STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	07/22/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and record review the facility failed to provide nail care for 2 of 5 residents (Resident #3 and Resident #4) who were dependent on facility staff for activities of daily living. The findings included: 1. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's significant change Minimum Data Set ((MDS) dated [DATE] revealed Resident #3 was moderately cognitively impaired with unclear speech and needed extensive to total assistance with activities of daily living. Resident had no behaviors or rejection of care and required total assistance with personal hygiene and bathing. The resident's care plan updated 7/8/20 indicated Resident #3 needed extensive total assistance with activities of daily living. The interventions included check nail length and trim and clean as necessary. During an observation on 7/16/20 at 10:15 AM Resident #3's nails were observed to be approximately inch long with debris under the nails. An observation and interview were conducted on 7/16/20 at 10:19 AM with the Director of Nursing who stated she was unsure why Resident #3's nails were too long and dirty. She further stated she was not sure if Resident #3 had a shower since her return from the hospital on [DATE]. An interview was conducted with Nursing Assistant (NA) #1 on 7/20/20 at 3:36 PM who stated that she washed her residents' hands. She further stated that the nurses trimmed nails and if she saw a resident that needed nail care she would notify a nurse. NA #1 explained that many of the residents were diabetic and the nurses performed nail care. She reported that she did not do any nail care on Resident #3 because she was diabetic. During an interview on 7/21/20 at 8:13 AM Nurse #2 stated nail care should be completed by the assigned nurse aide every shift. She reported nails were considered long when they can be visualized when the resident's hand is turned over. An interview was conducted with the Director of Nursing on 7/21/20 at 2:19 PM who stated the nurse aides or nurses should complete nail care as needed. She stated she was not sure why nail care was not done for Resident #3. 2. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident's significant change Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 was severely cognitively impaired and needed extensive to total assistance with activities of daily living. Resident #4 had verbal behaviors directed towards others and required total assistance with personal hygiene and bathing. The resident's care plan updated 7/9/20 indicated Resident #4 needed extensive total assistance with activities of daily living. The interventions included check nail length and trim and clean as necessary. During an observation on 7/16/20 at 10:11 AM Resident #4's nails were observed to be approximately inch long with debris under the nails. An interview was conducted with Nursing Assistant (NA) #1 on 7/20/20 at 3:36 PM who stated that she washed her residents' hands. She further stated that the nurses trimmed nails and if she saw a resident that needed nail care she would notify a nurse. NA #1 explained that many of the residents were diabetic and the nurses performed nail care. An interview was conducted with NA #6 on 7/21/20 at 7:56 AM who stated he performed nail care on Resident #4 approximately two weeks ago. During an interview on 7/21/20 at 8:13 AM Nurse #2 stated nail care should be completed by the assigned nurse aide every shift. She reported nails are considered long when they can be visualized when the resident's hand is turned over. An interview was conducted with the Assistant Director of Nursing on 7/21/20 at 10:22 AM who stated she was aware that Resident #4 had refused care in the past but was unsure if he had refused nail care. An interview was conducted with the Director of Nursing on 7/21/20 at 2:19 PM who stated the nurse aides or nurses should complete nail care as needed. She stated she was not sure why nail care was not done for Resident #4.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to provide safe feeding assistance for 1 of 4 residents (Resident #3) reviewed for positioning. Findings included: Resident #3 was admitted to the facility on [DATE] with readmission on 6/30/20 with [DIAGNOSES REDACTED]. The most recent Minimum Data Set ((MDS) dated [DATE] revealed she had moderate cognitive impairment and required total assistance with activities of daily living (ADL) including feeding. Record review of Resident #3's hospital discharge summary dated 6/30/20 included diet recommendation of dysphagia on puree diet. Record review of Resident #3's care plan updated on 7/08/20, included problem onset of history of swallowing problem with Barrett's Esophagus with potential for aspiration. The care plan goal was that the resident will have no choking episodes when eating. The care plan approaches included to keep head of bed elevated 45 during meal and thirty minutes afterwards and give small bites and sips. During an observation on 7/16/20 at 10:19 AM, Hospitality Aide #1 was