

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER East Carolina Rehab and Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th 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 - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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
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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff and Physicians the facility failed to notify the physician when residents developed pressure sores for 2 of 3 sampled residents with pressure sores (Residents # 1 and Resident #8).The findings included:1. Resident # 1 resided at the facility from 3/11/25 until her discharge to the hospital on 8/29/25. Resident # 1's diagnoses included cellulitis of the lower extremities, lymphedema, venous insufficiency, chronic kidney disease, anxiety, and gout.Resident # 1's electronic record included pictures as part of the documentation regarding Resident # 1's sacral pressure sore development and assessment. The first picture was recorded on 4/4/25. In the documented picture, the sacral pressure sore appeared to have both black and yellow slough tissue in the wound bed.The electronic record did not include orders on 4/4/25 for the treatment of the pressure sore or that the physician was contacted.The Wound Care Nurse was interviewed on 9/9/25 at 4:15 PM and on 9/10/25 at 11:13 AM and reported she (the Wound Care Nurse) kept written notes that had not been included in the resident's electronic record. The Wound Care Nurse referenced these notes and reported the following information. Resident # 1 had been noncompliant with care. Resident # 1's sacral pressure sore was first identified by her on 4/1/25. She had been caring for the resident's legs on 4/1/25 because the resident had cellulitis. On 4/1/25 she saw the sacral pressure sore and measured the pressure sore. It was 7 cm (centimeters) X 6 cm and was not stageable because it had black necrosis (dead tissue). The Nurse Aide had not let her know about the pressure sore before she (the Wound Nurse) found it. She (the Wound Care Nurse) had been working closely with the Wound Physician, who visited every week, and the Wound Physician had educated her that black necrosis would need to be removed for healing to take place. In working with the Wound Physician, she had been told that skin prep would be an appropriate measure for necrotic tissue. Therefore, she applied skin prep for the first few days when she found the pressure sore with the plan that the Wound Physician would look at the pressure sore when the Wound Physician was next at the facility. She (the Wound Care Nurse) did not call and talk with the Wound Physician or the primary physician. She did not enter orders into the resident's record for skin prep to the pressure sore. On 4/4/25 Nurse Aide (NA) # 1 came to get her (the Wound Care Nurse) and told her that NA # 2 was applying a cream on the resident's bottom and that she (NA #1) thought it needed something more than a barrier cream. She again looked at the pressure sore and decided to use Santyl (which is a chemical debriding topical cream) and she dressed and cared for the pressure sore on that date. She again did not call the physician and notify the physician of the new pressure sore. On 4/8/25 the Wound Physician was notified when she was there to make rounds. On 4/8/25 the Wound Physician initiated a plan of care and orders were received.A review of the Wound Physician's 4/8/25 treatment plan revealed the orders included more than just the Santyl which the Wound Care Nurse had last initiated on 4/4/25. Both Santyl and calcium Alginate were to be applied to the wound bed daily per the Wound Physician's plan of care.The Wound Care Physician was interviewed on 9/10/25 at 4:32 PM and reported the following information. If she (the Wound Care Physician) had been contacted on 4/1/25 when Resident # 1 first was observed to have an unstageable wound to her sacrum she probably would not have ordered skin prep. The facility could contact her at any time to consult about orders. According to the Wound Physician, if she had been contacted on 4/1/25 she would have needed to consider how long it would be before she could actually see the resident and taken that into consideration in ordering what needed to be applied in the interim.During an interview with the Director of Nursing (DON) on 9/11/2025 at 7:55 AM the DON reported the following information. The facility does have standing orders for wound care. Nurses are supposed to apply Wet to Dry dressings until they can contact the physician for further orders if they identify new wounds. The facility also has protocols to use based on the appearance of the wound bed and the nurse should still contact the physician and obtain orders when a resident has a pressure sore. The DON indicated all this information is kept in a binder at the nursing desk and the nurses should know that.2. Resident # 8 was initially admitted to the facility on [DATE]. The resident had diagnoses which included diabetes, hypertension, history of stroke, dysphagia, and pain. On 7/28/25 a documented skin assessment showed no areas of skin breakdown.According to the record, Resident # 8 was hospitalized from [DATE] to 8/4/25 for altered mental status and a urinary tract infection. Upon the resident's return on 8/4/25 Nurse # 3 documented a nursing