

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/31/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345319</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/04/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>ELDERBERRY HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>415 ELDERBERRY LANE MARSHALL, NC 28753</b>		
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F 278 SS=D	<p>483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED</p> <p>(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.</p> <p>(h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>(i) Certification (1) A registered nurse must sign and certify that the assessment is completed.</p> <p>(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>(j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-</p> <p>(i) 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</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately assess 2 of 3 sampled</p>	F 278		8/31/17	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE
Electronically Signed					08/25/2017

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 278	<p>Continued From page 1</p> <p>residents utilizing the Minimum Data Set (MDS) in the area of pressure ulcers (Resident #90 and Resident #52) and 1 of 3 sampled residents for dental (Resident #80).</p> <p>The findings included:</p> <p>1. Resident #90 was admitted to the facility on 02/07/17.</p> <p>An Initial Wound Observation Sheet dated 02/07/17 indicated Resident #90 was admitted to the facility with an unstageable pressure ulcer.</p> <p>A review of the Pressure Ulcer Observation Sheet indicated the Director of Nursing (DON) performed a wound assessment on 02/11/17 and determined Resident #90 had an unstageable pressure ulcer.</p> <p>A review of an admission Minimum Data Set (MDS) assessment dated 02/14/17 indicated Resident #90 had been coded under Section M Skin Conditions 0300 B as having one stage 2 pressure ulcer on admission and did not indicate under Section M Skin Conditions 0300 F that Resident #90 had an unstageable pressure ulcer.</p> <p>On 08/02/17 at 10:14 AM an interview was conducted with the DON who stated she performed a wound assessment on Resident #90 on 02/11/17. The DON stated Resident #90 had an unstageable pressure ulcer on admission to the facility. The DON reviewed the admission MDS assessment dated 02/14/17 and stated the admission MDS assessment should have reflected that Resident #90 had an unstageable pressure ulcer on admission to the facility rather than a stage II pressure ulcer.</p>	F 278	<p>The facility continually strives to ensure the resident's assessment accurately reflects the resident's status through various sources and programs both internal and external including but not limited to chart audits, monthly nursing reviews, pharmacy tracking, pharmacy consultant audits, nurse consultant audits, physician reviews, QAA studies, and other system processes.</p> <p>Plan of Correcting-</p> <p>The inadvertent coding error on Resident #90's and #52's skin condition assessment was corrected on 8/4/17 per RAI manual guidelines to accurately reflect section M for those residents. The corrections were transmitted to CMS by the MDS Coordinator on 8/4/17.</p> <p>The inadvertent coding error on Resident #80's dental assessment was also corrected on 8/4/17 per RAI manual guidelines to accurately reflect section L for that resident. The correction was transmitted to CMS by the MDS Coordinator on 8/4/17.</p> <p>Procedures/Measures-</p> <p>Beginning on 8/4/17 the MDS Coordinator and the Assistant MDS Nurse re-reviewed the RAI manual regarding how to accurately reflect a resident's status in sections L and M according to the RAI manual.</p> <p>The MDS Coordinator re-observed residents from 8/4/17 through 8/22/17 regarding sections L and M on their MDS</p>		

