PRINTED: 04/11/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345377	B. WING				R-C
	ROVIDER OR SUPPLIER		B. WINO	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 W 5TH STREET GREENVILLE, NC 27834	<u> 04/</u>	(05/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 000}		sted onsite from 3/27/2024 to	{F ()00}			
{F 755} SS=E	remotely through 4/5 date was 4/5/2024. TF759, and F880 were Repeat tags were citresult of the complair was conducted at the The facility is still out U6G612. Pharmacy Srvcs/ProcCFR(s): 483.45(a)(b) §483.45 Pharmacy SThe facility must provdrugs and biologicals them under an agree §483.70(g). The facility personnel to administ permits, but only unda licensed nurse.	Services vide routine and emergency s to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law ler the general supervision of	{F 7	755}			
	pharmaceutical servi that assure the accur dispensing, and adm biologicals) to meet t	es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident.					
		Consultation. The facility in the services of a licensed					
		es consultation on all ion of pharmacy services in					
	. , , , ,	ishes a system of records of		_			
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345377	B. WING		R-C 04/05/2024	
	ROVIDER OR SUPPLIER	VELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	1 04/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
{F 755}	sufficient detail to en reconciliation; and §483.45(b)(3) Deter order and that an act is maintained and p This REQUIREMEN by: Based on record re Director/Physician in interview the facility medications from the parameters set by the narcotic medications for disposal of waste failed obtain an order prior to removing nathe medication cart. to have effective safe place to controlled residents right to be diversion. This was #6, Resident #7, Rereviewed for pharma medication. Finding 1. Resident #6 was 9/13/2023 with multincluded benign necessions.	mines that drug records are in account of all controlled drugs eriodically reconciled. IT is not met as evidenced view, staff interview, Medical enterview, and Pharmacist failed to remove narcotic pain e medication cart within the ene physician's orders for failed to follow procedures ed narcotic medication; and er for narcotic pain medication from additionally, the facility failed feguards and systems in account for, and periodically medications to protect the free from potential drug for three residents, (Resident #8) of three residents accy services for narcotic	{F 75!	,		
	revealed Resident # initiated on 10/27/20 Acetaminophen 5-3 be administered as	the current March 2024 orders f6 had a physician's order f023 for Oxycodone with f025 milligrams (mg) tablets to f1 tablet by mouth every 4 f1 severe pain at the 8 to 10				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WING				-C 05/2024
	ROVIDER OR SUPPLIER ROLINA REHAB AND WI	ELLNESS	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 W 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	Additional documenta 2024 orders revealed physician's order initiobservation of signs documented using characteristic physician's order initiobservation of signs documented using characteristic physician and commentation of the Medication Adrevealed a level of 0 10:57 PM by Nurse # Documentation on the Receipt/Record/Disphad the following information on the Coxycodone with Acet removed for Residen PM by Nurse #5. Two Oxycodone with Acet removed for Residen PM by Nurse #5. Two Oxycodone with Acet removed for Residen PM by Nurse #5. There was no docum 3/21/2024 for the adressity with Acetaminophen PM to 11:00 PM shifts. Documentation of the the MAR revealed a 16:54 PM written by N Documentation on the Receipt/Record/Disphad the following information on the Receipt/Record/Disphad the following information with Acetaminophen PM to 11:00 PM shifts.	ation on the current March at Resident # 6 had a ated on 9/13/2023 for and symptoms of pain to be hart codes. The pain level of Resident #6 aministration Record (MAR) on 3/21/2024 written at 15. The Controlled Drug cosition Form for Resident #6 aminophen 5-325 mg was at #6 on 3/21/2024 at 4:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 6:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 6:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/2024 at 8:00 to hours later, one tablet of aminophen 5-325 mg was at #6 on 3/21/20	{F 7	755}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345377	B. WING		R-C 04/05/2024	
	ROVIDER OR SUPPLIER	VELLNESS	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	1 0400,2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