assessment. The assessment form included an area which included directions note all skin issues. On this part of the assessment form, Nurse # 3 noted sacrum. There was no further information about the size or description of what the issue was with</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with staff and physicians the facility failed to 1) ensure Nurse Aides reported skin breakdown to a nurse prior to the wound bed being unstageable (Resident # 1); 2) ensure effective communication amongst nursing staff and the Wound Physician to ensure orders were obtained, initiated, and carried out for pressure sore treatments per the Wound Care Physician's plan of care (Resident # 1 and Resident #8); 3) ensure further diagnostic studies were completed per the Wound Care Physician's directions when a wound continued not to heal (Resident # 1), and 4) ensure the settings of a pressure relieving air mattress were set correctly for pressure relief (Resident # 8). This was for 2 of 3 of three sampled residents with pressure sores (Residents # 1 and # 8). The findings included: 1. Resident # 1 resided at the facility from [DATE] until her discharge to the hospital on [DATE]. Resident # 1's diagnoses included cellulitis of the lower extremities, lymphedema, venous insufficiency, chronic kidney disease, anxiety, and gout. Resident # 1's admission Minimum Data Set assessment, dated 3/17/25, coded Resident # 1 as cognitively intact and as needing substantial to maximum staff assistance for bathing needs. The resident was coded as needing partial to moderate assistance with turning in bed. Resident # 1 was not coded as having a pressure sore upon admission. She was coded as having verbal behaviors. Resident # 1's care plan, initiated on 3/12/25 and last updated on 8/29/25, included information that Resident # 1 had a pressure sore to her sacrum for which she required treatment. The care plan also included information that Resident # 1 had the potential to show verbal and physical aggression and that she could be resistive to wound care. Staff were directed on the care plan to educate the resident about possible outcomes of noncompliance. Resident # 1's electronic record included pictures as part of the documentation regarding Resident # 1's sacral pressure sore development and assessment. The first picture was recorded on 4/4/25. In the documented picture, the sacral pressure sore appeared to have both black and yellow slough tissue in the wound bed. The electronic record did not include orders on 4/4/25 for the treatment of the pressure sore. A review of Resident # 1's April 2025 Medication Administration Record and Treatment Administration Record revealed no documented treatment from 4/1/25 through 4/11/25. Documentation on these records showed that sacral pressure sore treatment began on 4/12/25. The Wound Care Nurse was interviewed on 9/9/25 at 4:15 PM and on 9/10/25 at 11:13 AM and reported she (the Wound Care Nurse) kept written notes that had not been included in the resident's electronic record. The Wound Care Nurse referenced these notes and reported the following information. Resident # 1 had been noncompliant with care. Resident # 1's sacral pressure sore was first identified by her on 4/1/25. She had been caring for the resident's legs on 4/1/25 because the resident had cellulitis. On 4/1/25 she saw the sacral pressure sore and measured the pressure sore. It was 7 cm (centimeters) X 6 cm and was not stageable because it had black necrosis (dead tissue). The Nurse Aide had not let her know about the pressure sore before she (the Wound Nurse) found it. She (the Wound Care Nurse) had been working closely with the Wound Physician, who visited every week, and the Wound Physician had educated her that black necrosis would need to be removed for healing to take place. In working with the Wound Physician, she had been told that skin prep would be an appropriate measure for necrotic tissue. Therefore, she applied skin prep for the first few days when she found the pressure sore with the plan that the Wound Physician would look at the pressure sore when the Wound Physician was next at the facility. She (the Wound Care Nurse) did not call and talk with the Wound Physician or the primary physician. She did not enter orders into the resident's record for skin prep to the pressure sore. On 4/4/25 Nurse Aide (NA) # 1 came to get her (the Wound Care Nurse) and told her that NA # 2 was applying a cream on the resident's bottom and that she (NA #1) thought it needed something more than a barrier cream. She again looked at the pressure sore and decided to use Santyl (which is a chemical debriding topical cream). She dressed and cared for the pressure sore on that date by doing so. During the interview with the Wound Care Nurse, the yearly calendar was reviewed with the Wound Care Nurse, and it was pointed out that the dates of 4/5/25 and 4/6/25 would have corresponded to a week-end. The Wound Care Nurse reported she worked week-days and that the floor nurses would have cared for the pressure sore on the week-end. The Wound Care Nurse was interviewed regarding how the primary care nurses would have known that the resident had a sacral pressure sore or what treatment orders should be followed if there were no orders entered into the resident's record. The Wound Care Nurse reported she had not recognized that as a problem NA # 1 was