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F 278	<p>Continued From page 2</p> <p>On 08/02/17 at 10:36 AM an interview was conducted with the Assistant MDS Coordinator who stated he had coded Section M Skin Conditions 0300 B on Resident #90's admission MDS assessment. The Assistant MDS Coordinator stated Resident #90 had been assessed on 02/11/17 as having an unstageable pressure ulcer and the assessment occurred during the look back period from 02/08/17 to 02/14/17. The Assistant MDS Coordinator stated Resident #90 should not have been coded under Section M 0300 B as having one stage 2 pressure ulcer and should have been coded under Section M 0300 F as having one unstageable pressure ulcer on admission. The Assistant MDS Coordinator stated he had made an error in coding Resident #90's admission MDS assessment dated 02/14/17. The Assistant MDS Coordinator stated the admission MDS assessment would need to be modified and submitted to accurately reflect Resident #90 had an unstageable pressure ulcer on admission and did not have a stage 2 pressure ulcer.</p> <p>On 08/02/17 at 11:11 AM an interview was conducted with the MDS Coordinator who stated Resident #90's admission MDS assessment dated 02/14/17 had been incorrectly coded under Section M Skin Conditions. The MDS Coordinator stated Resident #90's admission MDS assessment should have been coded under section M 0300 F as having 1 unstageable pressure ulcer on admission. The MDS Coordinator stated Resident #90's admission MDS assessment had been incorrectly coded under Section M 0300 B as having 1 stage 2 pressure ulcer on admission. The MDS Coordinator stated Resident #90's admission</p>	F 278	<p>assessment while comparing data from the medical record to ensure accuracy.</p> <p>The MDS Consultant provided additional refresher training on 8/24/17 to the MDS Coordinator and the Assistant MDS Nurse regarding resident observations, data collection and other RAI manual guidelines for completing sections L and M of an MDS.</p> <p>Monitor- Monitoring to verify accuracy of sections L and M on the MDS will be performed by the Resident Care Coordinator. During the care plan process the MDS and medical record will be compared to ensure accuracy and compliance by the Care Plan Coordinator.</p> <p>The MDS Consultant will audit the MDS process quarterly for accuracy. Findings from the Resident Care Coordinator and the MDS Consultant will be submitted by the Resident Care Coordinator for review monthly by the Quality Assessment &amp; Assurance Committee (QAA) for the next six (6) months.</p> <p>Person Responsible for Implementing PoC- The Resident Care Coordinator will be responsible for implementing the plan of correction.</p>		

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F 278	<p>Continued From page 3</p> <p>MDS assessment dated 02/14/17 would need to be modified and submitted to reflect Resident #90 had an unstageable pressure ulcer on admission.</p> <p>On 08/02/17 at 1:24 PM an interview was conducted with the DON who stated her expectation was that the Assistant MDS Coordinator would have reviewed all information available in Resident #90's medical record prior to completing Section M Skin Conditions to assure accuracy of coding the admission MDS assessment. The DON stated her expectation was that the admission MDS assessment dated 02/14/17 would have been accurately coded to reflect Resident #90 had an unstageable pressure ulcer on admission. The DON stated her expectation was that the admission MDS assessment dated 02/14/17 would be modified and submitted to accurately reflect Resident #90 had an unstageable pressure ulcer.</p> <p>On 08/02/17 at 1:34 PM an interview was conducted with the Administrator who stated her expectation was that the admission MDS assessment dated 02/14/17 would have been accurately coded to reflect Resident #90 had an unstageable pressure ulcer on admission to the facility. The Administrator stated her expectation was that the admission MDS assessment dated 02/14/17 would be modified and submitted to reflect Resident #90 had an unstageable pressure ulcer.</p> <p>2. Resident #52 was admitted to the facility on 02/10/17.</p> <p>A review of a physician's history and physical dated 02/13/17 indicated Resident #52 had a stage I pressure ulcer to the coccyx.</p>	F 278			

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F 278	Continued From page 4  A review of the Initial Wound Observation Sheet dated 02/13/17 indicated Resident #52 had a stage I pressure ulcer to the coccyx.  A review of the Pressure Ulcer Observation Sheet dated 02/13/17 indicated Resident #52 had a stage I pressure ulcer to the coccyx.  An admission Minimum Data Set (MDS) assessment dated 02/17/17 indicated Resident #52 had not been coded under Section M Skin Conditions 0300 A as having a stage I pressure ulcer.  On 08/03/17 at 2:53 PM an interview was conducted with the Assistant MDS Coordinator who stated he coded Section M Skin Conditions on Resident #52's admission MDS assessment dated 02/17/17. The Assistant MDS Coordinator stated Resident #52 had been assessed on 02/13/17 as having a stage I pressure ulcer during the look back period from 02/11/17 to 02/17/17. The Assistant MDS Coordinator stated Resident #52 should have been coded under Section M 0300 A as having a stage I pressure ulcer and the pressure ulcer was missed for coding. The Assistant MDS Coordinator stated he had made an error in coding Resident #52's admission MDS assessment dated 02/17/17. The Assistant MDS Coordinator stated the admission MDS assessment dated 02/17/17 would need to be modified and submitted to accurately reflect Resident #52 had a stage I pressure ulcer.  On 08/03/17 at 3:14 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the Assistant MDS Coordinator would have reviewed all	F 278			

