

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026
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NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center	STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 27834
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E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/22/26 through 03/25/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1F50D4-H1.	E0000		04/08/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/22/26 through 03/25/26. Event ID# 1F50D4-H1. The following intakes were investigated 2749073, 2796182, and 2794345. 5 of the 5 complaint allegations did not result in deficiency.	F0000		04/08/2026
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): §483.35(b)(1)-(3) §483.35(b) Registered Nurse §483.35(b)(1)Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 2 of 142 days reviewed for staffing (12/28/25 and 1/24/26).	F0727	F727 The facility acknowledges that there was not 8 hours of consecutive RN coverage on the following dates: 12-28-25 and 1-24-26. The facility could not rectify this situation since it is a past event and can't be corrected. The facility reviewed the upcoming nursing schedules for the next 2 weeks to ensure that there was 8 hours of consecutive RN coverage on a daily basis. This review was completed by the Staffing Coordinator and the Director of nursing. This review took place on 3-26-26. An inservice was conducted with the Staffing Coordinator, Director of Nursing, Assistant Director of Nursing and Human Resources Director regarding the requirement of having 8 consecutive hours of RN coverage on a daily basis. This inservice was conducted by the Administrator on 3-27-2026. A weekly audit will be conducted to ensure that the facility has 8 consecutive hours of RN coverage on a daily basis. This audit will be conducted by the Administrator. The audit will take place weekly x 12	04/21/2026

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0727 SS = F	<p>Continued from page 1 The findings included:</p> <p>Review of the facility's daily nurse staffing sheets from 11/1/25 through 3/22/26 revealed the following:</p> <p>a. On 12/28/25 the daily nurse staffing sheet indicated a daily census of 85.</p> <p>Review of the daily nurse staffing sheet revealed there was no RN working on any shift that day.</p> <p>b. On 1/24/26 the daily nurse staffing sheet indicated a daily census of 77.</p> <p>Review of the daily nurse staffing sheet revealed there was no RN working on any shift that day.</p> <p>In an interview with the Scheduler on 3/25/26 at 10:10 am, she stated she used the schedule to complete the daily nurse staffing sheets. The Scheduler stated if she had no RN coverage she would leave the RN space blank on the daily nurse staffing sheet for the number of RNs scheduled to work. She stated did not have RN coverage for 12/28/25 and 1/24/26. The Scheduler further stated she was unaware there could be no blank spaces on the daily nurse staffing sheets. The Scheduler was not sure what she needed to do when there was no RN coverage.</p> <p>An interview with the Director of Nursing (DON) on 3/25/26 at 10:30 am revealed she was unaware there was no RN coverage for 12/28/25 and 1/24/26. The DON stated there should be an RN for 8 consecutive hours in the building and she would be monitoring this more closely in the future.</p> <p>An interview with the Administrator on 3/25/26 at 12:02 pm stated his expectations were the facility should have an RN for 8 consecutive hours in the building.</p>	F0727	<p>Continued from page 1 weeks to ensure adequate RN coverage. This audit will begin during the week of 4-13-2026.</p> <p>The results will be reported to the monthly quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, the review will be completed on a random basis.</p> <p>5. Date of compliance: 4/21/2026</p>	04/21/2026
F0605 SS = D	<p>Right to be Free from Chemical Restraints</p> <p>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)</p> <p>§483.10(e) Respect and Dignity.</p>	F0605	<p>F605 POC AIMS ASSESSMENTS</p> <p>The facility did not have a current AIMS assessment completed for Resident #3. . The AIMS assessment</p>	04/21/2026

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F0605 SS = D	<p>Continued from page 2</p> <p>The resident has a right to be treated with respect and dignity, including:</p> <p>§483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).</p> <p>§483.12</p> <p>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.</p> <p>§483.12(a) The facility must- . . .</p> <p>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.</p> <p>. . . .</p> <p>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>(i) Anti-psychotic;</p> <p>(ii) Anti-depressant;</p> <p>(iii) Anti-anxiety; and</p> <p>(iv) Hypnotic.</p>	F0605	<p>Continued from page 2 for Resident #3 was completed on 3/23/2026 by the Unit Manager.</p> <p>The Regional Director of Clinical Services reviewed all residents on antipsychotic medications for quarterly AIMS assessments on 4/9/2026. Any resident without a current AIMS assessment had one completed on 4/9/2026 by the Unit Manager.</p> <p>The Director of Nursing educated the ADON and Unit Managers on 3/30/2026 on completing an AIMS assessment for all residents prescribed antipsychotic medications on admission, readmission, quarterly and with a new prescription for an antipsychotic medication.</p> <p>The DON, ADON and Unit Managers will monitor the need for completion of an AIMS assessment due in the clinical meeting 5x/week x 2 weeks, 3x/week x 4 weeks and 2x/week x 6 weeks. The# results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, the review will be completed on a random basis.</p> <p>Compliance: 4/21/2026</p>	04/21/2026

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<p>F0605 SS = D</p>	<p>Continued from page 3 §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-</p> <p>(1) In excessive dose (including duplicate drug therapy); or</p> <p>(2) For excessive duration; or</p> <p>(3) Without adequate monitoring; or</p> <p>(4) Without adequate indications for its use; or</p> <p>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or</p> <p>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.</p> <p>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--</p> <p>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;</p> <p>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;</p> <p>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and</p> <p>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p>	<p>F0605</p>		<p>04/21/2026</p>