{F 755}	one tablet of Oxyco- 5-325 mg was remo- 3/26/2024 at 5:20 P fifty minutes later, or Acetaminophen 5-3 Resident #6 on 3/26 #5. Fifty minutes late with Acetaminopher Resident #6 on 3/26 #5. One hour and to Oxycodone with Acetaminopher Resident #6 on 3/26 #5. One hour and to Oxycodone with Acetaminopher Resider PM by Nurse #5. Fifty Oxycodone with Acetaminopher Resider PM by Nurse #5. Or Oxycodone with Acetaministration of Oxycodone with Acetaministration of Oxycodone with Acetaministration of Oxycodone with Acetaministration of the MAR revealed at 6:54 PM written by 10 Documentation on the Receipt/Record/Dishad the following information on the Receipt/Record/Dishad	he hour and fifty minutes later, done with Acetaminophen oved for Resident #6 on M by Nurse #5. One hour and ne tablet of Oxycodone with 25 mg was removed for 6/2024 at 7:10 PM by Nurse er, one tablet of Oxycodone in 5-325 mg was removed for 6/2024 at 8:00 PM by Nurse en minutes later, one tablet of etaminophen 5-325 mg was nt #6 on 3/26/2024 at 9:10 fty minutes later, one tablet of etaminophen 5-325 mg was nt #6 on 3/26/2024 at 10:00 ne hour later, one tablet of etaminophen 5-325 mg was nt #6 on 3/26/2024 at 11:00 me hour later, one tablet of etaminophen 5-325 mg was nt #6 on 3/26/2024 at 11:00 mentation on the MAR for the exycodone with Acetaminophen 024 from 3:00 PM to 11:00 me pain level of Resident #6 in a level of 6 on 3/27/2024 at Nurse #5 for the evening shift.	{F 755}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R.	-C
		345377	B. WING			04/	05/2024
	ROVIDER OR SUPPLIER ROLINA REHAB AND WE	ELLNESS		25	REET ADDRESS, CITY, STATE, ZIP CODE 575 W 5TH STREET REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	Acetaminophen 5-32 Resident #6 on 3/27/ #5. Two hours later, of Acetaminophen 5-32 Resident #6 on 3/27/ #5. Two hours and te Oxycodone with Acet removed for Residen PM by Nurse #5. There was no docum administration of Oxy 5-325 mg on 3/27/20 PM. The Director of Nursing (#3/28/2024 at 1:50 PM #5 had been working The DON stated that cognitively impaired, capable and knowled medication had been stated Resident #6 had doses of Oxycodone medication cart by Nr 3/26/2024 and 3/27/2 Resident #6 would sureceiving Oxycodone the parameters stipul DON confirmed the CReceipt/Record/Disport the Medication Admir resident and the nursiphysician orders and within the parameters DON indicated the nursipon indicated the	e tablet of Oxycodone with 5 mg was removed for 2024 at 6:20 PM by Nurse one tablet of Oxycodone with 5 mg was removed for 2024 at 8:20 PM by Nurse on minutes later, one tablet of aminophen 5-325 mg was at #6 on 3/27/2024 at 10:30 entation on the MAR for the recodone with Acetaminophen 24 from 3:00 PM to 11:00 entation on the MAR for the recodone with Acetaminophen 24 from 3:00 PM to 11:00 entation on the facility for 2 years. It despite being severely Resident #6 was very geable of when his pain given to him. The DON ad been administered all the removed from the curse #5 on 3/21/2024, 2024. The DON did not think affer any ill effects of with Acetaminophen outside ated by the physician. The controlled Drug osition form should match histration record for each	{F 7	55}			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		LETED
		345377	B. WING _			-C 05/2024
	ROVIDER OR SUPPLIER ROLINA REHAB AND WE	ELLNESS		STREET ADDRESS, CITY, STATE, ZIP C 2575 W 5TH STREET GREENVILLE, NC 27834	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIA	(X5) COMPLETION DATE
{F 755}	resident matched the medications signed or Receipt/Record/Disport further explained that of narcotic medication assuring the count markeceipt/Record/Disportesident at the end of of a medication error. Nurse #5 was intervied AM. Nurse #5 stated documentation but, if the medication cart the Resident #6. Nurse #5 complaining on the 3sterrible neck pain on on 3/27/2024 so Nurse When questioned if he request permission for the parameters of the Resident #6, Nurse #5 stated that if resident #6 hurse #5 stated that if resident #6 hurse #5 stated that if resident #6 hurse #6 hurse #5 stated that if resident #6 hurse #6 hurs	number of narcotic ut on the Controlled Drug position form. The DON if after counting the number as for each resident and atches the Controlled Drug position form for each reach shift then, speculation for diversion was not made. Wewed on 4/1/2024 at 9:16 the was very bad at the removed narcotics from the he administered them to 5 revealed Resident #6 was 00 PM to 11:00 PM shift of 3/21/2024, 3/26/2024, and the #5 gave him Oxycodone. The each of the order for Oxycodone for 5 stated he did not. Nurse the each was were in pain, he gave the facility needed to provide the physician to be a facility needed to provide the facility needed to provide the facility needed to be asked as, the pain medication to the graph the medication to the graph the medication to the graph the medication was set stated it had not been	{F 7	55}		