observed sitting at Resident # 3 bedside feeding her a high calorie ice cream cup. Resident #3 was in lying bed with the head of the bed at approximately a 20 upright angle. During an observation and interview with the Director of Nursing (DON) on 7/16/20 at 10:19 AM, she stated the Resident #3 head of bed was not at a 45 angle and the resident should have been in a more upright position prior to being fed. She also stated she did not know why she was not positioned correctly for feeding. During an interview with the DON on 7/21/20 at 2:17 PM she stated she did not know if the Hospitality Aides had completed a state approved feeding assistant course. During an interview with the Hospitality Aide on 7/16/20 at 1:45 PM, she stated she thought that Resident #3 was positioned correctly to be fed her snack. She also stated she feeds her a snack every day she works between breakfast and lunch and said, I try to make sure she eats her magic cup. The Hospitality Aide stated she passed out ice, water and snacks to all residents. She also stated she assisted all residents with their snacks which included opening packages and feeding them. During an interview with the Speech Therapist (ST) on 7/22/20 at 9:02 AM, he stated he had not seen Resident #3 since her return from the hospital. He stated he knew before her hospitalization she had diagnosed swallowing issues and dysphagia. The ST stated Resident #3 should have been placed in a more upright position before feeding and was not sure if the Hospitality Aide should have been feeding her. During an interview with the Director of Therapy on 7/20/20 at 11:00 AM, he stated Resident #3 had cognitive issues and swallowing issues and should not be fed by a feeding assistant. During an interview with the Administrator on 7/21/20 at 3:15 PM, he stated that Resident #3 should have been repositioned to the correct position to ensure resident safety during eating.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff and physician interviews, the facility failed to stage pressure ulcers for 1 of 4 residents assessed to provide services to prevent or treat pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the most recent Minimum Data Set ((MDS) dated [DATE] indicated Resident #1 had moderate cognitive impairment and was totally

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) dependent on staff for activities of daily living (ADL). Resident #1 was coded to have 1 unstageable pressure ulcer. Observations of wound care during the Infection Control Focused survey and complaint investigation on 7/16/20 at 10:40 AM revealed Resident #1 had an open sacral wound with some slough, drainage and odor. Observations included the treatment nurse to clean the wound, pack with [MEDICATION NAME] agent and apply dressing. Review of hospital records dated 6/13/20 stated in part patient presents from facility with stage 3 pressure ulcer to coccyx which is in the process of healing. Physical exam stated nurse reports patient has a wound with yellow tissue extending from coccyx up to gluteal cleft skin fold. Review of nurses' progress note dated 6/23/20 at 4:25 PM revealed in part sacrum wound unstageable and has 40% slough and 60% eschar in wound bed. Review of nurse's progress note dated 7/02/20 at 2:03 PM revealed in part sacrum wound unstageable has 50% slough with surrounding edges intact. Review of nurses' progress note dated 7/16/20 at 3:34 PM revealed in part sacrum wound unstageable has 25% slough around upper wound edges and 75% pink tissue with tunneling at 12:00. During an interview on 7/21/20 at 9:30 AM with Nurse #1 who confirmed she was the facility treatment nurse. She stated she was taught if a pressure ulcer had slough or eschar not to give the wound a numerical stage. During an interview on 7/21/20 at 12:33 PM with Physician #2, she stated she was Resident #1's primary physician at the facility. She also stated she had reviewed the resident's most recent hospital records dated 6/17/20 and was aware the resident had developed a stage 3 coccyx/sacral pressure ulcer at the hospital. Physician #2 stated she had not seen the sacral wound, but treatment might be different if she had been informed the wound was a stage 3 instead of unstageable. During an interview on 7/21/20 at 12:51 PM with Nurse #1, she stated she had read some information on the Center for Medicaid and Medicare (CMS) website and it stated once a pressure ulcer is debrided of enough slough or eschar such that it can be seen, the ulcer can be numerically staged; the pressure ulcer does not have to be fully debrided of eschar or slough to be staged. Nurse #1 then stated she Resident #1's sacral pressure ulcer was clear enough of slough and eschar to be staged and she should have staged it. During an interview on 7/21/20 at 3:15 PM with the Administrator, he stated pressure ulcer wounds need to be appropriately staged and his treatment nurse provided the wound care at the facility. He further stated he had never had a problem with wound care before and his treatment nurse was very well qualified.