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
	345319	A. BUILDING _____ B. WING _____	C 10/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELDERBERRY HEALTH CARE	415 ELDERBERRY LANE MARSHALL, NC 28753

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #9MNF11.	F 000	Elderberry Health Care submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider's policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered	F 156		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Cutshall — TITLE: Administrator — (X6) DATE: 11-9-12

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.

Original Signature Date: 10-26-12

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F 156	Continued From page 1 under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156	The State Survey and Certification Agency's toll free complaint telephone number was posted on the bulletin board outside the Administrator's office on 10/04/12. An additional posting of the complaint number was posted on the bulletin board at the nurses' station. The facility was unable to determine why the sheet with the complaint number went missing during survey timeframe. The residents will be reminded at October and November Resident Council meetings of the location of the State complaint telephone number. The Social Worker will monitor and verify placement of the State complaint number weekly for the next 2 quarters. As part of the QAA process the Social Worker will report the results of her monitoring to QAA Committee monthly for next 2 quarters.	10/31/12

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F 156	Continued From page 2 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations, family interview, resident interview and staff interviews, the facility failed to prominently post the state survey and certification agency's toll free complaint telephone number. The findings are: On 10/02/12 at 10:50 AM a family member of Resident #21 was interviewed and stated they were aware of the state survey and certification agency's toll free complaint telephone number but it was not posted in the facility. On 10/03/12 at 4:00 PM it was observed that the state survey and certification agency's toll free	F 156		

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F 156	Continued From page 3 complaint telephone number could not be located in any prominent location within the facility. On 10/04/12 at 11:30 AM the chairperson of the Resident Council was interviewed and stated that he was unaware of the location of the state survey and certification agency's toll free complaint telephone number. On 10/04/12 at 5:08 PM Nurse #2 was interviewed. Nurse #2 stated that she sometimes worked as a charge nurse and the only location she knew where the state survey and certification agency's toll free complaint telephone number was posted was on a bulletin board by the Administrator's office. On 10/04/12 at 5:15 PM the Director of Nursing (DON) was interviewed and stated that in the past the state survey and certification agency's toll free complaint telephone number was posted on a bulletin board by the Administrator's office. On 10/04/12 at 5:20 PM the Administrator and Social Services Director were interviewed outside the Administrator's Office. The Administrator pointed to a blank spot on the lower left hand corner of the bulletin board outside her office and stated that the state survey and certification agency's toll free complaint telephone number was usually posted in that location. She stated that someone must have removed it from the bulletin board. The Social Services Director concurred that the state survey and certification agency's toll free complaint telephone number would normally be in that same location on the bulletin board.	F 156		
F 278	483.20(g) - (j) ASSESSMENT	F 278		

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F 278 SS=D	Continued From page 4 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. 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 medical record review and interveiws the facility failed to accurately assess a significant weight loss for one (1) of three (3) sampled residents reviewed for weight loss. (Resident #63)	F 278	Resident #63's care plan was updated on 10/09/12 with an individualized and personalized plan of action to address the 6 month weight change. Resident #63 was placed on a nutritional supplement on 10/03/12 and facility restorative dining program on 10/12/12. Weekly weights were implemented on 10/03/12. Resident #63 will continue with restorative dining and weekly weights until next care plan review on 10/21/12. A weight assessment was conducted to ensure there were no other residents with significant weight change not reflected on their MDS or care plan. The review did not identify any other residents.	