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	ROVIDER OR SUPPLIER	ELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	1 34/05/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
{F 755}	administered outside Pharmacist stated where the made sure the medications in the catter the number of medications in the catter number of medications in the catter number of medications are resident. The Pharmacompare the MAR to Drug Receipt/Record facility brought a constitution of the Medical Director for Resident #6, was 2:30 PM. The Medical Resident #6 was on Oxycodone and nursiparameters of the photoxycodone unless the otherwise. The Medication can residents. 2. Resident #7 was a 3/22/2024 with multipare included an ankle frame polyneuropathy, and Documentation on an revealed an order for 2 milligram (mg) table one tablet by mouth pain. Documentation on the Receipt/Record/Disphad the following infolydromorphone (Dilator).	cotic medications being of the orders. The nen she comes to the facility, umber of narcotic art for each resident matched ations on the Controlled I/Disposition forms for each acist stated she did not each residents Controlled I/Disposition form unless the cern to her attention. If who was also the physician interviewed on 4/4/2024 at all Director stated that a very high dose of es should be following the ysician's order for the here was authorization to do call Director stated narcotic not be arbitrarily given to the diagnoses some of which cture, osteoarthritis, fibromyalgia. If mission physician orders of the Hydromorphone (Dilaudid) ets to be administered as every 6 hours as needed for	{F 758			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345377	B. WING			R-C 04/05/2024	
	ROVIDER OR SUPPLIER		<u>. I</u>	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	1 04/	03/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	"lost on the floor" on a leaving 19 tablets rem that was "lost on the floor." One tablet of Did by Nurse #5 on 3/22/2 tablets remaining. Fo later, one tablet of Did by Nurse #5 on 3/22/2 tablets remaining. Two later, one tablet of Did by Nurse #5 on 3/22/2 tablets remaining. Two later, one tablet of Did by Nurse #5 on 3/22/2 tablets remaining. There was no docum. Administration Record the medication Dilaud. 3/22/2024. There was by Nurse #5 revealing. Resident #7 was or if from the three doses the medication cart of the medication cart of the medication cart t	signed out by Nurse #5 and 3/22/2024 at 3:30 PM naining. The Diludid tablet floor" did not have any g signature or initials from ning the pill was "lost on the bilaudid 2mg was signed out 2024 at 3:30 PM leaving 18 ur hours and thirty minutes audid 2 mg was signed out 2024 at 8:00 PM leaving 17 to hours and forty minutes audid 2 mg was signed out 2024 at 10:40 PM leaving 16 entation on the Medication of for the administration of did to Resident #7 on son documentation written g what the pain level of Resident #7 obtained relief of Dilaudid removed from an 3/22/2024. Sewed on 4/1/2024 at 9:16 he was very bad at he removed narcotics from the neadministered them to be premission for administration enters of the order for #7, Nurse #5 stated he did Basic Interview for Mental sement dated 3/25/2024	{F 7	755}			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345377	B. WING		R-C 04/05/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	04/05/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 755}	Continued From pa	ge 8	{F 75	5}	
	PM. Resident #7 sat #5. Resident #7 act be able to specifical she received medical Resident #7 stated at another facility stof 3 mg, and she wood stated she knew that take more than 2 m and she would not in such a short time. The Director of Nursing 3/28/2024 at 1:50 F Controlled Drug Reshould match the M record for each resifully the end of each shir of narcotic medication within the physician. The DON the end of each shir of narcotic medication Drug Receipt/Recofurther explained the of narcotic medication assuring the count Receipt/Record/Disresident at the end of a medication error and the state of the state of the same and the end of a medication error and the same and the end of a medication error and the same and the end of a medication error and the same and the same and the end of a medication error and the same and the end of a medication error and the same and the same and the end of a medication error and the same and the same and the end of a medication error and the same and th	terviewed on 4/1/2024 at 4:56 aid she did