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	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderberry Health Care	415 Elderberry Lane Marshall, NC 28753

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. 51089 Based on observation and staff interviews, the facility failed to post a list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. This observation occurred for 3 of the 4 days during the onsite recertification survey. The findings included: An observation of the facility's front hallway bulletin board was completed on 08/25/24 at 4:20 PM during end of day rounding. The observation revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. All other hallways and common areas within the facility were observed which revealed no signage or posting which included name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. On 08/26/24 at 4:05 PM, an observation was completed, and the facility's front hallway bulletin board was observed to be in the same state. The front hallway bulletin board did not include name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. On 08/27/24 at 9:07 AM, an observation was completed of the front hallway bulletin board. The front hallway bulletin board continued to not include name and contact information for the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. (continued on next page)

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.

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

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F 0575 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview with the Activities Director on 08/27/24 at 11:05 AM she stated there were Ombudsman posters with name/contact information posted throughout the facility. The Activities Director stated the other contact information inclusive of State Agency, State Long Term Care Ombudsman program, protection and advocacy group, and adult protective services, was posted at the front entrance as visitors leave the facility. An observation was completed with the Administrator and Activities Director on 08/27/24 at 11:07 AM of the posting board in the front hallway of the facility. The observation revealed no signage of the other required postings to include the State Survey Agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, and the protection and advocacy network. During an interview with the Administrator on 08/27/24 at 11:13 AM she stated the information should be posted with Regional, State, Local Ombudsman contact information and telephone number. The Administrator also stated the State Agency and other advocacy groups contact information and telephone numbers should be posted as well. The Administrator explained she updated the board as needed and verbalized there was signage in place with the State Agency contact information and telephone number as well as other advocacy group information. She continued to explain someone must have taken down the signage but was uncertain when the signage was removed and by whom from the front hallway bulletin board.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51093 Based on staff interview and record review, the facility failed to protect a resident's right to be free from resident-to-resident abuse when Resident #74 struck Resident #73 on the left side of the head with a statue after Resident #74 believed Resident #73 was going to enter her room. Resident #73 sustained a laceration to the left side of his head requiring steri strips (an alternative to sutures). This affected 1 of 3 residents (Resident #73) reviewed for abuse. The findings included: Resident #74 was admitted to the facility on [DATE] with diagnosis that included Unspecified dementia, unspecified severity, without behavioral disturbance (milder or mixed dementia with milder or nonaggressive behaviors), psychotic disturbance, mood disturbance, and anxiety. A review of Resident #74's Minimum Data Set (MDS) dated [DATE] indicated her cognition was intact. She was not documented as having any behavioral issues. A review of Resident #74's care plan dated 6-3-24 did not indicate any goals set for behaviors or any interventions for behavioral issues. The record review for Resident #73 revealed, on 06/04/2024 at 7:59pm there was a resident-to-resident altercation involving Resident #73 and Resident #74. Resident #73 was standing outside Resident #74's room and Resident #74 was yelling at Resident # 73 to move away from her room. Resided #73 was standing in the hallway near Resident #74's room looking outside the door end of the hall. Resident #73 did not leave when requested by Resident #74, she struck him with a wooden statue on the left side of his head. This caused Resident #73 to have an approximately one-inch laceration on his left temple. Nurse Aide (NA) #3 witnessed this incident and immediately requested assistance from a nurse and took Resident #73 back to his room where Resident #73's wound was cleaned and treated with steri strips and a bandage. Resident #74 was behaving his normal self and no infection was noted. On 08/28/2024 at 1:24pm a telephone interview was conducted with NA #3. NA #3 recalled the incident from 06/04/2024. She stated she was on her way to the laundry room when she heard Resident #74 yelling, and she observed Resident # 74 hit Resident # 73 on his head. She added that she ran towards Resident #73 and moved him away from Resident # 74. She stated she got the attention of a nurse (name unknown). She stated that Resident #74 informed her Resident #73 was trespassing in her room, and he should not have been there. NA #3 added Resident #73 was only in front of Resident #74's room and not inside her room. NA #3 stated she explained to Resident #74, that Resident #73 did not know what he was doing. She further stated she along with the nurse brought Resident #73 to his room. She stated she left the Resident's room when the NA (name unknown) from that hall entered the room. She stated she did not know Resident #74 as she worked in the Rehab Hall. She further added, she had known Resident #73 in passing, to be always smiling, and a happy person. