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	345319	A. BUILDING _____ B. WING _____	C 06/27/2019

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
E 000	Initial Comments An unannounced recertification survey was conducted on 06/24/19 through 06/27/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID KK8211.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was completed on 06/27/19. There was a total of 3 allegations investigated and none were substantiated. Event ID KK8211.	F 000		
F 641 SS=E	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) in the area of diagnoses for 1 of 3 residents reviewed for nutrition and 3 of 5 residents reviewed for unnecessary medications (Residents #1, #32, #38, and #43). Findings included: 1. Resident #1 was admitted to the facility on 12/12/18 with multiple diagnoses that included rheumatoid arthritis, diverticulosis, and hyperlipidemia. Review of Resident #1's signed Physician order summaries for the months of March 2019 and April 2019 revealed an order dated 12/14/18 for Hydroxychloroquine (medication used to	F 641	This Plan of Correction constitutes Elderberry Health Care□s written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law. 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. Any changes to Provider□s policy or procedures should be considered to be subsequent remedial measures as that concept is employed in	7/23/19

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

Electronically Signed | 07/19/2019

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F 641	Continued From page 1 decrease the pain and swelling of arthritis) 200 milligrams twice daily for inflammation/swelling. Review of Resident #1's corresponding Medication Administration Records for the months of March 2019 and April 2019 revealed the medication was administered as ordered. Review of the quarterly MDS dated 04/03/19 coded Resident #1 with severe impairment in cognition. There were no diagnoses marked under Section I, Active Diagnoses. During interviews on 06/27/19 at 8:13 AM and 10:42 AM, the MDS Coordinator explained the Nurse responsible for inputting the information on the MDS was on vacation but it was her responsibility to ensure the completed MDS was accurate. The MDS Coordinator reviewed Resident #1's MDS dated 04/03/19 and confirmed there were no diagnoses marked under Section I, Active Diagnoses. The MDS Coordinator stated it was her understanding if the Physician had not signed the diagnosis within the 7-day assessment period of the MDS then the diagnosis was not considered active or coded on the MDS. A team interview was conducted with the Administrator and the Resident Assessment Instrument (RAI) Clinical Coordinator (CC) for the state via telephone conference on 06/27/19 at 11:08 AM. The RAI CC explained the interpretation of the guidelines for completing Section I, Active Diagnoses of the MDS which meant if the resident received treatment for the disease within the assessment period, it was considered an active diagnosis and should be coded on the MDS. The Administrator voiced understanding of the interpretation and stated	F 641	Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. It has been the policy and goal of this facility for the resident assessment to accurately reflect the resident□s status through various aspects of Quality Assurance (QA). The facility has policies and procedures designed to maintain these goals. Nursing observations, checklists & monitoring; Minimum Data Set (MDS) audits; consultant reviews; QA monitoring and staff training are various examples of components utilized. Corrective Action- The MDSs for Resident□s #1, #32, #38 and #43 were reviewed by the MDS Coordinator from 7/1/19 and modified to add the missing active diagnoses. Identification of Others- Section I of the MDSs for all other residents were reviewed from 7/1/19 to 7/23/19 by_MDS and another RN for active diagnoses and modified to add active diagnoses where appropriate. Measures- A revision was made to the MDS data collection worksheet as of 6/28/19 to include a section for reviewing active diagnoses. The DON and ADON will review Section 1 on all MDS to ensure active diagnosis are listed before they are submitted, if errors MDS will correct. A log of all MDS has been developed to ensure the MDS are reviewed. Additionally MDS Coordinator to	