interviewed on 9/10/25 at 2:50 PM and reported the following</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with resident, staff, and a representative from the company that manufactures the mechanical lifts used at the facility, the facility failed to ensure a resident was safely transferred by a mechanical lift. A mechanical lift sling broke while Resident # 3 was being transferred resulting in Resident # 3 sustaining a fractured humerus (large bone of the upper arm). This was for 1 of 3 residents reviewed for accidents (Resident # 3). The findings included: Resident # 3 was admitted to the facility on [DATE]. The resident had diagnoses which included stroke and chronic pain. Resident # 3's quarterly Minimum Data Set assessment, dated 7/18/25, coded Resident # 3 as cognitively intact and as totally dependent on staff for transfers. Resident # 3's care plan, last updated on 8/29/25, included the information that Resident # 3 required total staff assistance for transfers. On 1/7/25 at 12:33 PM Nurse # 4 documented the following information. Two Nurse Aides were transferring Resident # 3 with a mechanical lift when one of the four straps broke, and the resident was lowered to the floor. The resident hit her head and her left shoulder. The Nurse Practitioner was made aware, and the resident was sent to the hospital for evaluation. Nurse Aide (NA) # 3 was one of the Nurse Aides who had been assisting in the transfer on 1/7/25. NA # 3 was interviewed on 9/10/25 at 3:11 PM and reported the following information. As he and NA # 4 were transferring Resident # 3 with the mechanical lift one of the straps tore away from the body of the sling where the strap was joined into the body of the sling. He had not noticed anything wrong with the sling or strap prior to the transfer, and they had been using the correct size lift sling also. NA # 4 was one of the Nurse Aides who had been assisting in the transfer on 1/7/25. NA # 4 was interviewed on 9/10/25 at 3:19 PM and reported the following information. On the day of the incident one of the straps broke away from the body of the lift sling where the strap joined the body of the sling. She had not noticed anything wrong with the lift sling prior to the incident. They lowered the resident to the floor and called the nurse immediately. Nurse # 4 was interviewed on 9/10/25 at 3:05 PM and reported the following information. It was reported to her that one of the straps broke and the resident was lowered to the floor. Resident # 3 bumped her head and left arm on the bed rail while going down. She did not recall what the sling looked like specifically that day. In general, she thought some of the slings had looked thin. After the incident Resident # 3 was sent to the hospital. Resident # 3 was interviewed on 9/9/25 at 10:00 AM and reported the following information. She recalled earlier in the year NA # 3 and NA # 4 were helping transfer her in the mechanical lift when the sling broke and she was dropped. It hurt when they dropped her. As she recalled it was her collarbone area that was broken. Review of 1/7/25 hospital records revealed Resident # 3 was evaluated in the hospital ED (Emergency Department) for left shoulder pain. The ED physician documented the following information. The resident was on Eliquis (an anticoagulant medication) at the facility. She was transferred to the ED for assessment following a fall. He had spoken to the facility staff who reported that a strap on the mechanical lift had broken, and the resident did not fully fall out of the lift. Her left arm dropped, and she hit her head on the bed rail. She was then lowered to the ground. X-rays and a CT (computerized tomography) scan were done. Resident # 3 was identified to have a left humerus fracture. An orthopedic consult was done, and the resident was not deemed to need surgery. Her arm was placed in a sling for immobilization with plans for an orthopedic follow up in three weeks. A CT of the head showed no evidence signs of hemorrhage. The resident's facility medications were reviewed by the ED physician who noted the resident already had orders for Cymbalta (used for chronic pain), baclofen (a muscle relaxer), and gabapentin (a seizure medication used to treat chronic pain) and also had orders for acetaminophen and tramadol (a controlled medication used for pain control) to be used as needed for pain. She was discharged back to the facility on 1/7/25 at 5:01 PM in stable condition according to hospital records. On 9/10/25 at 3:40 PM a Representative from the manufacturing company of the mechanical lifts was interviewed and reported the following information. It would be hard to say what had occurred with the sling without viewing the sling. It could have been that the sling was worn from normal use and laundering, or it could have been defective. The Representative indicated when incidents occur, the facility was welcome to call one of their regional representatives and the representative would come and view the sling to see if they could determine what had occurred. The Director of Nursing (DON) was interviewed on 9/8/25 at 7:38 AM and reported the following information. The lift sling was assessed by the facility after the incident, and it had been broken. The weight limit for all their slings was 600 pounds and Resident # 3 had not exceeded the weight limit of the sling. After the incident the</p>		