<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-  
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;  
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);  
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or  
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).  
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.  
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-  
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or  
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.  
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). | 10/29/18 |
§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to notify the responsible party of 1 of 1 resident (Resident #1) when the resident was sent from the facility to the hospital after a change in status.

Findings included:

Resident #1 was admitted to the facility 6/10/16 and re-admitted 9/13/18. Review of a Quarterly MDS (Minimum Data Set-a tool used for resident assessment) dated 9/26/18 revealed Resident #1 was severely cognitively impaired and displayed no behaviors or rejection of care. All activities of daily living required extensive to total assistance. Resident #1 had a feeding tube present.

Review of a nursing note dated 9/26/18 read, in part, "CNA (Nursing Assistant) told me resident didn't look right (on 9/25/18). This nurse (Nurse #1), and (Nurse #2) went to assess and evaluate. Agreed to send out. 911 (Emergency Medical Services) was called."

An interview was conducted on 10/16/18 at 3:40PM with Nurse #1. She stated if a resident was transported to the hospital, or had any change in status, the physician and family were
An interview was conducted on 10/16/18 at 4:00PM with Nurse #2. She stated, "If a resident goes out to the hospital you're supposed to notify the responsible party and the physician. I make sure the Director of Nursing (DON) is aware by leaving a note. I did not notify (Resident #1's) family because the nurse in charge of her (Nurse #1) asked my opinion about the patient's status only. I went and assessed the patient, and her abdomen was distended and firm. Her general appearance suggested sending her out so I told her to send her to the hospital. At that point, I asked (Nurse #1) if there was anything else I needed to do. She said no, so I gathered my things and went to the 100 Hall. (Nurse #1) was supposed to notify the family. She had all the paperwork, and had not turned care over to anyone. When I did my rounds later that night I saw (Resident #1) was already gone. The next day I became aware the family had not been notified when the DON or Assistant DON asked me if I had called the family. I told them no."

An interview was conducted with the DON on 10/16/18 at 4:15PM. She stated her expectation.
### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** Prodigy Transitional Rehab  
**Street Address, City, State, Zip Code:** 911 Western Boulevard, Tarboro, NC 27886

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<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>(X5) Completion Date</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
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<td>F 580</td>
<td>Continued From page 3 was for the physician and responsible party to be notified any time there was a change in status for a resident, or if they were sent to the hospital. She also stated a notification was to be made no matter what time of day or night it was if a resident went to the hospital. She stated it was her understanding the Resident #1 was not notified when she was sent out to the hospital. She also stated Nurse #1 thought Nurse #2 called, but it was Nurse #1's responsibility to call and she had not. She stated, &quot;(Nurse #1) should have called them and she had not.&quot;</td>
<td>F 580</td>
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