STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345319	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderberry Health Care	415 Elderberry Lane , Marshall, North Carolina, 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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/16/25 through 11/19/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1DB620-H1.	E0000		01/15/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted on 11/16/25 through 11/19/25. Event ID: 1DB620-H1. The following intake was investigated 2582720. 1 of 1 complaint allegation did not result in deficiency.	F0000		01/15/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other	F0578	PLAN OF CORRECTION F578 Request/Refuse/Discontinue Treatment/Formulate Advance Directives The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 11/18/25 the Assistant Director of Nursing updated Resident #1's code status order and banner in the electronic health record to a full code. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice;	01/15/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345319**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **11/19/2025**

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F0578 SS = D	Continued from page 1 entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident, staff, Medical Records Clerk, Minimum Data Set (MDS) Assistant and the Physician, the facility failed to have effective systems in place for updating advance directive information throughout the medical record for 1 of 1 resident reviewed for advance directive (Resident #1). The findings included: The medical record for Resident #1 included an advance directive form dated 8/11/23 that indicated Resident #1 was a Do Not Resituate (DNR). Resident #1 was readmitted to the facility on 10/20/25. Review of a physician order dated 11/3/25 indicated Resident #1 was a DNR. The medical record had an advance directive with an effective date of 11/4/25. The 11/4/25 advance directive stated that Resident #1 was a full code. The admission Minimum Data Set (MDS) assessment dated 11/6/25 revealed that Resident #1 was cognitively intact. An observation of Resident #1's electronic medical record on 11/16/25 revealed a banner for Resident #1 indicating he was a DNR. The November 2025 electronic Medication Administration Record (MAR) indicated that Resident #1 was a DNR. On 11/17/25 at 11:00 AM an interview was held with	F0578	Continued from page 1 All residents have the potential to be affected. On 11/24/25 the Director of Nursing, Medical Records Clerk and MDS Nurse Assistant audited all current residents to ensure their advance directives, code status order, and banner in the electronic health record were all up to date and matched. No other residents were identified in the audit. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On 11/24/25 the Administrator, Director of Nursing, Medical Records Clerk, Social Worker, and MDS Nurse Assistant reviewed the current procedures regarding documentation for advance directives. Effective 12/01/25 the Social Worker will complete the Advance Directive paperwork with the resident and/or their Power of Attorney or legal representative. The Advance Directive form will then be sent to the Provider to be signed. The Social Worker will notify the Director of Nursing, Medical Records Clerk, and the MDS Nurse Assistance of the resident's code status based off their advance directives and any changes or updates on the day the advance directive is completed. The Advance Directive form will also be sent to the Medical Records Clerk to be scanned into the electronic medical record and also place in the code status notebooks at the nurse's station. The MDS Nurse Assistant or designee will update the resident's code status order and banner in the electronic health record. The Medical Records Clerk will keep an ongoing audit of all advance directives to ensure the advance directive paperwork is signed by all parties, a copy is kept in the code status notebooks, a copy is scanned into their medical record, and their code status order and banner in the electronic health record have been updated to correctly match the advance directive forms. The Administrator educated the Director of Nursing, Medical Records Clerk, Social Worker, and MDS Nurse Assistant on the updated process for ensuring the advance directives are updated correctly and timely throughout the entire medical record on 12/01/25. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing or designee will audit 5	