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F 641	Continued From page 2 when the Nurse who was responsible for completing MDS returned from vacation, she would explain the interpretation to him and if he needed further clarification, she would have him consult with the state RAI CC to ensure diagnoses were correctly coded on the MDS. 2. Resident #43 was admitted to the facility on 11/02/15 with multiple diagnoses that included diabetes, Gastroesophageal Refux Disease (GERD; damage to the lining of the lower esophagus), anxiety and moderate bipolar disorder. Review of Resident #43's signed Physician order summary for the month of May 2019 revealed the following orders: *07/11/18: Cymbalta (antidepressant medication) 30 milligrams (mg) every morning for mood disorder. *10/30/18: Protonix (medication used to decrease the amount of stomach acid) 20 mg daily for GERD. Review of Resident #43's Medication Administration Record for the month of May 2019 revealed the medications, Cymbalta and Protonix, were administered as ordered. Review of the quarterly Minimum Data Set (MDS) dated 05/13/19 coded Resident #43 with intact cognition and indicated she received an antidepressant daily during the 7-day assessment period. Under Section I Active Diagnoses, bipolar disorder or GERD were not marked as an active diagnoses. During interviews on 06/27/19 at 8:13 AM and 10:42 AM, the MDS Coordinator explained the	F 641	telephone conference with the RAI Clinical Coordinator (CC) for the state to ensure an accurate understanding of the RAI guidelines for Section I by 7/23/19. Monitor- The MDS assessments will be double checked after data entry for accuracy by DON and ADON beginning 6/24/19 and ongoing.The MDS Assistant will collect and input data. The MDS Coordinator will complete physical assessments. The MDS Coordinator will review data for Section I for accuracy. The DON/ADON will then review MDS Section I for accuracy before MDSs are submitted. The MDS Coordinator will provide the Director of Nursing (DON) and/or Assistant Director of Nursing/Quality Assurance (ADON/QA) with a completed list of reviewed MDSs every week for twelve (12) weeks, then quarterly. As part of the facilities Quality Assurance process, the ADON will present any negative findings to Administrator and presented and reviewed at Quarterly Assurance Committee meetings. The completion date will be 07/23/19.	

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F 641	Continued From page 3	F 641		

Nurse responsible for inputting the information on the MDS was on vacation but it was her responsibility to ensure the completed MDS was accurate. The MDS Coordinator reviewed Resident #43's MDS dated 05/13/19 and confirmed bipolar disorder or GERD were not marked as active diagnoses under Section I of the MDS. The MDS Coordinator stated it was her understanding if the Physician had not signed the diagnosis within the 7-day assessment period of the MDS then the diagnosis was not considered active or coded on the MDS.

A team interview was conducted with the Administrator and the Resident Assessment Instrument (RAI) Clinical Coordinator (CC) for the state via telephone conference on 06/27/19 at 11:08 AM. The RAI CC explained the interpretation of the guidelines for completing Section I, Active Diagnoses of the MDS which meant if the resident received treatment for the disease within the assessment period, it was considered an active diagnosis and should be coded on the MDS. The Administrator voiced understanding of the interpretation and stated when the Nurse who was responsible for completing MDS returned from vacation, she would explain the interpretation to him and if he needed further clarification, she would have him consult with the state RAI CC to ensure diagnoses were correctly coded on the MDS.

3. Resident #32 was admitted to the facility on 01/26/17 with diagnoses which included Alzheimer's disease and hypothyroidism.

Review of Resident #32's signed Physician's orders for the months of 04/2019 and 05/2019 revealed the resident was ordered Synthroid (a

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F 641	Continued From page 4	F 641		

medication for hypothyroidism) 50 micrograms (mcg) by mouth once a day for thyroid condition.

Review of Resident #32's Medication Administration Record dated from 04/28/19 through 05/04/19 indicated the resident received Synthroid 50 mcg by mouth once a day.

Review of Resident #32's quarterly Minimum Data Set assessment dated 05/04/19 revealed, under Section I for Active Diagnosis the resident was not coded for thyroid disorder.

During an interview with the MDS Coordinator (MDSC) on 06/27/19 at 10:42 AM, she explained that the person responsible for completing the MDS was on vacation, but it was her responsibility to ensure the completed MDS was accurate. The MDSC stated, her understanding of coding Section I for Active Diagnosis on the MDS was that if the Physician had not signed the diagnosis within the look back period of 7 days then the diagnosis was not active therefore, it would not be coded on the MDS.

A team interview was conducted with the Administrator and the Resident Assessment Instrument (RAI) Clinical Coordinator (CC) for the state via telephone conference on 06/27/19 at 11:08 AM. After the RAI CC explained the interpretation of the guidelines for completing Section I of the MDS, which meant if the resident received treatment (medication) for a disease within the look back period, then the disease was considered active. The Administrator voiced understanding of the interpretation. The Administrator stated, when the Nurse who was responsible for completing the MDS's returned from vacation she would explain the interpretation

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F 641	Continued From page 5	F 641		

to him and if he could not understand the interpretation she would have him consult with the RAI CC to assure the MDS assessments were coded correctly.

