each quest Evaluation Factors, conclusions the space provided. "assessed, and the interpolation of the space provided of the interpolation of the space provided of the interpolation of the interpolation of the space provided of the interpolation of	heck yes/no as appropriate. ns used then summarize and recommendations in					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER  TRANSITIONAL REHAE	3		STREET ADDRESS, CITY, STA 911 WESTERN BOULEVARD TARBORO, NC 27886	,	00/10	<i></i>
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F 689	Continued From pag	e 29	F 6	89			
	be on the care plan of documentation in the summarization/concl section again. The Edid not specify if the elopement or not.  Review of a facility redirector of Nursing redirec	vere left blank. There was no e usions/recommendations lopement Risk Assessment resident was at risk for eport completed by the evealed on 7/22/18 the vas notified by staff that one out through the front hir. Resident #274 was a facility by Nurse #1. It is sessed and found to have #274 had a wander guard occurrence. The Resident was called and made aware. #274 was interviewed by the egarding her desire to sit of Resident #274 she could be only with staff or family at resident verbalized the wander guard was left in its signed by the Director of					
	-	or no longer worked at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		345510	B. WING			C 8/10/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 911 WESTERN BOULEVARD TARBORO, NC 27886		10/2016	
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F 689	During an interview Aide #2 stated Resident was. She further susually be in the broom and was very remember things to conversation. She consider Resident wandering becaus she did not feel she behavior. She furth wander guard, so resident. Nurse Aid the resident eloped During an interview #2 stated she was 200 hall. She furth Resident #274's ca #274 was very for compliant with ree first arrived in the Resident #274 wo every evening she ask where the dinistated Resident #2 since she arrived i reported to her that that she was leaving During an interview Aide #1 stated she #274 and was ass 3:00 PM to 11:00 Resident #274 had	available for interview.  If you on 8/7/18 at 3:22 PM Nurse sident #274 would easily get the her room or the dining room tated Resident #274 would eathroom or go to the dining you forgetful and would not that were told to her during further stated she did not #274's behavior to be the she would simply be lost, so the eashe would simply be lost, so the needed to report the their stated the resident had a she must be a wandering the #2 was not working when the working when the stated she was familiar with the stated she was	F6	589			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			7 BOILE			Ι ,	c
		345510	B. WING			1	-
NAME OF D	ROVIDER OR SUPPLIER	0.00.0			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2018
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PRODIGY	TRANSITIONAL REHAB	1					
					TARBORO, NC 27886		ı
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F 689	Continued From page	e 31 sed a lot. She further stated	F	689	9		
		gs said to her five minutes					
		as not very effective to					
		274. The Nurse Aide stated					
		said she was having a baby					
		of the facility to have the					
		had also stated to the Nurse					
	Aide that family was	coming to get her when no					
	one was coming to ge	et her. The Nurse Aide					
	stated she would go t	to the front lobby					
	, ,	confused about where she					
		she was being picked up by					
		ated this had been going on					
		since her admission in					
		stated this was her normal					
		not report it to anyone					
	_	new she was forgetful and					
		ngs. She then stated one was so convincing saying her					
		o get her that the Nurse Aide					
		'4 away from the lobby to the					
	•	on to check with the House					
		at #274's brother really was					
		ident. She stated it was					
		00 PM on the same day she					
		assisted but she was unsure					
	of the exact time or d	ate. She further stated the					
	brother was not comi	ng to get her and the House					
	Supervisor explained	to Resident #274 she could					
	-	without supervision. She					
		leved that was all that was					
	· ·	upervisor in response to the					
		Aide then stated later that					
	-	supposed to be in the dining					
		ide #1 last saw the resident					
		r 4:30 PM that day at the					
		on as the resident was going					
		#1 remained on the hall ents with dinner. She stated					
	i assistifia ottiel teside	ina wili ulliel. Ole Stateu	1		1		1

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			C 08/10/2018	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		567 167 20 16	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	stopped at the dining door. She further state facility and was head the Nurse Aide state she made it and only after Resident #274 inside the facility. Nu Resident #274 was wappropriate footwear her way to the dining.  During an interview of #1 stated she usually and was not assigne further stated she was #274's care. She state facility on 7/22/18 "wunsupervised exit and Resident #274 not knot go outside unsup the visitor please do before asking a nurs not intervened Resident #274 not intervened Resident #274 not knot go outside unsup the facility but had not she facility but had not she then stated she spoke to the House Supervisor for Reside Supervisor informed was not allowed to go supervision. A Nurse came and took the retailerted her to the facility outside. She was uncoccurred, but it was worth and the stated alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside. She was uncoccurred, but it was worth and the stated had alerted her to the facility outside.	left the dining room or never room and went out the front ted the resident left the led towards the eye center. It is she did not know how far room out about the incident had been brought back rese Aide #1 concluded that wearing clothing and that evening as she was on room.  On 8/7/18 at 4:34 PM Nurse room.  On	F 6	89			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION NG		(X3) DATE COMP	