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F0578 SS = D	Continued from page 2 Resident #1. Resident #1 stated he understood the difference between a DNR and full code. He stated that he wanted to be full code and should be given cardiopulmonary resuscitation (CPR) if needed. On 11/18/25 at 8:33 AM an interview was conducted with Medication Aide #1. She stated that if she had to look up a residents' advance directive, she would look at the banner on the computer profile page. Medication Aide #1 pulled up Resident #1's medical record and stated he was a DNR. On 11/18/25 at 9:10 AM an interview was conducted with a Nurse #1. Nurse #1 stated if she needed to look up an advance directive information, she would either look in the advance directive binder at the nurse's desk or on the banner under the resident's picture in the medical record. On 11/18/25 at 9:54 AM an interview was conducted with the Social Worker (SW) who confirmed that she completed the advance directive form for all residents. The SW stated first she would complete the Brief Interview for Mental Status (BIMs) questions. If the resident was deemed cognitively intact, she would proceed with the advance directive questions and if the resident was deemed to have a cognitive impairment, she would get in touch with the Power of Attorney (POA) or legal representative to get the advance directive questions completed. If the resident wished to be a DNR the SW stated she would get the medical provider to sign the advance directive form that day. If the resident wished to be a full code, she would leave the advance directive form in the doctor's box for them to sign. Once the advance directive form had all the required signatures it then went to medical records to be scanned into the chart. The medical records clerk would also put the code status on the medical record banner. If a resident wanted to change their advance directive the SW stated she would just start the whole process all over again. The SW stated Resident #1 indicated he wanted to be full code and after he signed the advance directive form, she put the form in the doctor's box to be signed. On 11/18/25 at 9:57 AM an interview was conducted with the Medical Records Clerk. The Medical Records Clerk stated that once the advance directive form was complete with all required signatures, he would scan the form into the medical record. He also kept a log of all the DNRs and full codes. The Clerk stated he was not responsible for entering the advance directive information in the banner portion of the medical	F0578	Continued from page 2 residents weekly for 4 weeks and then monthly for 2 months to ensure the resident's advance directives are up to date throughout the medical record and the code status order and banner match the resident's advance directive paperwork. Audit results will be documented on the audit tool titled Advance Directives Audit. The Director of Nursing will present the audit results in the monthly Quality Assurance Performance improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 01/15/2026	

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F0578 SS = D	Continued from page 3 record, that would be the MDS Assistant's responsibility. The Medical Records Clerk stated that if a resident changed his code status the physician would send an email to notify the medical records clerk of the changes. The new advance directive would be rescanned into the chart and MDS Assistant would change the banner in the medical record. The Clerk stated he would verbally tell the MDS Assistant of the code status change. The Medical Records Clerk stated the physician did not notify him of the advance directive being changed for Resident #1, therefore the advance directive was not updated and the MDS Assistant was not informed to change the banner. On 11/19/25 at 12:40 PM a second interview was conducted with the Medical Records Clerk. He stated after thinking about it and reviewing his advance directive log, he did remember being made aware of Resident #1 change to his advance directive. The Clerk could not remember who informed him of the change. He stated that he informed the MDS Assistant of the change but for some reason there was a delay in changing the medical record banner. On 11/18/25 at 10:06 AM an interview was conducted with the MDS Assistant. She stated that she would enter the code status information, so it showed up on the banner in the medical record. She stated the physician who signed the advance directive should have informed her of the change so that she could make the changes needed. She was not informed by any staff, so no change had been made to the banner of Resident #1's medical record. A follow up interview with the MDS Assistant was attempted on 11/19/25 and was unsuccessful. On 11/18/25 at 2:10 PM a telephone interview was conducted with the part-time Physician for the facility. She stated that she worked at the facility one week every month. The Physician stated that Resident #1 had been in and out of the facility and during his previous admission he had been a DNR. When Resident #1 was readmitted to the facility on 10/20/25 he was a DNR and once at the facility he changed his code status to a full code on 11/4/25. The Physician stated on 11/4/25 she signed the advance directive form with the change from DNR to full code for Resident #1 and left it at the nurse's desk. The Physician could not remember if she wrote a progress note regarding the	F0578		

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F0578 SS = D	Continued from page 4 change with Resident #1's advance directive. The Physician was unsure if she had written an order for the full code for Resident #1 but stated she would be expected to do so. The Physician was unsure what happened to the advance directive after she signs and leaves it at the nursing desk, but she did know that eventually the advance directive would be scanned into the medical record. The Physician stated the advance directive should always be consistent throughout the chart and in the advance directive binder. The Physician stated that it appeared the system for advance directives needed to be “sharpened up a bit”.	F0578		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by:	F0690	PLAN OF CORRECTION F690 Indwelling Catheter The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center’s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; On 11/18/25, the Director of Nursing obtained an order for the use of the indwelling urinary catheter for Resident #11. The Director of Nursing also placed a securement device (anchor) on the catheter tubing of Resident #11’s indwelling urinary catheter on 11/18/25. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; On 11/24/25 the Director of Nursing and the Assistant director of Nursing audited for other residents with indwelling urinary catheters to ensure they had an order for an indwelling urinary catheter and they have a securement device (anchor) in place to prevent pulling/tension or trauma from the catheter tube. There were no other residents with indwelling urinary catheters. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient	01/15/2026

