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 12/19/2024

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/16/24 through 12/19/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5BPZ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/16/24 through 12/19/24. Event ID# 5BPZ11. The following intakes were investigated NC00223411. Three of the three complaint allegations did not result in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 553		1/16/25

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

Electronically Signed | 01/13/2025

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.

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F 553	Continued From page 1 §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: 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). The findings included: Resident #271 was admitted to the facility on 11/21/24, and his diagnosis included non-traumatic brain dysfunction, renal insufficiency, diabetes, and hypertension. 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. Review of the admission Minimum Data Set (MDS) dated 11/25/24 revealed resident #271 was cognitively intact. 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	F 553	1. A care plan meeting for resident #271 is scheduled to be held on January 14, 2025 and both the resident and responsible party have been invited to attend. 2. An initial audit will be conducted to determine if the resident/responsible party have been invited to attend a care plan meeting within the last quarter. If any resident/responsible party have not had an invitation to attend a care plan meeting then a meeting will be set up. This audit will be completed by the Administrator or their designee. This audit will be completed by January 16, 2025. 3. The Care Plan team will be inserviced on the importance of inviting the resident/responsible party to attend scheduled care plan meetings and to document the invitation in the resident□s electronic medical record. This inservice will be conducted by the Administrator or their designee. This inservice will be completed by January 16, 2025.	

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F 553	Continued From page 2 development of his plan of care. An interview with Resident #271's Resident Rrepresentative 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. The Social Worker was interviewed on 12/17/14 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. 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.	F 553	4. A weekly audit will be conducted to ensure that those residents who are on the schedule for a care plan meeting have received an invitation to attend and that their responsible party has also received an invitation to attend and that the invitation has been documented in the electronic medical record. This audit will be completed by the Administrator or their designee. This audit will start the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the resident/responsible have received invitations to attend scheduled care plan meetings and that the invitation has been documented in the resident□s electronic medical record.	
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 638	1. Resident #48 had a quarterly	1/16/25

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F 638	Continued From page 3 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). Findings included: Resident #48 was admitted to the facility on 9/28/23. 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." 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. 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.	F 638	assessment that was completed and transmitted on 12-17-2024. 2. An initial audit will be conducted to ensure that quarterly MDS assessments are completed within 14 days following the ARD for that assessment. This audit will be completed by the Administrator or their designee. This audit will be completed by January 16, 2025. 3. The Care Plan team will be inserviced on the importance of ensuring that resident quarterly MDS assessments are completed within 14 days following the ARD for that assessment. This inservice will be conducted by the Administrator or their designee. This inservice will be completed by January 16, 2025. 4. A weekly audit will be conducted to ensure that resident quarterly MDS assessments are being completed within 14 days following the ARD for that assessment. This audit will be completed by the Administrator or their designee. This audit will start the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that resident quarterly MDS assessments are being completed within 14 days following the ARD for that assessment.	

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F 641	Continued From page 4	F 641		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: 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). Findings included: 1. Resident #50 was admitted to the facility on 8/31/22. Review of Resident #50's Minimum Data Set (MDS) assessment dated 11/12/24 revealed Resident #50 was assessed to have received an antipsychotic medication during the 7-day look back period. Review of Resident #50's Medication Administration Record (MAR) for November 2024 revealed Resident #50 did not receive an antipsychotic medication in November 2024. 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	F 641	1. A. The MDS assessment for Resident #50 dated for 11-12-2024 was corrected to show that resident did not receive any antipsychotic medication in November of 2024. This correction was made on 12-18-2024. This correction was made by the MDS Coordinator. B. The MDS assessment for Resident #173 dated for 12-2-2024 was corrected to show that resident is receiving hospice services. This correction was made on 1-8-25. This correction was made by the MDS Coordinator. C. The MDS assessment for Resident #58 dated for 10-25-2024 was corrected to show that resident does not have a pressure area. This correction was made on 1-2-25. This correction was made by the MDS Coordinator. 2. An initial audit will be completed to ensure that the following information is coded correctly on MDS assessments completed between 10-1-2024 and 1-10-2024: (1) that antipsychotic medications are correctly coded on the MDS assessment, (2) that hospice services are correctly coded on the MDS assessment, and (3) that pressure areas are correctly	1/16/25