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 08/28/2024 at 2:33pm. She explained the facility policy or process to deal with abuse situation. She stated they had physically assessed Resident #73 and Resident #74. She added, they would bring the doctor in the facility to assess the Residents involved or would send the residents to the hospital on doctor's order. She stated they would investigate the situation and interview staff and other residents that may have witnessed the abuse. She further stated that they would separate the residents, so they were not close to each other to prevent future altercations. She stated they monitored the residents after the incident. An attempt to interview the Director of Nursing on 08/28/2024 at 3:00pm was unsuccessful.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142 Based on observations, staff interviews and record review, the facility failed to apply signage indicating the use of oxygen outside residents' rooms with supplemental oxygen for 2 of 2 residents reviewed for oxygen use (Resident # 69 and Resident # 273). The findings included: 1.Resident # 69 was admitted on [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease and Emphysema. A physician's order for Resident # 69 dated 08/03/2024 read may use and titrate oxygen (O2) to maintain oxygen levels between 88-92% every shift. Review of the admission Minimum Data Set (MDS) dated [DATE] indicated Resident # 69 was cognitively intact and coded for the use of oxygen intermittently. During an observation on 08/25/24 at 1:11pm of Resident #69's room, there was no signage for oxygen use found anywhere near Resident # 69's room entrance. Resident # 69 was observed wearing oxygen via nasal cannula at 3.5 liters per minute (LPM). The oxygen concentrator was observed on the left side of the bed when facing the bed in Resident # 69's room. During an observation on 08/25/24 at 04:22 PM there was no signage for oxygen use found anywhere near entrance of Resident # 69's room. During an observation on 08/26/24 at 11:24 am there was no signage for oxygen use found anywhere near entrance of Resident # 69's room. An interview with Nursing Assistant (NA)#4 occurred on 08/27/24 at 08:32 AM. The NA said he was responsible for making sure a concentrator was in the room and changing the resident's oxygen tubing from the oxygen tank to the concentrator when the resident arrived. During an interview with Nurse #2 on 08/27/24 at 08:36 AM she stated she would make sure there was an order for oxygen, make sure to have an oxygen tank, and tubing, ready to go prior to a resident being admitted . Nurse #2 stated she would make sure the resident's oxygen was at a good level when they were admitted , she would make sure oxygen was applied to the resident and make sure they were monitored. She stated the nurse on the hall was responsible to put up signage for oxygen use. She did not know how it was missed on admission for Resident #69. She stated she should have caught it yesterday (8/26/24) but was busy. An interview occurred on 08/27/24 at 08:41 with the Director of Nursing (DON). She stated it was the nurse's responsibility to put up the oxygen in use sign on the resident's door, but if it was not done then the [NAME] Clerk would check during weekly rounds. The DON discussed the [NAME] Clerk was still in training and she had forgot to tell her about that responsibility. The DON stated the only admission check list they have was in the electronic record. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24 at 08:46 AM with NA#5 who was the new [NAME] Clerk, she stated she tried to check on 8/26/24 for oxygen signs, and that she thought she had most of them. NA #5 stated if a resident did not have an oxygen use sign, she would let the DON know and DON would get a sign made. An interview on 08/27/24 at 10:51 AM occurred with the Administrator. The Administrator stated the [NAME] Clerk was responsible for placing the oxygen use sign on the resident's door. She stated NA #5 had not fully taken over that position and had not completed the full orientation. 2. Resident # 273 was admitted [DATE] with diagnoses of Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with Hypercapnia, Obstructive Sleep Apnea, Chronic Respiratory failure with Hypoxia. Review of the Admission documentation dated 8/15/2024 revealed Resident # 273 was Cognitively intact. A physician's order for Resident # 273 dated 08/15/2024 read Baseline oxygen (O2) at 4 liters. May titrate O2 via nasal canula to keep oxygen level above 90%. Notify provider for increased O2 demand. During an observation on 08/25/24 at 01:21 PM of Resident # 273's room, there was no signage for oxygen use found anywhere near Resident #273's room entrance. Resident # 273 was observed wearing oxygen via nasal cannula at 2.5 liters per minute (LPM). The oxygen concentrator was observed on the left side when facing the bed in Resident # 273's room. During an observation on 08/25/24 at 04:23 PM there was no signage for oxygen use found anywhere near Resident 273's room entrance. During an observation on 08/26/24 at 11:25 am there was no signage for oxygen use found anywhere near Resident 