

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 12/19/2024
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)
<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404</p> <p>Based on record review, resident, Resident Representative (RR), and staff interviews, the facility failed to invite a resident to participate in the development of his plan of care for 1 of 3 residents were reviewed for care planning (Resident #271).</p> <p>The findings included:</p> <p>Resident #271 was admitted to the facility on [DATE], and his diagnosis included non-traumatic brain dysfunction, renal insufficiency, diabetes, and hypertension.</p> <p>Resident #271's care plan dated 11/22/24 revealed a goal to discharge to the community by the next review period with a target date of 12/11/24.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE] revealed resident #271 was cognitively intact.</p> <p>An interview with Resident #271 was held on 12/16/24 at 2:18 PM during which he stated he had never been invited to participate in the development of his plan of care.</p> <p>An interview with Resident #271's Resident Representative was held on 12/18/24 at 2:02 PM, she stated she had not ever been invited to participate in the development of Resident #271's plan of care.</p> <p>The Social Worker was interviewed on 12/17/24 at 4:04 PM and stated Resident #271 had not had a care plan meeting. Her expectation would have been a care planning meeting was held that included Resident #271 and his representative within 21 days after admission which would have been by 12/12/24. The Social Worker also stated this Resident should be on her care plan meeting scheduled for the week of 12/30/24 but could not produce evidence that the meeting had been scheduled or anyone invited to participate.</p> <p>The Administrator was interviewed on 12/18/24 at 3:48 PM at which time he stated he would expect a care planning meeting to be held within 21 days of admission that included Resident #271 and the resident representative. The Social Worker is tasked with scheduling and facilitating care planning meetings.</p>

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 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468</p> <p>Based on record review and staff interviews, the facility failed to complete a quarterly Minimum Data Set (MDS) assessment within 14 days following the Assessment Reference Date (ARD, last day of the assessment period) for 1 of 2 residents reviewed for assessments (Resident #48).</p> <p>Findings included:</p> <p>Resident #48 was admitted to the facility on [DATE].</p> <p>Review of Resident #48's MDS assessments revealed a quarterly MDS assessment with an ARD of 11/15/24 in the electronic health record with the status of in progress.</p> <p>During an interview on 12/17/24 at 12:45 PM MDS Nurse #1 and MDS Nurse #2 stated quarterly MDS assessments were to be completed no later than the ARD plus 14 calendar days. Due to staffing challenges, they were behind with Resident #48's quarterly MDS assessment and it was not completed timely according to the Resident Assessment Instrument (RAI) manual requirements as the assessment was still in progress.</p> <p>During an interview on 12/18/24 at 8:23 AM the Administrator stated MDS assessments should be completed according to the RAI manual's schedule.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468</p> <p>Based on record review and staff interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for antipsychotic use, hospice status, and wound status for 3 of 18 resident assessments reviewed (Resident #50, Resident #58, and Resident #173).</p> <p>Findings included:</p> <p>1. Resident #50 was admitted to the facility on [DATE].</p> <p>Review of Resident #50's Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #50 was assessed to have received an antipsychotic medication during the 7-day look back period.</p> <p>Review of Resident #50's Medication Administration Record (MAR) for November 2024 revealed Resident #50 did not receive an antipsychotic medication in November 2024.</p> <p>During an interview on 12/17/24 at 12:54 PM MDS Nurse #1 and MDS Nurse #2 stated due to staffing difficulties they were pulling answers forward from the previous assessment and then validating the information to save time when completing MDS assessments. Risperdal was discontinued on 10/2/24 for Resident #50 but the question was not corrected and was miscoded on the 11/12/24 MDS assessment.</p> <p>During an interview on 12/18/24 at 8:23 AM the Administrator stated MDS assessments should be accurate to the resident's status.</p> <p>48230</p> <p>2. Resident #173 was admitted to the facility on [DATE] with diagnoses that included congestive heart failure.</p> <p>The hospice admission paperwork revealed she was admitted to hospice on 11/26/24.</p> <p>Resident #173's payor source on her face sheet in the record was hospice Medicaid dated 11/26/24.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] indicated Resident #173 was severely cognitively impaired and was not coded for hospice services.