4. Resident #38 was admitted to the facility on 02/02/18 and had diagnoses which included cerebral vascular accident and depression.

Review of Resident #38's signed Physician's orders for the month of 05/2019 revealed an order for Zoloft (an antidepressant) 25 milligrams (mg) by mouth once a day.

Review of Resident #38's Medication Administration Record dated 05/01/19 to 05/08/19 revealed, the resident received Zoloft 25 mg by mouth once a day.

Review of Resident #38's quarterly Minimum Data Set (MDS) assessment dated 05/08/19 revealed, under Section N for Medications the MDS was coded as having received an antidepressant within the 7-day look back period but under Section I for Active Diagnoses the MDS was not coded as having depression within the look back period.

During an interview with the MDS Coordinator (MDSC) on 06/27/19 at 10:42 AM, she explained that the person responsible for completing the MDS was on vacation, but it was her responsibility to ensure the completed MDS was accurate. The MDSC stated, her understanding of coding Section I for Active Diagnosis on the MDS was that if the Physician had not signed the diagnosis within the look back period of 7 days then the diagnosis was not active therefore, it would not be coded on the MDS.

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F 641	Continued From page 6 A team interview was conducted with the Administrator and the Resident Assessment Instrument (RAI) Clinical Coordinator (CC) for the state via telephone conference on 06/27/19 at 11:08 AM. After the RAI CC explained the interpretation of the guidelines for completing Section I of the MDS, which meant if the resident received treatment (medication) for a disease within the look back period, then the disease was considered active. The Administrator voiced understanding of the interpretation. The Administrator stated, when the Nurse who was responsible for completing the MDS's returned from vacation she would explain the interpretation to him and if he could not understand the interpretation she would have him consult with the RAI CC to assure the MDS assessments were coded correctly.	F 641		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		7/23/19

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F 812	Continued From page 7 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure perishable foods were dated and labeled in 1 of 2 nourishment refrigerators, dated in 1 of 2 nourishment freezers, and dated and labeled in 2 of 2 nourishment rooms. The findings included: 1 a. An observation of nourishment room #2 refrigerator was conducted on 06/24/19 at 10:30 AM with the Dietary Manager (DM) and revealed 2 chocolate 4 ounce mighty shakes, 2 strawberry 4 ounce mighty shakes, and 1 vanilla 4 ounce mighty shake that were undated and available for resident use. Manufacturer specifications on the mighty shake container indicated mighty shakes were good for 14 days after being thawed. Further observation of nourishment room #2 refrigerator revealed 11 cherries and ¼ cup of blueberries in a clear zip lock plastic bag that were undated and unlabeled, and 1 opened can of 8 ounce diet lemon/lime soda that was undated and unlabeled. On 06/24/19 at 10:35 AM an interview was conducted with the DM who stated any leftover food in the nourishment room #2 refrigerator was required to be labeled with resident name and include a date when the food or beverage was placed in the refrigerator and was to be discarded within 3 days. The DM stated the leftover cherries, blueberries and opened soda container should have been dated and labeled with	F 812	It has been the policy and normal practice of this facility to store, prepare, distribute and serve food in accordance with professional standards for food service safety as reflected through various aspects of Quality Assurance (QA). The facility has policies and procedures designed to maintain these goals. Routine county food service safety inspections, dietary and nursing observations, checklists & monitoring, dietician planning and audits, consultant reviews, QA monitoring, Serve Safe Program and staff training are various examples of components utilized. Corrective Action- All items in nourishment rooms #1 and #2 that were undated and/or unlabeled were immediately discarded by the Dietary Manager (DM) as a precautionary measure on 6/24/19. Identification of Others- An inspection of all remaining perishable food items was conducted by the DM on 06/24/19 to ensure that no other foods items were undated and or unlabeled. No other items found. Measures- The Dm addressed with dietary staff the importance of dating and labeling of all food items. The facility policy on storing and labeling all food products was reviewed 6/24/19 - 6/27/19. The clinical staff was re-educated on the facility policy	