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F 278	<p>Continued From page 5</p> <p>information available in Resident #52's medical record prior to completing Section M Skin Conditions to assure accuracy of coding the admission MDS assessment. The DON stated her expectation was that the admission MDS assessment dated 02/17/17 would have been accurately coded to reflect Resident #52 had a stage I pressure ulcer. The DON stated her expectation was that the admission MDS assessment dated 02/17/17 would be modified and submitted to accurately reflect Resident #52 had a stage I pressure ulcer.</p> <p>On 08/03/17 at 3:29 PM an interview was conducted with the MDS Coordinator who stated Resident #52's admission MDS assessment dated 02/17/17 had been incorrectly coded under Section M Skin Conditions. The MDS Coordinator stated Resident #52's admission MDS assessment should have been coded under section M 0300 A that Resident #52 had a stage I pressure ulcer and was missed for coding. The MDS Coordinator stated Resident #52's admission MDS assessment dated 02/17/17 would need to be modified and submitted to reflect Resident #52 had a stage I pressure ulcer.</p> <p>On 08/03/17 at 3:49 PM an interview was conducted with the Administrator who stated her expectation was that the admission MDS assessment dated 02/17/17 would have been accurately coded to reflect Resident #52 had a stage I pressure ulcer. The Administrator stated her expectation was that the admission MDS assessment dated 02/17/17 would be modified and submitted to reflect Resident #52 had a stage I pressure ulcer.</p>	F 278			

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F 278	Continued From page 6  3. Resident #80 was admitted to the facility on 08/08/16.  A review of the Admission Data Collection Sheet for Resident #80 dated 08/08/16 confirmed upper and lower dentures were present upon admission to the facility.  An annual Minimum Data Set (MDS) assessment dated 04/07/17 indicated Resident #80 had been coded Z (none of the above problems exists) under section L of the oral/dental status.  On 08/04/17 at 12:09 PM an interview was conducted with the MDS Coordinator who confirmed having no natural teeth should have been coded B (no natural tooth or tooth fragments/edentulous) under section L of the oral/dental status of the annual MDS dated 04/07/17.  On 08/04/17 at 12:12 PM an interview was conducted with the Assistant MDS Coordinator who explained the look back period from 04/01/17 thru 04/07/17 was used to gather dental information for Resident #80. The information included an observation of the mouth and teeth. The Assistant MDS Coordinator confirmed the annual MDS dated 04/07/17 should have been coded B (edentulous).  On 08/04/17 at 1:04 PM an interview was	F 278			

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F 278	Continued From page 7 conducted with the Director of Nursing (DON) who revealed the expectations of the Assistant MDS Coordinator and the MDS Coordinator was for the MDS assessments to accurately reflect the dental status of Resident #80 and having no natural teeth would've been coded B (edentulous) under the oral/dental status of the annual MDS done 04/07/17.	F 278			
F 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  (b)(3) Comprehensive Care Plans  The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-  (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff and physician interview the facility failed to follow physicians' orders to administer a controlled medication to 1 of 7 residents (Resident #104) reviewed for medication administration.  The findings included:  Resident #104 was admitted to the facility on 07/19/17 with diagnoses including stroke and depression.	F 281	F281  It is this facility's philosophy and practice to ensure the services provided or arranged by the facility meet professional standards of quality. The facility has in place developed written policies and procedures. The clinical staff members are instructed during their orientation period concerning professional standards of quality. The nurse consultant, other support advisors provide routine refresher	8/31/17	



