DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345437	A. BUILDING ______ B. WING ______	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECKERD LIVING CENTER	190 HOSPITAL DRIVE HIGHLANDS, NC 28741

(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 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, work order review and staff interviews, the facility failed to maintain doors, walls, and furnishings on 2 of 3 hallways with issues in 6 rooms (Rooms 109, 110, 112, 123 and the shared bathroom for Room 124 and 125) and 1 hallway (Rosewood Court) reviewed for environmental concerns. Findings included: An observation on 08/09/16 at 1:23 PM of room 123 revealed the metal lever used for opening and shutting the door was loose from the door and had the screws adhering it to the door exposed between the door and the lever. This caused a half inch gap to be present on each side of the door, between the door and the lever. An observation on 08/09/16 at 4:09 PM of the hinged side of the wooden door facing the hallway for rooms 109, 110 and 112 revealed multiple areas where small pieces of the wood on the door edge were missing. The missing small wooden pieces resulted in a sharp exterior edge of the door for all 3 rooms. The common area on the Rosewood Court hallway had a wooden storage compartment at one entryway into the common area. The wooden storage unit had a strip of cabinet molding missing on the side, revealing a jagged edge. An observation on 08/09/16 at 4:52 PM of the bathroom shared by residents in rooms 124 and 125 revealed a large hole behind the toilet	F 253	Eckerd Living Center LLC□s response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: On 8/12/2016 the metal lever used for opening and shutting the door and the hole in the wall behind toilet were repaired. On 8/12/2016 the wooden storage compartment was removed from service. On 8/24/2016, a manufacturer of acrovyn doors was contacted to replace the doors with missing pieces of wood. No residents were affected by the deficient practice. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. On 8/24/2016 a complete and thorough audit if all patient areas was conducted	9/3/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/02/2016

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 253	Continued From page 1 extending two feet in length and up to 4 inches in height where the baseboard and drywall were missing from the wall. During an interview with the Maintenance Technician (MT) on 08/12/16 at 3:25 PM, the MT stated work orders are put in the computer by the Health Care Unit Coordinator or Administrative Staff. He was able to access all work orders on the computer currently pending. Review of the work orders for the past six months revealed no requests for repairs regarding the concerns for rooms 109, 110, 112, 123 and the shared bathroom for room 124 and 125 had been reported. During a walking tour with the Director of Facility Services (DFS) and the Maintenance Technician (MT) on 08/12/16 at 3:34 PM, the MT stated he was unaware of the issues noted in rooms 109, 110, 112, 123 and the shared bathroom for room 124 and 125 and there was no work order for these issues. During an interview with Nurse #1 (N #1) on 08/12/16 at 3:49 PM, she stated if something was wrong in a room she would let maintenance know by telling the ward clerk directly or she could go on the computer herself and enter the concern. N #1 also stated she had also called maintenance in the past and let them know about the repair or concern that needed to be addressed. During an interview with Nurse Aide #1 (NA #1) on 08/12/16 at 3:55 PM, NA #1 stated she has never needed to contact maintenance for anything, but if she did she would let the charge nurse know and she thought the charge nurse would tell her who she needed to notify. During an interview with the Administrator on 08/12/16 at 4:27 PM, she indicated her expectation was for a safe, homelike, aesthetically pleasing environment for the	F 253	by the Administrator and the Facilities Manager. All furniture, fixtures, and surfaces were evaluated for repair. Work orders were entered for any necessary repairs and additional doors were added to the purchase order for replacement. No residents were affected by the potential for deficient practice. Systemic changes to ensure the deficient practice will not occur: All nursing management staff received Education on the electronic work order system for requesting facility repairs on 8/29/2016 by the Administrator. All nursing, environmental services, and nutrition services staff received education, through a series of inservices, on the importance of timely reporting of needed repairs to furnishings, fixtures, and surfaces on 8/29/2016 by the Administrator. The Administrator and the Facilities Manager shall schedule monthly Environment of Care (EOC) quality rounds. The rounds shall identify any current EOC deficiencies, determine necessary corrections, and implement temporary measures to ensure safety and compliance until permanent corrections can be completed based on material acquisition, etc. if necessary. The Facilities Manager shall enter work orders into the computerized maintenance work order system for all required corrections. The rounds will be ongoing. How facility plans to implement the	

