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	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eckerd Living Center	250 Hospital Drive Highlands, NC 28741

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to obtain consent and inform the resident or Responsible Party in advance of the risks and benefits of psychotropic medications prior to initiation for 3 of 5 residents reviewed for unnecessary medications (Residents #36, #24, and #6).Findings Included: 1. Resident #36 was admitted to the facility on [DATE] with cumulative diagnoses that included unspecified dementia, anxiety disorder, depression and delusional disorder. A physician order dated 08/16/25 read quetiapine (anti-psychotic medication) 25 milligram (mg) tablet 1 tablet three times per day for anxiety and agitation. A physician order dated 12/10/25 read divalproex (anti-convulsant medication used for mood stabilization) 125 mg capsule 1 capsule three times per day for dementia with aggression and agitation. The order had a stop date of 04/09/26. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 had moderate cognitive impairment. She received anti-psychotic, anti-depressant and anti-convulsant medications and displayed physical and verbal behavioral symptoms directed towards others and rejection of care for 4-6 days during the lookback period. A physician order dated 04/09/26 read divalproex 125 mg capsule 2 capsules three times per day for dementia with aggression and agitation. Review of the April 2026 Medication Administration Record (MAR) for Resident #36 revealed quetiapine and divalproex were administered as ordered. Review of Resident #36's electronic medical record revealed no documentation that Resident #36's Responsible Party was informed in advance of the risks and benefits of initiating or increasing the dose of quetiapine or divalproex and consented to the treatment. During an interview on 04/10/26 at 11:50 AM the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Nurse Team Lead. She explained when there was a new psychotropic medication ordered a consent form was obtained from the resident or their Responsible Party. The Nurse Team Lead confirmed they were unable to find psychotropic medication consent forms for Resident #36 and could not recall if she had called Resident #36's Responsible Party or not. During an interview on 04/10/26 at 2:11 PM with the Director of Nursing (DON), she explained that the (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process for handling new orders including new or changed psychotropic medication orders was that the provider communicated all new or changed orders to the Nurse Team Lead, who was then responsible for calling the resident's Responsible Party. The DON stated she expected the Nurse Team Lead to document when they call the family in the resident's medical record. The DON stated she believed Resident #36's Responsible Party was called but acknowledged that this was not documented and that the required form had not been completed. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #36 was forgotten and should have been documented. 2. Resident #24 was admitted to the facility on [DATE] with cumulative diagnoses that included anxiety disorder and depression. A physician order dated 03/18/26 read duloxetine (antidepressant medication) 30 milligrams (mg) capsule one capsule two times a day for depression. The 5 Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #24 had severe cognitive impairment. She displayed behavioral symptoms not directed toward others that significantly interfered with Resident #24's social interactions and disrupted care. She received anti-anxiety and anti-depressant medications during the MDS assessment look back period. A physician order dated 04/01/26 read; lorazepam 0.5 mg tablet 0.25 mg every 24 hours as needed for daytime anxiety with agitation and lorazepam 0.5 mg tablet 0.5 mg every 24 hours as needed for bedtime anxiety with agitation. Both orders had a stop date of 04/14/26. Review of the April 2026 Medication Administration Record (MAR) for Resident #24 revealed the duloxetine was given as ordered. Further review of the MAR revealed the Lorazepam was given on 04/01/26, 04/02/26, 04/03/26, 04/04/26, 04/06/26, 04/07/26 and 04/09/26. Review of Resident #24's electronic medical record revealed no documentation that Resident #24's Responsible Party was informed in advance of the risks and benefits of initiating duloxetine or lorazepam and consented to the treatment. During an interview on 04/10/26 at 11:50 AM the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Team Nurse Lead. She explained when there was a new psychotropic medication ordered a consent form was obtained from the resident or their Responsible Party. The Nurse Team Lead confirmed they were unable to find psychotropic medication consent forms for Resident #24 and could not recall if she had called Resident #24's Responsible Party or not. During an interview on 04/10/26 at 2:11 PM with the Director of Nursing (DON), she explained that the process for handling new orders including new or changed psychotropic medication orders was that the provider communicated all new or changed orders to the Nurse Team Lead, who was then responsible for calling the resident's Responsible Party. The DON stated she expected the Nurse Team Lead to document when they call the family in the resident's medical record. Regarding Resident #24, the DON reported that she believed all consents were obtained verbally over the phone at admission; however, the psychotropic medication consent form was not documented. The DON (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated the documentation just fell through the cracks. