

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Physicians and Nurse Practitioners (NP), the facility failed to notify and consult with a medical provider for new onset and continued vomiting and when bolus tube feedings (liquid formula is administered through a feeding tube into the stomach in larger volumes over a short period) were held for a severely cognitively impaired resident with a diagnosis of traumatic brain injury (disruption in normal brain function caused by an external mechanical force) who received all fluid and caloric intake through tube feedings. Resident #145 had an acute vomiting episode on [DATE] (Friday) before 6:00 AM, and the 6:00 AM bolus feeding was held. The medical provider was not notified of the vomiting or that the bolus tube feeding was being held. The resident had a second vomiting episode on [DATE] before 10:00 PM, and the 10:00 PM bolus tube feeding was held. Nurse #2 contacted the on-call medical provider, and a kidney, ureters, and bladder (KUB) x-ray was ordered at 10:42 PM. Resident #145 vomited on [DATE] before the scheduled 10:00 AM bolus tube feeding and a medical provider was not notified of the vomiting or the bolus tube feeding being held. The x-ray was completed during the 3:00 PM to 11:00 PM shift on [DATE] and the results were received at 1:00 AM on [DATE] (Sunday) and a medical provider was not informed of or consulted regarding the results. The KUB results included abundant fecal material seen within the distal large bowel loops (outer, peripheral loops of the colon) and up to 0.5 centimeters (cm) dilated rectum in keeping with constipation and possible fecal retention (stool becomes hard and stuck in the rectum). Abundant air was seen within up to 9.7 cm dilated large bowel loops and small bowel loops, which may have represented obstipation (severe form of constipation when the patient cannot pass fecal material or gas) and/or ileus (temporary slowing or obstruction of the digestive tract. If untreated, ileus can lead to intestinal perforation, infection, or tissue death, making prompt medical attention essential). Resident #145 vomited on [DATE] before the scheduled 10:00 AM bolus tube feeding and a medical provider was not notified of the vomiting or the bolus tube feeding being held. The KUB results were not called to a medical provider on [DATE] but were reviewed by NP #1 at 1:55 PM on [DATE]. NP #1 ordered an aggressive bowel regimen for three days including lactulose (prescription laxative) daily, a suppository daily, and an herbal laxative syrup twice daily. On [DATE] Resident #145 vomited twice during the evening shift from 3:00 PM to 11:00 PM, anti-nausea medication was administered, and the 6:00 PM bolus tube feeding was held. A medical provider was not notified of the vomiting or the bolus tube feeding being held. Then on [DATE], Nurse #5 documented at 8:20 PM that the resident vomited five times and contacted the on-call medical provider. The on-call medical provider asked for the KUB results but did not have access to the radiology report. The 10:00 PM bolus tube feeding was held on [DATE] and an injection used to prevent and treat nausea and vomiting was prescribed every six hours for two days. The nurse documented on [DATE] at 7:03 AM (continued on next page)		

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	that the resident tolerated the 2:00 AM and 6:00 AM bolus tube feedings; however, he vomited afterward and had to be cleaned up. The medical provider was not notified of the vomiting. On [DATE] at 10:00 AM the nurse held the 10:00 AM bolus tube feeding and the medical provider was not notified. Later in the shift the nurse noted Resident #145 was sweating profusely, had labored breathing, and his skin was clammy but warm to the touch. His oxygen saturation was noted to be 79% (normal range 95 to 100%). The Physician was notified and ordered oxygen and for Resident #145 to be sent to the hospital for an evaluation. Emergency Medical Services (EMS) was contacted and was at the bedside at 12:20 PM and Resident #145 was found unresponsive, tachypneic (abnormally rapid and shallow breathing), clammy, cyanotic (a bluish or purplish discoloration of the skin and mucous membranes due to deficient oxygenation of the blood) and in obvious distress. His blood pressure (BP) was 98/64 (normal range <120 and <80), pulse 188 (normal range 60 to 100 bpm), respirations 46 (normal range 12 to 20), blood sugar 119 (normal range 70 to 140), pupils were 8 millimeters and nonreactive (fixed or nonreactive pupils are a serious neurological sign that requires immediate medical evaluation). The oxygen level in his blood was very low and a non- rebreather mask (oxygen mask that delivers high concentrations of oxygen) with oxygen at 15 liter per minute was applied at 12:26 PM. EKG (electrocardiogram) results noted subventricular tachycardia (SVT which is a type of arrhythmia where the heart beats too fast, originating in the upper chambers (atria) or the atrioventricular (AV) node). Cardioversion was attempted three times but was not successful (cardioversion involves delivering a controlled electric shock to the heart to restore a normal rhythm) and a chemical cardioversion was attempted and was not successful. At 12:38 PM assisted ventilations using a bag valve mask (BVM) with oxygen at 25 liters per minute was initiated. Vital signs at 12:44 PM included BP 64/44 (severely low blood pressure), pulse 180, respirations 29 and blood oxygen saturation was 75%. An intravenous (IV) drip of epinephrine (vasoconstrictor which can stimulate the heart and increase blood flow to the brain and other organs) was initiated at 12:46 PM with no improvement of blood pressure noted. EMS left the facility at 12:48 PM with Resident #145 and advised the Emergency Department (ED) of medical red which means the patient has conditions that required immediate medical attention to have a chance of survival. While enroute to the ED at 12:49 PM vital signs included BP 25/19 (critically low blood pressure), pulse 169, respirations 23, and blood oxygen saturation of 73%. His temperature was 103.1 degrees Fahrenheit at 1:00 PM, which was noted as an indication of sepsis. In the ED Resident #145 was unresponsive and in obvious respiratory distress with grunting and retractions (the chest [NAME] in when a person tries to breathe in). ED triage vital signs at 1:04 PM included BP 75/21 (hypotensive), pulse 182, respirations 26 and blood oxygen saturation of 75%. The physical exam noted the resident was in acute distress, had dark brown gastric contents oozing from mouth and nose, pupils were dilated and minimally reactive, sweating heavily, tachycardic, had abdominal distention and rhonchi (continuous, low-pitched, coarse lung sounds caused by partial obstruction of the larger airways, often due to mucus or secretions) was noted when lung sounds were assessed. Resident #145 required urgent intubation for airway protection which was complicated by copious amounts of gastric regurgitation in the airway and was suctioned extensively before the second attempt at intubation was successful. Resident #145 was started on three vasoconstrictors used to treat life-threatening low BP and became bradycardic (heart rate of less than 60 beats per minute) and received a dose of atropine (used to treat bradycardia) just prior to cardiac arrest. Resident #145 arrested a total of four times, and he underwent four rounds of Cardiopulmonary Resuscitation (CPR) and spontaneous circulation was restored each time. He was transferred to the Cardiac Intensive Care Unit (ICU) in guarded condition. The physician in the Cardiac ICU documented an orogastric tube (OGT) was placed in the ED and was placed to suction when (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #145 arrived in the Cardiac ICU. Bright red blood was observed from the OGT and despite continuous suction Resident #145's abdomen continued to increase in size. The CT (computed tomography) scans noted concerns for a small bowel obstruction and impacted stool in the rectum. Attempts were made to manually remove the impacted stool from the rectum but were unable to reach a large portion of the stool. Acute Care Surgery was consulted by the Cardiac ICU physician due to acute abdomen and concluded Resident #145 had multisystem organ failure and was not a surgical candidate. Despite aggressive medical interventions Resident #145 died on [DATE] at 12:21 AM. The Death Certificate dated [DATE] revealed that Resident #145's primary cause of death was sepsis (a systemic infection bacteria that could quickly progress to septic shock and multi organ failure) secondary to probable aspiration pneumonia. The deficient practice occurred for 1 of 2 residents reviewed for tube feeding management (Resident # 145). Immediate jeopardy began on [DATE], when nursing staff failed to notify and consult with a medical provider regarding the results of the KUB and Resident #145's continued vomiting. The immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #145 was a [AGE] year-old male who was readmitted to the facility on [DATE] with diagnoses that