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	11/19/2025

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

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with resident, staff, Medical Records Clerk, Minimum Data Set (MDS) Assistant and the Physician, the facility failed to have effective systems in place for updating advance directive information throughout the medical record for 1 of 1 resident reviewed for advance directive (Resident #1). The findings included:The medical record for Resident #1 included an advance directive form dated [DATE] that indicated Resident #1 was a Do Not Resituate (DNR).Resident #1 was readmitted to the facility on [DATE].Review of a physician order dated [DATE] indicated Resident #1 was a DNR.The medical record had an advance directive with an effective date of [DATE]. The [DATE] advance directive stated that Resident #1 was a full code.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 was cognitively intact.An observation of Resident #1's electronic medical record on [DATE] revealed a banner for Resident #1 indicating he was a DNR.The [DATE] electronic Medication Administration Record (MAR) indicated that Resident #1 was a DNR.On [DATE] at 11:00 AM an interview was held with Resident #1. Resident #1 stated he understood the difference between a DNR and full code. He stated that he wanted to be full code and should be given cardiopulmonary resuscitation (CPR) if needed.On [DATE] at 8:33 AM an interview was conducted with Medication Aide #1. She stated that if she had to look up a residents' advance directive, she would look at the banner on the computer profile page. Medication Aide #1 pulled up Resident #1's medical record and stated he was a DNR.On [DATE] at 9:10 AM an interview was conducted with a Nurse #1. Nurse #1 stated if she needed to look up an advance directive information, she would either look in the advance directive binder at the nurse's desk or on the banner under the resident's picture in the medical record. On [DATE] at 9:54 AM an interview was conducted with the Social Worker (SW) who confirmed that she completed the advance directive form for all residents. The SW stated first she would complete the Brief Interview for Mental Status (BIMs) questions. If the resident was deemed cognitively intact, she would proceed with the advance directive questions and if the resident was deemed to have a cognitive impairment, she would get in touch with the Power of Attorney (POA) or legal representative to get the advance directive questions completed. If the resident wished to be a DNR the SW stated she would get the medical provider to sign the advance directive form that day. If the resident wished to be a full code, she would leave the advance directive form in the doctor's box for them to sign. Once the advance directive form had all the required signatures it then went to medical records to be scanned into the chart. The medical records clerk would also put the code status on the medical record banner. If a resident wanted to change their advance directive the SW stated she would just start the whole process all over again. The SW stated Resident #1 indicated he wanted to be full code and after he signed the advance directive form, she put the form in the doctor's box to be signed. On [DATE] at 9:57 AM an interview was conducted with the Medical Records Clerk. The Medical Records Clerk stated that once the advance directive form was complete with all required signatures, he would scan the form into the medical record. He also kept a log of all the DNRs and full codes. The Clerk stated he was not responsible for entering the advance directive information in the banner portion of the medical record, that would be the MDS Assistant's responsibility. The Medical Records Clerk stated that if a resident changed his code status the physician would send an email to notify the medical records clerk of the changes. The new advance directive would be rescanned into the chart and MDS Assistant would change the banner in the medical record. The Clerk stated he would verbally tell the MDS Assistant of the code status change. The Medical Records Clerk stated the physician did not notify him of the advance directive being changed for Resident #1, therefore the advance directive was not updated and the MDS Assistant was not informed to change the banner. On [DATE] at 12:40 PM a second interview was conducted with the Medical Records Clerk. He stated after thinking about it and reviewing his advance directive log, he did remember being made aware of Resident #1 change to his advance directive. The Clerk could not remember who informed him of the change. He stated that he informed the MDS Assistant of the change but for some reason there was a delay in changing the medical record banner. On [DATE] at 10:06 AM an interview was conducted with the MDS Assistant. She stated that she would enter the code status information, so it showed up on the banner in the medical record. She stated the physician who signed the advance directive should have informed her of the change so that she could make the changes needed. She was not informed by any staff, so no change had been made to the banner of Resident #1's medical record. A follow up interview with the MDS Assistant was attempted on [DATE] and was unsuccessful. On [DATE] at

