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 _____	10/19/2017

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 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on record review, staff, and family interviews the facility failed to provide supervision to prevent a resident who was cognitively impaired from exiting the facility unaccompanied for 1 of 6 residents reviewed for accidents (Resident #87). Findings included: Resident #87 was admitted to the facility from	F 323	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. The process that lead to the deficiency sited.	11/8/17

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

Electronically Signed | 11/08/2017

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 _____	10/19/2017

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 323	Continued From page 1 home on 07/18/17 with a diagnosis of Alzheimer's dementia. A review of the Nursing Evaluation/Data Collection form dated 07/18/17 indicated Resident #87 was admitted to the facility from home with a diagnosis of Alzheimer's dementia. Per nurse evaluation Resident #87 was alert and confused with poor recall upon admission. A record review of Resident #87's initial care plan dated 07/18/17 revealed an identified problem of wandering and staff were to allow safe wandering and were to provide frequent checks on Resident #87's whereabouts in the facility. Other interventions included apply code alert bracelet and check code alert every shift and redirect as indicated. Documentation on the care plan specified the code alert bracelet was applied 07/18/17. A record review of the Wandering Evaluation dated 07/18/17 revealed Resident #87 was a new admission with a diagnosis of dementia, was ambulatory, was able to walk alone, and had a history of wandering with an exit seeking behavior noted on 07/18/17. A review of the physician's admission history and physical dated 07/18/17 indicated Resident #87 had Alzheimer's dementia, memory loss, confusion, and was pleasantly demented with no history of violence and was seemingly happy. A nurse's note written 07/18/17 at 8:00 PM by Nurse #3 indicated Resident #87 was exit seeking after eating supper in the dining room and stated "I am going to get my car and going home, back home to Florida."	F 323	Upon admission, Resident #87 was assessed as at risk for elopement based on his cognition and his independent ambulatory status. The documentation received from the physician□s office indicated the resident #87 frequently got up during the night but did not attempt to leave the home. A Code Alert bracelet was applied and assessed to be properly functioning. Resident #87 was added to the once per shift checklist utilized by the staff to visualize and document proper functioning for each resident wearing a Code Alert bracelet. On the second day of admission, resident #87 was noticed by a CNA walking along a sidewalk that provides maintenance access and egress from the back garden to the main entrance of the building. The CNA immediately called to other staff for assistance and exited the building to join resident #87 outside on the sidewalk. Other staff responded to assist but resident #87 was easily directed back inside the building. The Resident had exited the building on his way from the dining room to the front sitting area. The garden area has an automatic sliding door that allows easy access. Although the sliding door is located in a high traffic hallway, the resident moved quickly enough to exit without immediate observation by passing nursing staff, nutrition staff, families, and residents. Resident #87 followed the sidewalk to the very back of the garden and exited through the service gate which has a hook latch but no lock due to Life Safety egress standards.	