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of Centers for Disease Control (CDC) guidance, staff interviews, and physician interviews the facility failed to implement their policies and procedures for wearing Personal Protective Equipment (PPE) when 4 of 4 staff members Nursing Assistant (NA) #1, NA #2, NA #3, and NA #4), were observed not wearing appropriate (PPE) when entering or working on the COVID/quarantine unit. The facility also failed to assign dedicated health care personnel (HCP) to work only on the COVID-19 care unit (NA #1 and NA #2). These failures occurred during the COVID pandemic. Findings included: Infection Control signage posted on the COVID/quarantine unit door read in part Special Droplet/Contact Precautions; everyone must wear PPE; wear a face mask, eye protection (face shield or goggles), gown, gloves; keep door closed. Review of Centers for Disease Control and Prevention (CDC) guidance Responding to Coronavirus (COVID-19) in Nursing Homes updated April 30, 2020 read in part Assign dedicated HCP to work only on the COVID-19 care unit. During an observation on 7/16/20 at 8:26 AM NA #1 was observed pushing the breakfast tray cart through the COVID unit door without donning personal protective equipment. NA #1 did not have on face shield, gloves or gown. She did wear a mask. She pushed the breakfast tray cart onto the unit and exited the unit. She returned to the unit one minute later after she donned a gown and gloves but was not wearing a face mask or goggles. She was observed at 8:45 AM entering room [ROOM NUMBER] and room [ROOM NUMBER] on the COVID-19 unit. During an interview with NA #1 on 7/16/20 at 8:55 AM she reported she should have donned a face mask on the COVID unit while feeding residents. She stated she had a split assignment between the COVID hall and the non-COVID hall and neglected to replace her face shield. Additionally, NA #1 stated she should have donned PPE prior to pushing the breakfast trays onto the unit rather than pushing the tray cart into the unit and then exiting the unit to don PPE. During an observation and interview with NA #2 on 7/16/20 at 8:28 AM, she was observed walking through the COVID unit from east end to west end of the unit with wearing a mask but was not wearing any additional PPE. She exited the unit and then returned at 8:30 AM in mask, gown, gloves and face shield. During an interview with NA #2 on 7/16/20 at 8:32 AM she reported entered the COVID unit through the east end of the unit in order to secure PPE at the station at the west side door. She reported she was unaware of a better strategy to secure PPE. She stated she had residents assigned on the COVID hall and non-COVID halls. NA #2 stated she planned to speak with the administrator about the use of PPE when she had residents on both COVID and non-COVID units. During an observation and interview with NA #3 on 7/16/20 at 2:28 PM she was observed walking in the COVID unit without any PPE other than a face mask. She stated that she grabbed a bag of briefs from the COVID hall cart beside room [ROOM NUMBER] and was planning on placing them on the cart on the 200 hall outside the COVID unit. She reported that she was to don PPE if she was just briefly entering the unit. On 7/16/20 at 2:45 PM NA #4 observed to walk past Droplet/Contact precaution signs to enter COVID unit without a mask, gown, gloves, or any other PPE. He stated he was just walking through the unit to go to his assigned area on the 300 hall. On 7/16/20 at 3:00 PM during an interview with Assistant Director of Nursing (ADON), she stated staff should wear PPE when on the COVID unit and should not walk through the unit to get to the 300 hall. She stated staff should not have split assignments between the COVID unit and non COVID units on the same day. She further stated they had 4 new residents who have tested positive for COVID between 7/09/20 and 7/16/20. She further stated she felt the staff had probably transmitted COVID to the newly diagnosed residents since the residents had not been out of the facility. During an interview on 7/21/20 at 2:17 PM with the Director of Nursing (DON), she stated staff should not be walking through the COVID unit to go to the 300 hall. She also stated the COVID unit should have dedicated staff that only work on that unit. The DON stated she does the daily staff assignment and did not know how the staff got assigned residents on the COVID unit and non COVID unit on the same day. During an interview on 7/17/20 at 2:00 pm with the Medical Director, he stated there should be dedicated staff who only work on the COVID unit and all staff on the COVID unit should wear PPE from 'head to toe'. During an interview with the Administrator on 7/17/20 at 1:28pm, he stated 2 additional COVID positive residents last week in the facility. One was symptomatic and tested positive on 7/9/20. The other one was sent to the hospital on 7/10 and tested positive. Two additional residents were tested this week and were both positive. The Administrator also stated PPE should be worn on the COVID unit and there should be dedicated staff who only work on the COVID unit.