		345510	B. WING			00/	) 10/2018
NAME OF PE	ROVIDER OR SUPPLIER	0.00.0		STREET ADDRESS, CITY, STATE, ZI	IP CODE	<u> </u>	10/2016
	10115211 011 001 1 21211			911 WESTERN BOULEVARD	. 0022		
PRODIGY	TRANSITIONAL REHAB			TARBORO, NC 27886			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 689	stated she looked and exit door at the end or resident. She stated to directly across from the parking sections of facility. She immediate and assessed her to be reported what had just Supervisor and a 200 got Resident #274 and hall. She was unable was who retrieved the During an interview or Resident #110 stated one Saturday or Sund PM and saw a resident that time attempt to be #1 stopped the resided door and told the resided without super Nurse #1 then brough He stated his wife was on that same day and room. He saw the sar window and was condhis wheelchair, so he Nurse #1 and asked is supposed to be outside he informed her she wout the 100 hall back she goes." He stated outside in the parking in the middle to further	parking lot. She further discould see out the 100 hall of the hall and could see the here were two sections he rehab hall and she was in furthest away from the ely retrieved Resident #274 have no injuries. She st occurred to the House hall Nurse Aide came and discount to the hall of the teresident both times.  In 8/8/18 at 8:07 AM he was at the front lobby day (7/21 or 7/22) at about 2 hall that he did not know at eave the facility and Nurse ent who was halfway out the dent she could not go vision. He further stated that the resident back inside. In the blinds were open in his me resident pass by his beened. He was already in went to the hall and found her if that same resident was de. Nurse #1 told him no so was outside and then looked door and said, "in fact, there	F	689			
	During an interview o	n 8/8/18 at 8:35 AM Nurse ent #274 had dementia and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345510	B. WING		08/10/2018		
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	1 00/10/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
F 689	further stated she cowould talk about bein classroom. She furth Resident #274 wand nurse aide stated if yourse would docume Resident #274 had yourse stay in the facility sin baseline behavior so she wandered, she of her nurse.  During an interview of #3 who was the 200 stated if a resident we exit the facility who rethe facility, it was the wander guard on the She further stated the #274 had attempted would be abnormal be would have placed a resident and notified soon as she was aw staff had shared any Resident #274's con 7/22/18.  During an interview of Director of Nursing Fassessment form was computer system and dated by some staff. not prevent the staff summarization/conclusection. She stated if evaluation she would	member reeducation. She build sometimes get lost and ing a teacher and needing her iter stated she had seen der daily in the facility. The wandering was identified the ent it. She further stated vandered during her entire ince June and it was her in because staff were aware did not report the behavior to some stated vas observed attempting to equired supervision outside a facility's protocol to place a eresident and assess them, at if she was told Resident to leave the facility that behavior for her and she is wander guard on the the Director of Nursing as are. She further stated no is concerns with her about fusion or wandering prior to some stated it would from completing the lusions/recommendations of she performed the	F 689				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345510	B. WING_			C 08/10/2018	
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB	I		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		76/10/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 689	form were answered necessary to complet Assessment form. The the first Elopement R on 6/29/18 because i Elopement Risk Asses on 6/29/18. She state who performed the accomputer glitch. The the resident was not the fifteen questions further stated the sec Assessment was done date it was opened in Resident #274 exited and was at risk for eleguard was put in place.  During observation of parking lot where Resobserved. The approximately 50 fee traveled two-lane roa speed limit. The edge Resident #110 had sagoing, had a five-foot The edge dropped approximately for During an interview of Director of Nursing st stated she was being family member and here as the second speed second	nce all the questions in the she did not believe it was the the Elopement Risk the Director of Nursing stated isk Assessment was done in the computer program the essment had been opened and she was unable to know assessment due to the Director of Nursing stated at risk because only three of were answered "yes." She and Elopement Risk the 7/22/18, because of the at the computer, after the facility unsupervised openent and a wander set.  In 8/8/18 at 2:00 PM, the sident #274 was found was aximate location Resident about 175 feet from the year of the parking lot, where and Resident #274 was jagged edge in the cement. Oproximately three inches to ye road had a ditch along the way from where the resident	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	(X3)	(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			C <b>08/10/2018</b>	