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F 253	Continued From page 2 residents. She further acknowledged her expectation was for concerns to be reported and resolved in a timely manner.	F 253	corrective action and evaluate for its effectiveness: The Administrator and Facilities Manager will review all currently open facility work orders related to the EOC, review status, timeframe for completion, and adequacy of any temporary measures in place. The Administrator and Facilities Manager will review all work orders closed within the past month to ensure corrections are acceptable and will support long term safety for all residents. Work orders not completed in a timely manner or completed in an inadequate fashion may result in disciplinary action, as observed during EOC quality rounds, will be reviewed by the QAPI committee. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		9/3/16

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F 278	Continued From page 3 Under Medicare and Medicaid, an individual who willfully and knowingly 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 an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 2 of 16 sampled residents utilizing the Minimum Data Set (MDS) to reflect hospice care for (Resident #49) and active diagnoses for (Resident #49 and Resident #56). Findings included: 1 a. Resident #49 was admitted to the facility on 07/30/14 with diagnoses including Alzheimer's disease, aphasia (unable to speak), and cerebral vascular accident. A significant change Minimum Data Set (MDS) dated 03/03/16 indicated Resident #49 was coded under Section O-Special Treatments and Programs as receiving hospice care. A review of an Interdisciplinary Data Collection Form dated 05/25/16 indicated Resident #49	F 278	Eckerd Living Center LLC□s response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: The miscoded assessments were corrected via a significant correction on 8/12/2016. No residents were affected by the deficient practice. How corrective action will be accomplished for those residents having potential to be affected by	

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appeared comfortable with hospice care.

An MDS progress note dated 06/01/16 indicated Resident #49 was on hospice caseload.

A record review of the quarterly MDS dated 06/01/16 indicated Resident #49 was not coded under Section O-Special Treatments and Programs as receiving hospice care.

A review of the facility's list of hospice residents revealed that Resident #49 was included among the residents named on the list.

The MDS Coordinator was interviewed on 08/11/16 at 8:33 AM, regarding the accuracy of Resident #49's quarterly MDS. The MDS did not reflect hospice care for Resident #49. The MDS Coordinator stated the MDS should have been coded to reflect Resident #49 was receiving hospice care and was missed for coding. The MDS Coordinator stated the Quarterly MDS would require a correction to reflect Resident #49 was receiving hospice care.

On 08/11/16 at 10:08 AM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the quarterly MDS would have been coded accurately to reflect Resident #49 was receiving hospice care.

On 08/11/16 at 10:24 AM an interview was conducted with the Administrator. The Administrator stated it was her expectation that the quarterly MDS would have been coded accurately to reflect Resident #49 was receiving hospice care.

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the same deficient practice.
All MDS Assessments and CAA□s for the last 90 days were audited and compared to physician orders and medical diagnosis list appropriate for the corresponding ARD by 8/26/2016. No further miscoded diagnoses were identified. No residents were affected by the potential for deficient practice.

Systemic changes to ensure the deficient practice will not occur:
The MDS Nurse received education on the importance of properly coding diagnoses on the MDS on 8/29/2016 by the Administrator.
The MDS Coordinator will review all physicians orders, physician progress notes, and physician visits with in the last 90 days for new diagnoses. The MDS Nurse will include the new diagnoses on the MDS worksheet and properly code the diagnoses in the computerized assessment. Prior to locking each assessment, the MDS nurse will compare the list of diagnoses on the work sheet to the diagnoses selected on the computerized MDS assessment for accuracy.