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F 641	Continued From page 5 the 11/12/24 MDS assessment. During an interview on 12/18/24 at 8:23 AM the Administrator stated MDS assessments should be accurate to the resident's status. 2. Resident #173 was admitted to the facility on 11/26/24 with diagnoses that included congestive heart failure. The hospice admission paperwork revealed she was admitted to hospice on 11/26/24. Resident #173's payor source on her face sheet in the record was hospice Medicaid dated 11/26/24. The admission Minimum Data Set (MDS) dated 12/2/24 indicated Resident #173 was severely cognitively impaired and was not coded for hospice services. 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. 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. 3. Resident #58 was admitted to the facility on 10/21/24 with diagnoses that included cutaneous abscess of left lower limb. A review of the hospital discharge summary dated	F 641	coded on the MDS assessment. This audit will be completed by the Administrator or their designee. This initial audit will be completed by January 16, 2024. 3. The Care Plan team will be inserviced on the importance of accurately coding MDS assessments. This inservice will cover coding of: (1) Antipsychotic medication usage, (2) Hospice services, and (3) Pressure areas. This inservice will be conducted by the Administrator or their designee. This inservice will be completed by January 16, 2025. 4. A weekly audit will be conducted on the MDS assessment completed the previous week to ensure that the following are coded correctly: (1) Antipsychotic medication usage, (2) Hospice services and (3) Pressure areas. This audit will be completed by the Administrator or their designee. This audit will start the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the following areas are coded correctly on the MDS assessments: (1) Antipsychotic medication usage, (2) Hospice services and (3) Pressure areas.	

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F 641	Continued From page 6 10/21/24 revealed he was discharged with a wound from surgical abscess removal. No other wounds were noted. 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. The quarterly Minimum Data Set (MDS) dated 10/25/24 revealed that Resident #58 was moderately cognitively impaired and had a stage III pressure ulcer. 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. 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. 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.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the	F 656		1/16/25

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F 656	Continued From page 7	F 656		

resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive

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F 656	Continued From page 8 care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: 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). The findings included: 1. Resident #55 was admitted to the facility on 7/3/23 with diagnosis that included cerebral infarction, encephalopathy, and cognitive communication deficit. 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. A review of Resident #55's Minimum Data Set (MDS) dated 10/23/24 revealed he was mildly cognitively impaired and did exhibit verbal behavioral symptoms directed toward others. 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	F 656	1. A. The care plan for Resident #55 was updated to include a care plan addressing his behaviors. This care plan will be updated by 1-15-2025. This correction was made by the Social Worker. B. The care plan for Resident #62 was updated to include a care plan addressing the use of antipsychotic medication. This care plan will be updated by 1-15-2025. This correction was made by the MDS Coordinator. C. The care plan for Resident #58 was updated to include a care plan addressing wounds. This care plan will be updated by 1-15-2025. This correction was made by the MDS Coordinator. 2. An initial audit will be completed to ensure that comprehensive care plans include a care plan for the following areas for those residents in which it is needed: (1) Behaviors, (2) Antipsychotic medication usage, and (3) Wounds. This initial audit will be completed by the Administrator or their designee. This initial audit will be completed by January 16, 2024. 3. The Care Plan team will be inserviced on ensuring that resident comprehensive care plan have the appropriate care plans to address the following: (1) Behaviors,	

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F 656	Continued From page 9 included in Resident #55's care plan. 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. 2. Resident #62 was admitted to the facility on 8/29/24 with diagnosis that included hypertension, cystitis, dementia, psychotic disturbance and mood disturbance. A review of Resident #62's quarterly Minimum Data Set (MDS) assessment dated 11/18/24 revealed he was cognitively intact. The assessment also revealed Resident #62 received an antipsychotic medication. 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. 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. 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.	F 656	(2) Antipsychotic medication usage, and (3) Wounds. This inservice will be conducted by the Administrator or their designee. This inservice will be completed by January 16, 2024. 4. A weekly audit will be conducted to ensure that the resident comprehensive care plans have the appropriate care plans for the following: (1) Behaviors, (2) Antipsychotic medication usage, and (3) Wounds. This audit will be completed by the Administrator or their designee. This audit will start the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the resident comprehensive care plans have the appropriate care plans for the following: (1) Behaviors, (2) Antipsychotic medication usage, and (3) Wounds.	

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F 656	Continued From page 10	F 656		

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.

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.

3. Resident #58 was admitted to the facility on 10/21/24 with diagnoses that included cutaneous abscess (pocket of infection under the skin) of the left leg.

The quarterly Minimum Data Set (MDS) dated 10/25/24 revealed that Resident #58 was moderately cognitively impaired, and the assessment did not indicate the resident had a surgical wound.

A review of Resident #58's record revealed there was not a care plan for wounds.

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.

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.