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<p>F0605 SS = D</p>	<p>Continued from page 4</p> <p>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff, Medical Director, and Consultant Pharmacist interviews, the facility failed to provide ongoing Abnormal Involuntary Movement Scale (AIMS) assessments for potential adverse reactions to antipsychotic medications for 1 of 5 residents reviewed for unnecessary medications (Residents #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted on 6/13/24 with diagnoses including dementia with severe behavioral disturbance and agitation.</p> <p>Review of Resident #3's physician orders revealed she had an order dated 4/21/25 for haloperidol lactate (a first-generation antipsychotic injection used for the rapid treatment of acute psychosis, schizophrenia, and severe agitation) 2 milligram (mg)/ milliliter (ml) give 0.5 ml by mouth two times a day for behaviors.</p> <p>Review of Resident #3's electronic medical record (EMR) revealed the last AIMS assessment on file was dated 7/29/25. There were no other AIMS assessments found in the Resident #3's EMR after that date.</p> <p>Resident #3's quarterly Minimum Data Set (MDS) dated 7/31/25 revealed she was cognitively impaired and exhibited behaviors. She was coded for antipsychotic medication.</p> <p>An interview was conducted with Unit Manager #1 on 3/23/26 at 3:09 PM. She stated she began working at the facility in January 2026. The Unit Manager stated when the new company took over the facility (in November 2025), some assessments were not scheduled. Unit Manager #1 further stated AIMS assessments should be completed upon initial admission, at readmissions, and completed quarterly. Unit Manager #1 indicated Resident #3's quarterly AIMS should have been completed but was not.</p> <p>An interview was conducted with the Director of Nursing (DON) on 03/23/26 at 3:30 PM. The DON stated the facility changed ownership in November</p>	<p>F0605</p>		<p>04/21/2026</p>

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F0605 SS = D	<p>Continued from page 5</p> <p>2025 and she began working at the facility in December 2025. She stated staff were working to get all assessments correct and up to date. The DON stated that AIMS assessments were expected to be completed at the time of initial admission, at readmissions, with new medication prescriptions, as well as scheduled and completed quarterly. She further stated the unit managers were responsible for completing the AIMS assessments.</p> <p>An interview was conducted with the Pharmacy Consultant on 3/25/26 at 9:57 AM. The Pharmacy Consultant stated AIMS assessments should be completed at the start of the antipsychotic medication; if no changes were made to the medication dose, then again at 6 months. The Pharmacy Consultant stated his medication reviews included reviews of physician and psychiatric progress notes for any medication related side effects and if no issues were noted, he did not make recommendations. He further stated he left AIMS assessment information up to the treating physician to make recommendations.</p> <p>In an interview with the Medical Director on 3/25/26 at 10:16 AM he stated AIMS assessments should be completed at the minimum of every 6 months. He stated the physician and/or psychiatrist generally monitored antipsychotic medications. The Medical Director further stated Resident #3 had been in the hospital earlier this month, which could have interfered with the timing of her AIMS assessment, however it should have been completed at the 6-month mark regardless.</p> <p>An interview was conducted with the Administrator on 3/25/26 at 1:08 PM. He stated he expected that all assessments needed for antipsychotic medications, including AIMS assessments, were completed timely and were reviewed as necessary.</p>	F0605		04/21/2026
F0641 SS = D	<p>Accuracy of Assessments</p> <p>CFR(s): 483.20(g)(h)(i)(j)</p> <p>§483.20(g) Accuracy of Assessments.</p> <p>The assessment must accurately reflect the resident's status.</p> <p>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>	F0641	<p>F0641 Accuracy of Assessments (Tube Feeding)</p> <p>Correction for Affected Residents:</p> <p>The MOS Nurse reviewed Resident #87 identified during survey for accuracy of MOS Section K tube feeding coding. Physician orders, MAR, nursing documentation, dietary notes, and intake records were reviewed to verify tube feedings were provided during the ARD look-back period. MDS assessments were immediately corrected per RA! requirements, and care plans were updated on 3/25/2026.</p>	04/21/2026

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F0641 SS = D	<p>Continued from page 6 §483.20(i) Certification.</p> <p>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.</p> <p>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>§483.20(j) Penalty for Falsification.</p> <p>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by: Based on record review and facility staff interviews, the facility failed to accurately code Minimum Data Set (MDS) for 1 of 62 residents reviewed for accuracy of assessments (Resident #84).</p> <p>The findings included:</p> <p>Resident #84 was admitted to the facility on 11/6/25 with diagnoses which included dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body) and hemiparesis (one-sided muscle weakness) following cerebral infarction (ischemic stroke).</p> <p>Review of a physician order dated 1/16/26 for Resident #84 documented [brand name of formula] enteral nutrition (delivery of nutrients directly into the gastrointestinal tract, typically through a feeding tube) at 60 milliliters (ml) per hour every 12 hours from 6 p.m. to 6 a.m. and 200 ml water flush every four hours.</p> <p>Review of Resident #84's February 2026 Medication Administration Record (MAR) revealed [brand name of formula] enteral nutrition at 60 ml per hour per feeding tube every 12 hours from 6 p.m. to 6 a.m. and 200 ml of water flush every 4 hours per feeding</p>	F0641	<p>Continued from page 6</p> <p>Identification of Other Affected Residents:</p> <p>The MOS Regional Nurse conducted a facility-wide audit of all residents with tube feeding orders and/or K0520B coded "Yes" within the past 30 days on 4/15/2026. Assessments were reviewed for required documentation and corrected as indicated.</p> <p>Measures to Prevent Recurrence:</p> <p>All MDS Nurses received re-education on Section K coding requirements, including the 51% rule if receiving MCA services for enteral feeding and documentation standards. A standardized tube feeding MDS checklist was implemented and must be completed prior to locking assessments with tube feeding indicated. Education was provided by April Godwin, RN Regional MDS Nurse on 4/14/2026</p> <p>Monitoring:</p> <p>Weekly audits of MOS completed of residents with orders for tube feeding/coded "yes" for KOS 20B be completed for one month, then will continue one time a month for three months. Results will be reviewed by the Regional MDS Coordinator and DON and tracked through QAPI. Additional education will be provided if issues are identified.</p> <p>The results will be reported to the monthly Quality Committee for review and discussion To ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis.</p> <p>Date of Compliance : 4/21/2026</p>	04/21/2026

