## STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

### (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
- 345437

### (X2) MULTIPLE CONSTRUCTION
- A. BUILDING
- B. WING

### (X3) DATE SURVEY COMPLETED
- C 03/31/2022

### NAME OF PROVIDER OR SUPPLIER
- ECKERD LIVING CENTER

### STREET ADDRESS, CITY, STATE, ZIP CODE
- 250 HOSPITAL DRIVE
- HIGHLANDS, NC 28741

### ID PREFIX TAG
- SUMMARY STATEMENT OF DEFICIENCIES
- PROVIDER'S PLAN OF CORRECTION

### ID PREFIX TAG

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<th>ID</th>
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<tr>
<td>E 000</td>
<td>Initial Comments</td>
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An unannounced onsite recertification and complaint investigation survey were conducted on 03/28/2022 through 03/31/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #122111.

### F 000 INITIAL COMMENTS

An unannounced onsite recertification and complaint investigation survey were conducted on 03/28/2022 through 03/31/2022. A total of 2 allegations were investigated and they were not substantiated. NC00185990. Event ID #122111

### F 641 Accuracy of Assessments

**CFR(s): 483.20(g)**

§483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:

- Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 2 residents (Resident #17) reviewed for hospice services.

The findings included:

- Resident #17 was readmitted to the facility on 3/30/2019 with diagnoses which included Dementia and Cerebrovascular Accident (stroke).

- Hospice progress notes were reviewed and revealed Resident #17's hospices started on 11/25/2019 and was visited routinely by hospice staff. The Hospice progress notes included notes dated 1/11/2022 and 1/25/2022. Both progress

### COMPLETION DATE

- 4/23/22

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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<tr>
<td>F 641</td>
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<td>Continued From page 1 notes indicated Resident #17 was receiving hospice services with weekly visits from the home health aide and nurse.</td>
<td>F 641</td>
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<td>residents currently receiving hospice services were reviewed for accurate coding. No other deficient coding was found.</td>
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<td>An annual MDS assessment dated 10/13/2021 was reviewed and revealed Resident #17 was severely cognitively impaired and hospice services was coded as being received.</td>
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<td>• An audit report was generated from PointClickCare to monitor coding accuracy of MDS submissions. The audit report shows alerts related to inconsistencies in the coding from the prior assessment. The audit tool was used by the MDS Coordinator to review 100% of resident MDS’s. The audit tool will be generated with each MDS so the MDS Coordinator can compare coding on the previous assessment to the current assessment and make corrections immediately.</td>
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<td>A quarterly MDS assessment dated 1/12/2022 was reviewed and revealed Resident #17 was severely cognitively impaired and hospice services was not coded as being received.</td>
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<td>• To ensure improvements have been made, beginning 4/18/22, the MDS audit reports will be reviewed weekly by the Director of Nursing.</td>
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<td>A care plan dated 10/3/2021 and updated on 12/26/2021, 1/17/2022, 1/23/2022, and 3/28/2022 for Resident #17 showed a focus area for a terminal prognosis related to effects of a cerebral infarction with a goal stating resident’s comfort will be maintained through the review date. Interventions included to consult with physician and social worker to have hospice care for resident in the facility and to work cooperatively with hospice team to ensure the resident’s spiritual, emotional, intellectual, physical, and social needs are met.</td>
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<td>• Data related to the measure associated with this standard will be reported to the Eckerd Living Center Patient Safety &amp; Quality Committee for 3 consecutive months for 100% compliance. Any inaccurately coded MDS submissions will be discussed with MDS coordinator and action plan revised as necessary until goal is met.</td>
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<td>During an interview with the MDS coordinator on 3/31/2022 at 10:17 AM, the MDS coordinator indicated Resident #17 was on hospice and had been receiving hospice services for as long as the MDS coordinator had worked there which was a little over 2 years. The MDS coordinator stated it was an oversight that she had not coded hospice services for Resident #17 on the quarterly MDS dated 1/12/2022.</td>
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<td>• The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan.</td>
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<td>An interview with the Director of Nursing (DON) on 3/31/2022 at 12:18 PM revealed the quarterly</td>
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<td>• Completion date 4/23/22.</td>
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### Statement of Deficiencies and Plan of Correction