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP COD 911 WESTERN BOULEVARD TARBORO, NC 27886	)E	00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 689	wandering assessmentated no nurses or no concern to her attention she would have experiessues to her attention further stated she had Resident #274 had at earlier in the day on 78/8/18.  During an interview of Administrator stated of the Director of Nursin him of Resident #274 the facility. He further Nursing informed him been taken. A wander after the resident had elopement risk assess stated he was not fam Resident #274's care Administrator stated in concerns with him that she was leaving becaup. He further stated informed him that she facility earlier on 7/22 further stated he did in 7/23/18 and he only selopement and did not leave the facility unsurther Administrator cor Nursing handle clinical a reasonable person guard on Resident #2	sumented and at least a new int performed. She further urse aides had brought that on and if it had happened cted the staff to bring these in and they did not. She if not been made aware that tempted to leave the facility if 22/18 around 2 PM until if 18/9/18 at 8:25 AM the on 7/22/18 at around 7 PM ig called him and informed is unsupervised exit from stated the Director of in of the actions that had in guard was put in place exited the facility and an informed in an ament was done. He further initiar at that time with and behaviors. The in staff had shared in the resident #274 indicated use family was picking her until 8/8/18 no staff had in had attempted to exit the interview Resident #110 on hared with him the actual in the mention she had tried to pervised earlier on 7/22/18. Included he let his Director of all concerns, however he felt would have placed a wander 74 following her first attempt in did not know why the	F 6	89			

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	COMPLETED
		345510	B. WING		C 08/10/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION
F 689	was very challenging stated Resident #274 resistive to care and and psychiatric issue alert with a degree of continued to state Regood executive decisions about the state of the resident and was not information about elector observations of was on the hall in particles of the resident and was not information about elector observations of was on the hall in particles of the resident and was not information about elector of the resident and was not information about elector of the Administrator and immediate jeopardy 8/9/18 at 11:34 AM to following credible allein immediate jeopardy "Allegation of Comple 1. The plan of corrow the plan should add to the deficiency cite of Resident #2 on 6/29/18 and an Elector was completed. At the determined not to be she never expressed she did not wander, behavior. FL-2 's from indicated she was not only indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and state of the previously indicated leave the facility and the previously indicated leave the facility a	on 8/9/18 at 9:30 AM sician stated Resident #274 phehaviorally. He further 4 was combative and had a history of dementiales. He further stated she was fronfusion. The Physician esident #274 did not have sion making abilities for but her best interest. He is only had one visit with the stable to give further openent risk because his from the resident were when she saing.  Ind DON were notified of the on 8/8/18 at 12:35 PM. On the facility provided the egation of compliance for removal:  It is ance to be specific deficiency. The resident was an elopement risk because an elopement risk because an elopement risk because an elopement risk because and desire to leave the facility, and she had no exit-seeking mere her removes the revious facility.	F 68	9	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD		IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			C <b>08/10/2018</b>	
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAE	3		STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886		00/10/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 689	removed from being approximately 2:00 punrelated family men cautioned the family they were holding the someone through. The away from the door to administration. She surveyor.  At approximately 2:40 was notified by #274 was outside his outside and immediate facility.  The resident charge nurse #1 and Awanderg resident on 7/22/18 and Awanderg resident on 7/22/18 and administrator on The resident reported that she water where she was sitting on the front portal form the foot cause analy administration was notify administration resident try to exit the make nonsensical states.	dicates that the resident was near the door at .m. On 7/22/18 when an other was leaving, the nurse not to let the resident out as e door open as if to let ne nurse pulled the resident. The nurse did not report this e reported this to the sately 5:00 p.m., the charge of resident #1 that resident window. Nurse #1 went tely returned her to the twas assessed for injury by there was none. The was placed on the py nurse #1. Supervisor was immediately Supervisor was immediately Supervisor notified the DON 7/22/18 to son was notified and he is just admitted to us from an opermitted to and enjoyed with the resident went out the exceptionist left. The door had nonitor from 4:30-8:00 p.m.	F6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345510	B. WING			C 08/10/2018	