</p> <p>In an interview with MDS Nurse #1 on 12/18/24 at 1:40 PM she stated Resident #173's MDS should have been coded for hospice as she was admitted to hospice on 11/26/24.</p> <p>In an interview with the Administrator on 12/18/24 at 10:33 AM he stated that the MDS should be coded accurately according to the resident's situation and Resident #173 should have been coded as receiving hospice services.</p> <p>3. Resident #58 was admitted to the facility on [DATE] with diagnoses that included cutaneous abscess of left lower limb.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the hospital discharge summary dated 10/21/24 revealed he was discharged with a wound from surgical abscess removal. No other wounds were noted.</p> <p>A review of Resident #173's wound care sheets indicated he was admitted to the facility with a surgical wound from abscess removal in the hospital. No other wounds were noted.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #58 was moderately cognitively impaired and had a stage III pressure ulcer.</p> <p>In an interview with the Wound Care Nurse on 12/17/24 at 1:19 PM she stated Resident #58 did not have a pressure wound. She indicated he had a wound from an abscess removal done in the hospital.</p> <p>An interview with MDS Nurse #1 was conducted on 12/18/24 at 8:51 AM during which she stated the quarterly MDS for Resident #58 was miscoded for a pressure ulcer because he did not have one.</p> <p>In an interview with the Administrator on 12/18/24 at 10:33 AM he stated that the MDS should be coded accurately according to the resident's situation and Resident #58 should not have been coded as having a pressure ulcer.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50404</p> <p>Based on record review and staff interviews, the facility failed to develop and implement a comprehensive care plan for a resident that exhibited aggressive verbal behaviors, a resident prescribed an antipsychotic medication, and a resident that had a surgical wound, for 3 of 18 residents reviewed for development and implementation of a comprehensive care plan (Resident #55, Resident #62 and Resident #58).</p> <p>The findings included:</p> <p>1. Resident #55 was admitted to the facility on [DATE] with diagnosis that included cerebral infarction, encephalopathy, and cognitive communication deficit.</p> <p>A review of the comprehensive care plan dated 10/3/23 and last revised on 7/30/24 did not reveal a comprehensive care plan about behaviors.</p> <p>A review of Resident #55's Minimum Data Set (MDS) dated [DATE] revealed he was mildly cognitively impaired and did exhibit verbal behavioral symptoms directed toward others.</p> <p>An interview with the Social Worker on 12/17/24 at 1:37 PM, revealed Resident # 55 was referred to Psychiatric Therapy for counselling on 7/19/23, 3/20/24, 10/16/24, and 11/27/24 to address his verbal outbursts towards other residents. The Social Worker further stated she missed adding behavioral outbursts to Resident #55's care plan on the 07/30/24 care plan update. Her expectation would be that behaviors would be included in Resident #55's care plan.</p> <p>An interview was conducted with the Administrator on 12/18/24 at 3:43 PM, he stated he would expect behaviors to be added to the care plan.</p> <p>2. Resident #62 was admitted to the facility on [DATE] with diagnosis that included hypertension, cystitis, dementia, psychotic disturbance and mood disturbance.</p> <p>A review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. The assessment also revealed Resident #62 received an antipsychotic medication.</p> <p>Review of the December 2024 Medication Administration Record (MAR) revealed an antipsychotic medication was started on 8/30/24 and was prescribed to be given two times per day for a dementing illness with psychosis. The MAR indicated the medication was given two times a day as ordered.</p> <p>A review of the comprehensive care plan dated 10/1/24 and last revised on 12/16/24 did not reveal a comprehensive care plan had been established for the use of antipsychotic medication.</p> <p>An interview with the Social Worker on 12/18/24 at 12:00 PM revealed she would not put information regarding antipsychotic medication on a care plan unless the resident exhibited behaviors related to the side effects of the antipsychotic medication.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing was interviewed on 12/18/24 at 1:09 PM, she stated she would expect an antipsychotic medication would be included in the comprehensive care plan. The interventions would be added if behaviors related to the medication were exhibited.</p> <p>An interview with the Administrator on 12/18/24 at 3:45 PM revealed he would expect an antipsychotic medication to be included in comprehensive care plans.</p> <p>48230</p> <p>3. Resident #58 was admitted to the facility on [DATE] with diagnoses that included cutaneous abscess (pocket of infection under the skin) of the left leg.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #58 was moderately cognitively impaired, and the assessment did not indicate the resident had a surgical wound.</p> <p>A review of Resident #58's record revealed there was not a care plan for wounds.