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F 812	Continued From page 8 resident's name when place in the refrigerator and discarded within 3 days. The DM stated the mighty shakes should have been dated when they were removed from the freezer because they were good for 14 days when removed from the freezer. The DM stated because the mighty shakes had not been dated when they were removed from the freezer there was no way to determine when they expired and should have been discarded. The DM immediately removed the mighty shakes, cherries, blue berries, and can of lemon/lime soda from the refrigerator. The DM stated he had 2 dietary aides who were responsible for checking the nourishment refrigerator every afternoon and he did not know why the undated and unlabeled food items, mighty shakes, and open can of soda were not discarded. On 06/24/19 at 10:50 AM an interview was conducted with the Administrator who stated her expectation was that the unlabeled and undated food, mighty shakes, and can of soda in nourishment room #2 refrigerator would have been discarded. 1 b. An observation of nourishment room #2 freezer was conducted on 06/24/19 at 10:32 AM with the Dietary Manager (DM) and revealed 1 undated prepackaged round shaped peanut butter and grape jelly sandwich which was out of its original container and was not dated and was ready for resident use. The DM immediately removed the peanut butter and jelly sandwich from the freezer. On 06/24/19 at 10:35 AM an interview was conducted with the DM who stated the prepackaged peanut butter and jelly sandwich	F 812	for storing and labeling food products on 6/24/19 - 7/8/19 by DON and DM. Memo was sent to all family members in 6/28/19 monthly statements to educate them on the facility policy about labeling and dating all food items. Documentation was added to admission packet to educate new family members on facility policy of dating and labeling of food items 7/10/19. Signage was placed on the nourishment room refrigerators with instructions to date and label any food items before placing them in refrigerator. The sign states: Do Not Place Any Food Items Without Name and Date On Them in Refrigerators. Any items found without date and name will be discarded. Sign was placed 7/1/19. An updated checklist was developed and implemented to verify and inspect nourishment rooms and nourishment room refrigerators to ensure all food products are dated and labeled. 7/1/19 DM will inspect and verify through documentation on checklist if any food items were in nourishment room or refrigerators daily for 30 days and then 2x weekly for 3 quarters. All undated or no labeled items will be immediately discarded. The DM will report and present documentation of checklists to QA committee at monthly QA meetings beginning on 7/17/19. The facility will no longer serve Mighty Shakes beginning 7/10/19. Ensure will be used as supplement and it comes with a date stamped on it from manufacture.	

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should have been dated when placed in the freezer. The DM stated he had 2 dietary aides who were responsible for checking the nourishment refrigerator every afternoon and he did not know why the undated peanut butter sandwich was not discarded.

On 06/24/19 at 10:50 AM an interview was conducted with the Administrator who stated her expectation was that the undated peanut butter sandwich in nourishment room #2 freezer would have been discarded.

1 c. An observation of nourishment room #2 was made on 06/24/19 at 10:33 AM with the Dietary Manager and revealed 1 loaf of white appearing bread that was undated and was available for resident use. The bread was observed not molded. The DM verified that the bread had no label as to the type of bread and no expiration date. The DM immediately removed the loaf of bread from resident use.

On 06/24/19 at 10:35 AM an interview was conducted with the DM who stated the loaf of bread should have been labeled and dated. The DM stated he had 2 dietary aides who were responsible for checking the nourishment room every afternoon and he did not know why the undated and unlabeled bread was not discarded.

On 06/24/19 at 10:50 AM an interview was conducted with the Administrator who stated her expectation was that the unlabeled and undated bread in nourishment room #2 would have been discarded

1 d. An observation of nourishment room #1 was conducted on 06/24/19 at 10:15 AM with the

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Dietary Manager (DM) and revealed 1 container of 64 ounce peanut butter that was undated when opened and was ¾ percent empty and was available for resident use. The DM immediately removed the 64 ounce container of peanut butter.

On 06/24/19 at 10:17 AM an interview was conducted with the DM who stated the peanut butter container should have been dated when opened and should have been discarded. The DM stated he had 2 dietary aides who were responsible for checking the nourishment room every afternoon and he did not know why the undated peanut butter was not discarded.

On 06/24/19 at 2:40 PM an interview was conducted with the DM who stated the manufacturer's recommendation indicated that the 64 ounce container of peanut butter was good for 2 months once opened. The DM stated because the peanut butter had not been dated when opened there was no way to determine when the peanut butter had expired and should have been discarded.

On 06/24/19 at 10:50 AM an interview was conducted with the Administrator who stated her expectation was that the undated peanut butter in nourishment room #1 would have been discarded.