NAME OF PROVIDER OR SUPPLIER  PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 911 WESTERN BOULEVARD TARBORO, NC 27886		08/10/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From page		F 6	889			
	deficiency cited.  Resident #2 Risk Assessment con Wanderguard added updated 7/23/18.  On 7/24/18, on all residents regar by the DON and ADC residents that were drisks.  An audit was Wanderguard bracele assess proper function On 7/24/18, all care plans for those MDS Nurse.  On 7/23/18, assigned to monitor to the leaves (from 4:30 pm automatically locks from 1/23/18, remote buzzer/camer door to be visualized nurse's station and/or installed as soon as a continue to be monitor unlocked from 4:30 pm On 8/8/18 si aides, physical therap speech language the department manager laundry) were in-serv response to exit seek administration, and a monitoring of door frowere in-serviced on preservers.	rrection for the specific  74 had a new Elopement helpleted on 7/23/18, a on 7/22/18, and care plan  a 100% audit was completed ding the risk for elopement by the risk for all doors and by the risk for all doors and by the Administrator. In an audit was completed on the who wander on by the risk for a staff member was the door after the receptionist by the risk for a look for a look for a look for a look from the risk from the risk for a look from the risk for a look from the risk from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			C 08/10/2018	
	ROVIDER OR SUPPLIER  TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 911 WESTERN BOULEVARD TARBORO, NC 27886	DDE	00:10:20:10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (  X (EACH CORRECTIVE ACTIVE)  CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	-	e 40 eturn to work until they have	F 6	689			
		ommittee and Medical 18 and 8/8/18 and approved npliance.					
	plan of correction is e deficiency cited rema compliance with the r The DON or	procedure to ensure that the effective and that specific ins corrected and/or in egulatory requirements.  ADON will review all new					
	accuracy weekly x 8, x3.	nt Risk Assessments for monthly x 2, and quarterly  ADON will review all					
	for accuracy weekly x3.	opement Risk Assessments (8, monthly x2 and quarterly					
	completed monthly x4  The QAA Coresults monthly.	ent Audit Tool will be 4 and then quarterly x 3. ommittee will discuss all					
		responsible for this AOC attack attack attack attack. It is not compliance date is					
	removal was validate which removed the In 8/8/18, as evidenced in-service record revi	ews, and observation. The in					
	elopement risk, elope how to complete then residents who are at	ermation on Resident #274's ement risk assessments and in, and identification of risk for elopement and what					
	for elopement. The in information about have	sident appears to be at risk service also included ving a door monitor during he front door was unlocked.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345510	B. WING		C 08/10/2018
NAME OF PROVIDER OR SUPPLIER  PRODIGY TRANSITIONAL REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 911 WESTERN BOULEVARD TARBORO, NC 27886	06/10/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICLENCY)	D BE COMPLETION
F 761 SS=D	Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the applicable.  §483.45(h) Storage of §483.45(h)(1) In accordance Federal laws, the facility biologicals in locked at temperature controls, personnel to have accept when the Comprehensive EC Control Act of 1976 a abuse, except when the package drug distribution quantity storad is min be readily detected. This REQUIREMENT by:  Based on record revinterviews, the facility expired medications of 1 medication storad or label 7 unopened in packet of Zinc Sulfate	of Drugs and Biologicals are used in the facility must be a with currently accepted as, and include the yand cautionary expiration date when  If Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.  Cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nother drugs subject to the facility uses single unit atton systems in which the imal and a missing dose can is not met as evidenced sew, observation, and staff failed to remove 2 (two)  (Hydralazine and Gas Relief) ock supply drawers in 1 (one) ge room and failed to secure backets of medications (1 e., 2 unopened packets of d packets of Hydralazine,	F 76	F761- Label/Store Drugs and Biolog Criteria # 1: Two expired medication were identified in one medication storage in the overflow stock bins. Seven unopened individual doses were also identified overflow bins. It was determined that Nurses	area,

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBED:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345510	B. WING _			1	C / <b>10/2018</b>	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2010	
					11 WESTERN BOULEVARD			
PRODIGY	TRANSITIONAL REHAB	3			ARBORO, NC 27886			
()(1) ID	CLIMMADV CT	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 761	Continued From page	e 42	F 7	761				
	Findings included:				had not returned the expired and loose	<u></u>		
	Ū				meds			
	During a staff superv	ised observation of the			back to pharmacy.			