273's room entrance. An interview with Nursing Assistant (NA)#4 occurred on 08/27/24 at 08:32 AM. The NA said he was responsible for making sure a concentrator was in the room and changing the resident's oxygen tubing from the oxygen tank to the concentrator when the resident arrived. During an interview with Nurse #2 on 08/27/24 at 08:36 AM she stated she would make sure there was an order for oxygen, make sure to have an oxygen tank, and tubing, ready to go prior to a resident being admitted . Nurse #2 stated she would make sure the resident's oxygen was at a good level when they were admitted , she would make sure oxygen was applied to the resident and make sure they were monitored. She stated the nurse on the hall was responsible to put up signage for oxygen use. She did not know how it was missed on admission for Resident #69. She stated she should have caught it yesterday (8/26/24) but was busy. An interview occurred on 08/27/24 at 08:41 with the Director of Nursing (DON). She stated it was the nurse's responsibility to put up the oxygen use sign on the resident's door, but if it was not done then the [NAME] Clerk would check during weekly rounds. The DON discussed the [NAME] Clerk was still in training and she had forgot to tell her about that responsibility. The DON stated the only admission check list they have was in the electronic record. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/27/24 at 08:46 AM with NA#5 who was the new [NAME] Clerk, she stated she tried to check on 8/26/24 for oxygen signs, and that she thought she had most of them. NA #5 stated if a resident did not have an oxygen use sign, she would let the DON know and DON would get a sign made. An interview on 08/27/24 at 10:51 AM occurred with the Administrator. The Administrator stated the [NAME] Clerk was responsible for placing the oxygen use sign on the resident's door. She stated NA #5 had not fully taken over that position and had not completed the full orientation.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 51093 Based on staff interview and record review, the facility failed to ensure daily nurse staffing sheets were completed daily for 18 of the 59 days (07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08 /02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024) reviewed for nurse staffing information. The findings included: Observation on 08/25/2024 at 11:00am revealed the daily nurse staffing sheet posted at the nurses' station was dated 8/23/24. There were no daily nurse staffing sheets for 8/24/24. Review of the daily nurse staffing sheets from 07/01/2024 to 08/28/2024 indicated there were no daily nurse staffing sheets for the following days 07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08 /02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024. An interview occurred on 08/28/24 at 4.43PM with the Medical Record Staff responsible for posting staff information. The Medical Record staff stated that he was responsible for posting the daily nurse staffing sheets every morning on weekdays. He further added on weekends and on his days off the charge nurse was responsible for posting the daily nurse staffing sheet. He specified the following days 07/05/2024, 07/06/2024, 07/07/2024, 07/13/2024, 07/14/2024, 07/20/2024, 07/21/2024, 07/28/2024, 07/29/2024, 08/01/2024, 08/02/2024, 08/03/2024,08/04/2024, 08/10/2024, 08/11/2024, 08/17/2024, 08/18/2024, and 08/24/2024, were either weekends or his days off. He indicated on these days; the charge nurses would have had to post the nurse staffing on the board. An interview with the Administrator on 08/28/24 at 05:15 PM was completed. The Administrator indicated medical records staff was responsible to post the daily nurse staffing information on the board near the nurse's station. When he was out on leave and/or on weekends the charge nurse for the day was responsible to post this information. She stated she was not aware that in the absence of the Medical Record staff the charge nurse was not posting the daily nurse staffing sheet on the board. She did not specify if anyone checked the postings to ensure they were being completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51142 Based on observations and staff interviews the facility failed to ensure ready to use dishware was clean and not stacked wet, label and date leftover perishable foods in the walk-in cooler. This occurred for 1 of 2 kitchen observations. The findings included: 1. The initial tour of the kitchen occurred on 8/25/24 at 11:55am with [NAME] #1. The initial observation of the serving line and dishware area revealed the following: a. Dishware that was ready for use was put away and stacked wet. -7 out of 10 divided plates -11 out of 20 domed lids and bottoms -6 out of 20 trays b. Dishware that was ready for use was put away and/or stacked with white and yellow debris on them. -7 out of 10 divided plates had white and yellow dried debris. -1 out of 2 red plates had black and yellow dried debris. -1 out of 20 trays had a clear sticky substance present, substance was shiny when observed and was sticky when touched. -6 out of 20 domed lids and bottoms had dry white and yellow debris c. 3 large plastic bags that were not dated contained opened and partially used packages of yellow sliced cheese not individually wrapped in the walk-in cooler. During an interview with [NAME] #1 on 8/25/24 at 12:16pm [NAME] #1 said the open bagged cheese in the walk-in cooler should have been dated and did not know why it was not. During an interview with Dietary Manager on 08/26/24 at 08:57 am, Dietary manager stated divided plates, plates, trays and domed lids and bottoms should stay in the rack until dry. The Dietary Manager stated opened bagged items in the walk-in fridge should be dated. During an Interview On 08/28/24 at 05:24 PM the Administrator stated she expected open food to be labeled and dishes to be properly washed, dried and clean.