STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 11/28/22 through 12/1/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 58G311	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/28/22 through 12/1/22. The following intakes were investigated: NC00184845, NC00185563, NC00185823, NC00186118, NC00186191, NC00186291, NC00186484, NC00188322, NC00189067, NC189971, NC00191908, NC00192684, NC00193460, NC00193463, NC00193467, NC00193543, NC00193587, NC00194216, NC00194449 and NC00195312. Two of the 52 complaint allegations were substantiated resulting in a deficiency. Event ID# 58G311.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to	F 578		12/29/22

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

Electronically Signed | 12/19/2022

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F 578	Continued From page 1 inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interview Resident #192 was administered the Covid-19 booster vaccination by mistake after her health care power of attorney (HCPOA) had declined the vaccination. This was for 1 of 5 residents reviewed for vaccination status (Resident #192). The findings included: Resident #192 was admitted into the facility on 05/25/17 with diagnosis which included cerebrovascular accident (CVA), anxiety and	F 578	F578 - Immediate action was taken for resident found to be affected. Nursing monitored for signs and symptoms of adverse reaction to unconsented vaccine. The family and Medical Director was notified of the vaccine given to the resident without consent. Nurse consultant #1 stopped the vaccine clinic immediately, asking the pharmacy technician to leave the premises. - Determining consent for all residents	

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F 578	Continued From page 2 seizure disorder. Resident #192's quarterly Minimum Data Set (MDS) dated 11/08/21 revealed she was severely cognitively impaired requiring extensive assistance of one staff member for most activities of daily living (ADL). On 11/29/22 at 3:24 PM an interview was conducted with Resident #192's HCPOA. She stated when she entered the building on 1/19/22 Medical Records staff member #1 stated to her that Resident #192 had just received the Covid-19 booster vaccination. The interview revealed she stated to the staff member the resident shouldn't have received the vaccine because she had refused it to a total of 3 staff members in the building including Nurse Consultant #1, Director of Nursing (DON) and Medical Records Staff Member #1. A Medical Director (MD) note dated 1/26/22 revealed Resident #192 was evaluated on this date for a urinary tract infection. The note revealed the HCPOA was upset because Resident #192 had received the Covid-19 booster vaccination by mistake. The MD documented Resident #192 previously was administered the last two series of Covid-19 vaccinations however the HCPOA had declined the booster. The MD documented he spoke with the HCPOA regarding the incident and stated to her due to Resident #192's health condition the Covid-19 booster would have been indicated. The MD apologized to the HCPOA for the accidental oversight of her declination and the resident receiving the vaccine. The note revealed Resident #192 was experiencing no clinical signs of vaccine side effects.	F 578	related to vaccine/boosters is required for all residents. Therefore, all residents had the potential to be affected. - Upon notification of vaccine being given without consent the Director of Nursing educated all staff involved in the 01/19/22 clinic on importance of ensuring all residents must have/give consent before administering vaccine. Director of Nursing also, educated nurse consultant #1 that a licensed nurse should have been involved in the clinic. Director of Nursing initiated plan from the 01/19/22 plan that nursing administration administers vaccines/boosters not an outside party and that there is a clear list for do not vaccinate residents. This list must be checked and rechecked before entering residents room to administer vaccine. Director of nursing educated all nursing administration of the new plan and responsibility on 01/20/22 to start immediately. - To promote safety for all residents the Director of Nursing will ensure that consents are received for any and all vaccines and a list is made before the clinic with do not vaccinate residents clearly printed out. Nursing administration Director of Nursing, Assistant Director of Nursing and Unit managers will administer vaccine boosters after checking the do not vaccinate list. The Director of Nursing educated all nursing administration of this procedure on 01/20/22. Director of Nursing or Assistant Director of Nursing will head each clinic to be sure that each	

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F 578	Continued From page 3 On 11/29/22 at 9:20 AM an interview was conducted with Nurse Consultant #1. During the interview she stated the Director of Nursing who was originally over the vaccination clinic had a family emergency on the day of and she was asked to step in and take over last minute. She stated a pharmacist was in the building administering the vaccinations and she asked Medical Records staff member #1 to go with the pharmacy tech and tell her which residents to administer the vaccinations to. Medical Records staff member #1 was provided with a facility list of all residents to direct the pharmacy tech. She stated they initially set up the clinic in the dining room and were bringing residents to the pharmacy tech but once she finished in the dining room, they started moving room to room for residents that could not go into the dining room. The interview revealed Medical Records staff member #1 came to her and said the pharmacy tech had administered the Covid-19 booster vaccination to Resident #192 without a consent form. She stated she immediately went and asked the pharmacy tech to leave the building, called the HCPOA of the resident, notified the Physician and DON of the incident. She stated she didn't know why the staff members had gone into Resident #192's room and did not know why the Medical Records staff member #1 did not stop the pharmacy tech from administering the vaccine. On 11/30/22 at 9:25 AM an interview was conducted with Medical Records staff member #1. She stated she was asked to take the list of residents for the Covid-19 booster vaccination and go around with the pharmacy tech to let her know which residents to administer the	F 578	clinic is followed moving forward. QAPI plan was to have Admissions Director and Social Services Director audit consent forms for upcoming vaccinations and to audit the DO NOT vaccinate list beginning 01/20/22. Completion Date: 12/29/22	