</p> <p>In an interview with the Wound Care Nurse on 12/17/24 at 1:19 PM she stated Resident #58 had a wound from a surgical abscess removal done in the hospital. She was unaware he did not have a wound care plan.</p> <p>An interview with MDS Nurse #1 was conducted on 12/18/24 at 8:51 AM when she stated she was aware Resident #58 had a surgical wound. She was unaware he did not have a care plan for wounds. MDS Nurse #1 indicated nursing would have implemented a wound care plan on admission.</p> <p>In an interview with the Director of Nursing (DON) on 12/18/24 at 9:03 AM she indicated she did not see a care plan for wounds for Resident #58. She stated he should have had a care plan for wounds implemented by nursing upon admission.</p> <p>In an interview with the Administrator on 12/18/24 at 10:33 AM he stated Resident #58 should have had a wound care plan implemented upon admission.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>48295</p> <p>Based on observations, record review, and staff interviews, the facility failed to store the wet syringe separately from the barrel when Nurse #3 did not separate a bolus enteral feeding syringe (a large 2 part syringe used to administer oral medications or liquid feedings) used for medication administration through a gastrostomy tube (a hollow tube inserted directly through the skin of the abdomen into the stomach to deliver nutrition, hydration, and medication) for one of one resident (Resident #21). The deficient practice occurred for one of one staff member observed for medication administration via a gastrostomy tube.</p> <p>Findings included:</p> <p>During an observation of medication administration on 12/18/24 at 1:52 PM Nurse #3 entered Resident #21's room to administer medications via a gastrostomy tube. Nurse #3 administered the medication using a 2-part piston and barrel bolus enteral feeding syringe through a gastrostomy tube, rinsed the piston and barrel syringe with water and replaced the piston into the barrel and then placed the wet syringe back into a plastic storage bag.</p> <p>An interview conducted with Nurse #3 on 12/18/24 at 1:52 PM revealed she stored the syringe with the piston inserted into the barrel and did not separate them to dry. She stated she was not supposed to leave the piston and barrel separated to dry and stored them together and placed them in the plastic storage bag.</p> <p>During an interview with the Director of Nursing (DON) on 12/18/24 3:26 PM she stated Nurse #3 should have separated the bolus feeding syringe that was used to administer medication to Resident #21 to prevent the growth of bacteria in the syringe during storage.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48295</p> <p>Based on observations, record review, and staff interviews, the facility failed to implement their policy for Enhanced Barrier Precautions (EBP) when Nurse #3, the Wound Nurse, and the Wound Physician failed to apply a gown before entering residents' rooms to provide high contact care activities for two of two residents (Resident #21 and Resident #58). The deficient practice occurred for three of three caregivers observed for infection control practices. These deficient practices placed residents at risk for infection.</p> <p>Findings included:</p> <p>Review of the facility policy on EBP, dated 4/1/2024, revealed in part EBP was an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employed the use gloves and gowns during high contact resident care activities. The policy further stated EBP use included care for residents with indwelling medical devices during high contact resident care. High contact care was further defined to include feeding tubes.</p> <p>1. During an observation of medication administration on 12/18/24 at 1:52 PM Nurse #3 entered Resident #21's room to administer medications via a gastrostomy tube. Nurse #3 performed hand hygiene upon entering the room and donned (put on) a clean pair of gloves but did not don a gown. Nurse #3 administered the medication using a bolus enteral feeding syringe (a large 2-part syringe used to administer oral medications or liquid feedings) through a gastrostomy tube (a hollow tube inserted directly through the skin of the abdomen into the stomach to deliver nutrition, hydration, and medication).</p> <p>Review of the careplan for Resident #21 dated 7/17/24 revealed she was care planned for EBP related to a feeding tube.</p> <p>In an interview with Nurse #3 on 12/18/24 at 3:22 PM she stated the facility did not practice EBP for indwelling devices and was not aware she should have worn a gown for a Resident #21 when she administered medications via a gastrostomy tube.</p> <p>An interview was conducted with the Wound Physician on 12/18/24 at 2:45 PM. During the interview she stated the facility should have followed EBP for a resident with an indwelling device. She stated Nurse #3 should have worn gloves and a gown when she administered medications to Resident #21. She further indicated that there was risk for transmission of multidrug resistant organisms (bacteria) or other bacteria from the healthcare provider to the resident and vice versa and infection could be spread to other residents or staff members. She went on to state EBP should have been followed because it was recommended by the Centers for Disease Control and Prevention (CDC) to prevent the spread of infection.