	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING		C		
		345319	B. WING		06/27/2019		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
	RRY HEALTH CARE			415 ELDERBERRY LANE			
LEBERDE				MARSHALL, NC 28753			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD			
TAG	(LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			
E 000	Initial Comments		E 000				
	conducted on 06/24						
F 000	INITIAL COMMENT		F 000				
	There was a total of	vey and complaint was completed on 06/27/19. 3 allegations investigated stantiated. Event ID KK8211.					
F 641 SS=E	Accuracy of Assess CFR(s): 483.20(g)	ments	F 641		7/23/19		
	resident's status.	y of Assessments. ist accurately reflect the IT is not met as evidenced					
	Based on record re facility failed to accu Data Set (MDS) in the 3 residents reviewed	view and staff interviews, the irately code the Minimum he area of diagnoses for 1 of d for nutrition and 3 of 5 for unnecessary medications #38, and #43).		This Plan of Correction constitutes Elderberry Health Care s written allegation of compliance for the deficiencies cited. However, submissi of this Plan of Correction is not an admission that a deficiency exists or t			
	Findings included:			one was cited correctly. This Plan of correction is submitted to meet			
		admitted to the facility on le diagnoses that included diverticulosis, and		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 or criminal action against the Provider any employee, agent, officer, director	civil r or		
	summaries for the n April 2019 revealed	#1's signed Physician order nonths of March 2019 and an order dated 12/14/18 for (medication used to		shareholder of the Provider. Any char to Provider□s policy or procedures sh be considered to be subsequent reme measures as that concept is employe	nges nould edial		

Electronically Signed

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.

07/19/2019

			0.00			OMB NO	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE COMF	SURVEY
			A. BUILDIN	1G			
		345319	B. WING				C
	ROVIDER OR SUPPLIER	545519			TREET ADDRESS, CITY, STATE, ZIP CODE	06/	/27/2019
NAME OF PI	ROVIDER OR SUPPLIER						
ELDERBE	RRY HEALTH CARE				15 ELDERBERRY LANE IARSHALL, NC 28753		
				IVI	•		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 641	Continued From page	9 1	F 6	641			
		d swelling of arthritis) 200			Rule 407 of the Federal Rules of		
		for inflammation/swelling.			Evidence and should be inadmissible in	n	
	Review of Resident #	-			any proceeding on that basis.		
	Medication Administra	ation Records for the					
		9 and April 2019 revealed					
	the medication was a	dministered as ordered.					
					It has been the policy and goal of this		
		ly MDS dated 04/03/19			facility for the resident assessment to		
		ith severe impairment in			accurately reflect the resident s status	6	
	under Section I, Activ	e no diagnoses marked			through various aspects of Quality Assurance (QA). The facility has policie		
		e Diagnoses.			and procedures designed to maintain	55	
	During interviews on (06/27/19 at 8:13 AM and			these goals. Nursing observations,		
		Coordinator explained the			checklists & monitoring; Minimum Data	1	
		inputting the information on			Set (MDS) audits; consultant reviews;		
	the MDS was on vaca				monitoring and staff training are variou		
	responsibility to ensu	re the completed MDS was			examples of components utilized.		
	accurate. The MDS (Corrective Action-		
	Resident #1's MDS da				The MDSs for Resident⊡s #1, #32, #38	В	
		no diagnoses marked			and #43 were reviewed by the MDS		
		e Diagnoses. The MDS			Coordinator from 7/1/19 and modified t	0	
		was her understanding if the			add the missing active diagnoses.		
		ned the diagnosis within the riod of the MDS then the			Identification of Others- Section I of the MDSs for all other		
		nsidered active or coded on			residents were reviewed from 7/1/19 to	, ,	
	the MDS.				7/23/19 by_MDS and another RN for	,	
					active diagnoses and modified to add		
	A team interview was	conducted with the			active diagnoses where appropriate.		
	Administrator and the	Resident Assessment			Measures-		
		ical Coordinator (CC) for the			A revision was made to the MDS data		
		onference on 06/27/19 at			collection worksheet as of 6/28/19 to		
	11:08 AM. The RAI C				include a section for reviewing active		
		uidelines for completing			diagnoses. The DON and ADON will		
	-	noses of the MDS which			review Section 1 on all MDS to ensure		
		received treatment for the			active diagnosis are listed before they a		
		sessment period, it was			submitted, if errors MDS will correct. A of all MDS has been developed to ensu	-	
		diagnosis and should be The Administrator voiced			the MDS are reviewed.		
							1