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F 578	Continued From page 4	F 578		

vaccination to. She stated they did not have consent for Resident #192 to receive the vaccination and she told the pharmacy tech, but she stated, "you can send it to me later". She stated she observed the pharmacy tech administer the vaccination to Resident #192 and did not stop her. The interview revealed Resident #192's name was on the list provided to her for the pharmacy tech to see and administer a vaccination to. She stated she felt a nurse should have been the one to go around with the pharmacy tech and she did not feel comfortable stopping her from administering the vaccination.

On 11/30/22 at 9:34 AM an interview was conducted with the Admissions Coordinator. She stated she was responsible for completing the phone calls to residents HCPOA's to ask for consent of the vaccination. She stated Resident #192's HCPOA had declined the vaccination, so she wrote the declination on a note and placed it on the top of the other resident consent forms for the Director of Nursing.

On 11/30/22 at 9:41 AM an interview was conducted with the Director of Nursing (DON). The DON stated she wasn't in the building on the day of the vaccination clinic due to a family emergency but had set everything up for it. She stated she had received the information from the Admissions Coordinator and knew Resident #192 was to not receive the vaccination. She stated when she came back to work, she was told about the incident and the resident receiving the vaccination by mistake. The interview revealed Medical Records staff member #1 was supposed to read off the list of residents who had consented to the pharmacy tech. The DON stated the staff member was not provided with a clear list of who

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F 578	Continued From page 5 was to receive the vaccine and who wasn't. On 12/01/22 at 12:12 PM an interview was conducted with the Administrator. She stated she spoke with the HCPOA the day the incident occurred and had confirmed the family did not want the resident to receive the vaccination. She stated the vaccination booster was not handled appropriately and the pharmacy tech should have been given a clear list of residents who were to receive the vaccination. The interview revealed Resident #192 was the first resident to receive a vaccination outside of the dining room and the pharmacy tech was stopped following the mistake occurring. The Administrator stated the facility went back and checked the list of residents who had declined the vaccination to ensure no other resident had received the booster by mistake. She stated there were no other errors during the vaccination clinic.	F 578		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		12/29/22

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F 600	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a resident's right to be free from abuse for 1 of 3 residents (Resident #30). On 11/24/2022 while providing care Nurse Aide (NA) #2 rolled Resident #30 over, the resident was being combative, and NA #2 put her leg on Resident #30's upper leg to restrain the resident. The findings included: Resident #30 was admitted to the facility on 02/18/20 with diagnosis which included dementia. Review of the quarterly Minimum Data Set (MDS) dated 09/16/22 revealed Resident #30 was severely cognitively impaired and required extensive assistance for majority of activities of daily living (ADL). The MDS further revealed Resident #30 required extensive assistance with two people assist for bed mobility and transfers. The MDS further revealed Resident #30 was not coded for behaviors. Resident #30's care plan revised dated 11/09/22 revealed Resident #30 was unaware of safety needs and requires extensive assistance with two staff members. The care plan's goal indicated Resident #30 will not sustain serious injury through the review date. Review of the facility initial allegation report dated 11/25/22 indicated on 11/24/22 at 12:00 AM an employee, NA #2, was changing the brief of combative Resident #30, and placed her leg to restrain Resident #30 from kicking her. The report further revealed NA #1 witnessed the incident and NA #2, was suspended pending	F 600	F 600- Immediate action taken: On 11/25/2022, upon being notified of the incident, Resident #30 was immediately assessed for any harm or injury. No injuries were noted. NA #2 was immediately placed on leave, pending investigation. Investigation was initiated by Director of Nursing. - Identification of other residents having potential to be affected. The facility has determined that all residents have the potential to be affected. - Actions taken: On 11/28/22 all staff were trained on the resident’s rights to remain free from any abuse, neglect, misappropriation of resident’s property, and exploitation. All staff were also trained and educated on what is considered abuse, neglect, misappropriation of resident’s property, and exploitation, and how to identify it. Training and education were also provided on how to react when identifying a situation of possible abuse, neglect, misappropriation of resident’s property, and exploitation. This education included, but was not limited to, removing the residents from harm’s way, and notifying the proper authorities in a timely manner. All staff were also trained and educated on what to do/how to provide care for combative and resistant residents, and residents who refuse care. This training will be provided to all new hires as well as provided quarterly for all staff. All staff in all departments were	