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 51142 Based on observations and staff interviews the facility failed to contain trash when the dumpster doors were not closed and failed to keep the area around the dumpsters free of accumulated trash and debris for 2 of 2 dumpsters observed. The findings included: An observation was completed on 08/25/24 12:24 PM. The observation revealed two dumpsters, the 1st dumpster door was three quarters open, and the 2nd dumpster door was completely open with bags of trash that were viewable inside the dumpster. Trash and debris were noted around both dumpsters. The trash around both dumpsters included used plastic gloves, tissues, plastic cup, and a plastic food container with light brown food debris inside the lid of the container. The 2nd dumpster had sign reminding staff to close the dumpster doors due to bears in the area. Cook #1 was interviewed on 08/25/24 at12:27 PM because the Dietary Manager was not available. [NAME] #1 verified the dumpster doors were open, and there was trash/debris around the dumpsters. [NAME] #1 closed the dumpster doors. He stated that he checked the dumpsters and made sure the doors were closed at the end of his shift and that all shifts were supposed to check the doors to ensure they were closed and check for any trash around the dumpster. An interview was completed on 8/26/2024 at 9:01am with the Dietary Manager. Dietary Manager was informed of observations made on 8/25/2024 with [NAME] #1. The Dietary Manager stated he had placed the sign on the dumpster because they had previously had an issue with bears in the dumpster and stated the dumpster doors should remain closed and there should not be trash and debris around the dumpsters. He also stated all staff were responsible for ensuring the dumpster doors remained closed and no trash was left on the ground. An interview was completed on 08/28/24 at 05:24 PM with the Administrator. The Administrator stated she would expect dumpster doors to be closed and for no trash to be around dumpsters.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51142 Based on record review and staff interview, the facility failed to maintain a complete and accurate medical record when 1) staff documented that they provided suctioning to a resident twice a day when suctioning had not been provided and 2) staff failed to document treatment provided to resident after they sustained a laceration to the left lower leg. This occurred for 2 of 2 residents (Resident #4 and Resident #75) reviewed for accurate medical record. The findings included: 1. Resident #4 was admitted on [DATE] with diagnosis including acute and chronic respiratory failure with hypoxia and tracheostomy status. A physician's order dated 1/14/2024 read Tracheostomy Suctioning every 12 hours for secretions. A review of the quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #4 was moderately cognitively impaired and was documented for suctioning and tracheostomy care. A review of the Medication Administration Record (MAR) for the month of August 2024 revealed Resident #4 had suctioning completed 50 out of 51 times. During an interview on 08/26/24 at 9:18 AM with Nurse #1 stated Resident #4 was only suctioned in a dire emergency, that Resident #4 hated to be suctioned. During a phone interview on 08/27/24 at 10:02 AM Nurse #6 said Resident #4 was suctioned as needed. Nurse #6 said Resident #4 did not like to be suctioned but sometimes she did require it, but not that often. Nurse #6 said she had suctioned Resident #4 maybe 5 times. Nurse #6 had documented that she had suctioned Resident #4 11 times in August of 2024 by review of the MAR. Nurse # 6 said she was aware of an order that if the resident needed to be suctioned then do it. Nurse #6 stated I have not suctioned Resident #4 11 times. I understood the order meant to assess for the need to be suctioned. Nurse #6 said maybe she misunderstood the prompt on the computer. During a telephone interview on 08/27/24 at 10:17 AM Nurse #7 said Resident #4 had not needed to be suctioned because she cleared her secretions out on her own. Nurse #7 stated she had not suctioned Resident #4 since the end of June 2024. Review of the August 2024 MAR revealed Nurse #7 signed she had suctioned Resident #4 12 times. Nurse #7 reviewed how the order was written and stated yeah, I do see that I would need to chart no in the future. During an interview on 08/27/24 at 10:32 with Nurse #1, the nurse said on average she had suctioned Resident #4 three times per month if that much. Per review of Resident #4's MAR, Nurse #1 had signed off that she suctioned Resident #4 12 times in August 2024. Nurse #1 stated she had only suctioned Resident # 4 one time in August. The nurse stated she was unaware she could document that suctioning was not provided. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 08/27/24 at 10:40 AM with the Director of Nursing (DON), the DON said spot checks on accuracy of the MAR's were completed by the DON, or Assistant Director of Nursing (ADON). The DON said the order should be changed to just be as needed and she stated she was unaware the nursing staff were mis-documenting. During an interview on 08/27/24 at 10:45 AM the Administrator said the ADON and Nurse consultant monitor the MAR for accuracy, but the Administrator did not know the schedule of how often. The Administrator said the Nurse Consultant came in about every other month, otherwise the MARs were looked at randomly. The Administrator said the DON trained staff in the computer system. The Administrator said maybe Resident #4 was being suctioned daily at one time, but the order was never changed. The Administrator said it would need to be reviewed in the QA Meeting. 