remember Nurse knowledged that she would not lly say on what date and time rations from Nurse #5. that on one previous occasion he was given a Dilaudid tablet has so sleepy her family was had not wake up. Resident #7 hat she was not supposed to had of Dilaudid every 6 hours, have taken that much Dilaudid have if it was offered to her. Sing (DON) and Assistant (ADON) were interviewed on had the nurses should have ceipt/Record/Disposition form hedication Administration had the nurses should have parameters set by the have parameters set by the have indicated the nursing staff at have sure that the number have signed out on the Controlled hard/Disposition form. The DON hat if after counting the number has signed out on the Controlled hard/Disposition form. The DON hat if after counting the number has some and provide the have parameters that the number has signed out on the Controlled hard/Disposition form. The DON hat if after counting the number has some and provide the have parameters that the number has signed out on the Controlled hard/Disposition form. The DON hat if after counting the number has some and provide the have parameters and have have have			
	pharmacist on 4/2/2	onducted with the facility 2024 at 9:13 AM. The he facility needed to provide			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345377	B. WING			R-C 4/05/2024
	ROVIDER OR SUPPLIER	ELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	<u> </u>	7/03/2027
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 755}	what his pain level we signed out on the Cornection Receipt/Record/Disp the pain level, admin resident, and then signadministration recording given. The Pharmacic controlled medication signature or initial was Controlled Drug Recording The Pharmacist state facility, she made su medications in the cast the number of medicic Drug Receipt/Recording Receip	#5. The Pharmacist ent #6 needs to be asked as, the pain medication ntrolled Drug osition form if appropriate for ister the medication to the gn the medication was st confirmed that when a n was wasted, another as needed by a nurse on the eipt/Record/Disposition form. End when she comes to the rethe number of narcotic art for each resident matched ations on the Controlled I/Disposition forms for each acist stated she did not each residents Controlled I/Disposition form unless the cern to her attention.	{F 75	5}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345377	B. WING				-C 05/2024
	ROVIDER OR SUPPLIER ROLINA REHAB AND WI	ELLNESS	•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	physician's orders re physician's order initi Oxycodone HCL (Hy (mg) to be administe one tablet every six h Documentation on a Receipt/Record/Disp tablets of Oxycodone received for the use of 11/10/2023. Resident #8 was disc of 11/13/2023 and was of 11/13/2023 and was of 11/17/2023. Documentation on phosic has been administered to be administered needed for pain for the 11/20/2023. There were no additional medication Hydrocodomg in the electronic of the wital signs portion revealed a pain level PM by Nurse #5. Documentation on the Receipt/Record/Disp revealed on 11/21/20	vealed Resident #8 had a ated on 4/5/2023 for drocholoride) 5 milligrams red by mouth in the form of nours for pain. Controlled Drug osition form revealed 60 e HCL 5 mg tablets were of Resident #8 on Charged to the hospital on readmitted to the facility on hysician orders for Resident revealed an order for ninophen oral tablets 5-325 ed by mouth every 6 hours as a bree days only until conal orders for narcotic pain done-Acetaminophen 5-325 medical record for Resident ovember 2023 or December e pain level of Resident #8 in a of the electronic record of 0 on 11/21/2023 at 6:00	{F 7	755}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		, ,	OMPLETED		
		345377	B. WING _			R-C 04/05/2024
	ROVIDER OR SUPPLIER	/ELLNESS		STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	'	J. 1.00.202
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 755}	Nurse #5 at 8:00 PN	ge 11 I without an order to do so. nentation on the MAR	{F 75	55}		
	administration of oxyon 11/21/2023.	stration Record) of the ycodone 5 mg to Resident #8				
the rev	the vital signs portio	ne pain level of Resident #8 in not the electronic record el of 0 on 11/22/2023 at 5:34				
	revealed on 11/22/2 5 mg was removed	ne Controlled Drug position form for Resident #8 023 one tablet of Oxycodone from the medication cart by M without an order to do so.				
		mentation on the MAR of the ycodone 5 mg to Resident #8				
	revealed on 11/23/2 5 mg was removed	ne Controlled Drug cosition form for Resident #8 023 one tablet of Oxycodone from the medication cart by If without an order to do so.				