How facility plans to implement the corrective action and evaluate for its effectiveness:
The Director of Nursing is responsible for monitoring and auditing the MDS Assessments and CAA□s to ensure

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F 278	Continued From page 5 1 b. A physician's order dated 03/16/16 indicated Resident #49 had diagnoses of neurogenic bladder. A care plan dated 03/16/16 indicated Resident #49 had an indwelling urinary catheter for a diagnoses of neurogenic bladder. A record review of the quarterly MDS dated 06/01/16 indicated Resident #49 was not coded under Section I-Active Diagnoses as having a diagnoses of neurogenic bladder. On 08/11/16 at 5:09 PM an interview was conducted with the Minimum Data Set (MDS) Coordinator who stated she was responsible for coding the diagnoses section of the quarterly MDS dated 06/01/16. The quarterly MDS did not reflect an active diagnoses of neurogenic bladder for Resident #49. The MDS Coordinator stated the MDS should have been coded to reflect Resident #49's active diagnoses of neurogenic bladder and was missed for coding. On 08/11/16 at 5:17 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the quarterly MDS dated 06/01/16 would have been coded accurately to reflect Resident #49 had an active diagnoses of neurogenic bladder. On 08/11/16 at 05:20 PM an interview was conducted with the Administrator. The Administrator stated it was her expectation that the quarterly MDS would have been coded accurately to reflect Resident #49 had an active diagnoses of neurogenic bladder. 2. Resident #56 was admitted to the facility on	F 278	no diagnoses have been missed or incorrectly coded. The Director of Nursing or their designee will perform weekly random audits of at least 5 assessments for the next 6 months. Audits are reviewed by the QAPI Committee, which meet monthly. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure changes to ensure that compliance is achieved and maintained.	

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F 278	Continued From page 6 07/10/15 with diagnoses including Alzheimer's disease, diabetes mellitus, and cerebral vascular accident. A review of the Care Area Assessment (CAA) for visual function dated 07/06/16 indicated Resident #56 had a diagnoses of macular degeneration. A record review of the annual Minimum Data Set dated 07/06/16 indicated under Section B-Hearing, Speech, and Vision that Resident #56 was coded as visually impaired. Resident #56 was not coded under Section I-Active Diagnoses as having a diagnoses of macular degeneration. On 08/11/16 at 3:30 PM an interview was conducted with the Minimum Data Set (MDS) Coordinator who stated she was responsible for coding the diagnoses section of the annual MDS dated 07/06/16. The annual MDS did not reflect an active diagnoses of macular degeneration for Resident #56. The MDS Coordinator stated the MDS should have been coded to reflect Resident #56's active diagnoses of macular degeneration and was missed for coding. On 08/11/16 at 3:56 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was her expectation that the annual MDS dated 07/06/16 would have been coded accurately to reflect Resident #56 had an active diagnoses of macular degeneration. On 08/11/16 at 04:13 PM an interview was conducted with the Administrator. The Administrator stated it was her expectation that the annual MDS would have been coded accurately to reflect Resident #56 had an active diagnoses of macular degeneration.	F 278		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure perishable foods were dated with their expiration date and labeled in 2 of 2 reach in refrigerators, failed to ensure perishable foods were dated with their expiration date in 2 of 2 iced beverage holding containers, and in 1 of 2 nourishment refrigerators. The findings included: 1 a. An initial tour of the satellite kitchen was conducted on 08/9/16 at 10:45 AM with the Patient Services Supervisor (PSS). Observation of reach in refrigerator #1 revealed 1 square plastic container with a mixed light brown food substance that was covered with plastic wrap and was unlabeled and undated, 1 small silver metal bowl of a green leafy vegetable which was covered in clear plastic wrap and was unlabeled and undated, and 1 large silver metal bowl of green leafy vegetable which was covered in clear plastic wrap and was undated and unlabeled, approximately 20 hardboiled eggs in a plastic container with a lid which was undated, and 7	F 371	Eckerd Living Center LLC□s response to this report of survey does not denote agreement with the statement of deficiencies; nor does it constitute an admission that any stated deficiency is accurate. We are filing the POC because it is required by law. Corrective Actions(s) that will be accomplished for those residents found to have been affected by the deficient practice: The unlabeled items were discarded at the time of survey. No residents were found to be affected by the deficient practice. How corrective action will be accomplished for those residents having potential to be affected by the same deficient practice. All food service and patient area refrigerators were checked for	9/3/16