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F 600	Continued From page 7 investigation on 11/25/22. The facility substantiated abuse and NA #2 was terminated. Review of the investigation completed by the Director of Nursing on 11/25/22 related to Resident #30's incident revealed the following: Nurse Aide (NA) #1 statement dated 11/25/22 revealed she witnessed NA #2 changing Resident #30 and had her leg bent on top of Resident #30 to keep the resident on his side while NA #2 changed him. An interview conducted with NA #1 on 11/29/22 at 2:05 PM revealed she worked on 11/24/22 during second shift and witnessed NA #2's leg on Resident #30 to restrain him to change him. A phone interview conducted with NA #2 revealed she had worked second shift on 11/24/22 and cared for Resident #30. NA #2 further revealed she had cared for Resident #30 three different rounds on 11/24/22. The NA indicated first round Resident #30 was combative, second round Resident #30 refused care, and third round Resident #30 also was combative. NA #2 revealed she assisted Resident #30 by herself but was aware he was a two person assist. NA #2 further revealed she rolled Resident #30 on his hip and the resident became combative and grabbed NA #2 left hand and bent her finger back. NA #2 stated she placed her right leg on his hip to hold the resident still so she could complete changing him. NA #2 stated Resident #30's bed was in a lower position.NA #2 revealed once she fastened the brief, she took her leg off and pulled away to unlink her fingers from Resident #30. NA #2 stated she continued to work the rest of night with an estimated 20 residents and was let go the	F 600	educated on 11/28/22. Director of Nursing will train all new hires. In the Certified Nursing Assistants schedule book, there will be a visual cue as a reminder of all the policies and procedures pertaining to abuse, neglect, misappropriation of resident's property, and exploitation. All staff all departments were educated on this 11/28/22. - How the corrective actions will be monitored: Administrator and/or designee will periodically monitor/audit staff at random over the next three months to ensure proper knowledge by interviewing and documenting of the above policies and procedures. Administrator and/or designee will periodically monitor/audit and document staff at random 5 weekly on multiple shifts over the next three months while providing resident care. Administrator and/or designee will periodically interview 5 verbal residents a week on the care that they received from the nurses' aides. These audits will be reviewed monthly by the Administrator, Director of Nursing, and the Medical Director monthly for the next 3 months. Administrator and/or designee will take the audits and results of audits to monthly QAPI meetings. Issues and Audits will be reviewed by QA for 3 months. Compliance date: 12/29/2022	

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F 600	Continued From page 8 next morning without being spoken too. NA #2 stated she should have not put her leg on Resident #30 but did it out of self-defense. NA #2 revealed she had been educated to walk away from Resident #30 when he had become combative during care. An interview conducted with the Director of Nursing on 12/1/22 at 10:00 AM revealed NA #1 should have walked away from Resident #30 when he had become combative and not used her leg to restrain the resident to complete care.	F 600		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to report to Adult Protective Services (APS) and immediately report to nursing or	F 610	F 610- Immediate Action: As soon as the facility was made aware the resident was administered a full body assessment for	12/29/22

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F 610	Continued From page 9 administration which resulted in a lack of protection for Resident #30 and all residents for 1 of 3 residents (Resident #30). On 11/24/2022 while providing care Nurse Aide (NA) #2 rolled Resident #30 over, the resident was being combative, and NA #2 placed her leg on Resident #30's leg to restrain the resident. The findings included: Resident #30 was admitted to the facility on 02/18/20 with diagnosis which included dementia. Review of the quarterly Minimum Data Set (MDS) dated 09/16/22 revealed Resident #30 was not severely cognitively impaired and required extensive assistance for majority of activities of daily living (ADL). The MDS further revealed Resident #30 required extensive assistance with two people assist for bed mobility and transfers. Review of the facility initial allegation report dated 11/25/22 on 11/24/22 at 12:00 AM an employee, NA #2, was changing the brief of combative Resident #30, and placed her leg to restrain Resident #30 from kicking her. The report further revealed NA #1 witnessed the incident and NA #2, was suspended pending investigation on 11/25/22. The facility substantiated abuse and NA #2 was terminated. Review of the investigation completed by the Director of Nursing on 11/25/22 related to Resident #30's incident revealed the following: Nurse Aide (NA) #1 statement dated 11/25/22 revealed she witnessed NA #2 changing Resident #30 and had her leg bent on top of Resident #30 to keep the resident on his side while NA #2	F 610	any harm. No negative outcomes. Nurse Aide #2 was suspended 11/25/22 pending investigation. Law enforcement was called to facility. - Identification: The facility has determined that all residents had potential to be affected. All other residents on Nurse Aide #2 assignment were administered a full body assessment for any harm. No negative outcomes. Social Services interviewed all capable residents. No negative outcomes. - Actions Taken/ Systems put into place to reduce the risk: The Director of Nursing was educated on 12/01/22 on the policies for effective investigations including interviews with alert and oriented residents, body audits for nonverbal residents, interviews with staff on shift at time of allegation as well as interviewing accused staff and ensuring that Adult Protective Services is notified by the Administrator. On 11/30/22 trainings and education were conducted on the rules and regulations regarding reporting of any and all abuse and neglect allegations to the abuse coordinator immediately for all staff by the Administrator and Director of Nursing. All staff were re-educated that the abuse coordinator is the Administrator or in his/her absence the Director of Nursing. All staff all departments were educated on the location of numbers for Administrator and Director of Nursing and to call 24/7 if there is an allegation of abuse and neglect. The policies for investigations on abuse and neglect was	