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F0641 SS = D	<p>Continued from page 7 tube had been documented as administered.</p> <p>A review of Resident #84's quarterly Minimum Data Set (MDS) assessment dated 2/12/26 revealed Resident #84 was not coded for having a Feeding Tube or the Percent of Intake by Artificial Route.</p> <p>During an interview with the Regional MDS Consultant on 3/25/26 at 10:50 a.m. she stated the Dietary Manager completed the Nutrition section of the MDS and it should have been completed by the MDS Coordinator. The MDS indicated Resident #84 had a feeding tube, this had been an error, and it should have been coded correctly including the amount of intake by artificial route.</p> <p>During an interview with the Administrator on 3/25/26 at 12:02 p.m. he stated the MDS assessments should have been coded accurately to reflect the feeding tube and the amount of intake by artificial route.</p>	F0641		04/21/2026
F0756 SS = D	<p>Drug Regimen Review, Report Irregular, Act On</p> <p>CFR(s): 483.45(c)(1)(2)(4)(5)</p> <p>§483.45(c) Drug Regimen Review.</p> <p>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>§483.45(c)(2) This review must include a review of the resident's medical chart.</p> <p>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.</p> <p>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.</p> <p>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.</p> <p>(iii) The attending physician must document in the</p>	F0756	<p>F756</p> <ol style="list-style-type: none"> The facility's Pharmacy Consultant failed to identify and report irregularities when conducting the monthly drug regimen for Resident #3. The AIMS assessment for Resident #3 was completed by the Unit Manager on 3/23/2026. The Director of Nursing and the Regional Director of Clinical Services reviewed the March pharmacy report to include the Psychotropic Medication Report on 3/30/2026. There were no other instances noted where an AIMS assessment was missed or due at that time. The DON educated the pharmacy consultant on 4/9/2026 on the facility's protocol for AIMS assessment completion. The DON and ADON will monitor the psychotropic medication report monthly for AIMS assessment completion for 3 months. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, the review will be completed on a random basis. Compliance: 4/21/2026 	04/21/2026

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<p>F0756 SS = D</p>	<p>Continued from page 8 resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.</p> <p>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and an interview with the Pharmacy Consultant, the Pharmacy Consultant failed to identify and report irregularities when conducting monthly drug regimen reviews for 1 of 5 residents reviewed for unnecessary medications (Resident #3).</p> <p>The findings included:</p> <p>Resident #3 was admitted on 6/13/24 with diagnoses including dementia with severe behavioral disturbance and agitation.</p> <p>Review of Resident #3's physician orders revealed she had an order dated 4/21/25 for haloperidol lactate (a first-generation antipsychotic injection used for the rapid treatment of acute psychosis, schizophrenia, and severe agitation) 2 milligram (mg)/ milliliter (ml) give 0.5 ml by mouth two times a day for behaviors.</p> <p>Review of Resident #3's electronic medical record (EMR) revealed the last AIMS assessment on file was dated 7/29/25. There were no other AIMS assessments found in the Resident #3's EMR after that date.</p> <p>Review of the Pharmacy Consultant monthly drug regimen reviews for Resident #3 dated 10/10/25, and monthly pharmacy reports dated November 2025 through February 2026, revealed no documentation of the need for the facility to complete AIMS assessments.</p> <p>An interview was conducted with the Pharmacy Consultant on 3/25/26 at 9:57 AM. The Pharmacy Consultant stated AIMS assessments should be completed at the start of the antipsychotic</p>	<p>F0756</p>		<p>04/21/2026</p>