2. Resident # 75 was admitted on [DATE] with the diagnosis of laceration without foreign body left lower leg. A facility initiated initial investigation report dated 10/28/23 written by the Director of Nursing (DON) revealed Resident #75 sustained a 3.7 centimeter by 2.5-centimeter laceration to her left leg while transferring from her wheelchair to her bed. The summary of the investigation documented Resident #75's laceration was treated with steri strips by Nurse #3 initially and that the steri strips had come off on 10-29-23 causing the laceration to re-open and Nurse #2 had placed another type of dressing and ordered a dry multifunctional wound dressing for Resident #75. Review of resident record revealed there was no documentation about a change to Resident #75's orders or condition of her laceration on 10/29/23. Review of Resident #75's orders dated 10/29/23 and 10/31/23 revealed the resident was to have a multifunctional dressing applied. Review of Resident #75's October 2023 Treatment Administration Record (TAR) showed no documentation that steri-strips had been applied. During an interview on 08/27/24 at 4:29 PM with Nurse #2, the nurse remembered doing treatments on Resident #75's leg on 10/29/23. Nurse #2 said the injury would be documented in an incident report, weekly assessment would be completed on the wound. Steri strips would be documented on the Treatment Administration Record (TAR). Nurse #2 said she should have documented Resident #4's dressing came off and was replaced. During a telephone interview on 08/28/24 at 10:11 AM with Resident #75's Physician, the Physician said he would typically expect measurements, description of the wound and treatment to be in the order and progress note. The Physician stated he thought there was poor documentation. During an interview on 08/28/24 at 12:23 PM with the Director of Nursing (DON), the DON said she would expect to see measurement, drainage, pain, and order for treatment in the progress notes. She would expect to see how it was cleaned and what was used to clean and treat, what dressing was applied. The DON stated she was unaware there was a lack of documentation for Resident #75's laceration. (continued on next page)

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	08/28/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 08/28/24 at 1:37 PM with the Administrator, the Administrator said nurses should have assessed and notified family and the Doctor and document treatment for dressing if the Doctor felt it was needed. The Administrator would expect to see documentation of the dressing in the progress notes, that the exact dressing would be in the Treatment Administration Record (TAR). The Administrator stated she was unaware of the lack of documentation for Resident #75's laceration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51089 Based on record review and staff interviews, the facility failed to ensure their arbitration agreement explicitly stated: 1) the resident or legal representative has the right to rescind the arbitration agreement within a 30 day timeframe; and 2) that neither the resident nor his or her representative was required to sign an agreement as a condition of admission or as a requirement to continue to receive care in the facility. This deficient practice affected 1of 1 resident (Resident #60) reviewed for arbitration. The findings included: A review of the facility admission packet and arbitration agreement dated 06/21/23 titled Terms did not include statements of the following: 1) The resident or his or her representative has the right to rescind the agreement within 30 days after signing it. 2) The resident nor his or her representative was required to sign an agreement as a condition of admission or as a requirement to continue to receive care in the facility. Resident #60 was admitted to the facility on [DATE]. Review of Resident #60's arbitration agreement revealed the resident's representative had signed the agreement on 06/21/23. Resident #60's admission Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. An interview was conducted with the Social Worker on 08/28/24 at 11:00 AM which revealed she reviewed the Arbitration Agreement with residents and families upon admission to the facility. The Social Worker explained the residents have a choice whether they want to accept, decline, or rescind the arbitration agreement. The Social Worker stated that specific verbiage regarding the ability to rescind the agreement within a 30 day timeframe and not signing the arbitration agreement as a condition of admission or a requirement to receive care were not in the current Arbitration Agreement dated 06/21/23 that was being used. An interview was conducted with the Administrator on 08/28/24 at 11:10 PM which revealed the residents can rescind the Arbitration Agreement within a 30 day timeframe. The Administrator explained that resident's or their legal representative (if the resident was not cognitively intact) could rescind or decline the agreement and that signage of the Arbitration Agreement was not a condition of admission to the facility. The Administrator was surprised to see the Arbitration Agreement document currently being used did not have the required information in the agreement.