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 _____	10/19/2017

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 323	Continued From page 2 A nurse's note written 07/19/17 at 6:40 PM by Nurse #2 indicated Resident #87 was found walking outside of the facility at Cherry Hall and was easily directed back into the facility. A record review of the facility's Safety and Security Event dated 07/19/17 at 6:40 PM indicated Resident #87 had been admitted to the facility on 07/18/17 and had cognitive impairment, was confused and disoriented, and was seen walking out side of the facility at Cherry Hall and was easily directed back into the facility. An interview was conducted with Nurse #1 on 10/17/2017 at 11:02 AM. She stated on 07/19/17 Resident #87 had finished eating supper in the main dining room and then was noticed walking outside of the facility by Nurse Aide (NA) #1 who alerted Nurse #1. Nurse #1 stated she immediately ran outside of the facility to approach Resident #87. The resident stated he was going to his car. Nurse #1 described Resident #87 as being easily redirected back into the facility. Nurse #1 explained Resident #87 was a new admission to the facility and was adjusting to the facility and had wandering behaviors. Nurse #1 stated Resident #87 used to be a salesman by trade and thought he was staying in a hotel. Nurse #1 stated the resident was not observed leaving the building. The nurse thought after eating supper in the main dining room and was ambulating back to his room, Resident #87 exited the building through the sliding glass doors to the garden. Nurse #1 further explained the garden gate located in the back of the garden was not locked with a secure lock due to fire codes. A telephone interview was conducted with NA #1	F 323	The procedure for implementing the acceptable plan of correction. Upon re-entry to the facility, staff were instructed to visualize Resident #87 every 30 minutes for potential elopement. The sliding door that he had exited through was alarmed for cold weather, meaning it would alarm any time the door was open. This was implemented immediately. This feature had been disarmed due to the longer days and warmer summer weather, and because there had never been any prior attempts to elope through the latched service gate. The maintenance gate was observed closed, but this is not unusual as it is self-latching. The next morning, a work order was entered to install a motion device on the back gate that would alarm at the nurses station if any person passed through the gate. The motion device was installed that day (7/20/2017.) A live security camera was also ordered for installation to be viewed on a monitor at the nurse□s station. This was installed 8/1/2017. New admissions who are noted to be actively exit seeking during the first 72 hours will be assigned a □buddy who will provide frequent oversight. The resident will be handed off from the buddy to an acceptable staff member, such as a dietary aide, volunteer, or activities professional, and then returned to the buddy at the completion of the activity. The interdisciplinary team will evaluate the resident 72 hours after admission (or sooner) to determine if the additional supervision is still required.	

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 _____	10/19/2017

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 323	Continued From page 3 on 10/17/17 at 3:06 PM. NA #1 stated as she was charting in the computer around supper time on Cherry Hall. Through the glass exit doors at the end of Cherry Hall she observed Resident #87 walking outside of the facility on the sidewalk. NA #1 stated she immediately called for staff assistance and went out of the facility to assist Resident #87 back into the facility. NA #1 stated Resident #87 stated he was looking for his car and was easily directed back into the facility. An interview was conducted with the Director of Nursing (DON) on 10/17/17 at 4:29 PM. The DON explained the sliding glass doors located on the "Main Street" hallway remained unlocked during the day when the weather was nice. The facility wanted the residents to enjoy being in the garden if they wanted. The door could be opened by standing in front of it. At night and on bad weather days, the door was locked. It could be opened by pushing a button next to the door. The button set off an alarm to alert staff someone had exited through the sliding glass door. A gate at the back of the garden had a latch but it was not a secure lock. Fire codes prohibited the garden gate to be locked since this was considered a fire exit. The DON stated after Resident #87 exited the facility through the garden gate, a motion sensor had been installed by the gate. The sensor was installed so that a person walking by or propelling in a wheelchair would set off an alarm. The DON added no resident had ever gone out that garden gate until Resident #87's exit. A telephone interview was conducted with Resident #87's Responsible Party (RP) on 10/18/17 at 9:52 AM. The RP stated Resident #87 was up frequently during the night to use the	F 323	The monitoring procedure to ensure that the plan of correction is effective and that the sited deficiency remains corrected and/or in compliance. Interventions initiated for Resident #87 have been successful as there have been no instances of elopement or aggressive wandering since 7/19/2017. The interdisciplinary team will review the Wandering Monitoring Sheet for 7 days for each new admission assessed to be at risk for elopement. Residents who continue to display aggressive wandering behaviors will continue to be monitored using the Wandering Monitoring Sheet until at risk behaviors are deemed manageable by the interdisciplinary team. The Wandering Monitoring Sheet documents trends in time of day, intent, situation, and location to provide nursing staff with resident specific information on wandering habits to ensure wandering behaviors are appropriately anticipated and care is modified to provide the highest level of safety. Nursing staff will be educated on the need to implement a resident specific intervention if a wandering behavior is indicated on the sheet. The interdisciplinary team will audit the immediacy and accuracy of interventions and reconcile them to the resident care plan. The Administrator will review all incident reports daily to identify any new elopement attempts or failures in interventions. Facility maintenance performs bi-weekly checks of all delayed egress and alarmed exits for proper functioning. Facility	