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, the facility failed to obtain a physician order for the use of an indwelling urinary catheter and failed to use a securement device (anchor) to prevent pulling/tension or trauma from the catheter tubing for 1 of 1 resident reviewed for an indwelling urinary catheter (Resident #11). Findings included: Resident #11 was admitted to the facility on [DATE] with diagnoses which included chronic urinary retention. Resident #11's baseline care plan dated 11/03/25 revealed a bowel and bladder section marked for an indwelling catheter appliance. The 5-day Minimum Data Set, dated [DATE] revealed Resident #11 had severe cognitive impairment and was coded for an indwelling urinary catheter. Review of Resident #11's physician orders revealed no order for an indwelling urinary catheter. Further review of Resident #11's physician order revealed an order dated 11/03/25 that read; provide catheter care and document output every shift. An observation of urinary catheter care on 11/18/25 at 2:01 PM with Nursing Assistant (NA) #1 and NA #2 revealed that Resident #11 had an indwelling urinary catheter. There was no urinary catheter tubing securement device. There was no tension observed on the urinary catheter tubing and the urinary bag was on the side of the bed below the resident's bladder. An interview on 11/18/25 at 2:14 PM with NA #1 and NA #2 revealed NA #1 was assigned to provide care for Resident #11 that shift. They did not know why Resident #11 did not have a urinary catheter securement device but indicated he should have a securement device in place. NA #1 stated she should notify the nurse if the resident did not have a securement device. An interview on 11/18/25 at 2:19 PM with NA #3 revealed he was assigned to the hall where Resident #11 resided. He stated he had checked on him in the morning of 11/18/25 but had not noticed he had no urinary catheter securement device. He stated if he had noticed he would have gotten a securement device from supply and applied it to the resident's leg. An interview on 11/18/25 at 2:26 PM with Nurse #2 revealed he was normally assigned to Resident #11 and he was unaware he did not have a urinary catheter securement device. He was unable to say why Resident #11 did not have a catheter tubing securement device but stated he should have. An interview on 11/18/25 at 3:24 PM with the Director of Nursing (DON) revealed Resident #11 should have a urinary catheter tubing securement device and a physician's order for a urinary catheter. She stated these were staff oversights. The DON indicated when Resident #11 was admitted to the facility with the urinary catheter, the admission nurse was responsible for entering the urinary catheter order. An interview on 11/19/25 at 1:14 PM with the Administrator revealed she had been notified of Resident #11's lack of urinary catheter securement device and absence of a physician's order. She stated it was due to human error.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to date and label food stored in the walk-in refrigerator. The facility also failed to dispose of a box of apples stored past their usable life. This was for 1 of 2 refrigerators (walk-in refrigerator) and 1 of 1 cart observed and had the potential to affect food served to residents in the facility.Findings included:On 11/16/25 at 8:45 AM an observation of the walk-in refrigerator was conducted. The observation found a slice of cake that was uncovered and not dated, a disposable container that was not dated and was labeled tomato containing 4 slices of tomatoes, and 2 opened resealable plastic bags that contained deli meat missing an opened date. The observation also found a tomato slice wrapped in plastic wrap that was missing a date, 2 blocks of opened sliced cheese that were undated and in an unsealed bag, and 1 opened bag of shredded cheese that did not include an open date. On 11/16/25 at 8:55 AM an observation in the kitchen found a box of apples stored on a cart. Approximately 7 apples were observed with signs of bruising with brown areas. Additionally, several fruit flies were observed around the apples. On 11/19/25 at 12:28 PM the Dietary Manager was interviewed. He stated the food that was not labeled, dated and expired was disposed of. The Dietary Manager said the [NAME] was responsible for checking the walk-in refrigerator for expired and dated food each morning. He also stated every dietary staff was responsible for dating and labeling food when it was stored for later use, and to dispose of any food past use. The [NAME] was not available for interview on 11/19/25. The Administrator was interviewed on 11/19/25 at 5:04 PM. The Administrator stated food stored in the kitchen should be dated and labeled and unusable food should be disposed of.