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F 610	Continued From page 10 changed him. An interview conducted with NA #1 on 11/29/22 at 2:05 PM revealed she worked on 11/24/22 during second shift and witnessed NA #2's leg on Resident #30 to restrain him to change him. NA #1 stated she did not stop NA #2 because she had quickly finished assisting Resident #30. NA #1 further revealed she did not report to nursing staff that evening and reported it to the Director of Nursing (DON) the next morning. NA #1 indicated she was not aware she had to report to nursing staff immediately. A phone interview conducted with NA #2 revealed she had worked second shift until 10:30 PM on 11/24/22 and cared for Resident #30. NA #2 further revealed she had cared for Resident #30 three different rounds on 11/24/22. The NA indicated first round Resident #30 was combative, second round Resident #30 refused care, and third round Resident #30 also was combative. NA #2 revealed she assisted Resident #30 at an estimated time of 9:00 PM by herself but was aware he was a two person assist. NA #2 further revealed she rolled Resident #30 on his hip and the resident became combative and grabbed NA #2 left hand and bent her finger back. NA #2 stated she placed her right leg on his hip to hold the resident still so she could complete changing him. NA #2 stated Resident #30's bed was in a lower position. NA #2 revealed once she fastened the brief, she took her leg off and pulled away to unlink her fingers from Resident #30. NA #2 stated she continued to work the rest of night with an estimated 20 residents and was let go the next morning without being spoken too. An interview conducted with the Director of	F 610	reviewed by the Administrator and the Director of Nursing. This education will be conducted for all new hires by the Director of Nursing, and quarterly for all staff Administrator and/or Designee. On 11/28/22 a 1:1 education was provided for Nurse Aide #1 on the policies and procedures of reporting abuse and neglect allegations immediately. In the Certified Nursing Assistants schedule book, there will be a visual cue as a reminder of policy and pertinent phone numbers for reporting alleged abuse. - How the corrective action will be monitored. The Administrator and in his/her absence the Director of Nursing will be responsible for auditing, thoroughly investigating and calling APS immediately per facility policy. In the absence of the administrator the Social Worker will ensure that the Director of Nursing has completed a thorough investigation and that the investigation is reviewed to be sure that the staff member reported abuse/neglect immediately. The policy for investigating abuse and neglect allegations was reviewed by Administrator and Director of Nursing and found to not need revisions on 12/28/22. QAPI committee will discuss each new reportable event in monthly meetings and review with the medical director for the next three months. Completion Date: 12/29/2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345233	A. BUILDING _____ B. WING _____	C 12/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH AND REHABILITATION	306 DEER PARK ROAD NEBO, NC 28761

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F 610	Continued From page 11	F 610		

Nursing on 12/1/22 at 10:00 AM and revealed the incident between NA #2 and Resident #30 was reported to her early morning on 11/25/22 by NA #1. The DON indicated she reported the incident on 11/25/22 to the state agency and law enforcement. The DON further revealed she did not speak to NA #2 about the allegation but terminated her. The DON indicated she did not feel that she needed to interview and receive a written statement from NA #2. The DON stated she did not assess other residents but had assessed Resident #30 on 11/25/22 and he did not obtain any injuries. The DON further revealed NA #1 should had reported it the night of 11/24/22 and a thorough investigation should have been completed.

An interview conducted with the Administrator on 12/01/22 at 12:05 PM revealed she is the abuse coordinator but was out of town on 11/24/22 and was not made aware of the incident until 11/28/22. The Administrator further revealed she had expected the DON to complete a thorough investigation and it was not because body audits, training, and interviews had not been completed.