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NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 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
F0756 SS = D	Continued from page 9 medication; if no changes were made to the medication dose, then again at 6 months. The Pharmacy Consultant stated his medication reviews included reviews of physician and psychiatric progress notes for any medication related side effects and if no issues were noted, he did not make recommendations. He further stated he left AIMS assessment information up to the treating physician to make recommendations.	F0756		04/21/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Dialysis Dietician/Nurse Practitioner, and Medical Director interviews, the facility failed to ensure medications were administered in accordance with physician orders for 1 of 9 residents reviewed for medications (Resident #7). The findings included: Resident #7 latest admission date to the facility was 10/8/2025 following a hospitalization from 10/3/2025 to 10/8/2025 for dialysis access complications and anemia. Resident #7 admitting diagnoses included end stage renal disease (ESRD) requiring hemodialysis, chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and moderate protein-calorie malnutrition. A care plan dated 10/08/2025 addressed ESRD and fluid volume management, including administering medications as ordered, monitoring vital signs, and providing diet as ordered. The care plan was revised on 03/05/2026 to include activities of daily living (ADL) assistance needs. The care plan did not include interventions addressing medication availability, administering medications on dialysis days, or medication refusals. Further review of physician orders revealed an order dated 6/12/2025 for Sevelamer Carbonate (phosphate binder used to control elevated phosphorus in people with chronic kidney disease) 0.8 gram packet give one (1) packet by mouth three times daily with a meal.	F0760	F 760 POC SIGNIFICANT MEDICATION ERROR The facility failed to ensure medications were administered in accordance with physician orders for Resident #7. THE UNIT MANAGER ADJUSTED MEDICATIONS FOR RESIDENT #7 TO BE GIVEN PRIOR TO DIALYSIS AND WITH MEALS ON 4/13/2026. ON 4/13/2026, MEDICATIONS WERE REVIEWED FOR ALL OTHER RESIDENTS ON DIALYSIS BY THE DON, ADON AND UNIT MANAGERS. MEDICATIONS WERE SCHEDULED AROUND DIALYSIS CHAIR TIMES. THE DON AND ADON BEGAN EDUCATING ALL LICENSED NURSES TO SCHEDULE DIALYSIS MEDICATIONS AROUND DIALYSIS CHAIR TIMES TO ENSURE MEDICATIONS ARE GIVEN AS ORDERED ON 4/13/2026. THIS EDUCATION WILL BE COMPLETED BY 4/17/2026. ANYONE WHO HASN'T RECEIVED THIS EDUCATION BY 4/17/2026 WILL BE TAKEN OFF OF THE SCHEDULE UNTIL THE EDUCATION IS RECEIVED. THE DON AND ADON WILL MONITOR EXISTING AND NEW DIALYSIS RESIDENTS FOR NEW MEDICATION ORDERS AND ADJUST MEDICATIONS AS ORDERED 5X/WEEK X 2 WEEKS, 3X/WEEK X 4 WEEKS AND 2X/WEEK X 6 WEEKS. THE RESULTS WILL BE REPORTED TO THE MONTHLY QUALITY COMMITTEE FOR REVIEW AND DISCUSSION TO ENSURE SUBSTANTIAL COMPLIANCE. ONCE THE QA COMMITTEE DETERMINES THE PROBLEM NO LONGER EXISTS, THE REVIEW WILL BE COMPLETED ON A RANDOM BASIS. 5. COMPLIANCE:4/21/2026	04/21/2026

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F0760 SS = D	<p>Continued from page 10</p> <p>On 11/11/2025 a physician order was written for Carvedilol (used to treat heart failure, hypertension and heart attack) 6.25 mg, 2 tablets twice daily and Sertraline (used to treat depression and anxiety) 50 mg daily.</p> <p>On 2/12/2026 a physician order specified Sevelamer HCl (phosphate binder) 800 mg 3 tablets with meals and Sevelamer HCl 800 mg 2 tables with snacks twice daily.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 01/14/2026 documented diagnoses including ESRD requiring dialysis and moderate protein-calorie malnutrition, with severe cognitive impairment requiring cues for decision-making.</p> <p>A review of Medication Administration Records (MARs) for January 2026 and February 2026 revealed that on 01/07/2026, 01/19/2026, 01/28/2026, 02/06/2026, 02/11/2026, 02/13/2026, 02/16/2026, 02/18/2026, 02/20/2026 and 02/20/2026, the Sevelamer, Sertraline 50 mg and Carvedilol 6.25 mg were documented as not administered because the resident was "out of facility" or "at dialysis" at the time of medication administration.</p> <p>On 3/11/2026 a physician order was written to discontinue Sevelamer and start Velphoro (phosphate binder) 500 mg with instructions to administer one tablet three times daily with meals and one tablet with a snack. Velphoro serves the same purpose as Sevelamer except the Velphoro is less pills per dose.</p> <p>An interview with the Dialysis Dietician/Nurse Practitioner on 3/24/2025 at 11:10 am revealed that Resident #7 was switched from Sevelamer to Velphoro because his phosphorous levels were not controlled and she believed facility was not administering medication as ordered. She stated that Resident #7 phosphorous levels were still not controlled and latest phosphorous level was 6.5 on 3/11/2026. She stated that they like patients to be 5.5 or less. She indicated that Resident #7's phosphorous levels were well controlled prior to his coming to this facility. She stated that Resident #7 does not take any medication while at the dialysis facility. She confirmed that Resident #7 did not take the medication at the dialysis center because the resident did not always eat while at dialysis and medication must be taken with food. She further stated that Resident #7 could have taken the medication upon his return to the facility with his meals or snacks.</p>	F0760		04/21/2026

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F0760 SS = D	<p>Continued from page 11</p> <p>According to the National Kidney Foundation, high phosphorous levels harden blood vessels and increases the risk of heart disease, stroke and death.</p> <p>At an interview on 3/25/2026 at 9:50 am the Director of Nursing stated that if nurses hold a medication or if the medication is not available from pharmacy, the nurse should call the on-call provider and make them aware. She stated that at the direction of the on-call provider they should either hold the medication for that day or administer it to the patient upon their return to the facility.</p> <p>An interview with the Nurse Unit Manager on 3/25/2026 at 10:30 am revealed that Resident #7's? resident medications were held when the patient was out of the facility for dialysis. She stated that if they were held, they were not given when he returned to the facility. She stated they do not contact the Medical Director or on-call provider when they hold medications. She stated that the resident has dialysis on Mondays, Wednesdays and Fridays and his chair time started at 11:15 am and returns around 4:00 pm. She stated that the resident had several medications held during that time including a 2:00 pm blood pressure medication Carvedilol which was held every Monday, Wednesday and Friday.</p> <p>A 3/25/2026 interview with Medical Director at 10:53 am revealed that it was his expectation that nursing staff contact the on-call doctor or himself if a patient misses medication due to being out of the building. The Medical Director stated that he had not received any communication regarding Resident #7 being out to dialysis and missing doses of his medication. He stated that if nursing staff held a medication they should contact on-call providers, tell them which medication was held and which ones still needed to be given. The Medical Director indicated now that he was aware they could adjust medications times so that they are not given while Resident #7 is at dialysis. The Medical Director stated that he did not follow Resident #7 dialysis care and allowed the dialysis center to make any medication changes or follow up on labs.</p>	F0760		04/21/2026
F0919 SS = D	<p>Resident Call System</p> <p>CFR(s): 483.90(g)(1)(2)</p> <p>§483.90(g) Resident Call System</p> <p>The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area</p>	F0919	F919	04/21/2026
			A. The facility failed to ensure the resident call light system was functioning properly for Resident #78. The call light for Resident #78 was repaired so that when the call light was pressed it would illuminate on the outside of the door in the hallway. This repair was completed on 4-13-26 by the Maintenance Director.	