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F 278	Continued From page 5 The findings are: Resident #63 was admitted to the facility 11/25/09 with diagnoses which included Alzheimers dementia. Review of the current Minimum Data Set (MDS) revealed a quarterly assessment dated 8/23/12 which indicated no significant weight changes. The care plan for Resident #63 was last updated 8/30/12 and did not address actual or the potential for weight loss. Review of weights (measured in pounds) recorded in the medical record for Resident #63 included the following: 1/2012 116 2/2012 117 3/2012 117 4/2012 114 5/2012 112 6/2012 112 7/2012 108 8/2012 105 9/2012 103 10/2012 99 On 10/3/12 at 9:55 AM the assistant MDS coordinator stated he completed the nutrition section on the quarterly MDS dated 8/23/12 for Resident #63. The assistant MDS coordinator stated when completing a quarterly assessment his practice had been to only address weight changes of 5% or greater in the past month. Guidance included in the instructions on the MDS assessment indicates to note a "loss of 5% or more in last month or loss of 10% or more in last six months". The assistant MDS coordinator located the Quarterly Assessment Information	F 278	A revision was made to the weight section of the MDS quarterly assessment form. The revised MDS quarterly assessment form will be utilized at care plan meetings. The revised form will be compared with the weight report to ensure that all residents at risk for weight change are identified. All data collected for the MDS will continue to be reviewed by the care plan team. The data for weight change will be compared with the weight report which includes daily weights, weekly weights and monthly weights. All residents that trigger for weight change >5% in 30 days or >10% in 6 months will be identified and entered correctly on the MDS. The facility care plan team will continue to create a plan of care that addresses actual weight change or weight change potential. The facility will continue to hold its weekly Risk Meeting, with the DON, ADON, MDS staff and Dietary Manager in attendance.	

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F 278	Continued From page 6 form located in the medical record of Resident #63. The assistant MDS coordinator stated the information on the form was utilized when completing the assessment. Weights recorded on this form only included the current weight, weight 30 days prior and weight 90 days prior. The assistant MDS coordinator stated these were the weights used for the assessment which did not include a weight from the past six months. In the six month period from 2/12 (117 lbs) to 8/12 (105 lbs) Resident #63 had a greater than 10% weight loss. The assistant MDS coordinator stated because weight loss was not triggered on the 8/23/12 MDS it was not identified as an issue when the resident's care plan was reviewed 8/30/12. On 10/4/12 at 10:30 AM the Director of Nursing stated it was her expectation any changes in weight in the look back period of 30 and 180 days would be identified on a quarterly assessment. The DON stated she was not aware weight loss had not been identfied when the care plan for Resident #63 was updated 8/30/12 and felt the incorrect coding on the 8/23/12 quarterly MDS contributed to the problem.	F 278	This meeting will include discussions of all residents who trigger for weight change based on the weight report and MDS care planning. With the reviews occurring on a weekly and quarterly basis, the management nursing staff will be able to review the effectiveness of all interventions in place to prevent avoidable weight change and that the MDS data is being entered correctly. The ADON will review the MDS quarterly assessment form and the facility weight report weekly for next 2 months and then monthly for next 2 quarters to ensure all residents with significant weight change have been identified and care plan addresses any weight change. The ADON will report findings to QAA Committee monthly for next 2 quarters.	10/31/12
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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F 325	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to implement recommendations to prevent further weight loss for one (1) of three (3) sampled residents reviewed for weight loss. (Resident #63) The findings are: Resident #63 was admitted to the facility 11/25/09 with diagnoses which included Alzheimers dementia. Review of the current Minimum Data Set (MDS) revealed a quarterly assessment dated 8/23/12 which indicated no significant weight changes. The care plan for Resident #63 was last updated 8/30/12 and did not address actual or the potential for weight loss. The height recorded in the medical record for Resident #63 was 60 inches. Review of weights (measured in pounds) recorded in the medical record for Resident #63 included the following: 1/2012 116 2/2012 117 3/2012 117 4/2012 114 5/2012 112 6/2012 112 7/2012 108 8/2012 105 9/2012 103 10/2012 99	F 325	On 10/03/12, resident #63 was started on a supplement. Resident #63 was also started on restorative dining program on 10/12/12. Resident #63 has had a weight gain of 2.6 pounds since starting dining program. Resident #63 was reviewed by Registered Dietician on 10/10/12. Procedural changes were made to report and identify residents with significant weight change. The ADON will provide the Registered Dietician with a report identifying all residents with significant weight change.	10/31/12