		mentation on the MAR of the cycodone HCL 5 mg to 3/2023.				
	the vital signs portio	ne pain level of Resident #8 in n of the electronic record el of 4 on 11/23/2023 at 9:59				
		ne pain level of Resident #8 in nof the electronic record				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED		
		345377	B. WING			R-C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS				STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834		04/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 755}	PM. Documentation on t Receipt/Record/Disy revealed on 12/21/2 HCL 5 mg was remote by Nurse #5 at 7:50 There was no docurt administration of Ox Resident #8 on 12/2 Documentation on t Physician orders rev #8 dated as initiated HCL 5 mg tablets to tablet by mouth eve moderate to severe Documentation on t Receipt/Record/Disy revealed one dose of tablet was removed Nurse #5 on 3/22/20 Documentation of the vital signs portion revealed a pain leve PM by Nurse #5. Two hours and 30 m on the Controlled Disy Receipt/Record/Disy dose of Oxycodone removed from the m at 7:10 PM.	the Controlled Drug position form for Resident #8 2023 one tablet of Oxycodone oved from the medication cart PM with no order to do so. mentation on the MAR of the exycodone HCL 5 mg to 21/2023. The current March 2024 ovealed an order for Resident of on 1/8/2024 for Oxycodone obe administered as one ry 6 hours as needed for pain. The Controlled Drug position form for Resident #8 of Oxycodone HCL 5 mg from the medication cart by 224 at 4:40 PM. The pain level of Resident #8 in on of the electronic record el of 4 on 3/22/2024 at 5:39	{F 75	5}			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345377	B. WING _			R-C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834		0410012024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 755}	revealed one dose of tablet was removed to Nurse #5 on 3/22/20 There was no documadministration of Oxy Resident #8 by Nurse Documentation on the revealed Nurse #5 we Resident #8 resided PM to 11:00 PM shifts Documentation on CReceipt/Record/Disprevealed one dose or removed from the meat an undiscernible tidoses remaining. Documentation of the vital signs portion revealed a pain level PM by Nurse #5. Documentation on the Receipt/Record/Disprevealed one dose or removed from the meat 3/23/2024 at 8:10 PM Documentation on the Receipt/Record/Disprevealed one dose or removed from the meat revealed from the meat revealed one dose or removed from the meat remov	osition form for Resident #8 f Oxycodone HCL 5 mg from the medication cart by 24 at 10:50 PM. Identation on the MAR of the Accodone 5 mg tablets to the #5 on 3/22/2024. The nursing staffing schedule torked on the hallway to 3/23/2024 for the 3:00 The ontrolled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the pain level of Resident #8 in the of the electronic record to f 4 on 3/23/2024 at 5:51 The Controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the pain level of Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Oxycodone HCL 5mg was the controlled Drug to osition form for Resident #8 f Ox	{F 75	5}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345377	B. WING				-C 05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS			25	REET ADDRESS, CITY, STATE, ZIP CODE 75 W 5TH STREET REENVILLE, NC 27834	<u> 04/</u>	03/2024		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
{F 755}		nentation on the MAR of the	{F 7	55}				
	Resident #8 by Nurs	codone 5 mg tablets to e #5 on 3/23/2024. ewed on 4/1/2024 at 9:16						
	the medication cart t	he was very bad at f he removed narcotics from hen he administered them to questioned if he called the						
	outside of the param Oxycodone 5 mg for	Resident #7, Nurse #5						
	were in pain, he gave	rse #5 stated that if residents them pain medication. Ing (DON) and Assistant						
	Director of Nursing (and 3/28/2024 at 1:50 PM Controlled Drug Reconshould match the Me	ADON) were interviewed on M. The DON confirmed the eipt/Record/Disposition form edication Administration ent and the nurses should						
	follow the physician of medication within the physician. The DON	orders and provide the eparameters set by the indicated the nursing staff at make sure that the number						
	of narcotic medicatio card for each resider narcotic medications	ns left on the medication nt matched the number of signed out on the Controlled						
	further explained tha of narcotic medicatio	I/Disposition form. The DON t if after counting the number ns for each resident and tatches the Controlled Drug						
	Receipt/Record/Disp resident at the end o	•						