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F0919 SS = D	<p>Continued from page 12 from-</p> <p>§483.90(g)(1) Each resident's bedside; and</p> <p>§483.90(g)(2) Toilet and bathing facilities.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and resident and staff interviews, the facility failed to ensure the resident call light system was functioning properly for 3 of 97 residents observed for resident call system (Resident #78, Resident #4, and Resident #94).</p> <p>The findings included:</p> <p>Record review of maintenance related purchase orders revealed on 2/9/26 light bulbs were ordered and a delivery date of 2/10/26 was noted.</p> <p>a. Resident #78 was admitted to the facility on 4/21/25 with diagnoses that included inflammatory and immune myopathies (a group of rare, chronic diseases where the body's immune system mistakenly attacks its own healthy muscle fibers), generalized weakness, and abnormalities of gait and mobility.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 2/20/26 revealed Resident #78 was cognitively intact. Resident #78 required substantial/maximal assistance for oral hygiene, upper body dressing, personal hygiene, rolling left and right, and wheeling 150 feet. She was dependent on others for toileting hygiene, shower/bathing herself, lower body dressing, putting on/taking off footwear, sitting to lying, lying to sitting on side of bed, sitting to standing, and chair/bed to chair transfers.</p> <p>A grievance for Resident #78 dated 2/24/26 indicated her call light was not working. The resolution included that maintenance looked at the call light and deemed it to be in working order at that time; the grievance was signed by the Administrator.</p> <p>An interview was conducted with Resident #78 on 3/24/26 at 11:35 AM. Resident #78 stated her call light had not lit up on the outside of her door for approximately one month. She explained that when she thought her call light was not working she asked a staff member (unsure name and date) to check the light above her door. She stated she</p>	F0919	<p>Continued from page 12</p> <p>B. The facility failed to ensure the resident call light system was functioning properly for Resident #4. The call light for Resident #4 was repaired so that when the call light was pressed it would illuminate on the outside of the door in the hallway. This repair was completed on 4-13-26 by the Maintenance Director.</p> <p>C. The facility failed to ensure the resident call light system was functioning properly for Resident #94. The call light for Resident #94 was repaired so that when the call light was pressed it would illuminate on the outside of the door in the hallway. This repair was completed on 4-13-26 by the Maintenance Director.</p> <p>An initial audit was performed to ensure that all call bells in resident rooms would illuminate on the outside of the door in the hallway. The audit was performed by the Maintenance Director and the Administrator. The audit was completed on 3-25-2026.</p> <p>The facility staff will be inserviced on how to report if a resident call bell is not illuminating on the outside of the door in the hallway when it is pressed. The inservice will be led by the Administrator or their designee. This inservice will be completed by 4-16-2026.</p> <p>An audit will be performed to ensure that the resident call bells are illuminating on the outside of the door in the hallway when it is pressed. This audit will be performed by the Administrator or their designee. This audit will be performed weekly x 4 weeks and then monthly x 3 months. The weekly audits will look at the 25% of the call lights. The monthly audit will review 100% of the call lights. This audit will begin during the week of 4-13-2026.</p> <p>The results will be reported to the monthly quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, the review will be completed on a random basis.</p> <p>Compliance Date : 4/21/2026</p>	04/21/2026

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F0919 SS = D	<p>Continued from page 13</p> <p>informed her nurse aide and her nurse that the call light was not working. She indicated she was unsure of names of the staff or the exact date she informed them. Resident #78 stated a maintenance staff member (unsure of name and date) came and informed her a part had to be ordered; however, no one came back to fix it. She stated she was given a handheld bell to ring by the Activities Director.</p> <p>An observation of Resident #78's call light was conducted on 3/24/26 at 11:36 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.</p> <p>An interview was conducted with the Activities Director on 3/25/2026 at 12:08 PM. She stated she found out about Resident #78's call light not working during a Resident Council meeting in February 2026. The Activities Director stated she went to Resident #78's room to check her call light and it wasn't working. She stated she told maintenance about it verbally and gave Resident #78 a handheld bell to use until her call light was fixed.</p> <p>b. Resident #4 was admitted to the facility on 4/1/24 with diagnoses that included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), generalized weakness, neuromuscular dysfunction of the bladder (a condition where nerve damage disrupts the communication between the brain, spinal cord, and bladder muscles), and abnormalities of gait and mobility.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 12/12/25 revealed Resident #4 was severely cognitively impaired. Resident #4 required substantial/maximal assistance for personal hygiene, rolling left and right, sitting to lying, and lying to sitting on side of bed. She was dependent on others for toileting hygiene, shower/bathing herself, upper and lower body dressing, putting on/taking off footwear, sitting to standing, chair/bed to chair transfers, and tub/shower transfer.</p> <p>Resident #4 was not interviewable.</p> <p>An observation of Resident #4's call light was conducted on 3/24/26 at 11:38 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.</p> <p>c. Resident #94 was admitted to the facility on 7/26/24 with diagnoses that included intervertebral</p>	F0919		04/21/2026