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #24 was forgotten and should have been documented. 3. Resident #6 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and generalized anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had intact cognition. She displayed no behavioral symptoms and received antidepressant medication during the MDS assessment look-back period. Review of the March 2026 Medication Administration Record for Resident #6 revealed an active physician order dated 09/23/25 for escitalopram oxalate (antidepressant medication) 20 milligrams (mg) one time a day for depression/anxiety. Review of Resident #6's electronic medical record revealed no documentation that Resident #6 was informed in advance of the risks and benefits of initiating escitalopram oxalate 20 mg and consented to the treatment. During interviews on 04/10/26 at 11:50 AM and 04/10/26 at 2:05 PM, the Nurse Team Lead revealed she was responsible for obtaining psychotropic medication consents. She explained when a provider had a new order they gave it to the Nurse Team Lead and if the order was for a new psychotropic medication, the Nurse Team Lead obtained a consent form from the resident or their Responsible Party. The Nurse Team Lead stated she was not sure what had happened and confirmed they were unable to find a psychotropic medication consent form for Resident #6. During an interview on 04/10/26 at 3:04 PM, the Director of Nursing (DON) explained that new orders, including orders for psychotropic medications, were communicated by the provider to the Nurse Team Lead, who was responsible for notifying the resident or their Responsible Party (RP). The DON stated she expected the Nurse Team Lead to document the notification in the resident's medical record. The DON stated she believed Resident #6 was aware of the risks and benefits of the medication because she was followed by the Psychiatric Nurse Practitioner who discussed that information with her. The DON acknowledged they were unable to find a psychotropic medication consent form for Resident #6 and stated it was an oversight. During an interview on 04/10/26 at 3:15 PM, the Administrator revealed that she believed this problem occurred because there was no second check in place and once it fell through the cracks it was unknown that the consent form was missing. The Administrator stated the psychotropic medication consent form for Resident #6 was overlooked and should have been completed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to complete a discharge summary that included a recapitulation of the resident's stay for 1 of 1 sampled resident reviewed for discharge (Resident #47).Findings included:Resident #47 was admitted to the facility on [DATE].The 5-Day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had intact cognition and active discharge planning was in place.The discharge-return not anticipated MDS assessment dated [DATE] revealed Resident #47 discharged to the community.Review of Resident #47's electronic medical record on 04/10/26 revealed an undated, Transfer/Discharge Report containing the resident's demographic and clinical information including date of birth , date of admission to the facility, age, insurance details, allergies, primary contact information, primary physician information, medical diagnoses, most recent vital signs, and immunization history. It was noted under the section for current medications to refer to the medication administration record. The following sections of the report were left blank:*Advanced directive*Diet type/texture/fluid consistency*Resident-specific information related to behavior(s), ambulation, bladder/bowel status, feeding, and usual level of functioning.*Signature and date indicating the resident or representative received a copy of the Transfer/Discharge Report.During an interview on 04/10/26 at 11:14 PM, the Social Worker (SW) revealed she was responsible for long-term resident discharges and the Discharge Planner/Case Manger handled short-term resident discharges. The SW explained that the discharge process included arranging post-discharge needs, such as follow-up appointments, home health or equipment, and providing the resident or their representative with a satisfaction survey and list of the resident's medications with administration times. She also documented a progress note in the resident's medical record outlining the discharge arrangements. The SW stated if a follow-up appointment was arranged prior to the resident's discharge, the resident's medical records were faxed to the provider that included provider notes, therapy notes, and list of medications. The SW indicated she was not aware that a discharge summary that included a recapitulation of the resident's course of treatment while residing in the facility was also required.The Discharge Planner/Case Manager responsible for short-term resident discharges was unavailable for an interview.During an interview on 04/10/26 at 3:15 PM, the Administrator acknowledged that although the Transfer/Discharge Report they utilized contained some of the required discharge summary components, it did not summarize the resident's course of treatment while at the facility. The Administrator stated a discharge summary that included a recapitulation of Resident 47's stay with input from all disciplines should have been completed per the regulatory guidelines.