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 _____	C 03/31/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECKERD LIVING CENTER	250 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
E 000	Initial Comments 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.	E 000		
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 000		
F 641 SS=D	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	F 641	Accuracy of Assessments During the recent survey the facility failed to accurately code the Minimum Data Set (MDS) for hospice services. An oversight in coding led to this deficiency. • On 3/31/2022, the Director of Nursing educated the MDS Coordinator on standard CFR: 483.20(g) and the finding from the recent survey. • On 3/31/2022 a significant correction of the MDS was submitted with the correct documentation of hospice services indicated on the corrected MDS. • On 3/31/2022, the MDS for all	4/23/22

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

Electronically Signed | 04/19/2022

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F 641	Continued From page 1 notes indicated Resident #17 was receiving hospice services with weekly visits from the home health aide and nurse. 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. 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. 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. 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. An interview with the Director of Nursing (DON) on 3/31/2022 at 12:18 PM revealed the quarterly	F 641	residents currently receiving hospice services were reviewed for accurate coding. No other deficient coding was found. • 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. • To ensure improvements have been made, beginning 4/18/22, the MDS audit reports will be reviewed weekly by the Director of Nursing. • 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.	

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F 641	Continued From page 2 MDS assessment dated 1/12/2022 for Resident #17 should have been coded for hospice services.	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident to screen for a Level II Preadmission Screening and Resident Review (PASARR) after the new mental health diagnoses for 1 of 2 residents (Resident #24) reviewed for Level II PASARR. Findings included: Review of Resident #24's PASARR documentation revealed a Level I screening was	F 644	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	4/23/22

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F 644	Continued From page 3	F 644		

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

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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. During an interview with the MDS Coordinator on 03/29/2022 at 2:17 PM, she stated Resident #24 was diagnosed with bipolar disorder and delusional disorder after she admitted to the facility. She confirmed Resident #24 had not been evaluated for Level II PASARR and explained the error was caused by her oversight. A joint interview with the Director of Nursing (DON) and the Administrator was conducted on 03/29/2022 at 2:28 PM. Both stated whenever a resident's level of care had changed, such as new diagnosis of bipolar disorder, they expected the MDS Coordinator to refer the resident for a Level II PASARR evaluation in a timely manner.	F 644	request for the Level II PASARR. • To ensure improvements have been made, beginning 4/1/22, the MDS diagnosis report will 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.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §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	F 656		4/23/22

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F 656	Continued From page 5 (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	F 656	Development/Implement Comprehensive Care Plan During the recent survey the facility failed to develop a care plan for a resident with a diagnosis of diabetes mellitus. The deficiency was the result of an oversight. The MDS Nurse failed to compare the resident's diagnosis/medication list to the care plan. • On 3/31/22, the Director of Nursing	

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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.	