included traumatic brain injury (TBI), protein calorie malnutrition, gastrostomy status (means a person has a surgically placed gastrostomy tube/feeding tube that provides direct access to the stomach for nutrition, fluids, or medication), dysphagia (difficulty swallowing), and quadriplegia. On [DATE] a physician's order was entered for bolus tube feeding six times a day with one can of Nutren 2.0 (tube feeding formula) 240 milliliters (mL) via the gastrostomy tube after placement was confirmed. Hold for residuals (the volume of formula or stomach contents that remain in the stomach after a feeding) greater than 200 mL. After 2 hours recheck and if the residuals remain greater than 200 mL, notify the physician and make sure the resident had a recent bowel movement if the tube feeding was held. Review of Resident #145's medical record from [DATE] through 7/2025 revealed no documentation of any vomiting episodes. Nursing staff schedules revealed Nurse #1 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. A nursing progress note dated [DATE] at 7:18 AM by Nurse #1 revealed that Resident #145 vomited twice with a light brown milky substance like the tube feeding. The resident position was high bed [NAME] (the bed is elevated 60 to 90 degrees) lying on the bed. He did not have shortness of breath. The oxygen saturation measured 97% (normal range 95 to 100%), and the 6:00 AM tube feeding was held. Nurse #1 would continue to monitor Resident #145. The [DATE] Medication Administration Record (MAR) revealed that Resident #145 did not receive the 6:00 AM bolus tube feeding on [DATE] due to vomiting. There was no documentation in Resident #145's medical record that showed Nurse #1 contacted a medical provider when the 6:00 AM bolus tube feeding was held on [DATE] or about the vomiting episode. Nurse #1 was interviewed via telephone on [DATE] at 8:15 AM and confirmed she was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. She revealed that she did not notify a provider by phone when she held the bolus tube feeding on [DATE] at 6:00 AM. Nurse #1 stated that she recorded Resident #145's vomiting episode in the provider notification book (a central communication binder for all updates, alerts, and/or instructions between nurses and providers) located at the nurses' station. Nurse #1 felt that this was the appropriate action after Resident #145's first vomiting episode rather than contacting a provider directly. She indicated that she was unsure if a provider saw her documentation on [DATE]. Nursing staff schedules revealed Nurse #2 was assigned to the resident on [DATE] from (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	3:00 PM until 11:00 PM. At 10:05 PM on [DATE], Nurse #2 included a note on the [DATE] MAR that coincided with the 10:00 PM bolus tube feeding administration that read: vomiting x1. A nursing progress note dated [DATE] at 10:51 PM by Nurse #2 revealed that Resident #145 had one vomiting episode. The substance appeared as clear content with yellow content of the resident's tube feeding. Resident #145 was stable with no facial grimacing noted. The abdominal area had hypoactive bowel sounds and was distended/bloated. The on-call provider was contacted, and they ordered Zofran 4 mg (milligrams) every 8 hours for three days for nausea and vomiting. A KUB of the abdomen was also ordered related to nausea and vomiting. Resident #145's last bowel movement was on [DATE] and was large in appearance. An on-call provider note dated [DATE] completed by Nurse Practitioner #2 revealed that Resident #145's vital signs at the time of notification from Nurse #2 at 10:42 PM included temperature of 97.2 degrees Fahrenheit (normal range 97 to 99 degrees Fahrenheit), BP of 113/82, pulse of 100 beats per minute, respiration rate per minute was 20, and the oxygen saturation measured 94%. The resident was stable, at normal baseline, and smiling. Resident #145 had a vomiting episode, and the last feeding for the evening shift scheduled for 10:00 PM was held. The vomiting content appeared clear and had some yellow content, which was the same color as the tube feeding he received. Residual measured 30 mL. The abdomen was bloated with hypoactive bowel sounds, and his last large bowel movement was on [DATE]. Nurse Practitioner #2 recommended Zofran as needed and a KUB of the abdomen due to the vomiting episode reported by Nurse #2. Multiple attempts were made to interview Nurse Practitioner #2 by phone, but she was unable to be reached during the investigation and no longer worked with the facility. A Change in Condition Evaluation dated [DATE] by Nurse #2 indicated that Resident #145 had a nausea/vomiting episode with a distended abdomen and no pain. The change in condition started during the night of [DATE]. There were no changes in mental or functional status noted. The on-call provider ordered a KUB of abdomen and anti-nausea medicine every eight hours for three days. Nurse #2's contact information was not available; she no longer worked at the facility and was unable to be contacted for interview during the investigation. Nursing staff schedules revealed Nurse #4 was assigned to the resident on [DATE] from 7:00 AM until 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding was held on [DATE] by Nurse #4 due to vomiting that resembled his tube feeding formula. There was no documentation in Resident #145's medical record that Nurse #4 contacted a medical provider when the 10:00 AM bolus tube feeding was held on [DATE] or about the vomiting episode. Nursing staff schedules revealed Nurse #3 was assigned to the resident on [DATE] from 3:00 PM until 11:00 PM. A nursing note dated [DATE] at 11:09 PM by Nurse #3 revealed that the KUB was completed during the evening shift and results were pending. Nurse #3's contact information was not available; she no longer worked at the facility and was unable to be contacted for interview during the investigation. The Radiology Results Report for Resident #145's KUB was received by the facility on [DATE] at 1:00 AM. The results showed abundant fecal material seen within the distal large bowel loops and up to 0.5 centimeters (cm) dilated rectum in keeping with constipation and possible fecal retention. Abundant air was seen within up to 9.7 cm dilated large bowel loops and small bowel loops, which may have represented obstruction and/or ileus. The radiologist recommended review of the KUB results and an appropriate follow up evaluation was clinically warranted. A computed tomography (CT) scan, or more detailed x-ray, was recommended to be considered by the facility. According to the results report, Nurse Practitioner #1 reviewed the KUB results on [DATE] at 1:55 PM. Nursing staff schedules revealed Nurse #7 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. There was no documentation in Resident #145's medical record that Nurse #7 contacted a medical provider with the results of the KUB during the 11:00 PM to 7:00 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	AM shift. Multiple attempts were made to interview Nurse #7 by phone, but she was unable to be reached during the investigation and no longer worked at the facility. The [DATE] MAR revealed on [DATE] Resident #145 received the 2:00 AM and 6:00 AM bolus tube feedings given by Nurse #1. At 6:26 AM on [DATE], Nurse #1 included a note that coincided with the August MAR for as needed Zofran administration that read: vomit x 1 this shift, large amount of large brown substance that appears to be (the tube) feeding. Nursing staff schedules revealed Nurse #4 was assigned to Resident #145 on [DATE] from 7:00 AM to 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding on [DATE] was held by Nurse #4 due to a vomiting episode prior to the feeding. A nursing progress note dated [DATE] at 3:49 PM by Nurse #4 revealed that Resident #145 vomited once which resembled the tube feeding during the day shift. The morning feeding was held, and Resident #145 tolerated the afternoon feeding. No further vomiting episodes were noted. Vital signs were measured and included temperature of 95.5 degrees Fahrenheit, pulse of 88 beats per minute, and blood pressure of 110/70. There was no documentation in Resident #145's medical record that Nurse #4 contacted a provider when the 10:00 AM bolus tube feeding was held on [DATE] or about the vomiting episode. Nurse #4 was interviewed via telephone on [DATE] at 4:00 PM. She revealed that Resident #145's temperature measurement of 95.5 degrees Fahrenheit included in the [DATE] at 3:49 PM nursing progress note was a data entry error. Nurse #4 explained if Resident #145 displayed a temperature of 95.5, she would first recheck the temperature and if still measured 95.5 degrees Fahrenheit she would notify the provider immediately and follow orders. Nurse #4 stated that it was facility protocol for nursing staff to contact the provider after a vomiting episode for any resident. She could not recall the details of Resident #145's vomiting episode on [DATE] during her shift. Nurse #4 indicated that she could not recall if she contacted the provider or not when the 10:00 AM tube feeding bolus was