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 10/21/2015

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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		11/16/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/11/2015

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.

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to document evidence that an injury of unknown origin was thoroughly investigated and report the results of the investigation to the Health Care Personnel Registry for 1 of 1 resident sampled for injuries of unknown origin. (Resident #4). The findings included: Resident #4 was admitted to the facility on 08/06/13. Her diagnoses included atherosclerotic heart disease, anemia, thrombocytopenia, diabetes, osteoporosis, major depressive disorder, anxiety, renal insufficiency. The annual Minimum Data Set (MDS) dated 07/02/15 coded her with moderately impaired cognitive skills (scoring a 9 out of 15 on the Brief Interview for Mental Status), having altered consciousness, having no behaviors and requiring extensive assistance for all activities of daily living skills, including bed mobility and transfers requiring 2 person assistance. An Incident Report for Resident #4 dated 09/12/15 and completed by Nurse #1 was reviewed. The type of incident was "unknown trauma to (R) LE (right lower extremity)." The date of incident was 09/12/15 at 8:00 AM. The witness was listed as nurse aide (NA) #1. The description was that the resident complained of right foot pain and the nurse aide observed and reported to the nurse. The right "foot/ankle" was noted with dark purple bruising and a scab to the right lower extremity distal to ankle with a scant amount of dried blood on the sheet. Swelling was	F 225	F255&The facility has a policy on reporting and investigating incidents with unknown origin. Resident #4 was re-interviewed but unable to give a report of the incident. The Director of Nursing that did the investigation conducted a more thorough assessment of the incident involving Resident #4 on 10/22/15 that included the following: All staff involved with care of resident #4 during timeframe of incident was re-interviewed. NA #1 reported she had witnessed Resident # 4 attempt to transfer from bed to wheelchair. NA #2 reports that she also has witnessed Resident # 4 attempt to transfer self from bed to wheelchair. Leg protectors were placed on Resident #4 in addition to the safety matt on the floor and alarm on the bed that were already in place. The fall risk committee conducted a thorough assessment of Resident #4□s bed and wheelchair to determine if environment was a factor .NA #1 and NA#2 were observed transferring resident #4 to determine if transfer was proper and safe and for any risks of injury. If her feet dangle while transferring the right foot could have hit the wheelchair during transfer. Resident #4 will be transferred with assist of two staff. After reviewing all of the information gathered from the initial investigation completed on 09/14/15 and the second investigation completed on 10/22/15 there was no evidence of abuse. It was determined that Resident #4 may have hit her foot on wheelchair.	

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F 225	Continued From page 2 noted along the anterior right foot. Range of motion caused pain and pain was noted with weight bearing. Resident stated she could not remember cause of injury. Diagnoses related to the incident noted "?osteoporosis?". First aid included cold compresses, elevation of lower extremity and immobilize. An in-house X-ray was obtained. Both the Administrator and Director of Nursing (DON) signed (no date) that the follow up showed "severe osteoporosis" and no care plan was altered. A mobile X-Ray completed 09/12/15 at 12:06 PM included: *Right Ankle Complete 3 view: No displaced fracture evident. There is severe osteoporosis which could limit evaluation for nondisplaced fracture. *Right Foot Complete 3 view: Impression: "Question nondisplaced fracture proximal phalanx second toe in oblique view only." Review of the medical record revealed no nursing notes after 09/01/15 until 09/12/15. Nursing notes dated 09/12/15 at 1:30 PM listed vital signs and noted the resident complained of right foot pain. On exam noted bruising to anterior foot and ankle with swelling of foot. A scabbed area was present above the ankle with a small amount of dried blood on sheet. Beneath that area the right foot was tender to palpation, movement and weight bearing. A phone interview with Nurse #1 occurred on 10/21/15 at 10:37 AM. Nurse #1 stated that the injury was found during morning care. She stated bruising was observed on the ankle and heel to halfway down foot and just the ankle was swollen. She had received no reports of any trauma from	F 225	The DON and Administrator to determine if any injuries of unknown origin had occurred and to determine if the incident was thoroughly investigated, and if there was a need to report the incident to the Health Care Registry reviewed all incident/accident reports for the past month. There were no incidents / accidents of unknown origin. All reports of unknown injury will be reviewed by Administrator to ensure 24 hour and 5 reports are completed. Assistant Director of Nursing will review all reports of injury to determine if any of reports of injury are of unknown origin and report to Administrator and Director of Nursing immediately. Licensed nurses will be in-serviced by Director of Nursing on how to conduct and thorough investigation and how and when injuries of unknown origin are to be reported to the state. All reports of injury will be reviewed daily by Administrator and at weekly risk meetings to determine if any reports are injuries of unknown origin have occurred and to assure the incident was thoroughly investigated and reported to the Health Care Registry if applicable. If no issues were identified, the reports will be reviewed and discussed in the monthly Quality Assurance Performance improvement Committee meetings. The QA Committee will asses and modify the action plan as needed to ensure continual compliance.	

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F 225	Continued From page 3	F 225		

the off going shift. She stated she usually asked the previous shifts for information to help determine cause and will write down her findings. When explained that no interviews were documented, Nurse #1 stated she received no reports of trauma and could not determine if it occurred on the previous shift.

On 10/21/15 at 11:57 AM the DON was interviewed. DON stated the nurse was to fill out an incident report, start an investigation and implement interventions as appropriate, All incidents were discussed at morning meetings, all information gathered was reviewed and a determination was made for the need of any further interviews or investigations. She stated Resident #4 was very particular as to how her bed covers were to be on the bed and she determined the bruising occurred after she got her foot tangled in the sheet. She stated at this time she did not investigate or report to the state as an injury of unknown origin.

