STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345510	A. BUILDING ______ B. WING ______	C 01/09/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/06/25 through 01/09/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #CCPI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/06/25 through 01/09/25. Event ID# CCPI11. The following intakes were investigated: NC00217789, NC00216085, NC00215529, NC00214775 and NC00212673. 10 of the 10 complaint allegations did not result in deficiency.	F 000		
F 567 SS=C	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in	F 567		1/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 01/17/2025

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.

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F 567	Continued From page 1 an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to provide access to resident funds after normal banking hours to include the weekends. This was for 2 of 2 residents (Resident #11, Resident #24) reviewed for personal funds and had the potential to affect all residents with personal funds accounts. Findings included: a. Resident #11 was admitted to the facility on 2/1/2017 and readmitted on 2/17/24. Resident #11's quarterly Minimum Data Set assessment dated 11/6/24 indicated she was cognitively intact.	F 567	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/7/25 the facility failed to provide access to resident funds after normal banking hours to include the weekends. This was for Resident #11 and Resident #24. The Director of Reimbursement immediately educated the Business Office Manager on ensuring resident funds were available after hours and weekends. Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	

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F 567	Continued From page 2 An interview conducted with Resident #11 on 1/6/25 at 3:36 PM revealed she was unable to access her money the facility held for her after the business office closed for the day and on weekends. b. Resident #24 was admitted to the facility on 10/4/23. Resident #24's quarterly Minimum Data Set assessment dated 12/20/24 indicated she was cognitively intact. An interview conducted with Resident #24 on 1/6/25 at 10:52 AM revealed she was unable to access her money the facility held for her after the business office closed for the day and on weekends. During an interview with the Business Office Manager (BOM) on 1/7/25 at 9:17 AM revealed she worked at the facility Monday through Friday, 9:00 AM to 5:00 PM and residents could not get money out of their account after she left the facility for the day and on the weekends. The BOM stated if residents wanted to withdraw money from their account, they needed to do so during business hours on working days. The interview further revealed the BOM was unaware that residents could request their funds after office hours during the week or on the weekend. During an interview with the facility's corporate Director of Reimbursement on 1/7/25 at 9:20 AM she stated resident funds should be available to residents 24 hours a day 7 days a week. During an interview with the Administrator on 1/7/25 at 9:27 AM he stated money used to be	F 567	On 1/7/25 the Director of Reimbursement and Business Office Manager audited all resident trust fund accounts to confirm accuracy and availability of funds. On 1/7/25 the Director of Reimbursement and Business Office Manager ensured that residents who requested funds were provided access immediately by making funds available at the receptionist desk for afterhours requests. On 1/7/25 the Director of Reimbursement and Business Office Manger purchased a lock box to be held at the receptionist desk to ensure there are funds available to residents at all times. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/7/25 the Regional Operations Manager educated all receptionists on the procedure of distributing resident funds to residents after hours. No Receptionist will work without being educated. On 1/7/25 the Regional Operations Manager educated all third shift Licensed Nursing Staff on how to access Residents Fund through the available funds at the receptionist's desk. No staff will work without being educated. On 1/7/25 the Staff Development Coordinator was instructed by the Regional Operations Manager to add the education to the new hire orientation and that she would be responsible for ensuring new reception staff and licensed nursing staff does not work until education has been completed.	

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F 567	Continued From page 3 kept in an envelope in the locked medication room for the weekend cash access for residents. He stated he was not aware that this practice had been stopped. He stated residents did not have access to cash after business office hours (9:00 AM to 5:00 PM) during the week but concluded money should have been available to residents on weekends for residents who had accounts with the facility.	F 567	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: To ensure continued compliance the Business Office Manager will conduct monthly audits of Resident Trust Fund logs and access records for the next six months to ensure residents receive funds as requested. The Business Office Manager will report all findings to be reviewed during monthly Quality Assurance and Performance Improvement (QAPI) meeting for the next three months. The date of compliance is 1/10/25	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and Resident, staff and Nurse Practitioner (NP) interviews the facility failed to ensure a physician's order for the administration of supplemental oxygen was in place for 1of 2 residents (Resident #2) reviewed for respiratory care.	F 695	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 1/6/25 the facility failed to ensure a physician's order for the administration of	1/10/25