held on [DATE]. The physician orders for Resident #145 revealed that Nurse Practitioner #1 entered orders on [DATE] at 2:11 PM and included Lactulose solution (prescription laxative used to treat chronic constipation) via gastrostomy tube one time a day for constipation for three days, Bisacodyl suppository (fast acting laxative used to relieve occasional constipation) insert one suppository rectally one time a day for constipation for three days, and Senna oral syrup (herbal laxative used to relieve occasional constipation) give via gastrostomy tube two times a day for bowel regulation for three days. Review of the medical record revealed Nurse Practitioner #1 did not document a progress note on [DATE]. Nurse Practitioner #1 was interviewed via telephone on [DATE] at 12:50 PM. She revealed she had not worked at the facility since [DATE]. Nurse Practitioner #1 stated that if Resident #145's KUB x-ray results were received over the weekend, then the nurse on duty who received it should have contacted the on-call provider with the results. She could not recall the details of Resident #145's vomiting episodes or the KUB results and indicated she needed Resident #145's medical record in front of her to answer further questions. NP #1 then ended the call noting a current medical problem. Nursing staff schedules revealed Nurse #3 was assigned to Resident #145 on [DATE] from 3:00 PM until 11:00 PM. A nursing progress note dated [DATE] at 10:37 PM by Nurse #3 revealed that Resident #145 vomited twice during the evening shift from 3:00 PM to 11:00 PM. The as needed Zofran was given, and the 6:00 PM bolus tube feeding was held. The [DATE] MAR revealed that Resident #145's 6:00 PM bolus tube feeding was held on [DATE] by Nurse #3. There was no documentation in Resident #145's medical record that Nurse #3 contacted a provider when the 6:00 PM tube feeding bolus was held on [DATE] or about vomiting twice earlier during the evening shift on [DATE]. Nursing Staff schedules revealed Nurse #5 was assigned to Resident #145 from 3:00 PM until 11:00 PM on [DATE]. A nursing progress note dated [DATE] at 8:20 PM by Nurse #5 revealed that Resident #145 vomited five times during the evening shift. His abdomen was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	distended, and the vomit substance appeared to be yellow. The on-call provider was notified and ordered Phenergan 25 mg intramuscular every six hours for two days for nausea and vomiting. An on-call provider note dated [DATE] completed by Nurse Practitioner #3 revealed that Resident #145's vital signs at the time of notification from Nurse #5 at 8:20 PM included temperature of 97.8 degrees Fahrenheit, blood pressure of 134/76, pulse of 76 beats per minute, respiration rate per minute was 18, and the oxygen saturation measured 96%. Resident #145 had a vomiting episode, and the contents were yellow and appeared to be stomach acid. His abdomen was distended. The as needed Zofran was administered at 7:30 PM but was not effective, and Resident #145 had vomited twice since then. Nurse Practitioner #3 asked Nurse #5 if the KUB results ordered by Nurse Practitioner #2 on [DATE] were available for her to review and asked what was given to Resident #145 due to the x-ray results. Nurse #5 told Nurse Practitioner #3 about the bowel regimen of Lactulose, Bisacodyl suppository, and Senna liquid ordered by Nurse Practitioner #1 on [DATE]. Phenergan (antihistamine used to prevent and treat nausea and vomiting) intramuscular every six hours as needed for two days for nausea/vomiting was recommended. Nurse Practitioner #3 was contacted via telephone for an interview on [DATE] at 4:18 PM; however, she no longer worked at the facility and refused to answer any questions related to Resident #145. Nurse Practitioner #4 was interviewed via telephone on [DATE] at 3:21 PM after reviewing Resident #145's medical record. She revealed that she was the current Nurse Practitioner Supervisor for the facility on-call providers. Nurse Practitioner #4 stated that based on her own opinion she would not have held the bolus tube feeding after Resident #145 first vomited on [DATE] until bowel sounds were assessed. NP #4 indicated when NP #2 was notified on [DATE] in the evening that it was the second vomiting episode and had only 30 mL of residuals, then she would not have held the 10:00 PM bolus tube feeding. The on-call providers would not automatically receive the KUB results unless notified. NP #4 explained on [DATE] during the evening shift, Nurse Practitioner #3 asked for the KUB results, but the KUB results were not included in the resident's chart and could not be seen presently. After reviewing the KUB results, Nurse Practitioner #4 stated that she would have implemented a more aggressive bowel regimen just as Nurse Practitioner #1 did on [DATE]. However, she would be more reserved about holding the bolus tube feedings in general due to reduced caloric intake and possible blood sugar issues. The [DATE] MAR revealed that Resident #145's 10:00 PM bolus tube feeding was held on [DATE] by Nurse #5. Multiple attempts were made to interview Nurse #5 by phone, but she was unable to be reached during the investigation and no longer worked at the facility. Nursing Staff schedules revealed Nurse #1 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. A nursing progress note dated [DATE] at 7:03 AM by Nurse #1 revealed that Resident #145 was alert and responsive, tolerated the bolus feedings at 2:00 AM and 6:00 AM during the overnight shift, and vomited once. He was bathed and the linens were changed. There was no documentation in Resident #145's medical record that showed Nurse #1 contacted a provider when Resident #145 vomited once during the overnight shift from 11:00 PM on [DATE] until 7:00 AM on [DATE]. During a follow-up interview with Nurse #1 on [DATE] at 9:37 AM, she revealed that during the overnight shift from 11:00 PM on [DATE] through 7:00 AM on [DATE] when Resident #145 vomited, she did not contact the provider and only recorded the episode in the provider communication book because it had occurred towards the end of her shift and it was not an out of the ordinary occurrence. Nursing Staff schedules revealed Nurse #4 was assigned to Resident #145 on [DATE] from 7:00 AM to 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding was held on [DATE] by Nurse #4. There was no documentation in Resident #145's medical record that Nurse #4 contacted a provider when the 10:00 AM bolus tube feeding was held on [DATE]. A nursing progress note dated [DATE] at 12:34 PM (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	by Nurse #4 revealed that Physician #3 was in the facility making rounds to address Resident #145's continued nausea and vomiting unrelieved by as needed Zofran. Resident #145 was sweating excessively and had labored breathing. His skin was clammy and warm to the touch. Oxygen saturation was noted to be 79% on room air. Orders were received from Physician #3 for 2 liters of oxygen via nasal cannula and were implemented. Physician #3 then placed the order for Resident #145 to be sent to the emergency department (ED) for altered mental status and change of condition. Emergency Medical Services (EMS) arrived and assumed care of the resident. Nurse #4 was interviewed via telephone on [DATE] at 4:00 PM. Nurse #4 stated that it was facility protocol for nursing staff to contact the provider after a vomiting episode for any resident. She could not recall the details of Resident #145's vomiting episode on [DATE] during her shift. Nurse #4 indicated that she could not recall if she contacted the provider or not when the 10:00 AM tube feeding bolus was held on [DATE]. Review of the medical record revealed Physician #3 did not document a progress note on [DATE]. On [DATE] at 4:08 PM Physician #3 was interviewed via telephone. He revealed that the last time he evaluated Resident #145 was on [DATE]. He never had any interaction with Resident #145 after that date. Physician #3 stated that no nursing staff came to him on [DATE] while he was in the facility and told him there was an emergency with Resident #145. He could not recall if any nursing staff asked him to come to Resident #145's room to assess him or if he ordered two liters of oxygen or to send Resident #145 to the ED. Physician #3 stated that if he sent any resident to the ED, he would have written a progress note of his evaluation and the reason for sending the resident to the hospital. The EMS Report dated [DATE] revealed that 911 was contacted at 12:10 PM for a resident with difficulty breathing, EMS was dispatched at 12:12 PM, arrived at the facility at 12:16 PM, and was at the bedside at 12:20 PM. Resident #145 was found unresponsive, tachypneic, clammy, cyanotic and in obvious distress. At 12:20 PM his BP was 98/64, pulse 188, respirations 46, blood sugar 119, pupils were 8 millimeters and nonreactive, and a Glasgow Coma Scale of 6 (GCS- clinical tool used to assess a patient's level of consciousness, with scores ranging from 3 (deep coma) to 15 (fully alert)). A GCS of 6 indicates a lack of responsiveness suggesting a