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F 371	Continued From page 8 clear plastic 4 ounce containers which were undated and unlabeled and contained a white thick substance. On 08/09/16 at 10:45 AM an interview was conducted with the PSS who stated any leftover food in refrigerator #1 was required to have a label, a date when the food was prepared, and a date when the food would expire. The PSS stated the mixed light brown food substance was tuna salad and had not been dated or labeled and stated the thick white food substance was yogurt and had not been dated or labeled. The PSS stated the green leafy vegetable in the 2 silver bowls was a salad and had not been dated or labeled and stated the hard boiled eggs in the plastic container had not been dated. The PSS stated the tuna fish, yogurt, and green leafy vegetable should have been labeled and dated when prepared and should have contained an expiration date and further indicated the hardboiled eggs should have been dated. The PSS stated the hardboiled eggs were good for 7 days when they were removed from the original packaging. The PSS stated the hardboiled eggs had not been dated when taken out of the original packaging and placed in refrigerator #1. The PSS stated because the hardboiled eggs were not dated then it could not be determined if the hardboiled eggs had expired. The PSS stated he had no tracking system in place for checking refrigerator #1 for unlabeled and undated leftover foods. On 08/09/16 at 3:28 PM an interview was conducted with the Dietary Aide from the main kitchen who stated any leftover food which was stored in refrigerator #1 required a label, a date when the food was prepared, and a date when	F 371	unlabeled items. No further deficient practices were found. No residents were affected by the potential for deficient practice. Systemic changes to ensure the deficient practice will not occur: The nutrition services staff received education regarding the importance of properly labeling and dating perishable food items and individually packaged food items through a series of inservices ending on 9/2/2016 by the Food Services Manager. A food labeling gun was purchased And all nutrition services staff were educated on proper use. The gun enables stickers labeled with date and expiration date to be easily affixed to all individually packaged items. How facility plans to implement the corrective action and evaluate for its effectiveness: The Food Services Manager or Dietician is responsible for monitoring and auditing all food service refrigerators or items that require labeling for identification and expiration dates. The Food Services Manager or Dietician will perform weekly random audits of all food service refrigerators for the next 4 months. Audits are reviewed by the QAPI Committee, which meet monthly. The QAPI Committee is responsible for reviewing any trends or reoccurring issues and implementing procedure	

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the food would expire. The dietary aide stated leftover food was good for 3 days from when it was prepared and then should be discarded. The dietary aide stated yogurt was good for 7 days once it was removed from the original packaging but was required to be labeled and dated with an expiration date. The dietary aide stated the yogurt, tuna salad, and green leafy vegetable in refrigerator #1 should have been labeled and dated when prepared, and should have included an expiration date. The Dietary Aide stated the hardboiled eggs should have been dated when they were brought from the main kitchen and placed in refrigerator #1.

On 08/10/16 at 5:34 PM an interview was conducted with the Director of Food Service (DFS) who stated his expectation was that the dietary staff would have labeled and dated the tuna salad, yogurt, green leafy vegetable, and dated the hardboiled eggs in refrigerator #1 as per facility policy. The DFS stated his expectation would have been for the PSS to have checked refrigerator #1 daily to assure all leftover foods were dated and labeled. The DFS stated the unlabeled and undated foods should have been discarded and should not have been in refrigerator #1. The DFS stated he felt the dietary staff were aware of the facility policy for labeling and dating leftover foods but the unlabeled and undated leftover foods just got missed.

1 b. An initial tour of the satellite kitchen was conducted on 08/09/16 at 10:45 AM with the Patient Services Supervisor (PSS). Observation of reach in refrigerator #2 revealed 9 chocolate 4 ounce mighty shakes, and 5 strawberry plus 8 ounce mighty shakes were not dated when thawed. Manufacturer specifications on the

changes to ensure that compliance is achieved and maintained.