Facility ID: 923148

If continuation sheet Page 2 of 11

	-				FOR	D: 07/25/2019 M APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	CONSTRUCTION	(X3) DATI	O. 0938-0391 E SURVEY PLETED
		345319	B. WING		06	C / 27/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
			4	15 ELDERBERRY LANE		
ELDERBE	RRY HEALTH CARE		N	IARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 641	would explain the interneeded further clarific consult with the state diagnoses were correr 2. Resident #43 was a 11/02/15 with multiple diabetes, Gastroesop (GERD; damage to the esophagus), anxiety a disorder. Review of Resident # summary for the mon following orders: *07/11/18: Cymbalta (30 milligrams (mg) ev disorder. *10/30/18: Protonix (r the amount of stomac GERD. Review of Resident # Administration Record revealed the medicati were administered as Review of the quarter dated 05/13/19 coded cognition and indicate antidepressant daily of period. Under Sectio	was responsible for rned from vacation, she erpretation to him and if he sation, she would have him RAI CC to ensure actly coded on the MDS. admitted to the facility on e diagnoses that included hageal Refux Disease he lining of the lower and moderate bipolar 43's signed Physician order th of May 2019 revealed the (antidepressant medication) rery morning for mood medication used to decrease ch acid) 20 mg daily for 43's Medication d for the month of May 2019 ons, Cymbalta and Protonix, ordered.	F 641	DEFICIENCY) telephone conference with the RAI Coordinator (CC) for the state to er an accurate understanding of the F guidelines for Section I by 7/23/19. Monitor- The MDS assessments will be dou checked after data entry for accura DON and ADON beginning 6/24/19 ongoing. The MDS Assistant will co and input data. The MDS Coordina complete physical assessments. TI MDS Coordinator will review data f Section I for accuracy. The DON/A will then review MDS Section I for accuracy before MDSs are submitt MDS Coordinator will provide the D of Nursing (DON) and/or Assistant Director of Nursing/Quality Assurar (ADON/QA) with a completed list o reviewed MDSs every week for twe (12) weeks, then quarterly. As part of the facilities Quality Assu process, the ADON will present any negative findings to Administrator a presented and reviewed at Quarter Assurance Committee meetings. T completion date will be 07/23/19.	sure AI De cy by and lect tor will tor will tor DON ed. The irector de f lve rance nd	
		06/27/19 at 8:13 AM and Coordinator explained the				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		345319	B. WING				C 27/2019
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
ELDERBE	ERRY HEALTH CARE				415 ELDERBERRY LANE MARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 641	Nurse responsible for the MDS was on vaca responsibility to ensur- accurate. The MDS (Resident #43's MDS (confirmed bipolar disc marked as active diag the MDS. The MDS (understanding if the F diagnosis within the 7 the MDS then the dia active or coded on the A team interview was Administrator and the Instrument (RAI) Clini state via telephone co 11:08 AM. The RAI (interpretation of the g Section I, Active Diag meant if the resident disease within the ass considered an active coded on the MDS. T understanding of the when the Nurse who completing MDS return would explain the inter needed further clarific consult with the state diagnoses were correct 3. Resident #32 was a 01/26/17 with diagnos	r inputting the information on ation but it was her re the completed MDS was Coordinator reviewed dated 05/13/19 and order or GERD were not gnoses under Section I of Coordinator stated it was her Physician had not signed the day assessment period of gnosis was not considered e MDS. conducted with the Resident Assessment ical Coordinator (CC) for the onference on 06/27/19 at CC explained the uidelines for completing noses of the MDS which received treatment for the sessment period, it was diagnosis and should be The Administrator voiced interpretation and stated was responsible for rmed from vacation, she erpretation to him and if he cation, she would have him RAI CC to ensure octly coded on the MDS.	F	641			