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F0919 SS = D	<p>Continued from page 14</p> <p>disc degeneration: lumbar region (a common condition where the soft, rubbery cushions {discs} between the bones {vertebrae} in your lower back wear down), kyphosis (an abnormal, excessive outward curve of the spine that causes a rounded, hunched-over posture), and generalized weakness.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated 1/30/26 revealed Resident #94 was moderately cognitively impaired. Resident #94 required substantial/maximal assistance for toileting hygiene, shower/bathing herself, upper and lower body dressing, personal hygiene, rolling left and right, lying to sitting on side of bed, sitting to standing, and chair/bed to chair transfers. She was dependent on others for putting on/taking off footwear, toilet transfer, and tub/shower transfer.</p> <p>An observation of Resident #94's call light was conducted on 3/24/26 at 11:38 AM. When the call light was pressed, it did not illuminate on the outside of her door in the hallway. A handheld bell was observed in her room.</p> <p>An interview was conducted with Resident #94 on 3/24/26 at 12:31 PM. She stated her call light hadn't worked properly for a few weeks; she was unsure of the exact date it stopped working. Resident #94 stated she informed her nurse aide about her call light not working (unsure of name and exact date) and the nurse aide gave her a handheld bell. She further stated a maintenance staff member (unsure of name) looked at her call light and told her, "He would get it later."</p> <p>Work orders dated January 2026 through March 2026 were reviewed. There were no work orders for Resident #78, Resident #4, and Resident #94 related to call lights in need of repair.</p> <p>During an interview on 3/24/26 at 11:54 AM with Nurse Aide #1 who was assigned to Resident #4 and Resident #94, she stated she was not aware their call lights were not working. She stated if she found a call light was not working, she would report it to maintenance verbally.</p> <p>During an interview on 3/24/2026 at 3:23 PM with Nurse Aide #2 who was assigned to Resident #78, she stated she did not know Resident #78's call light was not working. She further stated if she found something that was not working, she would report it to maintenance verbally.</p> <p>An interview was conducted on 3/24/26 at 11:44 AM with Nurse #1 who was assigned to Resident #78,</p>	F0919		04/21/2026

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F0919 SS = D	<p>Continued from page 15</p> <p>Resident #4, and Resident #94. Nurse #1 stated she was not aware these residents' call lights were not working. She stated if she found something that needed repair, she would notify maintenance verbally and write it in the maintenance communication book which was kept at the nurse's station. Nurse #1 further stated she would inform the nurse aides that a resident's call light was not working properly so the nurse aides could check on the residents more frequently until the call light was fixed.</p> <p>An interview was conducted on 3/24/26 at 12:01 PM with Unit Manager #1. She stated she was not aware that Resident #78's, Resident #4's, and Resident #94's call bells were not working. Unit Manager #1 stated if something needed repaired, she expected staff to put the maintenance request into the web-based building management system utilized by the facility (a web-based system specifically designed for senior living and healthcare facilities to help operators manage maintenance, regulatory compliance, and vendor services through a central, mobile platform); a resident should also be given a handheld bell until their call light was fixed.</p> <p>An interview was conducted on 3/24/26 at 3:24 PM with the Maintenance Director. He stated he was notified of the call lights not working for Resident #78, Resident #4, and Resident #94 (unsure of date and how he was notified). He stated he fixed the call lights twice, but they kept "blowing out." The Maintenance Director stated he realized it was a problem with the inside panels. He stated he switched out the panel but had to order more bulbs because they kept "burning out." The Maintenance Director stated he did not have documentation of the dates and times he worked on (fixed) the call lights and stated he should have kept a record.</p> <p>A follow-up interview was conducted on 3/25/26 at 10:54 AM with the Maintenance Director for clarification of the light bulb invoice. He stated the invoice was created on 2/9/26. The delivery date on the invoice of 2/10/26 was not the actual delivery date. The Maintenance Director stated the shipment was delayed and was delivered on 3/18/26.</p> <p>During an interview with the Director of Nursing (DON) on 03/25/26 at 12:33 PM she stated she was unaware of Resident #78's, Resident #4's, and Resident #94's call lights not working. The DON stated her expectation was that if staff discovered a call light was not working properly, they notified maintenance verbally, entered it into the web-based building management system, and gave a resident a handheld bell to use until the call light was fixed.</p>	F0919		04/21/2026

