| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345377 | A. Building<br>B. Wing | 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| East Carolina Health and Rehabilitation Center | 2575 W 5th Street<br>Greenville, NC 27834 |

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| F 0727<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.<br><br>Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 2 of 142 days reviewed for staffing (12/28/25 and 1/24/26).The findings included: Review of the facility's daily nurse staffing sheets from 11/1/25 through 3/22/26 revealed the following: a. On 12/28/25 the daily nurse staffing sheet indicated a daily census of 85. Review of the daily nurse staffing sheet revealed there was no RN working on any shift that day. b. On 1/24/26 the daily nurse staffing sheet indicated a daily census of 77. Review of the daily nurse staffing sheet revealed there was no RN working on any shift that day. In an interview with the Scheduler on 3/25/26 at 10:10 am, she stated she used the schedule to complete the daily nurse staffing sheets. The Scheduler stated if she had no RN coverage she would leave the RN space blank on the daily nurse staffing sheet for the number of RNs scheduled to work. She stated did not have RN coverage for 12/28/25 and 1/24/26. The Scheduler further stated she was unaware there could be no blank spaces on the daily nurse staffing sheets. The Scheduler was not sure what she needed to do when there was no RN coverage. An interview with the Director of Nursing (DON) on 3/25/26 at 10:30 am revealed she was unaware there was no RN coverage for 12/28/25 and 1/24/26. The DON stated there should be an RN for 8 consecutive hours in the building and she would be monitoring this more closely in the future. An interview with the Administrator on 3/25/26 at 12:02 pm stated his expectations were the facility should have an RN for 8 consecutive hours in the building. |

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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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Medical Director, and Consultant Pharmacist interviews, the facility failed to provide ongoing Abnormal Involuntary Movement Scale (AIMS) assessments for potential adverse reactions to antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (Residents #3).The findings included: Resident #3 was admitted on [DATE] with diagnoses including dementia with severe behavioral disturbance and agitation.Review of Resident #3's physician orders revealed she had an order dated 4/21/25 for haloperidol lactate (a first-generation antipsychotic injection used for the rapid treatment of acute psychosis, schizophrenia, and severe agitation) 2 milligram (mg)/ milliliter (ml) give 0.5 ml by mouth two times a day for behaviors.Review of Resident #3's electronic medical record (EMR) revealed the last AIMS assessment on file was dated 7/29/25. There were no other AIMS assessments found in the Resident #3's EMR after that date. Resident #3's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively impaired and exhibited behaviors. She was coded for antipsychotic medication.An interview was conducted with Unit Manager #1 on 3/23/26 at 3:09 PM. She stated she began working at the facility in January 2026. The Unit Manager stated when the new company took over the facility (in November 2025), some assessments were not scheduled. Unit Manager #1 further stated AIMS assessments should be completed upon initial admission, at readmissions, and completed quarterly. Unit Manager #1 indicated Resident #3's quarterly AIMS should have been completed but was not.An interview was conducted with the Director of Nursing (DON) on 03/23/26 at 3:30 PM. The DON stated the facility changed ownership in November 2025 and she began working at the facility in December 2025. She stated staff were working to get all assessments correct and up to date. The DON stated that AIMS assessments were expected to be completed at the time of initial admission, at readmissions, with new medication prescriptions, as well as scheduled and completed quarterly. She further stated the unit managers were responsible for completing the AIMS assessments.An interview was conducted with the Pharmacy Consultant on 3/25/26 at 9:57 AM. The Pharmacy Consultant stated AIMS assessments should be completed at the start of the antipsychotic medication; if no changes were made to the medication dose, then again at 6 months. The Pharmacy Consultant stated his medication reviews included reviews of physician and psychiatric progress notes for any medication related side effects and if no issues were noted, he did not make recommendations. He further stated he left AIMS assessment information up to the treating physician to make recommendations.In an interview with the Medical Director on 3/25/26 at 10:16 AM he stated AIMS assessments should be completed at the minimum of every 6 months. He stated the physician and/or psychiatrist generally monitored antipsychotic medications. The Medical Director further stated Resident #3 had been in the hospital earlier this month, which could have interfered with the timing of her AIMS assessment, however it should have been completed at the 6-month mark regardless.An interview was conducted with the Administrator on 3/25/26 at 1:08 PM. He stated he expected that all assessments needed for antipsychotic medications, including AIMS assessments, were completed timely and were reviewed as necessary. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and facility staff interviews, the facility failed to accurately code Minimum Data Set (MDS) for 1 of 62 residents reviewed for accuracy of assessments (Resident #84). The findings included:Resident #84 was admitted to the facility on [DATE] with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (ischemic stroke).Review of a physician order dated 1/16/26 for Resident #84 documented [brand name of formula] enteral nutrition (delivery of nutrients directly into the gastrointestinal tract, typically through a feeding tube) at 60 milliliters (ml) per hour every 12 hours from 6 p.m. to 6 a.m. and 200 ml water flush every four hours. Review of Resident #84's February 2026 Medication Administration Record (MAR) revealed [brand name of formula] enteral nutrition at 60 ml per hour per feeding tube every 12 hours from 6 p.m. to 6 a.m. and 200 ml of water flush every 4 hours per feeding tube had been documented as administered. A review of Resident #84's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #84 was not coded for having a Feeding Tube or the Percent of Intake by Artificial Route. During an interview with the Regional MDS Consultant on 3/25/26 at 10:50 a.m. she stated the Dietary Manager completed the Nutrition section of the MDS and it should have been completed by the MDS Coordinator. The MDS indicated Resident #84 had a feeding tube, this had been an error, and it should have been coded correctly including the amount of intake by artificial route. During an interview with the Administrator on 3/25/26 at 12:02 p.m. he stated the MDS assessments should have been coded accurately to reflect the feeding tube and the amount of intake by artificial route. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and an interview with the Pharmacy Consultant, the Pharmacy Consultant failed to identify and report irregularities when conducting monthly drug regimen reviews for 1 of 5 residents reviewed for unnecessary medications (Resident #3).The findings included: Resident #3 was admitted on [DATE] with diagnoses including dementia with severe behavioral disturbance and agitation.Review of Resident #3's physician orders revealed she had an order dated 4/21/25 for haloperidol lactate (a first-generation antipsychotic injection used for the rapid treatment of acute psychosis, schizophrenia, and severe agitation) 2 milligram (mg)/ milliliter (ml) give 0.5 ml by mouth two times a day for behaviors.Review of Resident #3's electronic medical record (EMR) revealed the last AIMS assessment on file was dated 7/29/25. There were no other AIMS assessments found in the Resident #3's EMR after that date. Review of the Pharmacy Consultant monthly drug regimen reviews for Resident #3 dated 10/10/25, and monthly pharmacy reports dated November 2025 through February 2026, revealed no documentation of the need for the facility to complete AIMS assessments. An interview was conducted with the Pharmacy Consultant on 3/25/26 at 9:57 AM. The Pharmacy Consultant stated AIMS assessments should be completed at the start of the antipsychotic medication; if no changes were made to the medication dose, then again at 6 months. The Pharmacy Consultant stated his medication reviews included reviews of physician and psychiatric progress notes for any medication related side effects and if no issues were noted, he did not make recommendations. He further stated he left AIMS assessment information up to the treating physician to make recommendations. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Dialysis Dietician/Nurse Practitioner, and Medical Director interviews, the facility failed to ensure medications were administered in accordance with physician orders for 1 of 9 residents reviewed for medications (Resident #7).The findings included:Resident #7 latest admission date to the facility was 10/8/2025 following a hospitalization from 10/3/2025 to 10/8/2025 for dialysis access complications and anemia. Resident #7 admitting diagnoses included end stage renal disease (ESRD) requiring hemodialysis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and moderate protein-calorie malnutrition. A care plan dated 10/08/2025 addressed ESRD and fluid volume management, including administering medications as ordered, monitoring vital signs, and providing diet as ordered. The care plan was revised on 03/05/2026 to include activities of daily living (ADL) assistance needs. The care plan did not include interventions addressing medication availability, administering medications on dialysis days, or medication refusals.Further review of physician orders revealed an order dated 6/12/2025 for Sevelamer Carbonate (phosphate binder used to control elevated phosphorus in people with chronic kidney disease) 0.8 gram packet give one (1) packet by mouth three times daily with a meal.On 11/11/2025 a physician order was written for Carvedilol (used to treat heart failure, hypertension and heart attack) 6.25 mg, 2 tablets twice daily and Sertraline (used to treat depression and anxiety) 50 mg daily.On 2/12/2026 a physician order specified Sevelamer HCl (phosphate binder) 800 mg 3 tablets with meals and Sevelamer HCl 800 mg 2 tables with snacks twice daily. A quarterly Minimum Data Set (MDS) assessment dated [DATE] documented diagnoses including ESRD requiring dialysis and moderate protein-calorie malnutrition, with severe cognitive impairment requiring cues for decision-making.A review of Medication Administration Records (MARs) for January 2026 and February 2026 revealed that on 01/07/2026, 01/19/2026, 01/28/2026, 02/06/2026, 02/11/2026, 02/13/2026, 02/16/2026, 02/18/2026, 02/20/2026 and 02/20/2026, the Sevelamer, Sertraline 50 mg and Carvedilol 6.25 mg were documented as not administered because the resident was out of