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F 281	<p>Continued From page 8</p> <p>Review of physicians' orders indicated an order for Resident #104 to receive Modafinil 100 milligram tablet (2 tabs for a total of 200mg) every morning beginning 07/20/17.</p> <p>On 08/04/17 at 10:45 AM during a review of the narcotic sign off log of the 100 hall medication cart it was discovered that a scheduled IV controlled medication (Modafinil) for Resident #104 was not signed off as given on 08/03/17. Nurse #3 pulled the narcotic medication card and verified the Modafinil had not been given on 08/03/17 as there was one dose left and the card should have been empty and the new card started.</p> <p>Review of Resident #104's August 2017 medication administration record (MAR) revealed the Moafinil was initialed as given on 08/03/17.</p> <p>On 08/04/17 at 11:01 AM, Nurse #2 stated she was the nurse who had given Resident #104's medication on 08/03/17 in the morning but was not able to remember if she gave him the Modafinil. Nurse #2 stated she remembered opening the medication cart to retrieve his medications but could not remember if she had actually opened the other drawer where controlled medications were kept under a second locked drawer.</p> <p>On 08/04/17 at 11:32 AM, the Director of Nursing (DON) stated it was her expectation for nursing staff to follow doctors' orders and to give Modafinil as prescribed and sign off on all medications after they are given.</p> <p>On 08/04/17 at 11:37 AM, Nurse #2 stated she typically reviewed one page of the MAR at a time</p>	F 281	<p>training and in-services, physician reviews, consultant reviews, quality assurance monitoring and routine staff training are examples of the various components utilized.</p> <p>Plan of Correcting- The single dose medication for Resident #104 that was not administered on 8/3/17 just prior to being transported from the facility was documented and addressed with the resident's physician on 8/4/17. Resident's physician indicated no harm was caused by a missed dose of this medication.</p> <p>The Director of Nursing provided on 8/4/17 direct one-on-one re-education with Nurse #2 regarding standard of practice for medication administration and charting procedures including the eight rights of medication administration (right person, right medicine, right time, right dose, right route, right documentation, right effect, and right education). The Director of Nursing conducted follow-up one-on-one observations with nurse #2 on 8/22/17.</p> <p>Procedures/Measures- The Director of Nursing provided one-on-one re-education with nurse #2 on 08/04/17 regarding standard of practice for medication administration including correct charting procedures.</p> <p>The Director of Nursing provided refresher training to other licensed nurses regarding the same topics as reviewed</p>		

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F 281	<p>Continued From page 9</p> <p>and retrieve all the medications on that page and sign off on them. Nurse #2 stated she would repeat the same process until she came to the last page of the MAR for that resident. Nurse #2 acknowledged she initialed off that medications were given before they were administered for Resident #104.</p> <p>On 08/04/17 at 11:41 AM, the physician stated she expected nursing staff to follow medical orders as written and sign off after a medication was given. The physician further stated no harm was done to Resident #104 from missing one dose of this medication as it was being used as a daytime stimulant for him after his stroke.</p>	F 281	<p>with nurse #2. Training and observations were completed on 8/22/17.</p> <p>Monitor- Pharmacy Consultant will observe medication passes with clinical nurses over the next quarter to monitor effectiveness of refresher training and submit findings to the Director of Nursing.</p> <p>Pharmacy Consultant and Administrative RN will conduct random observations monthly for the next 3 months and then quarterly for the next 2 quarters to monitor effectiveness of plan and submit findings to the Director of Nursing.</p> <p>The monitoring reports will be provided to the Quality Assessment &amp; Assurance Committee (QAA) by the Director of Nursing.</p> <p>Person Responsible for Implementing PoC- The Director of Nursing will be responsible for implementing the plan of correction.</p> <p>F000 Disclaimer 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,</p>		

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F 281	Continued From page 10	F 281	<p>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 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 deficiencies cited in the CMS-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process.</p>	