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PRINTED: 07/25/2019

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/25/2019 MAPPROVED D. 0938-0391
STATEMENT OF	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345319	B. WING				C 27/2019
NAME OF PRO	VIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				4	415 ELDERBERRY LANE		
ELDERBERF	RY HEALTH CARE			ſ	MARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
n (i) FRA thS FEDUW E (() th M real o M d th w A A Ir s 1 ir S re we u A re	mcg) by mouth once Review of Resident #3 Administration Record Administration Record Synthroid 50 mcg by r Review of Resident #3 Data Set assessment under Section I for Ac vas not coded for thy During an interview w MDSC) on 06/27/19 a nat the person respon MDS was on vacation esponsibility to ensur accurate. The MDSC of coding Section I for MDS was that if the P liagnosis within the lo hen the diagnosis was would not be coded of team interview was administrator and the nstrument (RAI) Clini tate via telephone co 1:08 AM. After the R therpretation of the gr Section I of the MDS, eceived treatment (m vithin the look back p considered active. The inderstanding of the i administrator stated, versionsible for completion and the instrument (state) of the instrument.	yroidism) 50 micrograms a day for thyroid condition. 32's Medication d dated from 04/28/19 cated the resident received mouth once a day. 32's quarterly Minimum dated 05/04/19 revealed, tive Diagnosis the resident roid disorder. ith the MDS Coordinator at 10:42 AM, she explained hsible for completing the , but it was her the the completed MDS was stated, her understanding Active Diagnosis on the hysician had not signed the book back period of 7 days s not active therefore, it in the MDS. conducted with the Resident Assessment cal Coordinator (CC) for the inference on 06/27/19 at AI CC explained the uidelines for completing which meant if the resident redication) for a disease eriod, then the disease was ne Administrator voiced	F	641			

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If continuation sheet Page 5 of 11

CENTER STATEMENT (AND PLAN OF	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345319	. ,	ING _	E CONSTRUCTION	FORM OMB NC (X3) DATE COMF	D: 07/25/2019 MAPPROVED D. 0938-0391 SURVEY PLETED C 27/2019
				4	415 ELDERBERRY LANE MARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 641	RAI CC to assure the coded correctly. 4. Resident #38 was a 02/02/18 and had diagon cerebral vascular accorrectly and had diagon cerebral vascular accorrectly. Review of Resident # orders for the month of order for Zoloft (an arrow of the context of the month of the correct for Zoloft (an arrow of the context of the c	 anot understand the uld have him consult with the MDS assessments were admitted to the facility on gnoses which included ident and depression. 38's signed Physician's of 05/2019 revealed an htidepressant) 25 milligrams a day. 38's Medication d dated 05/01/19 to 05/08/19 t received Zoloft 25 mg by 38's quarterly Minimum ssment dated 05/08/19 on N for Medications the aving received an the 7-day look back period or Active Diagnoses the MDS ving depression within the with the MDS Coordinator at 10:42 AM, she explained nsible for completing the h, but it was her re the completed MDS was stated, her understanding r Active Diagnosis on the Physician had not signed the pok back period of 7 days as not active therefore, it 	F	641			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 07/25/2019 / APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345319	B. WING				C 27/2019
NAME OF PI	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
ELDERBE	RRY HEALTH CARE			415 ELDERBERRY LANE MARSHALL, NC 28753	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641	Continued From page	6	F 64	1			
F 812 SS=E	Instrument (RAI) Clini state via telephone co 11:08 AM. After the R interpretation of the g Section I of the MDS, received treatment (m within the look back p considered active. Th understanding of the i Administrator stated, responsible for compl from vacation she wo to him and if he could interpretation she wo to him and if he could interpretation she wo RAI CC to assure the coded correctly. Food Procurement, St CFR(s): 483.60(i)(1)(2 §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pr gardens, subject to co safe growing and food (iii) This provision doe	Resident Assessment cal Coordinator (CC) for the onference on 06/27/19 at AI CC explained the uidelines for completing which meant if the resident nedication) for a disease eriod, then the disease was ne Administrator voiced nterpretation. The when the Nurse who was eting the MDS's returned uid explain the interpretation not understand the uid have him consult with the MDS assessments were ore/Prepare/Serve-Sanitary 2) y requirements. e food from sources ed satisfactory by federal, es. ood items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable	F 81	2			7/23/19