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F 325	Continued From page 8 Physician progress notes for Resident #63 dated 5/18/12, 7/16/12, 8/17/12, 9/6/12, 9/10/12 and 9/18/12 did not address weight loss. Review of the medical record of Resident #63 from 1/12-current revealed she remained on a regular diet. No supplements had been ordered with or between meals. Dietary progress notes in the medical record of Resident #63 were reviewed from 1/2012 to current. The first time weight loss had been identified in the progress notes was 8/2/12. The note written by the consultant dietitian (RD) indicated "weight loss 3.4 lbs/month and 12 lbs/6 months (10.4%)". The recommendation to address the weight loss was "will continue regular diet and add 60cc Resource 2.0 BID (twice a day) to prevent further weight loss." Review of physician orders for Resident #63 did not include initiation of the Resource 2.0. Review of the Medication Administration Record (MAR) for August 2012-October 2012 did not include initiation of Resource 2.0. Review of Resident #63's tray card for breakfast, lunch and dinner did not include Resource or any other supplementation. On 10/3/12 at 9:55 AM the assistant MDS coordinator stated he completed the nutrition section on the quarterly MDS dated 8/23/12 for Resident #63. The assistant MDS coordinator stated when completing a quarterly assessment his practice had been to only address weight changes of 5% or greater in the past month. Guidance included in the instructions on the MDS assessment indicates to note a "loss of 5% or more in last month or loss of 10% or more in last	F 325	Registered Dietician will review residents identified to have significant weight change and make recommendations to physicians. The Dietary Manager and the ADON will compare weight reports and MDS assessment forms with Dietician's recommendations to ensure all residents with significant weight loss are identified and recommendations addressed. The ADON will monitor the accuracy of weight reports and MDS assessment form weekly for next 2 months and quarterly thereafter. ADON will report her findings to QAA committee monthly for next 2 quarters.	10/31/12

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F 325	Continued From page 9 six months". The assistant MDS coordinator located the Quarterly Assessment Information form located in the medical record of Resident #63. The assistant MDS coordinator stated the information on the form was utilized when completing the assessment. Weights recorded on this form only included the current weight, weight 30 days prior and weight 90 days prior. The assistant MDS coordinator stated these were the weights used for the assessment which did not include a weight from the past six months. In the six month period from 2/12 (117 lbs) to 8/12 (105 lbs) Resident #63 had a greater than 10% weight loss. The assistant MDS coordinator stated because weight loss was not triggered on the 8/23/12 MDS it was not identified as an issue when the resident's care plan was reviewed 8/30/12. On 10/3/12 at 10:25 AM the Food Service Director (FSD) stated all recommendations made by the RD ware given to management nursing staff. The FSD stated the RD usually wrote orders based on her recommendations. The FSD stated he does not follow-up on recommendations made by the RD to ensure they are implemented. The FSD stated he was present at the care plan meeting for Resident #63 on 8/30/12 and could not explain why the weight loss had not been addressed or identified as a concern. On 10/3/12 at 10:28 AM the Director of Nursing (DON) stated the practice in place for some time was for the RD to write a telephone order based on recommendations. The DON stated the physicians were all comfortable with following the RD recommendations and would sign the orders	F 325		