patient is in critical condition with a severe disruption in nervous system function and often associated with the need for airway protection. The oxygen level in his blood was very low and a non- rebreather mask with oxygen at 15 liter per minute was applied at 12:26 PM. EKG results noted subventricular tachycardia. Cardioversion was attempted three times but was not successful and a chemical cardioversion was attempted and was not successful. At 12:38 PM assisted ventilations using BVM with oxygen at 25 liters per minute was initiated. Vital signs at 12:44 PM included BP 64/44, pulse 180, respirations 29 and blood oxygen saturation was 75%. An intravenous (IV) drip of epinephrine was initiated at 12:46 PM with no improvement of blood pressure noted. EMS left the facility at 12:48 PM with Resident #145 and advised the ED of medical red. While enroute to the ED at 12:49 PM vital signs included BP 25/19, pulse 169, respirations 23, and blood oxygen saturation of 73%. His temperature was 103.1 degrees Fahrenheit at 1:00 PM, which was noted as an indication of sepsis. The report noted Resident #145's care was transferred to the ED. The ED provider note dated [DATE] indicated when Resident #145 arrived at the ED EMS reported to the ED physician Resident #145 had been vomiting in the days prior, was unresponsive when they arrived at the facility, and SVT was noted on the EKG. In the ED he was unresponsive and in obvious respiratory distress with grunting and retractions. ED triage vital signs at 1:04 PM included BP 75/21, pulse 182, respirations 26 and blood oxygen saturation of 75%. The physical exam noted the resident was in acute distress, had dark brown gastric contents oozing from mouth and nose, pupils were dilated and minimally reactive, sweating heavily, tachycardic, had abdominal distention and rhonchi was noted when lung sounds were assessed. Resident #145 required (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	urgent intubation for airway protection which was complicated by copious amounts of gastric regurgitation in the airway and was suctioned extensively before the second attempt at intubation was successful. Resident #145 was then started on epinephrine, levophed and vasopressin which are all vasoconstrictors used to treat life-threatening low BP. He became bradycardic and received a dose of atropine (used to treat bradycardia) prior to PEA arrest (Pulseless Electrical Activity which means the heart stops and the patient is in cardiac arrest) and CPR (cardiopulmonary resuscitation) was started immediately and there was a return of spontaneous circulation prior to a second cardiac arrest. CPR was started again and a return of spontaneous circulation was achieved a second time. During goals of care discussions with Resident #145's family member it was requested the resident remain a full code. In all Resident #145 underwent four rounds of CPR. The ED provider documented that due to Resident #145's hemodynamic instability and critical condition the Cardiac Intensive Care Unit (ICU) was consulted, and he was admitted in guarded condition. The Cardiac Critical Care (ICU) admission noted dated [DATE] indicated Resident #145 had CT scans completed and was brought to the Cardiac ICU. The physician further noted had been vomiting the days prior and the facility had sent a KUB report which showed distended bowel loops. It was noted the resident was hemodynamically unstable with high and difficulty maintaining oxygen saturation on the ventilator. An orogastric tube (OGT) was placed in the ED and was placed to suction when Resident #145 arrived in the Cardiac ICU. Bright red blood was observed from the OGT and despite continuous suction Resident #145's abdomen continued to increase in size. The CT scans noted concerns for a small bowel obstruction and impacted stool in the rectum. Attempts were made to manually remove the impacted stool from the rectum but were unable to reach a large portion of the stool. Acute Care Surgery was consulted by the Cardiac ICU physician due to acute abdomen and concluded Resident #145 had multisystem organ failure and was not a surgical candidate. A goal of care meeting was held with Resident #145's family member and his code status was changed to DNR (Do Not Resuscitate). Despite aggressive medical interventions Resident #145 died on [DATE] at 12:21 AM. The Death Summary and Certificate Information from the hospital dated [DATE] revealed that Resident #145 expired at 12:21 AM. The final disease resulting in death was documented as multi-system organ failure and circulatory shock due to aspiration pneumonia. The Death Certificate dated [DATE] revealed that Resident #145's primary cause of death was sepsis secondary to probable aspiration pneumonia. Physician #1 was interviewed via telephone on [DATE] at 12:59 PM. She revealed that she was the interim Medical Director in [DATE], and her last day at the facility was [DATE]. Physician #1 indicated that she did not see any residents [NAME][TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with staff, Physicians and Nurse Practitioners (NP), the facility failed to identify the seriousness of new onset and continued vomiting, complete and document ongoing comprehensive nursing assessments of the residents condition or identify the urgent need for medical attention for a severely cognitively impaired resident with a diagnosis of traumatic brain injury who received all fluid and caloric intake through bolus tube feedings six times a day. Resident #145 had an acute vomiting episode on [DATE] and the 6:00 AM bolus feeding was held. Nursing staff provided three scheduled bolus tube feedings on [DATE] before the 10:00 PM bolus tube feeding was held due to vomiting. The on- call provider was contacted and notified Resident #145's abdominal area had hypoactive bowel sounds and was distended/bloated. The on-call provider ordered a kidney, ureters, and bladder (KUB) x-ray at 10:42 PM and Zofran (antiemetic). On [DATE] Resident #145 vomited before the bolus tube feeding was due at 10:00 AM and the feeding was held. The KUB was completed during the 3:00 to 11:00 PM shift on [DATE] and the results were received at 1:00 AM on [DATE] (Sunday) which showed abundant fecal material seen within the distal large bowel loops (outer, peripheral loops of the colon) and up to 0.5 centimeters (cm) dilated rectum in keeping with constipation and possible fecal retention (stool becomes hard and stuck in the rectum). Abundant air was seen within up to 9.7 cm dilated large bowel loops and small bowel loops, which may have represented obstipation (severe form of constipation when the patient cannot pass fecal material or gas) and/or ileus (temporary slowing or obstruction of the digestive tract. If untreated, ileus can lead to intestinal perforation, infection, or tissue death, making prompt medical attention essential). All scheduled bolus tube feedings were provided after 10:00 AM on [DATE] until [DATE] when the resident vomited and the 10:00 AM and the feeding was held. The KUB results were not reviewed by a medical provider until NP #1 on [DATE] at 1:55 PM who ordered an aggressive bowel regimen for three days including lactulose daily, a suppository daily, and an herbal laxative syrup twice daily. NP #1 did not assess Resident #145 on [DATE]. Despite continued vomiting episodes and KUB results which noted abundant fecal retention and possible ileus nursing staff continued to provide the bolus tube feedings except when the resident vomited. The 2:00 PM bolus tube feeding was provided on [DATE] and when Resident #145 vomited twice during the evening shift the 6:00 PM tube feeding was held. Resident #145 was provided with all scheduled bolus tube feeding after 6:00 PM on [DATE] until the resident vomited five times and the 10:00 PM on [DATE] was held. Then on [DATE], Nurse #5 documented at 8:20 PM that the resident vomited five times and contacted the on-call medical provider. The nurse documented his abdomen was distended, and the vomited substance appeared to be yellow. The on-call medical provider asked for the KUB results but did not have access to the radiology report. The 10:00 PM bolus tube feeding was held on [DATE] and an injection used to prevent and treat nausea and vomiting was prescribed every six hours for two days. The 2:00 AM and 6:00 AM bolus tube feedings were provided however, the resident vomited after the 6:00 AM feeding. The nurse held the 10:00 AM bolus tube feeding on [DATE] and later in the shift the nurse noted Resident #145 was sweating profusely, had labored breathing, and his skin was clammy but warm to the touch. His oxygen saturation was noted to be 79% (normal range 95% to 100%). The Physician was notified and ordered oxygen and for Resident #145 to be sent to the hospital for an evaluation. Emergency Medical Services (EMS) was contacted and was at the bedside at 12:20 PM and Resident #145 was found unresponsive, tachypneic (abnormally rapid and shallow breathing), clammy, cyanotic (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	(a bluish or purplish discoloration of the skin and mucous membranes due to