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		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	E SURVEY IPLETED
			A DOILDING			С
		345319	B. WING		06	6/27/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP		
	RRY HEALTH CARE			415 ELDERBERRY LANE		
ELDERBE	KKI HEALIH CARE			MARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 812	Continued From page	7				
F 012	10		F 81	12		
		prepare, distribute and ance with professional				
	standards for food se	•				
		is not met as evidenced				
	by:					
	-	ns and staff interviews the		It has been the policy and	d normal practice	
	facility failed to ensur	e perishable foods were		of this facility to store, pre		
	dated and labeled in	1 of 2 nourishment		and serve food in accorda	ance with	
	refrigerators, dated in			professional standards for		
	freezers, and dated a	ind labeled in 2 of 2		safety as reflected through		
	nourishment rooms.			aspects of Quality Assura		
	The findings included			facility has policies and pr designed to maintain thes		
	The findings included			county food service safety		
	1 a An observation o	f nourishment room #2		dietary and nursing obser		
		ucted on 06/24/19 at 10:30		checklists & monitoring, d		
		Anager (DM) and revealed		and audits, consultant rev		
	2 chocolate 4 ounce i	mighty shakes, 2 strawberry		monitoring, Serve Safe Pr	ogram and staff	
	4 ounce mighty shake	es, and 1 vanilla 4 ounce		training are various exam	ples of	
		re undated and available for		components utilized.		
		cturer specifications on the		Corrective Action-		
		er indicated mighty shakes		All items in nourishment r		
	were good for 14 day	s after being thawed. of nourishment room #2		that were undated and/or		
		11 cherries and ¼ cup of		immediately discarded by Manager (DM) as a preca	-	
	-	zip lock plastic bag that		measure on 6/24/19.	utionally	
		labeled, and 1 opened can		Identification of Others-		
		/lime soda that was undated		An inspection of all remain	ning perishable	
	and unlabeled.			food items was conducted		
				06/24/19 to ensure that no	o other foods	
		AM an interview was		items were undated and c	or unlabeled. No	
		M who stated any leftover		other items found.		
		ent room #2 refrigerator was		Measures-	iotony staff the	
	-	d with resident name and the food or beverage was		The Dm addressed with d importance of dating and	-	
		ator and was to be discarded		food items. The facility po	-	
	within 3 days. The DM			and labeling all food produ		
	-	and opened soda container		reviewed 6/24/19 - 6/27/1		
	should have been dat	-		staff was re-educated on		