	pharmacist on 4/2/20	nducted with the facility 024 at 9:13 AM. The e facility needed to provide						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		345377	B. WING	B. WING		R-C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS			•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 755}	what her pain level we signed out on the Co Receipt/Record/Disp the pain level, admin resident, and then sign administration record given. The Pharmacic controlled medication signature or initial was Controlled Drug Receipt Pharmacist confing be given if there do so. The Pharmacist the facility, she made medications in the cast the number of medications in the cast the number of medications. The Pharmacist Compare the MAR to Drug Receipt/Record resident. The Pharmacist Compare the MAR to Drug Receipt/Record facility brought a confirmed nurses she parameters of the phimedication unless the otherwise. The Medicineeded to monitor the Receipt/Record/Disp so that the pain mediciding administration medication medication medication medication medication medication medication medicined the pain medication the pain medica	#5. The Pharmacist ent #8 needs to be asked as, the pain medication introlled Drug osition form if appropriate for ister the medication to the general that the medication was at confirmed that when a needed by a nurse on the eipt/Record/Disposition form. It is needed by a nurse on the eipt/Record/Disposition form. It is stated when she comes to est stated she did not each residents Controlled (Disposition form unless the corn to her attention. Inducted with the Medical so the Physician for Resident 30 PM. The Medical Director ould be following the yesician's order narcotic pain ere was authorization to do cal Director stated the facility econtrolled Drug osition form versus the MAR cation orders were followed assess he really needed her	{F 7				
SS=E	CFR(s): 483.75(c)(d)		įΓ C	,u / }			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		345377	B. WING			R-C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS				STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834		04/03/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 867}	Continued From pag	e 16	{F 86	7}			
	monitoring. A facility must establ policies and procedu collections systems, adverse event monit	feedback, data systems and implement written res for feedback, data and monitoring, including oring. The policies and lude, at a minimum, the					
	systems to obtain an from direct care staff resident representati information will be us	y maintenance of effective d use of feedback and input , other staff, residents, and ves, including how such sed to identify problems that lume, or problem-prone, and rovement.					
	systems to identify, of information from all of not limited to the facility \$483.70(e) and inclu	y maintenance of effective collect, and use data and departments, including but lity assessment required at ding how such information op and monitor performance					
	and evaluation of pe including the method	v development, monitoring, rformance indicators, lology and frequency for such bring, and evaluation.					
	including the method systematically identifianalyze and use data adverse events in the	y adverse event monitoring, is by which the facility will by, report, track, investigate, a and information relating to be facility, including how the state to develop activities to ints.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345377	B. WING		R-C 04/05/2024		
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS		1	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	1 047	03/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{F 867}	systemic action. §483.75(d)(1) The fact aimed at performance implementing those a and track performance improvements are reasily as a system of the performance improvement of the performance implement policies and (i) How they will use a determine underlying impacting larger system (ii) How they will dever will be designed to efficient to prevent quality safety problems; and (iii) How the facility with of its performance improvements are that improvements are that improvements are that improvements are sident to incidence of problems in those a outcomes, resident sare sident choice, and of \$483.75(e)(2) Performance improvements are sident events, analytics.	cility must take actions improvement and, after ctions, measure its success, in to ensure that alized and sustained. cility will develop and addressing: a systematic approach to causes of problems ems; elop corrective actions that feet change at the systems by of care, quality of life, or activities to ments are sustained. cility must set priorities for its ment activities that focus on a corproblem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care.	{F &	867)			
		and learning throughout the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
					R-C		
		345377	B. WING			04/	05/2024
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EAST CAE	EAST CAROLINA REHAB AND WELLNESS			2	575 W 5TH STREET		
EAST CAP	COLINA REHAB AND WE	ELLNESS		G	REENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Continued From page facility. §483.75(e)(3) As part improvement activitie distinct performance in number and frequency conducted by the faci and complexity of the available resources, as assessment required Improvement projects annually a project that problem-prone areas collection and analysis (c) and (d) of this section (d) of this section (e) of this section in a governing body, or defunctioning as a gove	e 18 It of their performance Is, the facility must conduct Improvement projects. The Ity of improvement projects Ility must reflect the scope Ifacility's services and Its reflected in the facility Its at §483.70(e). Its must include at least It focuses on high risk or Itidentified through the data Its described in paragraphs Ition. Its sessment and assurance. It is allowed a reports to the facility's Its esignated person(s) It is must include at least It focuses on high risk or Itidentified through the data Its described in paragraphs Ition. It is allowed a reports to the facility's It is esignated person(s) It is allowed a report to the QAPI It is allowed a report to the QAPI It is allowed a report to the QAPI It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the quality deficiencies; It is allowed a report to the facility's It is allowed a report to the facility's It is allowed a report to the facility to the	(F 8	67}		TE.	DATE