	medication storage re	oom on 8/9/18 at 3:20 PM, 2			Expired meds and loose meds			
	plastic container bins	, each with 3 (three) drawers			were written up and returned to pharma	асу		
		e counter of the medication			for credit and/or destruction.			
		drawer contained boxes and			08/09/18			
		medications, labeled with			0 11 1 11 0 100 07 111 1			
		n was marked "200 West			Criteria # 2: 100 % audit of all med roo	ms		
		vas marked "200 East e drawer of the 200 East			for expired meds and loose meds was completed	hv		
		ed 1 loose, unopened, and			the Director of Nursing on 08/09/18.	Jy		
	unlabeled packet of 2	•			the Birector of Natising off 00/03/10.			
		loose, unopened, and			Criteria #3: 100% of all nurses and me	d		
		Clonidine 0.1 mg tablets, 3			aides were	-		
		abeled, and expired packets,			re-educated regarding the return of			
		te of 7/18/18, of Hydralazine			expired,			
	12.5 mg tablets, and	1 loose, unopened, and			discontinued meds, and loose meds to			
	-	Hydroxyzine 25 mg. The			pharmacy.			
		ined 1 bottle of 60 tablets of			08/20/18			
	_	hich was marked with an						
	expiration date of 7/4	/18.			All newly hired Nurses and Med Aides	will		
	A :				be	_		
		iducted on 8/9/18 at 3:30 PM			educated during the Orientation proces	iS		
		ated she was responsible for s. She stated the hall nurses			regarding the return of expired, discontinued			
		checking the expiration			meds, and loose meds to pharmacy.			
		bin medications and then			meds, and loose meds to pharmacy.			
		cations in the "return to			08/20/18			
		d in the medication storage						
		d she was not aware of any			Criteria # 4: The Director of Nursing wi	il		
		ing assigned to check for			assume			
	expired medications,	but the expectation was for			responsibility of this POC and in her			
	nurses to check the e				absence			
	medications before the	ney were administered.			the Assistant Director of Nursing, RN			
					Supervisor			
		iducted with the Director of			and/or Pharmacy Consultant will monit			
		3:35 PM. She stated when			Med rooms weekly x 4 weeks, Bi-mont			
	stock or overflow me	dications were expired they			x 1 month and monthly x 2 months. The	Э		

Facility ID: 923550

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
	0.45540	D. MINO		С	
	345510	B. WING _		08/10/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PRODIGY TRANSITIONAL REHAB			911 WESTERN BOULEVARD		
			TARBORO, NC 27886		
(X4) ID SUMMARY STATEMENT PREFIX (EACH DEFICIENCY MUST B TAG REGULATORY OR LSC IDENT	E PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 761 Continued From page 43 were pulled, written up on a sto pharmacy to be destroyed. She stated this was typically 25th of every month. She als consultant pharmacist or any designee checked the medications, not labeled with should not be loose in the drawner expectation was the med would not contain any expired medications not labeled with	or credited back. completed by the o stated the team leader or ation room for o stated a resident name, awers. She stated ication storage room d medications or	F 7	Director of Nursing will incorporate the POC facility's monthly QAA meeting to evaluate effectiveness and compliance wit regulatory requirements. 08/20/18	•	