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F0919 SS = D	Continued from page 16 In an interview with the Administrator on 3/25/26 at 1:08 PM, the Administrator stated he expected repairs to be done timely. The Administrator did not explain what specific period of time equated to a "timely manner."	F0919		04/21/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.	F0732	F732 The posted nurse staffing information for the following dates were corrected to ensure the required information was filled out: 12/12/25, 12/17/25, 2/2/26, 2/4/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 2/28/26, 3/3/26, 3/4/26, 3/5/26, 3/7/26, 3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/21/26, 3/22/26. The corrections to the posted nurse staffing information sheets took place on 3-25-26 and were completed by the Staffing Coordinator and the Director of Nursing. The facility reviewed the posted nurse staffing information for 3-26-26 to ensure that the information was accurate and posted correctly. This review was completed by the Staffing Coordinator and the Director of Nursing. An inservice was conducted with the Staffing Coordinator, Director of Nursing, Human Resources Director, Assistant Director of Nursing explaining the information that needed to be filled out on the posted nurse staffing information sheets. The inservice was led by the Administrator and took place on 3-26-26. An audit will take place to ensure that the posted nurse staffing information sheets are filled out accurately. This audit will take place weekly x 12 weeks. This audit will be performed by the Director of Nursing or their designee. This audit will begin during the week of 4-13-2026.	04/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center			STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 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
F0732 SS = C	<p>Continued from page 17</p> <p>(B) In a prominent place readily accessible to residents, staff, and visitors.</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to ensure daily nurse staffing sheets were complete and accurate for 36 of 53 days reviewed for 12/1/25 through 3/22/26 (12/12/25, 12/17/25, 2/2/26, 2/4/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 2/28/26, 3/3/26, 3/4/26, 3/5/26, 3/7/26, 3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/21/26, 3/22/26).</p> <p>The findings included:</p> <p>Review of the facility's daily nurse staffing sheets for 12/12/25, 12/17/25, 12/28/25, 1/24/26, 2/2/26, 2/4/26, 2/5/26, 2/6/26, 2/9/26, 2/10/26, 2/11/26, 2/13/26, 2/15/26, 2/16/26, 2/17/26, 2/18/26, 2/19/26, 2/21/26, 2/24/26, 2/25/26, 2/26/26, 2/27/26, 2/28/26, 3/3/26, 3/4/26, 3/5/26, 3/7/26, 3/9/26, 3/10/26, 3/11/26, 3/12/26, 3/13/26, 3/14/26, 3/15/26, 3/17/26, 3/18/26, 3/21/26, 3/22/26 revealed the following:</p> <p>On 12/12/25 the total number for each staff discipline (Registered Nurse (RN), Licensed Practical Nurse (LPN), Nursing Assistant (NAs) and total hours worked for each staff discipline for the evening (3:00 pm – 11:00 pm) and night shift (11:00 pm – 7:00 am) were blank.</p> <p>On 12/12/25 the census was blank.</p> <p>On 12/17/25 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p>	F0732	<p>Continued from page 17</p> <p>The results will be reported to the monthly quality committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, the review will be completed on a random basis.</p> <p>5.Date of compliance: 4/21/2026</p>	04/21/2026

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 03/25/2026</p>	
<p>NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 27834</p>		
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<p>F0732 SS = C</p>	<p>Continued from page 18</p> <p>On 12/17/25 the census was blank.</p> <p>On 2/2/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/4/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/5/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/6/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/6/26 the census was blank.</p> <p>On 2/9/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/10/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/11/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/13/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/15/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/16/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p>	<p>F0732</p>		<p>04/21/2026</p>

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<p>NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 27834</p>		
(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
<p>F0732 SS = C</p>	<p>Continued from page 19</p> <p>On 2/17/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/18/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/19/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/19/26 the census was blank.</p> <p>On 2/21/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/24/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/25/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/26/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/27/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 2/28/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/3/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/4/26 the total number for each staff discipline</p>	<p>F0732</p>		<p>04/21/2026</p>

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<p>F0732 SS = C</p>	<p>Continued from page 20 and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/5/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/7/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/7/26 the census was blank.</p> <p>On 3/9/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/10/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/11/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/12/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/13/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/14/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/14/26 the census was blank.</p> <p>On 3/15/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/15/26 the census was blank.</p>	<p>F0732</p>		<p>04/21/2026</p>

<p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</p>	<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377</p>	<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING</p>	<p>(X3) DATE SURVEY COMPLETED 03/25/2026</p>	
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<p>F0732 SS = C</p>	<p>Continued from page 21</p> <p>On 3/17/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/18/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/21/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>On 3/22/26 the total number for each staff discipline and total hours worked for each staff discipline for the evening and night shift were blank.</p> <p>In an interview with the Scheduler on 3/25/26 at 10:10 am, she stated she used the schedule to complete the daily nurse staffing sheets. The Scheduler explained she would have to start and stop working on the daily nurse staffing sheets to find staff coverage for staff call outs. She explained she forgot to go back and complete the daily nurse staffing sheets for the dates in question. The Scheduler further stated she was unaware there could be no blank spaces on the daily nurse staffing sheets.</p> <p>An interview with the Director of Nursing (DON) on 3/25/26 at 10:30 am, revealed the Scheduler was responsible for completing the daily nurse staffing sheets. The DON revealed she was unaware the daily nurse staffing sheets were not completely filled out. The DON indicated the daily nurse staffing sheets should be completed with the total number of staff for each discipline for each shift and the total hours worked for each discipline for each shift, and the census.</p> <p>An interview was conducted with the Administrator on 3/25/26 at 12:02 pm. He stated the daily nursing staffing sheets were supposed to be completed by the Scheduler. The Administrator stated his expectations were that the daily nursing staffing sheets were completed correctly.</p>	<p>F0732</p>		<p>04/21/2026</p>

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F0582 SS = A	<p>Medicaid/Medicare Coverage/Liability Notice</p> <p>CFR(s): 483.10(g)(17)(18)(i)-(v)</p> <p>§483.10(g)(17) The facility must--</p> <p>(i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of-</p> <p>(A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged;</p> <p>(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and</p> <p>(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.</p> <p>§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.</p> <p>(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.</p> <p>(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.</p> <p>(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.</p> <p>(iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility.</p>	F0582		04/08/2026