During follow up interview with DON on 10/21/15 at 12:57 PM, she stated the incident occurred on a Saturday. She spoke with Nurse #1, looked at the resident's foot and thought she spoke with NA #1 the following Tuesday. She stated the resident did not know what happened. She stated that in the past she has had "near misses" of falling out of bed from her feet getting tangled in the sheets and her feet swell sometimes. With that information she did not see a need to follow up further. When asked what would constitute an injury of unknown origin that would need investigation and reporting to the state agency, DON stated an unknown fracture or something she could not determine the cause after an initial evaluation. She further stated based on her

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preliminary investigation she determined the injury was not severe enough to support the need of a 24 hour and 5 day investigation report to the state agency. Upon further interview and review of the night shift schedule of 09/11/15, DON stated she also spoke with NA #2 who worked with Resident #4 the shift before the injury was found. She stated she had no documentation other than the incident report of any of her investigation into Resident #4's swollen bruised foot.

NA #2 was unable to be reached via telephone for interview.

An interview was conducted with NA #1 and NA #3 on 10/21/15 at 2:50 PM. NA #1 stated she found the injury when she came on her shift. Both nurse aides stated Resident #4 would ring her bell for assistance to use the toilet but usually stayed in bed the majority of the time. They stated the resident did not propel herself much down the hall when up in a wheelchair, was not up very long, and she did not move much or often in bed. Neither could recall her ever getting her feet tangled in the sheets.

Interview with the Administrator on 10/21/15 at 3:21 PM revealed she expected an injury such as a bruise or skin tear to be documented on an incident report. Administration then did an initial investigation, interviewing everyone that had any involvement with the resident surrounding the incident. She stated sometimes written statements were gathered. She stated that if then there was any concern that staff could not determine the cause of injury or that the injury was suspicious in nature, then a 24 hour and 5 day report was submitted to the state agency.

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F 225	Continued From page 5 The Administrator further stated that the resident could usually tell you what happened but she could not recall about this incident. She stated a judgement call was made that this injury did not warrant an investigation and report to the state agency as there was no fracture. She also stated she was not suspicious of the nature of the injury as she was "fragile" and the X-ray gave them false security.	F 225		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to secure a compressed oxygen cylinder during transport during one of one sampled residents. (Resident #5). The findings included: Resident #5 was admitted to the facility on 02/14/14 with diagnoses which included acute and chronic respiratory failure, pneumonia, chronic obstructive pulmonary disease, asthma,	F 328	F328&It is the policy of this Facility to secure a compressed oxygen cylinder during transport. Resident #5 will have oxygen cylinder secured while being transferred at all times. Oxygen cylinder was placed in secured flange immediately for Resident #5. NA # 4 was counseled by DON concerning the appropriate way to transport oxygen cylinders. All residents with oxygen were observed by DON to ensure oxygen tanks were secured. No	11/16/15

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F 328	Continued From page 6 and anxiety. The most recent quarterly Minimum Data Set (MDS) dated 07/24/15 indicated Resident #5 was severely impaired cognitively for daily decision making skills. The MDS further indicated Resident #5 was coded for receiving continuous oxygen therapy. Review of the care plan last updated 07/30/15 revealed Resident #5 received continuous oxygen therapy via a nasal cannula. The care plan further revealed interventions for Resident #5 were to be monitored for shortness of breath, check her oxygen saturation levels every shift and as needed. Further interventions included report shortness of breath to the physician and ensure that her tank was full prior to walking through the facility. Review of the facility procedure for Handling, Storage and Transporting Compressed Gases from the Long term Care Resident Care procedures Manual dated 2006 revealed compressed gases and cylinders should always be transported with a cart or hand truck, with the cylinder secured, cylinders were to have proper caps when not in use and during transport and rough handling, dropping and dragging of cylinders should be avoided. During an observation on 10/20/15 at 11:39 AM NA #4 was observed carrying an oxygen cylinder with her fingers by the oxygen valve into the shower room for Resident #5. The NA was interviewed and stated she did not think about using a cart to secure the empty compressed oxygen cylinders for transportation. She stated she should have used a cart to transport the compressed oxygen cylinders but she was in a hurry.	F 328	oxygen cylinders were found unsecured. Nursing staff will be re-educated on procedure of transporting oxygen cylinders securely by Assistant Director of Nursing.. Director of Nursing will check all residents using oxygen cylinders daily to ensure cylinders are secured properly and being transported securely for two weeks. Reports of monitoring of secure transport of oxygen cylinders will be reviewed in monthly QA meetings for 60 days and results reported to Administrator. Hall nurses will be monitoring oxygen cylinders daily to ensure cylinders are secure and properly transported.	

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F 328	Continued From page 7 An interview was conducted on 10/21/15 at 10:13 AM with the Nurse #2 the charge nurse. The Nurse #2 stated oxygen tanks were always to be transported securely in the wire rack with wheels. Nurse #2 revealed that oxygen cylinders should never be carried by hand by the neck or the valve of the cylinders. An interview was conducted on 10/21/15 at 1:08 PM with the Administrator. The Administrator stated compressed oxygen cylinders should be secured and transported in the hand held rolling cart. The Administrator further stated it was her expectation for all oxygen cylinders to always be transported in the carriers with wheels and never hand carried by the neck of the cylinder or the valve. An interview was conducted on 10/21/15 at 1:30 PM with the Director of Nursing (DON). The DON stated compressed oxygen cylinders should be secured and transported in the hand held rolling cart. The DON further stated there were spare oxygen cylinders in carrier carts in the oxygen storage room in case of emergencies ready for resident care. The DON stated it was her expectation for all oxygen cylinders to always be transported in the carriers with wheels and never hand carried by the neck of the cylinder or the valve.	F 328		