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F0690 SS = D	Continued from page 5 Based on observation, record review, and staff interviews, the facility failed to obtain a physician order for the use of an indwelling urinary catheter and failed to use a securement device (anchor) to prevent pulling/tension or trauma from the catheter tubing for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #11). Findings included: Resident #11 was admitted to the facility on 11/01/25 with diagnoses which included chronic urinary retention. Resident #11's baseline care plan dated 11/03/25 revealed a bowel and bladder section marked for an indwelling catheter appliance. The 5-day Minimum Data Set dated 11/08/25 revealed Resident #11 had severe cognitive impairment and was coded for an indwelling urinary catheter. Review of Resident #11's physician orders revealed no order for an indwelling urinary catheter. Further review of Resident #11's physician order revealed an order dated 11/03/25 that read; provide catheter care and document output every shift. An observation of urinary catheter care on 11/18/25 at 2:01 PM with Nursing Assistant (NA) #1 and NA #2 revealed that Resident #11 had an indwelling urinary catheter. There was no urinary catheter tubing securement device. There was no tension observed on the urinary catheter tubing and the urinary bag was on the side of the bed below the resident's bladder. An interview on 11/18/25 at 2:14 PM with NA #1 and NA #2 revealed NA #1 was assigned to provide care for Resident #11 that shift. They did not know why Resident #11 did not have a urinary catheter securement device but indicated he should have a securement device in place. NA #1 stated she should notify the nurse if the resident did not have a securement device. An interview on 11/18/25 at 2:19 PM with NA #3 revealed he was assigned to the hall where Resident #11 resided.	F0690	Continued from page 5 practice will not recur; On 11/25/25 the Director of Nursing re-educated all licensed nurses (including full time, part time, on the requirement to obtain a Physician order for all indwelling urinary catheters. Any licensed nurses that did not receive the education by 01/15/26 will not be allowed to work until they receive the education. Newly hired licensed nurses will be educated on the topic listed above during their orientation. On 11/25/25 the Director of Nursing re-educated all licensed nurses, medication aides, and certified nurse aides (including all full time, part time, and contact staff) on the need to ensure all indwelling urinary catheters have a securement device (anchor) in place to prevent tension/pulling and trauma from the catheter tubing. Any licensed nurses, medication aides, and certified nurse aides that did not receive the education by 01/15/26 will not be allowed to work until they receive the education. Newly hired licensed nurses, medication aides, and certified nurse aides will be educated on the topic listed above during their orientation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Director of Nursing, Assistant Director of Nursing or designee will audit all residents with indwelling catheters weekly for 4 weeks and then monthly for 2 months to ensure the resident has an order for the indwelling urinary catheter and a securement device (anchor) in place. Audit results will be documented on the audit tool titled Indwelling Catheter Audit. The Director of Nursing will present the audit results in the monthly Quality Assurance Performance improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 01/15/2026	

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F0690 SS = D	Continued from page 6 He stated he had checked on him in the morning of 11/18/25 but had not noticed he had no urinary catheter securement device. He stated if he had noticed he would have gotten a securement device from supply and applied it to the resident's leg. An interview on 11/18/25 at 2:26 PM with Nurse #2 revealed he was normally assigned to Resident #11 and he was unaware he did not have a urinary catheter securement device. He was unable to say why Resident #11 did not have a catheter tubing securement device but stated he should have. An interview on 11/18/25 at 3:24 PM with the Director of Nursing (DON) revealed Resident #11 should have a urinary catheter tubing securement device and a physician's order for a urinary catheter. She stated these were staff oversights. The DON indicated when Resident #11 was admitted to the facility with the urinary catheter, the admission nurse was responsible for entering the urinary catheter order. An interview on 11/19/25 at 1:14 PM with the Administrator revealed she had been notified of Resident #11's lack of urinary catheter securement device and absence of a physician's order. She stated it was due to human error.	F0690		
F0812 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	F0812	PLAN OF CORRECTION F812 Food Procurement, Store/Prepare/Serve- Sanitary The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. # 1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; The following items in the walk in refrigerator were	01/15/2026