</p> <p>During an interview with the Director of Nursing (DON) on 12/18/24 3:26 PM she stated Nurse #3 should have worn gloves and a gown to provide care to protect the resident from infection. The DON stated staff were trained on EBP on hire and as needed. She stated EBP signage was not posted for residents with indwelling medical devices because it was not required. The DON further stated residents that were on EBP were care planned and staff had access to the careplan.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Administrator on 12/19/24 at 11:17 AM he stated all staff were educated on EBP upon hire as it is part of the infection control training they received. He further stated Nurse #3 should have worn a gown when she provided care to Resident #21. The Administrator further indicated staff were trained on infection control on hire and that included EBP.</p> <p>48230</p> <p>2. A review of the facilities policy titled Enhanced Barrier Precautions (EBP) dated 4/1/24 stated in part: For residents for whom EBP are indicated (ie: wounds), EBP is employed when performing the following high-contact resident care activities: wound care: any skin opening requiring a dressing.</p> <p>During an observation on 12/18/24 at 2:02 PM, the Wound Care Physician and Wound Care Nurse entered Resident #58's room to provide wound care without donning gowns. The Wound Care Physician performed a wound treatment with an ultrasonic mist machine that sprays mist onto the wound to help with wound healing. She provided this treatment for three minutes wearing clean gloves and no gown. Afterwards, the Wound Care Nurse went into the hall to collect supplies to cover the wound. The Wound Care Nurse collected the supplies, put on clean gloves and entered the room again without donning a gown. She proceeded to apply the ordered wound dressing to the wound.</p> <p>The care plan dated 7/2/24 indicated Resident #58 was on EBP. The goal was for EBP to be maintained by staff during high contact resident care. Interventions included staff to don disposable gown and gloves for chronic wound care.</p> <p>In an interview with the Wound Care Physician and the Wound Care Nurse on 12/18/24 at 2:19 PM the Wound Care Physician stated she was unaware that the resident was on EBP and if she had known she would have worn a gown. The Wound Care Nurse stated she was unaware that the facility used EBP, that she was not trained on EBP and had worked there since May of 2024.</p> <p>An interview with the Director of Nursing (DON) was conducted on 12/18/24 at 2:29 PM. The DON stated the Wound Care Physician and the Wound Care Nurse should have worn gloves and a gown to provide wound care to protect the resident from possible infection. She further stated they did not use EBP signage. The DON indicated that staff should know which resident needs EBP based on the policy, education they received, and the Residents needs.</p> <p>In an interview with the Administrator on 12/18/24 at 2:34 PM he stated all staff were educated on EBP upon hire as it is part of the infection control training they received. He further stated the Wound Care Physician and Wound Care Nurse should have worn a gown when providing wound care to Resident #58. The Administrator indicated the facility did not use EBP signage but that staff were trained on the policy upon hire.</p>		

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<p>F 0945</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program.</p> <p>48230</p> <p>Based on record review and staff interviews, the facility failed to follow their infection control policy and procedure to ensure facility staff received infection control training on Enhanced Barrier Precautions (EBP) to know what required EBP and when to implement EBP for 1 of 1 staff reviewed for infection control training (Wound Care Nurse).</p> <p>The findings included:</p> <p>The facility Enhanced Barrier Precautions Policy stated in part: East Carolina Rehab and Wellness will educate all employees on the reason for EBP.</p> <p>In an interview with the Wound Care Nurse on 12/18/24 at 2:19 PM, she stated she had worked at the facility since May of 2024, she had not been trained on EBP and was unaware that the facility used EBP.</p> <p>An interview with the Director of Nursing (DON) on 12/18/24 at 2:29 PM revealed she did not know if the Wound Care Nurse had been educated on EBP. She further stated the Staff Development Coordinator (SDC) provided the education and the DON did not know where those education documents were located. The SDC was no longer employed at the facility. The DON was not able to produce evidence that the Wound Care Nurse was trained in EBP since being hired.</p> <p>In an interview with the Administrator on 12/18/24 at 2:34 PM he stated staff were trained on EBP when hired and the SDC or DON would have those records. He was unaware the DON did not know where the training records were kept.</p>