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 _____	10/19/2017

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 323	Continued From page 4 toilet. The RP stated she needed surgery and could no longer care for him at home because he had dementia and he made frequent trips to the bathroom all night. The RP explained before Resident #87 was admitted to the facility she sometimes took him during the day to a Senior Center. The RP stated while at the Senior Center Resident #87 would go to the door of the Senior Center and tell staff he was going to get his car so that he could pick her up. The RP stated he never exited the Senior Center. The RP added he had not wandered while at home and would go to the mail box daily to get the mail and come back inside the house. The RP stated she was informed by staff that Resident #87 had exited the facility and was redirected back into the facility. The wife further explained she had informed Resident #87 that he was staying in a hotel and had not informed him he was staying in a long term care facility. The RP stated she had no concerns whatsoever that staff were not keeping Resident #87 safe and he was immediately directed by staff back into the facility. An interview was conducted with Nurse #2 on 10/18/17 at 10:18 AM. The nurse stated she was on duty when Resident #87 exited the facility on 07/19/17. Nurse #2 stated Resident #87 had ambulated to and from the dining room unaccompanied by a staff member. Nurse #2 stated Resident #87 had been assessed on admission as being a wanderer. Nurse #2 added she had been informed by Resident #87's RP that when she took Resident #87 to the Senior Center, he had tried to look for his car. Nurse #2 stated she was completing end of shift charting around 6:40 PM at the nurses station when NA #1 informed her Resident #87 was outside of the facility at Cherry Hall. Nurse #2 stated she and	F 323	maintenance performs bi-weekly checks for proper functioning of the motion sensor on the maintenance gate and to ensure the gate is properly latched per Life Safety Code. The Cherry Trail night nurse performs nightly checks of all delayed egress and alarmed exits for proper functioning. The Cherry Trail nurse performs nightly checks for proper functioning of the motion sensor on the maintenance and to ensure the gate is properly latched per Life Safety Code. Proper functioning of doors, alarms, and Code Alert bracelets is documented on a check sheet. If a Code Alert bracelet if found to be improperly functioning, it is replaced with a new unit. If an alarming door, egress door, or motion sensor is found to be improperly functioning, Facilities is notified immediately (using the on-call schedule, if indicated) and a staff member is stationed at the faulty exit until Facilities arrives. Any system failure is reported to the Administrator. Audits/check sheets will be reviewed monthly by the Administrator for 4 consecutive months of 100% compliance. The QAPI team is responsible for reviewing any trends or reoccurring issues monthly. The QAPI team will perform a root cause analysis of any deficits in technology, education, or process that contributes to elopement risk and implement procedural changes to ensure that compliance is achieved and maintained. The title of the person responsible for implementing the plan of correction.	

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 _____	10/19/2017

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 323	Continued From page 5 Nurse#1 immediately went outside of the facility along with NA #1 and easily redirected Resident #87 back into the facility. An additional interview was conducted with the DON on 10/19/17 at 8:46 AM. The DON stated her expectation was that after Resident #87 finished eating supper in the dining room a staff member would have accompanied Resident #87 back to his hall and handed him over to a staff member. The DON stated Resident #87 was a new admission with wandering behaviors and should not have been left unaccompanied when exiting the dining room to return to his hallway and room. An interview was conducted with the Administrator on 10/19/17 at 10:31 AM who stated her expectation was that staff would have kept Resident #87 in visual range. The Administrator stated her expectation was that staff would have monitored Resident #87 when leaving the dining room until he was back on the hallway on which he resided.	F 323	Nursing Home Administrator	