facility or at dialysis at the time of medication administration.On 3/11/2026 a physician order was written to discontinue Sevelamer and start Velphoro (phosphate binder) 500 mg with instructions to administer one tablet three times daily with meals and one tablet with a snack. Velphoro serves the same purpose as Sevelamer except the Velphoro is less pills per dose.An interview with the Dialysis Dietician/Nurse Practitioner on 3/24/2025 at 11:10 am revealed that Resident #7 was switched from Sevelamer to Velphoro because his phosphorous levels were not controlled and she believed facility was not administering medication as ordered. She stated that Resident #7 phosphorous levels were still not controlled and latest phosphorous level was 6.5 on 3/11/2026. She stated that they like patients to be 5.5 or less. She indicated that Resident #7's phosphorous levels were well controlled prior to his coming to this facility. She stated that Resident #7 does not take any medication while at the dialysis facility. She confirmed that Resident #7 did not take the medication at the dialysis center because the resident did not always eat while at dialysis and medication must be taken with food. She further stated that Resident #7 could have taken the medication upon his return to the facility with his meals or snacks.According to the National Kidney Foundation, high phosphorous levels harden blood vessels and increases the risk of heart disease, stroke and death. At an interview on 3/25/2026 at 9:50 am the Director of Nursing stated that if nurses hold a medication or if the medication is not available from pharmacy, the nurse should call the on-call provider and make them aware. She stated that at the direction of the on-call provider they should either hold the medication for that day or administer it to the patient upon their return to the facility.An interview with the Nurse Unit Manager on 3/25/2026 at 10:30 am revealed that Resident #7's? resident medications were held when the patient was out of the facility for dialysis. She stated that if they were held, they were not given when he returned to the facility. She stated they do not contact the Medical Director or on-call provider when they hold<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medications. She stated that the resident has dialysis on Mondays, Wednesdays and Fridays and his chair time started at 11:15 am and returns around 4:00 pm. She stated that the resident had several medications held during that time including a 2:00 pm blood pressure medication Carvedilol which was held every Monday, Wednesday and Friday.A 3/25/2026 interview with Medical Director at 10:53 am revealed that it was his expectation that nursing staff contact the on-call doctor or himself if a patient misses medication due to being out of the building. The Medical Director stated that he had not received any communication regarding Resident #7 being out to dialysis and missing doses of his medication. He stated that if nursing staff held a medication they should contact on-call providers, tell them which medication was held and which ones still needed to be given. The Medical Director indicated now that he was aware they could adjust medications times so that they are not given while Resident #7 is at dialysis. The Medical Director stated that he did not follow Resident #7 dialysis care and allowed the dialysis center to make any medication changes or follow up on labs. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interviews, the facility failed to ensure the resident call light system was functioning properly for 3 of 97 residents observed for resident call system (Resident #78, Resident #4, and Resident #94).The findings included:Record review of maintenance related purchase orders revealed on 2/9/26 light bulbs were ordered and a delivery date of 2/10/26 was noted.a. Resident #78 was admitted to the facility on [DATE] with diagnoses that included inflammatory and immune myopathies (a group of rare, chronic diseases where the body's immune system mistakenly attacks its own healthy muscle fibers), generalized weakness, and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #78 was cognitively intact. Resident #78 required substantial/maximal assistance for oral hygiene, upper body dressing, personal hygiene, rolling left and right, and wheeling 150 feet. She was dependent on others for toileting hygiene, shower/bathing herself, lower body dressing, putting on/taking off footwear, sitting to lying, lying to sitting on side of bed, sitting to standing, and chair/bed to chair transfers.A grievance for Resident #78 dated 2/24/26 indicated her call light was not working. The resolution included that maintenance looked at the call light and deemed it to be in working order at that time; the grievance was signed by the Administrator. An interview was conducted with Resident #78 on 3/24/26 at 11:35 AM. Resident #78 stated her call light had not lit up on the outside of her door for approximately one month. She explained that when she thought her call light was not working she asked a staff member (unsure name and date) to check the light above her door. She stated she informed her nurse aide and her nurse that the call light was not working. She indicated she was unsure of names of the staff or the exact date she informed them. Resident #78 stated a maintenance staff member (unsure of name and date) came and informed her a part had to be ordered; however, no one came back to fix it. She stated she was given a handheld bell to ring by the Activities Director. An observation of Resident #78's call light was conducted on 3/24/26 at 11:36 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.An interview was conducted with the Activities Director on 3/25/2026 at 12:08 PM. She stated she found out about Resident #78's call light not working during a Resident Council meeting in February 2026. The Activities Director stated she went to Resident #78's room to check her call light and it wasn't working. She stated she told maintenance about it verbally and gave Resident #78 a handheld bell to use until her call light was fixed.b. Resident #4 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), generalized weakness, neuromuscular dysfunction of the bladder (a condition where nerve damage disrupts the communication between the brain, spinal cord, and bladder muscles), and abnormalities of gait and mobility. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #4 was severely cognitively impaired. Resident #4 required substantial/maximal assistance for personal hygiene, rolling left and right, sitting to lying, and lying to sitting on side of bed. She was dependent on others for toileting hygiene, shower/bathing herself, upper and lower body dressing, putting on/taking off footwear, sitting to standing, chair/bed to chair transfers, and tub/shower transfer.Resident #4 was not interviewable. An observation of Resident #4's call light was conducted on 3/24/26 at 11:38 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.c. Resident #94 was admitted to the facility on [DATE] with diagnoses that included intervertebral disc degeneration: lumbar region (a common condition where the soft, rubbery cushions {discs} between the bones {vertebrae} in your lower back wear down), kyphosis (an abnormal, excessive outward curve of the spine that causes a rounded, hunched-over posture), and generalized weakness. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #94 was moderately cognitively impaired.<br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #94 required substantial/maximal assistance for toileting hygiene, shower/bathing herself, upper and lower body dressing, personal hygiene, rolling left and right, lying to sitting on side of bed, sitting to standing, and chair/bed to chair transfers. She was dependent on others for putting on/taking off footwear, toilet transfer, and tub/shower transfer.An observation of Resident #94's call light was conducted on 3/24/26 at 11:38 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.An interview was conducted with Resident #94 on 3/24/26 at 12:31 PM. She stated her call light hadn't worked properly for a few weeks; she was unsure of the exact date it stopped working. Resident #94 stated she informed her nurse aide about her call light not working (unsure of name and exact date) and the nurse aide gave her a handheld bell. She further stated a maintenance staff member (unsure of name) looked at her call light and told her, He would get it later. Work orders dated January 2026 through March 2026 were reviewed. There were no work orders for Resident #78, Resident #4, and Resident #94 related to call lights in need of repair.During an interview on 3/24/26 at 11:54 AM with Nurse Aide #1 who was assigned to Resident #4 and Resident #94, she stated she was not aware their call lights were not working. She stated if she found a call light was not working, she would report it to maintenance verbally. During an interview on 3/24/2026 at 3:23 PM with Nurse Aide #2 who was assigned to Resident #78, she stated she did not know Resident #78's call light was not working. She further stated if she found something that was not working, she would report it to maintenance verbally. An interview was conducted on 3/24/26 at 11:44 AM with Nurse #1 who was assigned to Resident #78, Resident #4, and Resident #94. Nurse #1 stated she was not aware these residents' call lights were not working. She stated if she found something that needed repair, she would notify maintenance verbally and write it in the maintenance communication book which was kept at the nurse's station. Nurse #1 further stated she would inform the nurse aides that a resident's call light was not working properly so the nurse aides could check on the residents more frequently until the call light was fixed.An interview was conducted on 3/24/26 at 12:01 PM with Unit Manager #1. She stated she was not aware that Resident #78's, Resident #4's, and Resident #94's call bells were not working. Unit Manager #1 stated if something needed repaired, she expected staff to put the maintenance request into the web-based building management system utilized by the facility (a web-based system specifically designed for senior living and healthcare facilities to help operators manage maintenance, regulatory compliance, and vendor services through a central, mobile platform); a resident should also be given a handheld bell until their call light was fixed. An interview was conducted on 3/24/26 at 3:24 PM with the Maintenance Director. He stated he was notified of the call lights not working for Resident #78, Resident #4, and Resident #94 (unsure of date and how he was notified). He stated he fixed the call lights twice, but they kept blowing out. The Maintenance Director stated he realized it was a problem with the inside panels. He stated he switched out the panel but had to order more bulbs because they kept burning out. The Maintenance Director stated he did not have documentation of the dates and times he worked on (fixed) the call lights and stated he should have kept a record. A follow-up interview was conducted on 3/25/26 at 10:54 AM with the Maintenance Director for clarification of the light bulb invoice. He stated the invoice was created on 2/9/26. The delivery date on the invoice of 2/10/26 was not the actual delivery date. The Maintenance Director stated the shipment was delayed and was delivered on 3/18/26.During an interview with the Director of Nursing (DON) on 03/25/26 at 12:33 PM she stated she was unaware of Resident #78's, Resident #4's, and Resident #94's call lights not working. The DON stated her expectation was that if staff discovered a call light was not working properly, they notified maintenance verbally, entered it into the web-based building management system, and gave a resident a handheld bell to use until the call light was fixed.In an interview with the Administrator on 3/25/26 at 1:08 PM, the Administrator stated he expected repairs to be done timely. The Administrator did not explain what specific period of time equated to a timely manner. |