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F 656	Continued From page 11 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. 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.	F 656		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		1/16/25

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F 693	Continued From page 12 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. Findings included: 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. 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. 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	F 693	1. The tube feeding syringe piston and barrel for Resident #21 was separated to allow them to dry and to help prevent the growth of bacteria in the syringe during storage. The syringe was separated by the Director of Nursing. 2. An initial audit will be conducted to ensure that tube feeding syringe pistons and barrels are kept separated to prevent the growth of bacteria in the syringe during storage. This initial audit will be completed by the Director of Nursing or their designee. This initial audit will be by January 16, 2024. 3. The facility nurses will be inserviced on the importance of ensuring that the tube feeding pistons and barrel are stored separately in the bags to allow them the properly dry and to help prevent the growth of bacteria in the syringe during storage. This inservice will be conducted by the Director of Nursing or their designee. This inservice will be completed by January 16, 2024. 4. A weekly audit will be conducted to ensure that tube feeding syringe pistons and barrels are kept separate during storage to help prevent the growth of bacteria in the syringe during storage. This audit will be completed by the Director of Nursing or their designee. This audit will start the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months.	

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F 693	Continued From page 13 that was used to administer medication to Resident #21 to prevent the growth of bacteria in the syringe during storage.	F 693	5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that the tube feeding syringe pistons and barrels are kept separate during storage to help prevent the growth of bacteria in the syringe during storage.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		1/16/25

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F 880	Continued From page 14 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff	F 880	1. A. The facility wound nurse and the	

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F 880	Continued From page 15 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. Findings included: 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. 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). Review of the careplan for Resident #21 dated	F 880	wound physician will be inserviced on the Enhanced Barrier Precautions and the importance of ensuring these precautions are following when providing treatments to the residents under the enhanced barrier precautions. This inservice will be conducted by the Director of Nursing or their designee. This inservice will take place by 1-16-2025. B. The facility wound nurse and wound physician will be inserviced on the Enhanced Barrier Precautions and the importance of ensuring these precautions are following when providing treatments to the residents under the enhanced barrier precautions. This inservice will be conducted by the Director of Nursing or their designee. This inservice will take place by 1-16-2025. 2. A. The facility wound nurse and wound physician will be provided with a list on a weekly basis that shows all of the residents who are under the enhanced barrier precautions so that she is aware of which residents they have to use the precautions on when providing any treatments. B. The facility wound nurse and wound physician will be provided with a list on a weekly basis that shows all of the residents who are under the enhanced barrier precautions so that she is aware of which residents they have to use the precautions on when providing any treatments.	

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F 880	Continued From page 16 7/17/24 revealed she was care planned for EBP related to a feeding tube. 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. 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. 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. In an interview with the Administrator on 12/19/24	F 880	3. All facility nursing staff will be inserviced on Enhanced Barrier Precautions. This inservice will review what Enhanced Barrier Precautions are, what they are used for, when they are to be used and how to identify those residents who are under enhanced barrier precautions. This inservice will be conducted by the Director of Nursing or their designee. This inservice will be completed by January 16, 2024. 4. A weekly audit will be conducted to ensure that enhanced barrier precautions are being used properly on those residents under the precautions. This audit will be completed on a minimum of 5 residents who are under the enhanced barrier precautions. This audit will be completed by the Director of Nursing or their designee. This audit will begin during the week of January 20-24, 2025. This audit will be conducted weekly x 4 weeks and then monthly x 3 months. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that enhanced barrier precautions are being used properly while working with those residents under these precautions.	

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F 880	Continued From page 17	F 880		

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.

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.

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.

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.

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F 880	Continued From page 18 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. 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. 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.	F 880		
F 945 SS=D	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2).	F 945		1/16/25

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F 945	Continued From page 19 This REQUIREMENT is not met as evidenced by: 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). The findings included: The facility Enhanced Barrier Precautions Policy stated in part: East Carolina Rehab and Wellness will educate all employees on the reason for EBP. 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. 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. 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.	F 945	1. The wound care nurse was inserviced on enhanced barrier precautions on 1-10-2025. The Director of Nursing provided the inservice to the wound care nurse. 2. All facility nursing staff will be inserviced on Enhanced Barrier Precautions. This inservice will review what Enhanced Barrier Precautions are, what they are used for, when they are to be used and how to identify those residents who are under enhanced barrier precautions. This inservice will be conducted by the Director of Nursing or their designee. This inservice will be completed by January 16, 2024. 3. An enhanced barrier precautions inservice will take place yearly for all facility nursing staff. All new employees in the nursing department will receive the enhanced barrier precautions inservice during their new employee orientation to the facility. 4. An audit will be conducted to ensure that all facility staff are inserviced on enhanced barrier precautions yearly and that new employees receive the enhanced barrier precautions inservice during orientation. The audit will be conducted by the Administrator. The audit for all facility staff will take place 1x/year. The audit for new employees will be conducted 1x/month. This audit will start during the week of January 20-24, 2025.	

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F 945	Continued From page 20	F 945	5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that staff have received training on enhanced barrier precautions annually and during new employee orientation.	