**Name of Provider or Supplier:** ECKERD LIVING CENTER

**Street Address, City, State, Zip Code:**
250 HOSPITAL DRIVE
HIGHLANDS, NC 28741

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>F 641</td>
<td>Continued From page 2</td>
<td></td>
<td>MDS assessment dated 1/12/2022 for Resident #17 should have been coded for hospice services.</td>
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<tr>
<td>F 644</td>
<td>Coordination of PASARR and Assessments</td>
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<td>4/23/22</td>
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**F 641**
MDS assessment dated 1/12/2022 for Resident #17 should have been coded for hospice services.

**F 644**
Coordination of PASARR and Assessments

**SS=D**
Coordination of PASARR and Assessments

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**Findings included:**

Review of Resident #24's PASARR documentation revealed a Level I screening was

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**Coordination of PASARR and Assessments**

During the recent survey the facility failed to refer a resident to screen for a Level II Preadmission Screening and Resident Review (PASARR) after the resident received a new mental health diagnosis in 2019. The oversight occurred due to lack of oversight of the MDS when the MDS Coordinator position was in transition and
F 644 Continued From page 3
completed on 07/31/2015.

Resident #24 was readmitted to the facility on
12/10/2018 with diagnoses included anxiety,
depression, delusional disorder, and bipolar
disorder.

Review of the diagnosis list indicated Resident
#24 was diagnosed with bipolar disorder on
04/13/21 and delusional disorders since
09/10/2021. Both diagnoses remained active.

The annual Minimum Data Set (MDS) dated
01/12/2022 coded Resident #24 with moderate
impairment in cognition and required supervision
for activities of daily living (ADL). Further review
of the MDS revealed Resident #24 had not been
referred to the appropriate state-designated
authority for Level II PASARR evaluation and
determination after she was diagnosed with
bipolar disorder and delusional disorder.

The comprehensive care plan dated 01/17/2022
indicated Resident #24 had mood problems
related to depression. She was at risk for adverse
reactions and side effects due to receiving
multiple psychotropic medications. The goal was
to have improved mood state without signs and
symptoms of depression, anxiety, or sadness
through the next review date. Interventions
included educated Resident #24 and family
regarding expectations of treatment and concerns
related to potential adverse effects of
medications. Monitored, documented, and
reported as needed when signs and symptoms of
self-harming occurred.

The March 2022 Medication Administration
Record (MAR) revealed Resident #24 was
being temporarily filled by a Registered
Nurse that was unaware of the
requirement and did not report the newly
coded diagnosis to the Social Worker.
The new MDS Coordinator was aware of
residents who met this requirement since
she assumed the role, but was unaware
that it was necessary to check for a Level
II PASARR on prior admissions.

- On 3/11/22, the Director of Nursing
verbally educated the MDS Coordinator
on standard CFR 483.20(e)(2) and the
finding from the recent survey.
- On 3/31/22, a Level II Change in
Condition PASARR was submitted for
Resident #24.
- On 3/31/22, all residents with newly
evident or possibly serious mental
disorders, intellectual disabilities, or a
related condition were reviewed for a
significant change in status assessment
and Level II PASARR submission. No
other deficiency was found.