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F0812 SS = E	Continued from page 7 consuming foods not procured by the facility. §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 date and label food stored in the walk-in refrigerator. The facility also failed to dispose of a box of apples stored past their usable life. This was for 1 of 2 refrigerators (walk-in refrigerator) and 1 of 1 cart observed and had the potential to affect food served to residents in the facility. Findings included: On 11/16/25 at 8:45 AM an observation of the walk-in refrigerator was conducted. The observation found a slice of cake that was uncovered and not dated, a disposable container that was not dated and was labeled “tomato” containing 4 slices of tomatoes, and 2 opened resealable plastic bags that contained deli meat missing an opened date. The observation also found a tomato slice wrapped in plastic wrap that was missing a date, 2 blocks of opened sliced cheese that were undated and in an unsealed bag, and 1 opened bag of shredded cheese that did not include an open date. On 11/16/25 at 8:55 AM an observation in the kitchen found a box of apples stored on a cart. Approximately 7 apples were observed with signs of bruising with brown areas. Additionally, several fruit flies were observed around the apples. On 11/19/25 at 12:28 PM the Dietary Manager was interviewed. He stated the food that was not labeled, dated and expired was disposed of. The Dietary Manager said the Cook was responsible for checking the walk-in refrigerator for expired and dated food each morning. He also stated every dietary staff was responsible for dating and labeling food when it was stored for later use, and to dispose of any food past use. The Cook was not available for interview on 11/19/25. The Administrator was interviewed on 11/19/25 at 5:04 PM. The Administrator stated food stored in the kitchen should be dated and labeled and unusable food should be disposed of.	F0812	Continued from page 7 discarded on 11/17/25 by the Dietary Manager: Slice of cake that was uncovered and not dated. The disposable container of 4 tomato slices that was missing a date. The 2 opened resaleable plastic bags of deli meat that were missing an open date. Tomato slice wrapped in plastic wrap that was missing a date. The 2 blocks of sliced cheese that were undated and in an unsealed bag. The 1 opened bag of shredded cheese that did not include an open date. The box of apples with bruising/dark spots and fruit flies was discarded on 11/17/25 by the Dietary Manager. # - 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice; All residents have the potential to be affected. On 11/19/25 the Dietary Manager completed an audit of all food in storage to ensure all open food items were stored appropriately (in a sealed container/bag or covered in wrap), labeled, and dated. All fruits and vegetables were also audited for bruising/dark spots, signs of being unusable, and pests. No other food items were identified during the audit of the food storage areas. # -3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; All Dietary staff (full time, part time were re-educated by the Dietary Manager and Dietician 11/24/25 and 12/10/25 on the following topics: Ensuring all open food items are stored appropriately in a sealed container, sealed bag, or covered in wrap.	

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Elderberry Health Care	**415 Elderberry Lane , Marshall, North Carolina, 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
F0812 SS = E		F0812	Continued from page 8 Labeling and dating all open food items in storage. Checking all fruits and vegetables for bruising/dark spots, signs of being unusable, and pests. Any Dietary staff that did not receive the education by 01/15/26 will not be allowed to work until they receive the education. Newly hired Dietary staff will be educated on all topics listed above during their orientation. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. The Dietary Manager or designee will complete routine audits to ensure all open food items are stored appropriately in a sealed container/bag and are labeled and dated. Vegetables and fruit will also be reviewed during the audit to ensure there are no bruises/dark spots, signs of being unusable, or pest. The audit will be completed weekly for 4 weeks and then monthly for 2 months. Audit results will be documented on the audit tool titled Food Storage Audit. The Dietary Manager will present the audit results in the monthly Quality Assurance Performance Improvement Committee meetings for review and discussion. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date: 01/15/2026	