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mighty shake container indicated mighty shakes were good for 14 days after being thawed.

On 08/09/16 at 10:45 AM an interview was conducted with the Patient Services Supervisor (PSS) who stated he believed once the mighty shakes were thawed they were good for 7 days. The PSS stated the 9 chocolate 4 ounce and the 5 strawberry 8 ounce mighty shakes were not dated when they were taken out of the freezer to thaw. The PSS stated the mighty shakes were available for resident use and he could not determine if the mighty shakes had expired because they had not been dated when they were removed from the freezer to thaw. The PSS stated the process that was currently being used was that when the new mighty shakes were removed from the freezer the dietary staff rotated them without dating them to the back of the remaining mighty shakes in refrigerator #2. The PSS stated the oldest mighty shakes were rotated to the front of refrigerator #2 every 2 weeks by the dietary staff. The PSS stated there was no tracking system that the dietary staff actually rotated the mighty shakes in refrigerator #2. The PSS stated the dietary staff did not date any mighty shakes when they were removed from the freezer and he had no tracking system in place to determine when the mighty shakes would expire once thawed.

On 08/09/16 at 3:28 PM an interview was conducted with the Dietary Aide from the main kitchen who stated that the 9 chocolate 4 ounce and the 5 strawberry 8 ounce mighty shakes should have been dated when removed from the freezer. The Dietary aide stated the mighty shakes per facility policy would expire 7 days from removal from the freezer.

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(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 371	Continued From page 11	F 371		

On 08/10/16 at 5:34 PM an interview was conducted with the Director of Food Service (DFS) who stated his expectation was that the dietary staff would have dated the mighty shakes when they were removed from the freezer.

1 c. On 08/09/16 at 12:31 PM an observation was made in the main dining room of 1 chocolate 4 ounce undated mighty shake that was available for resident use and was located in an iced beverage holding container. An observation was made in the restorative dining room of 1 vanilla 4 ounce mighty shake, 1 chocolate 4 ounce mighty shake, and 1strawberry 8 ounce mighty shake that were undated and available for resident use and were located in an iced beverage holding container.

On 08/09/16 at 1:08 PM an interview was conducted with the Patient Services Supervisor (PSS) who stated he believed once the mighty shakes were thawed they were good for 7 days. The PSS stated the mighty shakes were available for resident use in the main dining room and the restorative dining room and he could not determine if the mighty shakes had expired because they had not been dated when they were removed from the freezer to thaw. The PSS stated the dietary staff did not date any mighty shakes when they were removed from the freezer and he had no tracking system in place to determine when the mighty shakes would expire once thawed.

08/10/16 at 5:34 PM an interview was conducted with the Director of Food Service (DFS) who stated his expectation was that the dietary staff would have dated the mighty shakes when they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345437	A. BUILDING ______ B. WING ______	08/12/2016

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were removed from the freezer.

1 d. On 08/09/16 at 1:06 PM an observation was made of the Dogwood nourishment refrigerator and revealed 1 banana/strawberry 4 ounce mighty shake that was undated.

On 08/09/16 at 1:08 PM an interview was conducted with the Patient Services Supervisor (PSS) who stated he believed once the mighty shake was thawed then it was good for 7 days. The PSS stated he could not determine if the 4 ounce banana/strawberry mighty shake in the Dogwood nourishment refrigerator had expired because the mighty shake had not been dated when it was removed from the freezer to thaw. The PSS stated the dietary staff did not date any mighty shakes when they were removed from the freezer and he had no tracking system in place to determine when the mighty shake would have expired once thawed and placed in the Dogwood nourishment refrigerator.

On 08/10/16 at 5:34 PM an interview was conducted with the Director of Food Service (DFS) who stated his expectation was that the dietary staff would have dated the mighty shakes when they were removed from the freezer.