deficient oxygenation of the blood) and in obvious distress. His blood pressure (BP) was 98/64 (normal range <120 and <80), pulse 188 (normal range 60 to 100), respirations 46 (normal range 12 to 20), blood sugar 119 (normal range 70 to 140), pupils were 8 millimeters and nonreactive (fixed or nonreactive pupils are a serious neurological sign that requires immediate medical evaluation). The oxygen level in his blood was very low and a non- rebreather mask (oxygen mask that delivers high concentrations of oxygen) with oxygen at 15 liter per minute was applied at 12:26 PM. EKG (electrocardiogram) results noted subventricular tachycardia (SVT which is a type of arrhythmia where the heart beats too fast, originating in the upper chambers (atria) or the atrioventricular (AV) node). Cardioversion was attempted three times but was not successful (cardioversion involves delivering a controlled electric shock to the heart to restore a normal rhythm) and a chemical cardioversion was attempted and was not successful. At 12:38 PM assisted ventilations using a bag valve mask (BVM) with oxygen at 25 liters per minute was initiated. Vital signs at 12:44 PM included BP 64/44 (severely low blood pressure), pulse 180, respirations 29 and blood oxygen saturation was 75%. An intravenous (IV) drip of epinephrine (vasoconstrictor which can stimulate the heart and increase blood flow to the brain and other organs) was initiated at 12:46 PM with no improvement of blood pressure noted. EMS left the facility at 12:48 PM with Resident #145 and advised the Emergency Department (ED) of medical red which means the patient has conditions that required immediate medical attention to have a chance of survival. While enroute to the ED at 12:49 PM vital signs included BP 25/19 (critically low blood pressure), pulse 169, respirations 23, and blood oxygen saturation of 73%. His temperature was 103.1 degrees Fahrenheit at 1:00 PM, which was noted as an indication of sepsis. In the ED Resident #145 was unresponsive and in obvious respiratory distress with grunting and retractions (the chest [NAME] in when a person tries to breathe in). ED triage vital signs at 1:04 PM included BP 75/21 (hypotensive), pulse 182, respirations 26 and blood oxygen saturation of 75%. The physical exam noted the resident was in acute distress, had dark brown gastric contents oozing from mouth and nose, pupils were dilated and minimally reactive, sweating heavily, tachycardic, had abdominal distention and rhonchi (continuous, low-pitched, coarse lung sounds caused by partial obstruction of the larger airways, often due to mucus or secretions) was noted when lung sounds were assessed. Resident #145 required urgent intubation for airway protection which was complicated by copious amounts of gastric regurgitation in the airway and was suctioned extensively before the second attempt at intubation was successful. Resident #145 was started on three vasoconstrictors used to treat life-threatening low BP and became bradycardic (heart rate of less than 60 beats per minute) and received a dose of atropine (used to treat bradycardia) just prior to cardiac arrest. Resident #145 arrested a total of four times, and he underwent four rounds of Cardiopulmonary Resuscitation (CPR) and spontaneous circulation was restored each time. He was transferred to the Cardiac Intensive Care Unit (ICU) in guarded condition. The physician in the Cardiac ICU documented an orogastric tube (OGT) was placed in the ED and was placed to suction when Resident #145 arrived in the Cardiac ICU. Bright red blood was observed from the OGT and despite continuous suction Resident #145's abdomen continued to increase in size. The CT (computed tomography) scans noted concerns for a small bowel obstruction and impacted stool in the rectum. Attempts were made to manually remove the impacted stool from the rectum but were unable to reach a large portion of the stool. Acute Care Surgery was consulted by the Cardiac ICU physician due to acute abdomen and concluded Resident #145 had multisystem organ failure and was not a surgical candidate. Despite aggressive medical interventions Resident #145 died on [DATE] at 12:21 AM. The Death Certificate dated [DATE] revealed that Resident #145's primary cause of death was sepsis (a systemic infection caused by bacteria that (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	could quickly progress to septic shock and multi organ failure) secondary to probable aspiration pneumonia. The deficient practice occurred for 1 of 2 residents reviewed for tube feeding management (Resident # 145). Immediate jeopardy began on [DATE], when the facility failed to complete ongoing thorough nursing assessments for Resident #145 after a significant change and recognize the seriousness of the KUB results and seek a medical evaluation at a higher level of care. Immediate jeopardy was removed on [DATE] when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #145 was a [AGE] year-old male who was readmitted to the facility on [DATE] with diagnoses that included traumatic brain injury (TBI), protein calorie malnutrition, gastrostomy status (means a person has a surgically placed gastrostomy tube/feeding tube that provides direct access to the stomach for nutrition, fluids, or medication), dysphagia (difficulty swallowing), and quadriplegia. Resident #145's care plan initiated on [DATE] and last revised on [DATE] revealed that he was full code status. Resident #145's care plan had a focus added on [DATE] and last revised on [DATE] that indicated he was at risk for complications related to the need for tube feeding secondary to severe dysphagia. Interventions included administer tube feedings and flushes as ordered, head of bed elevated during feedings per order; pause feedings during personal care as indicated, observe for signs and symptoms of aspiration or aspiration pneumonia and notify the provider as indicated, resident was NPO, Registered Dietitian consult as needed and residual checks per order. A physician order for nothing by mouth (NPO) was added on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #145 had adequate hearing and vision, no speech, rarely/never understood/understands, and was severely cognitively impaired. He was not coded for any behavior or vomiting and was totally dependent on staff for all activities of daily living (ADL). Resident #145 was 72 inches tall, weighed 206 pounds, and all fluid and calorie intake were received through tube feeding. Review of Resident #145's medical record from [DATE] through 7/2025 revealed no documentation of any vomiting episodes. The Documentation Survey Report for [DATE] revealed on [DATE] Resident #145 had a large bowel movement at 11:48 AM and a medium bowel movement at 9:08 PM. On [DATE] a physician's order was entered for bolus tube feeding six times a day with one can of Nutren 2.0 (tube feeding formula) 240 milliliters (mL) via the gastrostomy tube after placement was confirmed. Hold for residuals (the volume of formula or stomach contents that remain in the stomach after a feeding) greater than 200 mL. After 2 hours recheck and if the residuals remain greater than 200 mL, notify the physician and make sure the resident had a recent bowel movement if the tube feeding was held. Nursing staff schedules revealed Nurse #1 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. A nursing progress note dated [DATE] (Friday) at 7:18 AM by Nurse #1 revealed that Resident #145 vomited twice with a light brown milky substance like the tube feeding. The resident position was high bed [NAME] (the bed is elevated 60 to 90 degrees) lying on the bed. He did not have shortness of breath. The oxygen saturation measured 97% (normal range 95 to 100%), and the 6:00 AM tube feeding was held. Nurse #1 would continue to monitor Resident #145. The [DATE] Medication Administration Record (MAR) revealed that Resident #145 did not receive the 6:00 AM bolus tube feeding on [DATE] due to vomiting. There was no physician order to hold the 6:00 AM bolus tube feeding on [DATE], and Nurse #1 added details about the vomiting episode in the provider communication book. There was no documentation in Resident #145's medical record that Nurse #1 completed a comprehensive nursing assessment after the morning vomiting episode on [DATE] including lung sounds, bowel sounds, and a full set of vital signs other than (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	oxygen saturation. Nurse #1 was interviewed via telephone on [DATE] at 8:15 AM. She revealed that after each vomiting episode on [DATE], [DATE], and [DATE], she checked Resident #145's lung and bowel sounds and all vital signs, especially oxygen saturation, and added all details to the provider's communication book. Nurse #1 stated that she also checked the residuals before each bolus tube feeding, and they were never above 200 mL. Nursing staff schedules revealed Nurse #2 was assigned to the resident from 3:00 PM until 11:00 PM on [DATE]. At 10:05 PM on [DATE], Nurse #2 included a note on the [DATE] MAR that coincided with the 10:00 PM bolus tube feeding administration that read: vomiting x1. The [DATE] Medication Administration Record (MAR) revealed that an order was entered at 10:49 PM for Zofran oral tablet 4 milligrams (mg) via gastrostomy tube every 8 hours as needed for nausea and vomiting until [DATE] at 11:59 PM. Resident #145 received Zofran 4mg at 10:15 PM on [DATE]. A nursing progress note dated [DATE] at 10:51 PM by Nurse #2 revealed that Resident #145 had one vomiting episode. The substance appeared as clear content with yellow content of the resident's tube feeding. Resident #145 was stable with no facial grimacing noted. The abdominal area had hypoactive bowel sounds and was distended/bloated. The on-call provider was contacted, and they ordered Zofran 4 mg (milligrams) every 8 hours for three days for nausea and vomiting. A KUB of the abdomen was also ordered related to nausea and vomiting. Resident #145's last bowel movement was on [DATE] and was large in appearance. An assessment of lung sounds was not documented. In the vital signs section of Resident #145's medical record, Nurse #2 recorded the following vital signs on [DATE] at the corresponding times: Blood pressure 113/82 at 11:54 PM Pulse 100 at 11:54 PM Oxygen saturation 94% at 10:42 PM An on-call provider note dated [DATE] completed by Nurse Practitioner #2 revealed that Resident #145's vital signs at the time of notification from Nurse #2 at 10:42 PM included temperature of 97.2 degrees Fahrenheit (normal range 97 to 99 degrees Fahrenheit), blood pressure of 113/82, pulse of 100 beats per minute, respiration rate per minute was 20, and the oxygen saturation measured 94%. The resident was stable, at normal baseline, and smiling. Resident #145 had a vomiting episode, and the last feeding for the evening shift scheduled for 10:00 PM was held. The vomiting content appeared clear and had some yellow content, which was the same color as the tube feeding he received. Residual measured 30 mL. The abdomen was bloated with hypoactive bowel sounds, and his last large bowel movement was on [DATE]. Nurse Practitioner #2 recommended Zofran as needed and a KUB of the abdomen due to the vomiting episode reported by Nurse #2. Multiple attempts were made to interview Nurse Practitioner #2 by phone, but she was unable to be reached during the investigation and no longer worked with the facility. A Change in Condition Evaluation dated [DATE] by Nurse #2 indicated that Resident #145 had a nausea/vomiting episode with a distended abdomen and no pain. The change in condition started during the night of [DATE]. There were no changes in mental or functional status noted. The on-call provider ordered a KUB of abdomen and anti-nausea medicine every eight hours for three days. Nurse #2's contact information was not available, and she was unable to be contacted during the investigation and no longer worked at the facility. Nursing staff schedules revealed that Nurse #4 was assigned to the resident on [DATE] from 7:00 AM until 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding was held on [DATE] by Nurse #4 due to vomiting that resembled his tube feeding formula. Resident #145 received Zofran 4 mg at 9:38 AM on [DATE]. There was no physician order to hold the 10:00 AM bolus tube feeding on [DATE]. There was no documentation in Resident #145's medical record that showed Nurse #4 completed a comprehensive nursing assessment after the morning vomiting episode on [DATE] including lung sounds, bowel sounds, and a full set of vital signs. Nursing staff schedules revealed that Nurse #3 was assigned to the resident on [DATE] from 3:00 PM until 11:00 PM. A nursing note dated [DATE] at 11:09 PM by (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Nurse #3 revealed that the KUB was completed during the evening shift and results were pending. Nurse #3's contact information was not available, and she was unable to be contacted during the investigation and no longer worked at the facility. The Radiology Results Report for Resident #145's KUB was received by the facility on [DATE] at 1:00 AM. The results showed abundant fecal material seen within the distal large bowel loops and up to 0.5 centimeters dilated rectum in keeping with constipation and possible fecal retention. Abundant air was seen within up to 9.7 cm dilated large bowel loops and small bowel loops, which may have represented obstipation and/or ileus. The radiologist recommended review of the KUB results and an appropriate follow up evaluation was clinically warranted. A computed tomography (CT) scan, or more detailed x-ray, was recommended to be considered by the facility. Nurse Practitioner #1 reviewed the KUB results on [DATE] at 1:55 PM. The Documentation Survey Report for [DATE] revealed that Resident #145 had a medium bowel movement at 2:59 PM [DATE]. Nursing staff schedules revealed that Nurse #7 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. There was no documentation in Resident #145's medical record that showed Nurse # 7 contacted a provider when the KUB results were received by the facility at 1:00 AM on [DATE]. Multiple attempts were made to interview Nurse #7 by phone, but she was unable to be reached during the investigation and no longer worked with the facility. Nursing staff schedules reviewed revealed that Nurse #1 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. The [DATE] MAR revealed on [DATE] Resident #145 received the 2:00 AM and 6:00 AM bolus tube feedings given by Nurse #1. At 6:26 AM, Nurse #1 included a note that Resident #145 had a vomiting episode with a large amount of brown substance that appeared to be the tube feeding. Further review of the MAR revealed Resident #145 received Zofran 4 mg at 6:26 AM on [DATE]. There was no documentation in Resident #145's medical record that Nurse #1 completed a comprehensive nursing assessment after the morning vomiting episode on [DATE] including lung sounds, bowel sounds, and a full set of vital signs. Nurse #1 was interviewed via telephone on [DATE] at 8:15 AM. She revealed that after each vomiting episode on [DATE], [DATE], and [DATE], she checked Resident #145's lung and bowel sounds and all vital signs, especially oxygen saturation, and added all details to the provider's communication book. Nurse #1 stated that she also checked the residuals before each bolus tube feeding, and they were never above 200 mL. Nursing staff schedules revealed that Nurse #4 was assigned to Resident #145 on [DATE] from 7:00 AM to 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding on [DATE] was held by Nurse #4 due to vomiting prior to the bolus tube feeding administration. There was no physician order to hold the 10:00 AM bolus tube feeding on [DATE]. A nursing progress note dated [DATE] at 3:49 PM by Nurse #4 revealed that Resident #145 vomited once which resembled the tube feeding during the day shift. The morning feeding was held, and Resident #145 tolerated the afternoon feeding. No further vomiting episodes were noted. Vital signs were measured and included temperature of 95.5 degrees Fahrenheit, pulse of 88 beats per minute, and blood pressure of 110/70. There was no documentation in Resident #145's medical record that Nurse #4 completed a comprehensive nursing assessment after the morning vomiting episode on [DATE] including lung sounds, bowel sounds, and oxygen saturation. Nurse #4 was interviewed via telephone on [DATE] at 4:00 PM. She revealed that Resident #145's temperature measurement of 95.5 degrees Fahrenheit included in the [DATE] at 3:49 PM nursing progress note was a data entry error. Nurse #4 stated that she could not recall if she had assessed lung sounds; however, bowel sounds were assessed. She indicated it was common practice for her to check lung sounds after an emesis episode. However, Nurse #4 could not recall the details of Resident #145's vomiting episodes during her shifts. The physician orders for Resident #145 revealed that Nurse Practitioner #1 entered (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	orders on [DATE] at 2:11 PM and included Lactulose solution (prescription laxative used to treat chronic constipation) via gastrostomy tube one time a day for constipation for three days, Bisacodyl suppository (fast acting laxative used to relieve occasional constipation) insert one suppository rectally one time a day for constipation for three days, and Senna oral syrup (herbal laxative used to relieve occasional constipation) via gastrostomy tube two times a day for bowel regulation. There was no documentation in Resident #145's medical record that Nurse Practitioner #1 completed a full evaluation after the KUB results were received on [DATE] at 1:00 AM and prior to ordering the aggressive bowel regimen that included lactulose, Bisacodyl suppository, and senna liquid on [DATE] at 2:11 PM. Nurse Practitioner #1 was interviewed via telephone on [DATE] at 12:50 PM. She revealed that she had not worked at the facility since [DATE]. Nurse Practitioner #1 stated that if Resident #145's KUB x-ray results were received over the weekend, then the nurse on duty who received it should have contacted the on-call provider with the results. She could not recall the details of Resident #145's vomiting episodes or the KUB and indicated she needed Resident #145's medical record in front of her to answer further questions. NP #1 then ended the call noting a current medical problem. Nursing staff schedules revealed that Nurse #3 was assigned to Resident #145 on [DATE] from 3:00 PM until 11:00 PM. The Documentation Survey Report for [DATE] revealed that Resident #145 had a small bowel movement at 6:55 PM on [DATE]. A nursing progress note dated [DATE] at 10:37 PM by Nurse #3 revealed that Resident #145 vomited twice during the evening shift. The as needed Zofran was given, and the 6:00 PM bolus tube feeding was held. The [DATE] MAR revealed that Resident #145's 6:00 PM bolus tube feeding was held on [DATE] by Nurse #3. Resident #145 received Zofran 4 mg at 4:39 PM on [DATE]. There was no physician order to hold the 6:00 PM bolus tube feeding on [DATE]. There was no documentation in Resident #145's medical record that showed Nurse #3 completed a comprehensive nursing assessment after the vomiting episode during the evening shift on [DATE] including lung sounds, bowel sounds, and a full set of vital signs. Nursing Staff schedules revealed Nurse #5 was assigned to Resident #145 from 3:00 PM until 11:00 PM on [DATE]. A nursing progress note dated [DATE] at 8:20 PM by Nurse #5 revealed that Resident #145 vomited five times during the evening shift. His abdomen was distended, and the vomit substance appeared to be yellow. The on-call provider was notified and ordered Phenergan 25 mg intramuscular every six hours for two days for nausea and vomiting. A comprehensive nursing assessment including vital signs, and an assessment of bowel sounds, or lung sounds was not documented in the progress note. An on-call provider note dated [DATE] completed by Nurse Practitioner #3 revealed that Resident #145's vital signs at the time of notification from Nurse #5 at 8:20 PM included temperature of 97.8 degrees Fahrenheit, blood pressure of 134/76, pulse of 76 beats per minute, respiration rate per minute was 18, and the oxygen saturation measured 96%. Resident #145 had a vomiting episode, and the contents were yellow and appeared to be stomach acid. His abdomen was distended. Resident #145 had vomited twice since then. Nurse Practitioner #3 asked Nurse #5 if the KUB results ordered by Nurse Practitioner #2 on [DATE] were available for her to review and asked what was given to Resident #145 due to the x-ray results. Nurse #5 told Nurse Practitioner #3 about the bowel regimen of Lactulose, Bisacodyl suppository, and Senna liquid ordered by Nurse Practitioner #1 on [DATE]. Phenergan (antihistamine use to prevent and treat nausea and vomiting) intramuscular every six hours as needed for two days for nausea/vomiting was recommended. Nurse Practitioner #3 was contacted via telephone for an interview on [DATE] at 4:18 PM; however, she no longer worked at the facility and refused to answer any questions related to Resident #145. Resident #145's physician orders revealed that the Phenergan injection solution 25 mg/mL inject 25 mg intramuscularly every six hours as needed for nausea and vomiting for two days was entered on [DATE] at 8:42 PM. The (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	[DATE] MAR revealed on [DATE] Resident #145's 10:00 PM bolus tube feeding was held by Nurse #5 and Phenergan injection was administered at 10:45 PM. There was no physician order to hold the 10:00 PM bolus tube feeding on [DATE]. Multiple attempts were made to interview Nurse #5 by phone, but she was unable to be reached during the investigation and no longer worked at the facility. Nursing staff schedules revealed that Nurse #1 was assigned to Resident #145 from 11:00 PM on [DATE] until 7:00 AM on [DATE]. A nursing progress note dated [DATE] at 7:03 AM by Nurse #1 revealed that Resident #145 was alert and responsive, tolerated the bolus feedings at 2:00 AM and 6:00 AM during the overnight shift, and vomited once. He was bathed and the linens were changed. There was no documentation in Resident #145's medical record that showed Nurse #1 completed a comprehensive nursing assessment after the vomiting episode during the overnight shift from 11:00 PM on [DATE] until 7:00 AM on [DATE] including lung sounds, bowel sounds, and a full set of vital signs. She also did not document the amount of the residuals. Nurse #1 was interviewed via telephone on [DATE] at 8:15 AM. She revealed that after each vomiting episode on [DATE], [DATE], and [DATE], she checked Resident #145's lung and bowel sounds and all vital signs, especially oxygen saturation, and added all details to the provider's communication book. Nurse #1 stated that she also checked the residuals before each bolus tube feeding, and they were never above 200 mL. Nursing staff schedules revealed that Nurse #4 was assigned to Resident #145 on [DATE] from 7:00 AM to 3:00 PM. The [DATE] MAR revealed that Resident #145's 10:00 AM bolus tube feeding was held on [DATE] by Nurse #4. There was no physician order to hold the 10:00 AM bolus tube feeding on [DATE]. A nursing progress note dated [DATE] at 12:34 PM by Nurse #4 revealed that Physician #3 was in the facility making rounds to address Resident #145's continued nausea and vomiting unrelieved by as needed Zofran. Resident #145 was excessively sweating and had labored breathing. His skin was clammy and warm to the touch. Oxygen saturation was noted to be 79% on room air. Orders were received from Physician #3 for 2 liters of oxygen via nasal cannula and were implemented. Physician #1 then placed the order for Resident #145 to be sent to the emergency department (ED) for altered mental status and change of condition. Emergency medical services (EMS) arrived and assumed care of the resident. Lung sounds, abdomen was not assessed, bowel sounds, no BP, pulse or respirations documented. Nurse #4 was interviewed via telephone on [DATE] at 4:00 PM. Nurse #4 stated that it was facility protocol for nursing staff to contact the provider after a vomiting episode for any resident. She could not recall the details of Resident #145's vomiting episode on [DATE] during her shift. Nurse #4 indicated that she could not recall if she contacted the provider or not when the 10:00 AM tube feeding bolus was held on [DATE]. During a follow-up interview with Nurse #4 on [DATE] at 1:53 PM, she revealed that she could not recall the details of [DATE] or the resident on that date. Review of the medical record revealed Physician #3 did not document a progress note on [DATE]. On [DATE] at 4:08 PM Physician #3 was interviewed via telephone. He revealed that the last time he evaluated Resident #145 was on [DATE]. He never had any interaction with Resident #145 after that date. Physician #3 stated that no nursing staff came to him on [DATE] while he was in the facility and told him there was an emergency with Resident #145. He could not recall if any nursing staff asked him to come to Resident #145's room to assess him or if he ordered two liters of oxygen or to send Resident #145 to the ED. Physician #3 stated that if he sent any resident to the ED, he would have written a progress note of his evaluation and the reason for sending the resident to the hospital. The EMS Report dated [DATE] revealed that 911 was contacted at 12:10 PM for a resident with difficulty breathing, EMS was dispatched at 12:12 PM, arrived at the facility at 12:16 PM, and was at the bedside at 12:20 PM. Resident #145 was found unresponsive, tachypneic, clammy, cyanotic and in obvious distress. At 12:20 PM his BP was 98/64, pulse 188, (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	respirations 46, blood sugar 119, pupils were 8 millimeters and nonreactive, and a Glasgow Coma Scale of 6 (GCS- clinical tool used to assess a patient's level of consciousness, with scores ranging from 3 (deep coma) to 15 (fully alert)). A GCS of 6 indicates a lack of responsiveness suggesting a patient is in critical condition with a severe disruption in nervous system function and often associated with the need for airway protection. The oxygen level in his blood was very low and a non-rebreather mask with oxygen at 15 liter per minute was applied at 12:26 PM. EKG results noted subventricular tachycardia. Cardioversion was attempted three times but was not successful and a chemical cardioversion was attempted and was not successful. At 12:38 PM assisted ventilations using BVM with oxygen at 25 liters per minute was initiated. Vital signs at 12:44 PM included BP 64/44, pulse 180, respirations 29 and blood oxygen saturation was 75%. An intravenous (IV) drip of epinephrine was initiated at 12:46 PM with no improvement of blood pressure noted. EMS left the facility at 12:48 PM with Resident #145 and advised the ED of medical red. While enroute to the ED at 12:49 PM vital signs included BP 25/19, pulse 169, respirations 23, and blood oxygen saturation of 73%. His temperature was 103.1 degrees Fahrenheit at 1:00 PM, which was noted as an indication of sepsis. The report noted Resident #145's care was transferred to the ED. The ED provider note dated [DATE] indicated when Resident #145 arrived at the ED EMS