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II PASRR (Preadmission Screening and Resident Review) evaluation for a resident with a serious mental health diagnosis for 1 of 2 residents reviewed for PASRR (Resident #3).Findings included:Review of Resident #3's medical records revealed the only evidence of a PASRR was a snapshot of the most recent evaluation completed on 07/28/22 and Resident #3 was determined as a Level I PASRR. Resident #3 was admitted to the facility on [DATE] with diagnosis which included bipolar disorder.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS revealed Resident #3 had an active bipolar disorder diagnosis and received antipsychotic medication on a routine basis only. Review of the physician's order dated 04/11/24 was for a psychiatric referral made for antipsychotic medication management. Review of Mental Health Psychiatric Nurse Practitioner (NP) medication management progress note dated 05/12/24 revealed Resident #3 was evaluated to have an active bipolar disorder diagnosis.Review of a Mental Health NP medication management progress note dated 03/17/26 revealed Resident #3 was evaluated for an active psychiatric diagnosis of bipolar disorder and recommended to continue the current treatment that included aripiprazole (antipsychotic) 7.5 milligrams (mg) at bedtime and bupropion (antidepressant) 300 mg extended release 24 hours.Review of the annual MDS assessment dated [DATE] revealed Resident #3 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. The MDS revealed Resident #3 was taking antipsychotic medications on a routine basis only and an antidepressant medication.Resident #3's comprehensive care plan revised on 04/06/26 included the use of psychotropic medications related to a bipolar disorder diagnosis with the goal to be free from psychotropic drug related complications through the review date. Interventions included to monitor, document, and report any adverse reactions of psychotropic medications. During an interview on 04/08/26 at 4:40 PM, the Social Worker (SW) revealed she had been in her position for five years and was responsible for ensuring newly admitted residents had a PASRR prior to their admission. She was aware Resident #3 had an active bipolar disorder diagnosis and was referred to psychiatric services. She explained no request for a Level II PASRR evaluation was made when Resident #3 was admitted on [DATE] because the resident did not demonstrate behaviors. She stated it was her understanding when a resident demonstrated behaviors, she needed to request an evaluation for Level II PASRR. The SW revealed she was not aware an evaluation for a Level II PASRR was needed when a resident was admitted with a mental health diagnosis and had a Level I PASRR. The SW confirmed on 02/28/24 she checked the North Carolina PASRR website prior to Resident #3's admission to ensure the resident had a PASRR but after 02/28/24 no request for a Level II PASRR evaluation had been made. During an interview on 04/10/26 at 3:12 PM, the Administrator confirmed no request was made for a Level II PASRR evaluation when Resident #3 was admitted on [DATE] with a mental health diagnosis. The Administrator stated going forward mental health diagnoses would be reviewed for newly admitted residents and if present a request would be made for a Level II PASRR evaluation.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to ensure a resident was seen by the physician within 30 days from admission for 1 of 1 sampled resident (Resident #2).Findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, dementia with agitation, diabetes, severe-protein calorie malnutrition, chronic kidney disease, and hypertension.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #2 had severe cognitive impairment.Review of Resident #2's electronic medical record (EMR) revealed no evidence he was seen by the physician.Review of Resident #2's EMR revealed he was seen by the Physician Assistant (PA) on 02/10/26 and the Nurse Practitioner (NP) on 03/05/26. During an interview on 04/10/26 at 11:33 AM, the Nurse Team Lead revealed she was responsible for keeping track of when physician regulatory visits were due. The Nurse Team Lead explained she ran a report from the computer system that listed the date residents were last seen by a provider (NP, PA or Physician,) manually marked the provider who conducted the visit on the report and then let the provider know what residents needed to be seen the next time the provider was at the facility. She stated once the resident was seen by the provider, she entered the date in the computer system. The Nurse Team Lead explained that typically the physician saw a resident for the initial admission visit; however, when the physician was at the facility on 02/25/26, Resident #2 did not show up on the list to be seen because the NP and PA had already seen him. She confirmed Resident #2 had not yet been seen by the physician and acknowledged it was an oversight.During an interview on 04/10/26 at 3:15 PM, the Administrator revealed the Nurse Team Lead was responsible for tracking when physician visits were due. The Administrator confirmed that although Resident #2 had been seen by both the NP and PA, he had not yet been seen by the physician. She explained the Nurse Team Lead was typically very good with keeping track of physician visits that were due but since Resident #2 was seen by both the NP and PA shortly after his admission, he did not appear on the physician-visit list and was inadvertently overlooked.