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F 325	Continued From page 10 written by the RD. The DON stated the RD left a list of all recommendations which were given to the Assistant Director of Nursing (ADON). On 10/3/12 at 10:35 AM the ADON discussed the facility practice for involving the RD in the assessment of residents with nutritional concerns. The ADON stated it was her responsibility to provide a list to the RD (on her monthly visit) of any residents with nutritional concerns. The ADON stated this list included residents with weight loss. The ADON located the list from 8/2/12 which included Resident #63. Beside the typed entry for Resident #63 was a handwritten recommendation for 60 cc's of Resource 2.0. A checkmark was next to the handwritten entry. The ADON explained that after the RD reviewed the record and documented recommendations on the sheet (that was provided during the visit) the recommendation was documented in a QA report. The ADON stated after documenting the information in the QA report she placed a check mark beside the recommendation. The ADON stated there was no follow-up to ensure orders were written for any recommendations by the RD. The ADON stated the RD must have forgotten to write the order for the 60 cc of Resource BID for Resident #63. The RD was not available for interview. Since 8/2/12 no other changes were made to address weight loss for Resident #63. Since 8/2/12, Resident #63 lost an additional six pounds.	F 325		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 11 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interviews and medical record review the facility failed to act upon pharmacy recommendations for one (1) of ten (10) sampled residents (Resident #75). The findings are: Resident #75's diagnoses included dementia with behaviors, agitation, and atrial fibrillation. Resident #75's physician orders for June 2012 through October 2012 included the antipsychotic Risperdal 0.5 milligrams at hour of sleep every night. A review of the Consultant Pharmacist Review Record revealed a recommendation was made on 6/12/12 for the physician to evaluate a dose reduction for Risperdal. The Pharmacist Review Record dated 8/17/12 repeated the recommendation made on 6/12/12 for the physician to evaluate a dose reduction for Risperdal.	F 428	The recommendations for resident #75 were addressed with the physician on 10/04/12. The physician acted upon both recommendations on 10/04/12. An audit was conducted to ensure no other residents had a pharmacy recommendation that their physician had not acted upon. Procedural changes were made to the follow-up portion of the system to reduce the risk of re-occurrence. The medical records clerk will double check the physician box at least weekly for communications from pharmacist to physicians including monthly pharmacist's reports to ensure reports are reviewed and acted upon by physician.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345319	A. BUILDING _____ B. WING _____	C 10/04/2012

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F 428	Continued From page 12 An interview with Nurse #2 on 10/4/12 at 12:50 PM revealed that the consultant pharmacist prints out the recommendations on-site the day of the review and gives those copies to the Director of Nursing (DON). The DON brings the recommendations to the nurse's desk and places them in the doctor's box to be addressed. After the recommendations are addressed, the doctor gives the recommendations to a nurse at the desk to have the order changed if needed. After the recommendation is addressed and the new order is completed, the form goes to medical records. An interview with Medical Records staff on 10/4/12 at 12:56 PM revealed the pharmacy recommendations for Resident #75 for 6/12/12 and 8/17/12 were found unsigned in the doctor's box at the nurse's desk and taken to the DON. An interview with the DON on 10/4/12 at 1:00 PM revealed that she received the consultant pharmacist recommendations the day of the review. After the recommendations were received, they were placed in the doctor's box at the nurse's station. The doctor's box contains documents that require a review and/or signature from a healthcare provider. After the recommendations are addressed by the healthcare provider, the nurse at the desk writes new orders as needed, and puts the signed recommendations in the medical records box to be filed. The DON stated that she would expect the healthcare provider to respond to the pharmacist recommendations within a month. The DON stated that the recommendations from June and August 2012 were brought to her today; Resident #75's physician was still in the building	F 428	The DON will verify that all pharmacist's reports are reviewed and acted upon by a physician monthly. As part of QAA process, the DON will report to the QAA Committee the findings of her reviews monthly for next 2 quarters.	

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F 428	Continued From page 13 and she took the recommendations directly to the physician. The physician addressed both recommendations at that time. The DON stated that she was not aware that pharmacy recommendations from June and August were located in the doctor's box unaddressed. The DON stated that there was no system to assure pharmacy recommendations were addressed timely after the recommendations were placed in the doctor's box. An interview with the Consultant Pharmacist on 10/4/12 at 1:24 PM revealed the recommendations are printed out the day of the medication review and given to the DON. The recommendations that required an immediate response were separated when given to the DON, and responses to those recommendations have been timely. All other recommendations that do not require an immediate response are placed in the doctor's box at the nurse's desk. The Consultant Pharmacist stated that if no response was received to the recommendation after approximately sixty (60) days, another recommendation to the doctor was issued.	F 428		