	interviews, hospice st interview, pharmacy of psychiatric nurse practice.	n, record review, staff taff interview, physician consultant interview, and citioner interview the ssment and Assurance					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345377	B. WING		R-C 04/05/2024
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS			:	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834	7 0400/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
{F 867}	procedures and more committee put into precertification and condition and condition and condition and condition are complaint investigated as repeat deficiencies to prevent accidents pharmacy services. facility during four fermattern of the facility effective Quality Assembles Program. The finding This citation is crossembles and implement interfurther falls and 2) error further further falls and 2) error further falls and 2) error further falls and 2) error further further falls and 2) error further falls and 3) error further f	maintain implemented nitor the interventions that the place following the complaint investigation of tification and complaint, the recertification and ion of 11/2/2023, and the ion of 2/27/2024. This was for is in the areas of supervision is, hospice services, and The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal surveys showed a design included: The continued failure of the ederal included: The continued failure of the ederal included in a fall design in the facility failed derail which resulted in a fall design which reviewed for	{F 867}		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	, ,	COMPLETED		
		345377	B. WING _			R-C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS				STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5TH STREET GREENVILLE, NC 27834		0410312024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
{F 867}	care planned fall safe residents reviewed for accidents. During a recertification investigation survey to provide supervision assessed as a super resident was smokin area, secure a reside complete quarterly some resident, who was assupervision when smaccidents. F755: Based on reconstruction medical Director/Phy Pharmacist interview narcotic pain medication; and failed pain medication; and failed pain medication from the the facility failed to his systems in place to operiodically reconciled protect the residents potential drug divers residents, (Resident #8) of three residents services for narcotic During a complaint in facility failed to provide time frame for a service some for a service service some for a service service some for a service serv	vas in place according to the ety interventions for 1 of 3 or supervision to prevent on and complaint of 11/2/2023 the facility failed in to a resident who was vised smoker, while a g in a designated smoking ent's smoking materials and moking assessments for a seessed as no requiring noking for 2 of 2 reviewed for ord review, staff interview, and interview, and interview, and interview tions from the medication meters set by the physician's edication; failed to follow sal of wasted narcotic di obtain an order for narcotic reference to removing narcotic pain medication cart. Additionally, ave effective safeguards and control for, account for, and a controlled medications to right to be free from ion. This was for three #6, Resident #7, Resident is reviewed for pharmacy medication.	{F 86				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345377	B. WING _			R-C 04/05/2024
NAME OF PROVIDER OR SUPPLIER EAST CAROLINA REHAB AND WELLNESS			STREET ADDRESS, CITY, STATE, ZIP COD 2575 W 5TH STREET GREENVILLE, NC 27834	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
{F 867}	interview, hospice stinterview the facility coordinate with hosp sustained a dislocate (Resident # 3) of two During a recertification investigation of 6/30/obtain a Physician's 2 of 4 residents revied The facility Administra 4/3/2024 at 12:55 Phexplained that the famet every Friday to that interventions coreoccurrence. The Anot feel further monit Administrator stated monitoring the issue cited regarding having medication available monitoring the medic Administrator further interdisciplinary teams the results of the methad just started and issues with pharmace. The Administrator was 4/5/24 at 8:53 AM. The facility was monit the hospice nursing started and results of the methad just started and issues with pharmace.	pass observation. ervation, record review, staff aff interview, and physician failed to communicate and ice to identify a resident had ed finger. This was for one a sampled hospice residents. On and complaint 12022 the facility failed to order for hospice services for ewed for hospice. The Administrator cility interdisciplinary team discuss falls and accidents so all do put in place to prevent diministrator indicated he did foring was warranted. The that the facility was the facility was previously age enough of liquid for the residents and cation pass. The explained that the facility in also discussed every Friday dication pass monitoring they had not identified any other	{F 86			