- An audit tool was generated from
PointClickCare to monitor for all residents
with a diagnosis of a newly evident or
possibly serious mental disorder,
intellectual disability, or a related condition
that would require a Level II PASARR.
The audit tool was sent to the MDS
coordinator to review on 100% of resident
MDS’s. If a resident is identified with a
diagnosis of a newly evident or possibly
serious mental disorder, intellectual
disability, or a related condition that would
require a Level II PASARR, the MDS
Coordinator immediately alerts the Social
Worker, and together, they process the
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X2) MULTIPLE CONSTRUCTION A. BUILDING</th>
<th>(X3) DATE SURVEY COMPLETED</th>
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<th>NAME OF PROVIDER OR SUPPLIER</th>
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<th>(X5) COMPLETION DATE</th>
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| F 644             | Continued From page 4 receiving Depakote (anticonvulsant) Delayed Release 250 milligrams (mg) twice daily related to bipolar disorder, and Seroquel (antipsychotic) 150 mg once daily at bedtime for delusional disorder. | F 644        | request for the Level II PASARR.  
- To ensure improvements have been made, beginning 4/1/22, the MDS diagnosis report will be reviewed weekly by the Director of Nursing to ensure the appropriate level of PASARR is in place.  
- Data related to the measure associated with this standard will be reported to the Eckerd Living Center Patient Safety & Quality Committee for 3 consecutive months for 100% compliance. Any inaccurately coded MDS submissions will be discussed with MDS coordinator and action plan revised as necessary until goal is met.  
- The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan.  
- Completion date 4/23/22. | 4/23/22 |
| F 656             | Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) | F 656        | §483.21(b) Comprehensive Care Plans  
§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -  
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and |
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<td>Development/Implement Comprehensive Care Plan</td>
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(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident’s exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).

(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.

(iv) In consultation with the resident and the resident's representative(s)-

(A) The resident's goals for admission and desired outcomes.

(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the facility failed to develop a care plan for a resident with a diagnosis of diabetes mellitus for 1 of 5 residents reviewed for diabetes (Resident #192).

The findings included:

Resident #192 was admitted to the facility on 5/18/2021 with diagnoses which included Type 2 Diabetes Mellitus (DM).

A quarterly Minimum Data Set (MDS) dated 3/31/22, the Director of Nursing.
F 656  Continued From page 6
1/5/2022 revealed Resident #192 was severely cognitively impaired and had a diagnosis of DM.

Care plan review revealed there were no care plans in place for DM.

Physician’s orders reviewed and revealed the following orders:

- Humalog Solution 100 unit/milliliter (mL)- inject as per sliding scale subcutaneously (SQ) before meals and at bedtime for diabetes dated 12/21/2021

- Lantus Solution 100 unit/mL- inject 12 units SQ at bedtime for diabetes dated 12/21/2021

An interview with the MDS coordinator on 3/31/2022 at 10:35 AM revealed there was not a care plan in place for diabetes for Resident #192. The MDS coordinator indicated she was responsible for implementing the diabetes care plan for Resident #192 and it should have been caught during record reviews for the previous MDS assessment on 1/5/2022.

An interview with the Director of Nursing (DON) on 3/31/2022 at 12:18 PM revealed Resident #192 should have had a care plan in place for DM.

F 656  educated the MDS Coordinator on standard CFR 483.21(b)(b1) and 483.10 (c)(3)(i)(ii) (iii)(iv) (A)(B)(C) and the finding from the recent survey with.

- Following the survey on 3/31/21, the MDS Coordinator implemented a diabetic care plan for Resident #192.
- On 3/31/2022, all Residents with a diagnosis of Diabetes were reviewed for a current diabetic care plan. No other deficient practice was found.
- Members of the multidisciplinary care plan team, including the MDS Coordinator, review the care plans for admission, quarterly, and annual assessments during the weekly care plan meeting to ensure the care plan includes treatment and services based on the resident’s needs identified by the assessment, reassessment, and diagnostic testing results. The team compares the medication list and diagnosis list to the current care plans and makes additions or revisions as appropriate.
- To ensure sustainability of improvements, beginning the week of 4/18/2022, 12 records from the previous month’s care plan meeting will be reviewed and assessed by the Director of Nursing or designee for consistency between diagnosis, medications, and care plan problems and goals. The care plans will be reviewed to ensure the care plan includes treatment and services based on the resident’s needs identified by their assessment, reassessment, and diagnostic testing results.
- This review will occur for 3
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| F 656 | Continued From page 7 | F 656 | consecutive months for 100% compliance.  
• The compliance with the care plan including treatment and services based on the resident's needs identified by their assessment, reassessment, and diagnostic testing results will be reported monthly at the Eckerd Living Center Patient Safety & Quality Committee.  
• The Director of Nursing is responsible for implementing and overseeing the actions taken with this plan.  
• Completion date 4/23/22. | Each corrective action should be cross-referenced to the appropriate deficiency. | |