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|---|---|
| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets were complete and accurate for 36 of 53 days reviewed for 12/1/25 through 3/22/26 (12/12/25, 12/17/25, 2/2/26, 2/4/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 2/28/26, 3/3/26, 3/4/26, 3/5/26, 3/7/26, 3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/21/26, 3/22/26). The findings included:Review of the facility's daily nurse staffing sheets for 12/12/25, 12/17/25, 12/28/25, 1/24/26, 2/2/26, 2/4/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 2/28/26, 3/3/26, 3/4/26, 3/5/26, 3/7/26, 3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/21/26, 3/22/26 revealed the following:On 12/12/25 the total number for each staff discipline (Registered Nurse (RN), Licensed Practical Nurse (LPN), Nursing Assistant (NAs) and total hours worked for each staff discipline for the evening (3:00 pm - 11:00 pm) and night shift (11:00 pm - 7:00 am) were blank. On 12/12/25 the census was blank. On 12/17/25 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 12/17/25 the census was blank. On 2/2/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/4/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/5/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/6/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/6/26 the census was blank. On 2/9/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/10/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/11/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/13/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/15/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/16/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/17/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/18/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/19/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/19/26 the census was blank. On 2/21/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/24/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/25/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/26/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/27/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 2/28/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/3/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/4/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/5/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345377 | A. Building<br>B. Wing | 03/25/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| East Carolina Health and Rehabilitation Center | 2575 W 5th Street<br>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.

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|---|---|
| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | blank. On 3/7/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/7/26 the census was blank. On 3/9/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/10/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/11/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/12/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/13/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/14/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/14/26 the census was blank. On 3/15/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/15/26 the census was blank. On 3/17/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/18/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/21/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. On 3/22/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank. In an interview with the Scheduler on 3/25/26 at 10:10 am, she stated she used the schedule to complete the daily nurse staffing sheets. The Scheduler explained she would have to start and stop working on the daily nurse staffing sheets to find staff coverage for staff call outs. She explained she forgot to go back and complete the daily nurse staffing sheets for the dates in question. The Scheduler further stated she was unaware there could be no blank spaces on the daily nurse staffing sheets. An interview with the Director of Nursing (DON) on 3/25/26 at 10:30 am, revealed the Scheduler was responsible for completing the daily nurse staffing sheets. The DON revealed she was unaware the daily nurse staffing sheets were not completely filled out. The DON indicated the daily nurse staffing sheets should be completed with the total number of staff for each discipline for each shift and the total hours worked for each discipline for each shift, and the census. An interview was conducted with the Administrator on 3/25/26 at 12:02 pm. He stated the daily nursing staffing sheets were supposed to be completed by the Scheduler. The Administrator stated his expectations were that the daily nursing staffing sheets were completed correctly. |