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F 695	Continued From page 4 Findings included: Resident #2 was admitted to the facility on 7/26/24 with a diagnosis of asthma (a chronic lung condition which can cause shortness of breath). A review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 11/22/24 revealed she was severely cognitively impaired. She was not coded for receiving respiratory or oxygen therapy. A review of Resident #2's comprehensive care plan revealed a focus area last revised on 11/27/24 for risk of complications due to her asthma diagnosis. The goal was for Resident #2 not to exhibit signs of respiratory distress. An intervention was to administer oxygen as ordered. On 1/6/25 at 1:38 PM an observation of Resident #2 revealed she was receiving 2 liters of oxygen via nasal cannula. An interview with Resident #2 at that time indicated she used oxygen sometimes, especially at night if she had trouble breathing. On 1/6/25 a review of Resident #2's electronic medical record did not reveal any evidence of a physician's order for the administration of oxygen. On 1/6/25 at 1:54 PM an interview with Nurse #1 indicated she was caring for Resident #2 on the 7AM-3PM shift. She stated Resident #2 had been receiving 2 liters of oxygen via nasal cannula when she began her shift at 7:00 AM that day. Nurse #1 went on to say if oxygen was being administered to a resident, there should be a	F 695	supplemental oxygen was in place for Resident #2. Director of Nursing and Regional Clinical Manager obtained order and placed it in the resident's MAR. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 1/6/25, 100% of all in-house residents were visualized by the nursing administration team to ensure any resident who required oxygen had an order for oxygen. Any resident with oxygen that did not have an order were corrected immediately. No other issues were identified in the audit. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 1/6/25, the Staff Development Coordinator initiated an in-service for all Licensed Nurses and Medication Aides for oxygen use orders. Any staff who did not receive the in-service will not be allowed to work until complete, the SDC will be responsible for ensuring staff do not work until education has been completed. On 1/6/25 the Administrator informed the SDC the education will be added to the New Hire education, and she will be responsible for ensuring new staff receive education before being allowed to work. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:	

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F 695	Continued From page 5 physician's order for this that would show up on the resident's medication administration record (MAR) letting the nurse know how much oxygen to administer. She stated she did not recall looking to see if Resident #2 had this order earlier, but she did not see a physician's order for oxygen now. On1/8/25 at 9:04 AM an interview with Nurse #3 indicated she cared for Resident #2 on 1/4/25 and 1/5/25 on the 3PM-11PM shift. She stated she did recall Resident #2 had been receiving oxygen at 2 liters via nasal cannula on her shifts on those days. She reported she did not check to see if Resident #2 had a physician's order for this oxygen. She went on to say if a resident experienced shortness of breath and needed supplemental oxygen, the facility had a standing order the nurse could activate. Nurse#3 stated once the nurse activated this order, it would appear on the resident's MAR. On1/8/24 at 9:08 AM an interview with Resident #2's Nurse Practitioner (NP) indicated he was familiar with Resident #2. He stated at times she experienced some anxiety that caused shortness of breath. He reported he would not want a nurse to wait to talk with him if a resident was experiencing a low oxygen saturation or shortness of breath. He stated there was some room for nursing judgement. He went on to say the facility had a standing order for oxygen therapy the nurse could initiate prior to speaking with a provider. The NP reported there should be an active physician's order in place if oxygen was being administered to a resident. On 1/9/25 at 8:39 AM an interview with the Director of Nursing (DON) indicated a resident	F 695	The Director of Nursing or designee will audit 5 residents 3x weekly x 4 weeks for oxygen orders, then weekly x 4 weeks, then monthly x 1 month. The Director of Nursing will bring the results of these audits to the Quality Assurance Committee for 3 consecutive months, at which time, the determination will be made if further monitoring is necessary. Date of Compliance: 1/10/25	

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F 695	Continued From page 6 should have an active physician's order in place if oxygen was being administered that included the amount of oxygen to be administered, and by what route. On 1/9/25 at 9:03 AM an interview with the Administrator indicated he would agree with the recommendation of Resident #2's NP and the DON regarding oxygen orders.	F 695		