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	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prodigy Transitional Rehab	911 Western Boulevard Tarboro, NC 27886

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0567 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48295 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 [DATE] and readmitted on [DATE]. Resident #11's quarterly Minimum Data Set assessment dated [DATE] indicated she was cognitively intact. 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 [DATE]. Resident #24's quarterly Minimum Data Set assessment dated [DATE] 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. (continued on next page)

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

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F 0567 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview with the Administrator on 1/7/25 at 9:27 AM he stated money used to be 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.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41009 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. Findings included: Resident #2 was admitted to the facility on [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.