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					0010771071011		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	1 Y /	E SURVEY PLETED
			A. BUILDING	G			С
		345319	B. WING				/27/2019
	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	00	/2//2015
					5 ELDERBERRY LANE		
ELDERBE	RRY HEALTH CARE				ARSHALL, NC 28753		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 812	Continued From page	- 9		10			
FOIZ	Continued From page		F 81	12	for staring and labeling for shore durate		
		n place in the refrigerator 3 days. The DM stated the			for storing and labeling food products of 6/24/19 - 7/8/19 by DON and DM. Mer		
		d have been dated when			was sent to all family members in 6/28		
		rom the freezer because they			monthly statements to educate them o		
		s when removed from the			the facility policy about labeling and da		
	freezer. The DM state	ed because the mighty			all food items. Documentation was add	ded	
		dated when they were			to admission packet to educate new		
		ezer there was no way to			family members on facility policy of da	ting	
	-	expired and should have			and labeling of food items 7/10/19.	t	
		DM immediately removed herries, blue berries, and can			Signage was placed on the nourishme room refrigerators with instructions to o		
	of lemon/lime soda fr			and label any food items before placing			
	stated he had 2 dieta	-			them in refrigerator. The sign states: [-	
	responsible for check				Not Place Any Food Items Without Nat		
		ernoon and he did not know			and Date On Them in Refrigerators. A		
		unlabeled food items,			items found without date and name wil	ll be	
	•••	open can of soda were not			discarded. Sign was placed 7/1/19.	un al	
	discarded.				An updated checklist was developed a implemented to verify and inspect	ina	
	On 06/24/19 at 10:50	AM an interview was			nourishment rooms and nourishment		
		dministrator who stated her			room refrigerators to ensure all food		
		the unlabeled and undated			products are dated and labeled. 7/1/19	9	
	food, mighty shakes,	and can of soda in			DM will inspect and verify through		
		2 refrigerator would have			documentation on checklist if any food		
	been discarded.				items were in nourishment room or	-	
	4 h An charmention -	f			refrigerators daily for 30 days and ther		
		of nourishment room #2 ed on 06/24/19 at 10:32 AM			weekly for 3 quarters. All undated or n	0	
		ager (DM) and revealed 1			labeled items will be immediately discarded. The DM will report and pres	sent	
		d round shaped peanut			documentation of checklists to QA		
		sandwich which was out of			committee at monthly QA meetings		
		and was not dated and was			beginning on 7/17/19.		
		e. The DM immediately			The facility will no longer serve Mighty		
	-	butter and jelly sandwich			Shakes beginning 7/10/19. Ensure will		
	from the freezer.				used as supplement and it comes with	а	
	On 06/24/10 at 10:25	AM an interview was			date stamped on it from manufacture.		
	conducted with the D	AM an interview was					

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	-	D HUMAN SERVICES					FORM): 07/25/2019 / APPROVED
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	LETED
		345319	B. WING _				(06/	C 27/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				41	15 ELDERBERRY LANE			
ELDERBE	RRY HEALTH CARE			М	IARSHALL, NC 28753			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 812	should have been dat freezer. The DM state who were responsible nourishment refrigera did not know why the sandwich was not disc On 06/24/19 at 10:50 conducted with the Ac expectation was that the sandwich in nourishm have been discarded. 1 c. An observation of made on 06/24/19 at Manager and revealed bread that was undate resident use. The breat molded. The DM verifi label as to the type of date. The DM immedi bread from resident u On 06/24/19 at 10:35 conducted with the DI bread should have be DM stated he had 2 d responsible for checkie every afternoon and h undated and unlabele On 06/24/19 at 10:50 conducted with the Ac expectation was that the bread in nourishment discarded 1 d. An observation of	ed when placed in the ed he had 2 dietary aides e for checking the tor every afternoon and he undated peanut butter carded. AM an interview was dministrator who stated her the undated peanut butter ent room #2 freezer would f nourishment room #2 was 10:33 AM with the Dietary d 1 loaf of white appearing ed and was available for ad was observed not ied that the bread had no bread and no expiration ately removed the loaf of se. AM an interview was M who stated the loaf of en labeled and dated. The ietary aides who were ing the nourishment room he did not know why the d bread was not discarded.	F	;12				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 07/25/2019 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345319	B. WING			-		C 27/2019
NAME OF P	ROVIDER OR SUPPLIER		ł		STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
ELDERBE	RRY HEALTH CARE				415 ELDERBERRY LANE MARSHALL, NC 28753			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 812	Dietary Manager (DM of 64 ounce peanut b opened and was ³ ⁄ ₄ pe available for resident removed the 64 ounce On 06/24/19 at 10:17 conducted with the Di butter container shou opened and should he DM stated he had 2 d responsible for check every afternoon and h undated peanut butte On 06/24/19 at 2:40 F conducted with the Di manufacturer's recom the 64 ounce containe for 2 months once op because the peanut butte have been discarded. On 06/24/19 at 10:50 conducted with the Ad	 and revealed 1 container utter that was undated when ercent empty and was use. The DM immediately e container of peanut butter. AM an interview was M who stated the peanut ld have been dated when ave been discarded. The lietary aides who were ing the nourishment room he did not know why the r was not discarded. PM an interview was M who stated the mendation indicated that er of peanut butter was good ened. The DM stated butter had not been dated vas no way to determine er had expired and should AM an interview was dministrator who stated her the undated peanut butter in 	F	812				

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