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<p>F0582 SS = A</p>	<p>Continued from page 23 (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to provide a Notice of Medicare Non-Coverage (NOMNC, a form used by skilled nursing facilities to inform residents of the last day of Medicare Part A coverage and provides instructions on how to file an expedited appeal) and/or a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, a form used by skilled nursing facilities to inform residents about potential costs and coverage limitations for services that may not be covered by Medicare) prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary notification review (Residents #63 and #68).</p> <p>Findings included:</p> <p>1. Resident #63 was admitted to the facility on 12/2/25.</p> <p>Record review revealed Resident #63's Medicare Part A coverage for skilled services ended on 12/25/25. Resident #63 remained in the facility. There was no evidence a SNF ABN was reviewed with or provided to Resident #63 or his Responsible Party (RP).</p> <p>During an interview on 03/24/26 at 9:26 AM, the Social Worker stated she had recently been assigned responsibility for NOMNCs and SNF ABNs when the Business Office Manager resigned. She explained that therapy staff informed her when a resident's Medicare Part A skilled coverage was scheduled to end. She explained that did not know a SNF ABN was required for Resident #63. The Social Worker confirmed the facility was unable to locate any documentation showing that a SNF ABN was issued to Resident #63.</p> <p>During an interview on 03/25/26 at 12:13 PM, the Administrator revealed the Social Worker was responsible for issuing a SNF ABN at least two days in advance of skilled services ending if the resident was planning to remain in the facility.</p> <p>2. Resident #68 was admitted to the facility on 12/12/25.</p> <p>Record review revealed Resident #68's Medicare</p>	<p>F0582</p>		<p>04/08/2026</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345377	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2026	
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F0582 SS = A	<p>Continued from page 24 Part A coverage for skilled services ended on 1/13/26 with benefit days remaining. Resident #68 remained in the facility.</p> <p>The facility provided a copy of a NOMNC/ABN Telephone Notice for Resident #68 completed by the Social Worker dated 1/12/26. This form was utilized when the Resident Representative was unable to come to the facility to sign the NOMNC and/or the SNF ABN and included information on who was spoken to by phone. This 1/12/26 notice indicated a "dated copy of the notice was mailed on the date of telephone contact" to Resident #68's Resident Representative. This NOMNC/ABN Telephone Notice did not include all required elements of NOMNC and/or SNF ABN, such as the right to appeal, the appeals process, the amount the resident would have to pay out of pocket for the skilled care and the options about whether to continue skilled care.</p> <p>During an interview on 03/24/26 at 9:26 AM, the Social Worker stated she had recently been assigned responsibility for NOMNCs and SNF ABNs when the Business Office Manager resigned. She explained that therapy staff informed her when a resident's Medicare Part A skilled coverage was scheduled to end. The Social Worker stated she did not mail a copy of the NOMNC or the SNF ABN to Resident #68's Resident Representative. She added she mailed a copy of the NOMNC/ABN Telephone Notice to the representative. The Social Worker acknowledged the NOMNC/ABN Telephone Notice did not have the required elements such as the right to appeal, the appeals process, the amount the resident would have to pay out of pocket for the skilled care and the options about whether to continue skilled care.</p> <p>During an interview on 3/25/26 at 12:03 PM, the Administrator revealed the Social Worker was responsible for issuing a NOMNC at least two days in advance of skilled services ending and a SNF ABN if the resident remained in the facility and/or appealed the NOMNC. The Administrator stated he would have expected Resident #68 to have received a SNF ABN and a NOMNC when his Medicare Part A skilled services were ending, per regulatory guidelines.</p>	F0582		04/08/2026
F0640 SS = A	<p>Encoding/Transmitting Resident Assessments</p> <p>CFR(s): 483.20(f)(1)-(4)</p> <p>§483.20(f) Automated data processing requirement-</p> <p>§483.20(f)(1) Encoding data. Within 7 days after a</p>	F0640		04/08/2026

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<p>F0640 SS = A</p>	<p>Continued from page 25 facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. <p>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.</p> <p>§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:</p> <ul style="list-style-type: none"> (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. <p>§483.20(f)(4) Data format. The facility must transmit</p>	<p>F0640</p>		<p>04/08/2026</p>

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<p>NAME OF PROVIDER OR SUPPLIER East Carolina Health and Rehabilitation Center</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE 2575 W 5th Street , Greenville, North Carolina, 27834</p>		
(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
<p>F0640 SS = A</p>	<p>Continued from page 26 data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record reviews and staff interviews, the facility failed to transmit a death in facility Minimum Data Set (MDS) tracker into the Internet Quality Improvement and Evaluation System (iQIES) Centers for Medicare and Medicaid Services (CMS) database within the regulated time frame for 1 of 1 resident reviewed for Resident Assessment (Resident #60).</p> <p>The findings included:</p> <p>Resident #60 was admitted on 9/26/19.</p> <p>On 3/23/26 a review of Resident #60's Electronic Medical Record (EMR) revealed a completed death in facility MDS tracker dated 1/4/26. The tracker had not been transmitted to iQIES.</p> <p>During an interview on 3/23/26 at 11:46 AM MDS Nurse #1 explained that transmitting the resident's death in facility tracker was accidentally missed. She reported she was unsure how that happened.</p> <p>During an interview on 3/25/26 at 12:02 PM, the Administrator indicated Resident #60's death in facility MDS tracker should have been submitted within the required timeframe.</p>	<p>F0640</p>		<p>04/08/2026</p>