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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 7/16/20 through 7/22/20. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# T63F11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 7/16/20 through 7/22/20. The facility was found not in compliance with 42 CFR §483.80 infection control regulations resulting in Federal Citation F880. Five of the 10 complaint allegations were substantiated resulting in deficiencies. Event ID #T63F11.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: 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 9/22/15 with diagnoses that included dementia and arthritis.	F 677		

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

Electronically Signed

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The resident's significant change Minimum Data Set (MDS) dated 7/6/20 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 ½ 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 6/30/20.

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

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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 9/29/19 with diagnoses that included dementia and diabetes mellitus.

The resident's significant change Minimum Data Set (MDS) dated 6/25/20 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 ½ 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

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F 677	Continued From page 3 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 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		

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care plan, and the residents' choices.
This REQUIREMENT is not met as evidenced by:
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 9/22/15 with readmission on 6/30/20 with diagnoses which included: dysphagia, depression, and feeding difficulties.

The most recent Minimum Data Set (MDS) dated 7/06/20 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°

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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

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F 684	Continued From page 6 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 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: 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 2/04/00 and readmitted to the facility on 6/17/20 with diagnoses that included dementia and manic depression.	F 686		

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Review of the most recent Minimum Data Set (MDS) dated 6/24/20 indicated Resident #1 had moderate cognitive impairment and was totally 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 debriding 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".

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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.

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F 880	Continued From page 9	F 880		
F 880 SS=E	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 §483.70(e) 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 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;	F 880		

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F 880	Continued From page 10 (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, 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	F 880		

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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 #227 and room #231 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,

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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 224 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.

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F 880	Continued From page 13	F 880		

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

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 07/22/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 the COVID unit and there should be dedicated staff who only work on the COVID unit.	F 880		