STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted on 8/01/23. Event ID# N7JE11. The following intakes were investigated NC00205136, NC00204972 and NC00202690. 2 of the 6 complaint allegations resulted in deficiency.	F 000		
F 580 SS=B	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any,	F 580		8/25/23

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

Electronically Signed | 08/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Responsible Party (RP) interviews, the facility failed to notify the RP of pressure ulcer changes and newly identified pressure ulcers for 2 of 2 residents reviewed for notification of change (Resident #2 and Resident #3). The findings included: 1. Record review of the hospital wound documentation dated 6/15/23 revealed Resident #2 had a right foot deep tissue pressure injury (DTI) which included the heel, plantar (arch), and ankle that was purple in color, a left ankle DTI that was maroon in color, and a left buttock abrasion upon discharge from the hospital on 6/15/23.	F 580	1. A. The facility's wound nurse will contact resident #2's RP regarding wound treatment and wound changes if resident returns to the facility. At the time of the survey resident #2 was not in the facility, she was at the hospital and as of this time resident #2 remains out of the facility. B. The facility's wound nurse will contact resident #3's RP regarding current wound status and any changes to wounds. The nurse will contact the RP by Friday 8-18-23 with updates to wound status. 2. The facility will do an initial audit to determine which residents have wounds	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 Resident #2 was admitted to the facility on 6/15/23 with diagnoses which included kidney stone with stent placement and kidney failure. The Admission Skin Assessment completed by the Wound Treatment Nurse dated 6/15/23 revealed Resident #2 had a right heel deep tissue injury (DTI), a left heel DTI, and an unstageable (unable to visualize the wound bed) pressure ulcer injury to her sacrum. The Minimum Data Set (MDS) admission assessment dated 6/22/23 revealed Resident #2 had unhealed pressure ulcers upon admission to the facility which included 1 stage 2 pressure ulcer and 2 unstageable DTI pressure ulcers. A nursing progress note dated 7/10/23 by Nurse #2 revealed Resident #2's right heel DTI was black and dry. An attempt to interview Nurse #2 on 8/01/23 at 12:30 pm was unsuccessful. The Skin/Wound Note dated 7/17/23 by the Wound Treatment Nurse revealed Resident #2's sacral pressure ulcer was observed to be necrotic with undermining. Review of Resident #2's progress notes revealed there was no documentation that her RP was notified of the changes to her right heel DTI and her sacral pressure ulcer. During an interview on 8/01/23 at 1: 24 pm with the Wound Treatment Nurse she revealed she did not notify Resident #2's RP of the decline of her pressure ulcers. She stated she expected	F 580	and to determine if those resident's RP had been contacted regarding wound status and any updates to the wounds. Those residents who are identified as having a wound will have their RP's called to give them an update on the wound status. This audit will be completed by the Director of Nursing or designee. The audit will be completed by Friday August 18, 2023. 3. The facility's wound care nurse was inservice on 8-15-2023. This inservice let the wound nurse know that they are to contact a resident's RP on a weekly basis for those resident who have a current wound. This call should discuss the wound and any changes to the wound. This inservice was conducted by the Administrator. 4. An audit will be performed to ensure that the resident's RP was contacted on a weekly basis with a wound update for those resident's in the facility that have a wound. This audit will be completed by the Director of Nursing or their designee. The audit will take place weekly x 4 weekly and then monthly x 3 months. The results of this audit will be taken to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the resident's RP is contacted with a wound update on a weekly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3	F 580		

the cart nurse to notify the family, but she did not follow-up with the cart nurse.

A telephone interview was conducted on 8/01/23 at 4:00 pm with Resident #2's RP who revealed he did not receive notification from the facility regarding Resident #2's pressure ulcers.

An interview on 8/01/23 at 4:25 pm with the Assistant Director of Nursing/Staff Development Coordinator revealed Resident #2 had right and left heel DTIs that were purple in color upon admission. She was unable to state when the right heel DTI and the sacrum pressure ulcer became necrotic (dead tissue black in color), but she stated she was aware of the change in Resident #2's DTI and sacral pressure ulcer because they were discussed in the clinical meeting. She stated the Wound Treatment Nurse was responsible to notify the RP of changes and she stated she assumed Resident #2's RP was notified of the changes to the pressure ulcers.

An interview was conducted on 8/01/23 at 4:53 pm with the Director of Nursing (DON) who revealed the Wound Treatment Nurse was responsible to notify the RP of the changes to Resident # 2's pressure ulcers.

During an interview on 8/01/23 at 5:00 pm with the Assistant Administrator she revealed the Wound Treatment Nurse was responsible to notify Resident #2's RP of the change in pressure ulcers.

2. Resident #3 was admitted to the facility on 4/21/23 with diagnoses which included diabetes, anemia, chronic venous insufficiency of lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4	F 580		

extremities, and congestive heart failure.

Record review of the hospital wound documentation dated 4/20/23 revealed Resident #3 had a left heel deep tissue pressure injury that was purple in color and a medial (center of sacral region) sacral abrasion which was pink in color.

The Skin/Wound Note dated 4/26/23 by the Wound Treatment Nurse revealed Resident #3's left heel was unstageable, and the sacral area was unmeasurable. There were no descriptions of the pressure ulcers in the documentation.

The Minimum Data Set (MDS) admission assessment dated 4/27/23 revealed Resident #3 had moderate cognitive impairment and required extensive assistance for turning and repositioning. Resident #3 was coded for 1 stage 2 pressure ulcer and 1 deep tissue injury upon admission to the facility.

The Skin/Wound Note dated 5/10/23 by the Wound Treatment Nurse revealed Resident #3's sacral pressure ulcer resolved.

The Skin/Wound Note dated 5/17/23 by the Wound Treatment Nurse revealed Resident #3's left heel wound was necrotic.

The Skin/Wound Note dated 5/18/23 by the Wound Treatment Nurse revealed an open area to Resident #3's sacrum was identified.

The Skin/Wound Note dated 6/16/23 by the Wound Treatment Nurse revealed Resident #3 had a newly identified wound to the right heel with eschar (black, dry necrotic tissue).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	C 08/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

Review of Resident #3's progress notes revealed there was no documentation that her Responsible Party (RP) was notified of the changes to her left heel deep tissue injury, the reopening of the sacral pressure ulcer, or the newly identified right heel DTI.

A telephone interview was conducted on 8/01/23 at 10:00 am with Resident #3's RP who revealed he was the only RP listed for Resident #3 and he stated the facility had not notified him about the pressure ulcer decline or the new pressure ulcer to her right foot.

During an interview on 8/01/23 at 1: 24 pm with the Wound Treatment Nurse she revealed she did not notify Resident #3's RP of the decline of her pressure ulcers. She stated she expected the cart nurse to notify the family, but she did not follow-up with the cart nurse.

An interview was conducted on 8/01/23 at 4:53 pm with the Director of Nursing (DON) who revealed the Wound Treatment Nurse was responsible to notify the RP of the changes to Resident # 3's pressure ulcers.

During an interview on 8/01/23 at 5:00 pm with the Assistant Administrator she revealed the Wound Treatment Nurse was responsible to notify Resident #3's RP when changes occurred to her skin.