reported to the ED physician Resident #145 had been vomiting in the days prior, was unresponsive when they arrived at the facility, and SVT was noted on the EKG. In the ED he was unresponsive and in obvious respiratory distress with grunting and retractions. ED triage vital signs at 1:04 PM included BP 75/21, pulse 182, respirations 26 and blood oxygen saturation of 75%. The physical exam noted the resident was in acute distress, had dark brown gastric contents oozing from mouth and nose, pupils were dilated and minimally reactive, sweating heavily, tachycardic, had abdominal distention and rhonchi was noted when lung sounds were assessed. Resident #145 required urgent intubation for airway protection which was complicated by copious amounts of gastric regurgitation in the airway and was suctioned extensively before the second attempt at intubation was successful. Resident #145[TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 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** Based on record review, observation, staff, Nurse Practitioner, Respiratory Therapist and Medical Director interviews, the facility failed to reconcile conflicting information regarding the resident's oxygen flow rate following readmission from the hospital, for 1 of 3 residents reviewed for respiratory services (Resident #32). Findings included: Resident #32 was readmitted to the facility on [DATE], following hospitalization from 7/2/2026 through 7/6/2026 for acute-on-chronic respiratory failure and pneumonia. Diagnoses included chronic respiratory failure, tracheostomy (trach) (an opening in the neck that leads directly into the windpipe) status, quadriplegia (paralysis or severe weakness in both arms and both legs), dysphagia (difficulty swallowing food or liquids), and recurrent pneumonia. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #32 had severe cognitive impairment and was coded as receiving continuous oxygen therapy and tracheostomy care. A care plan dated 5/25/2026 read, respiratory interventions included providing humidified oxygen as ordered, performing routine tracheostomy care, suctioning the tracheostomy as needed, monitoring respiratory status and oxygen saturation, maintaining tracheostomy equipment, and observing for increased secretions or signs of respiratory distress. Review of a physician order dated 7/6/2026, showed an active order for humidified oxygen to tracheostomy: 3 liters (L) every shift for tracheostomy use. This was entered by the admission Nurse as a verbal Order from the Medical Director. Review of Medication Administration Record (MAR) dated July 2026 showed a physician order entered 7/6/2026 for humidified oxygen to trach: 3 liters (L) every shift for Trach use. The MAR documented the order was signed as administered by the evening shift nurse on 7/6/2026, by both day and evening nurses on 7/7/2026 through 7/14/2026, and by the day shift nurse on 7/15/2026. A review of Nurse Practitioner (NP) #2 note dated 7/9/2026 revealed a recommendation that Resident #32 continue with tracheostomy and supplemental oxygen via tracheostomy collar at 6 liters per minute. On 7/15/2026 at 2:05 pm, Nurse #6, assisted by the Assistant Director of Nursing (ADON), was observed performing tracheostomy care on Resident #32. It was observed that Resident #32 breathed through a tracheostomy. A plastic trach collar was placed over the tracheostomy and connected to oxygen tubing, allowing oxygen to flow directly into the resident's airway to support breathing. Oxygen saturation (measurement of how much oxygen is in the blood) measured 97% prior to tracheostomy care and 98% following replacement of the inner cannula and completion of tracheostomy care. After completion of tracheostomy care, Nurse #6 noted that the oxygen concentrator was set at 10 liters. When asked why the oxygen concentrator was set at 10 liters, Nurse #6 stated it was ordered at 10 liters to keep oxygen saturation above 90%. Nurse #6 was unable to locate a physician order authorizing oxygen at 10 liters. On 7/15/2026 at 2:49 pm the Respiratory Therapist was observed to enter Resident #32's room. When asked if he was aware that Resident #32 was on 10 liters of oxygen the Respiratory Therapist questioned 10? and immediately went to Resident #32's oxygen concentrator. The Respiratory Therapist stated that sometimes the nurses would bump the oxygen up, but he did not recommend 10 liters. The Respiratory Therapist turned the oxygen flow down from 10 liters to 6 liters. He stated that the goal was to maintain oxygen levels above 91% and while he does not recommend 10 liters, it would not cause Resident #32 too much harm with him having a tracheostomy. An interview was conducted with the Director of Nursing (DON) on 7/15/2026 at 3:21 pm. The DON stated that when Resident #32 left for the hospital, he was on 6 to 10 liters of oxygen via tracheostomy. She stated that staff were very familiar with Resident #32 and would have immediately recognized that 3 liters was not enough oxygen for Resident #32. The DON (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated that the nursing staff should have contacted the NP for new orders. On 7/15/2026 at 3:56 pm the Medical Director stated he was not sure why Resident #32 would have been on 10 liters of oxygen. The Medical Director stated that NP #2 may have given an order for 10 liters of oxygen but he wouldn't have recommended it. The Medical Director stated that 10 liters would not have caused any harm since Resident #32 had a tracheostomy. When asked about the verbal order for 3 liters of oxygen the Medical Director stated that he did not recall giving the order but that may have just been a standing order. The Medical Director stated NP #2 was more familiar with this patient and the recommended liters of oxygen that should be ordered. An interview with NP #2 on 7/16/2026 at 3:35 pm revealed she verbally ordered oxygen at 6 to 10 liters per minute on 7/9/2026 due to Resident #32 respiratory status after hospitalization. NP #2 could not recall which nurse she gave the verbal order to. NP #2 stated the verbal order of 6 to 10 liters of oxygen per minute should have been entered into the electronic medical record by either herself or the receiving nurse; however, the order may not have been entered. NP #2 confirmed the active written physician order for humidified oxygen at 3 liters per minute did not reflect the oxygen therapy she intended the resident to receive following readmission. In an interview with the Administrator on 7/17/2026 at 11:53 am she stated that she expected staff to administer oxygen per physician orders. She stated that if the nurse felt that there was a change needed, they should notify the Medical Director or NP for assessment and to obtain new orders. The Administrator stated that NP #2 sometimes entered her orders and sometimes she gave a verbal order with the expectation that the nurse would enter the order. The Administrator believed that in this situation, NP #2 gave a verbal order and the nurse did not enter the order.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345181	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Greenville Health and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2578 West Fifth Street Greenville, NC 27834	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to maintain an accurate medical record for the administration of supplemental oxygen for 1 of 3 residents reviewed for respiratory services (Resident #32).Resident #32 was readmitted to the facility on [DATE].Review of a physician order dated 7/6/2026, showed an active order for humidified oxygen to tracheostomy: 3 liters (L) every shift for tracheostomy use.Review of Medication Administration Record (MAR) dated July 2026 showed a physician order entered 7/6/2026 for humidified oxygen to trach: 3 liters (L) every shift for tracheostomy use. The MAR documented the order was signed as administered by Nurse #6 for the dayshift on 7/15/2026. On 7/15/2026 at 2:05 pm, Nurse #6, assisted by the Assistant Director of Nursing (ADON), was observed performing tracheostomy care on Resident #32. After completion of tracheostomy care, Nurse #6 noted that the oxygen concentrator was set at 10 liters. When asked why the oxygen concentrator was set at 10 liters, Nurse #6 stated it was ordered at 10 liters to keep oxygen saturation above 90%. Nurse #6 was unable to locate a physician order authorizing oxygen at 10 liters. Nurse #6 acknowledged that she did sign off on the MAR on 7/15/2026 which said humidified oxygen to trach: 3L every shift for Trach use. Nurse #6 stated that she did not pay attention to the amount, only that Resident #32 was receiving humidified oxygen to tracheotomy.An interview was conducted with the Director of Nursing (DON) on 7/15/2026 at 3:21 pm. The DON stated that she would expect nurses to pay more attention to orders and when signing off on those orders in the MAR.In an interview with the Administrator on 7/17/2026 at 11:53 am she stated that she expected staff to verified oxygen orders before documenting that oxygen was being administered at the correct rate.		