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 07/18/2019

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DEER PARK HEALTH & REHABILITATION	**306 DEER PARK ROAD NEBO, NC 28761**

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation survey was conducted on 07/18/19 - Event ID# QBJ11. One of the seven allegations was substantiated and cited. Please see CMS 2567 of 07/18/19 for additional information.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced	F 561		8/7/19

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

Electronically Signed | 08/05/2019

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F 561	Continued From page 1 by: Based on observation, record reviews, resident and staff interview the facility failed to honor a resident's choice for showers for 1 of 3 residents reviewed for choices. (Resident #7). The findings included: 1. Resident #7 was admitted to the facility on 03/15/19 with diagnoses that included scoliosis and left lower extremity amputation. Review of the quarterly Minimum Data Set (MDS) dated 06/21/19 revealed Resident #7 was cognitively intact. The MDS further revealed Resident #7 required extensive two-person assistance with bed mobility, transferring, dressing and personal hygiene. Resident #7 was dependent of one-person assistance with bathing. On 7/18/19 at 4:40 PM an interview conducted with Resident #7 revealed she had not received her showers as scheduled. Resident #7 stated she had requested to have her shower time changed from first shift (7:00 AM to 3:00 PM) to second shift (3:00 PM to 11:00 PM) two times a week. She stated she didn't want to get up early in the mornings on first shift during at the time staff asked her to take a shower. Resident #7 stated she would request a shower on second shift, but staff would not assist her. She stated she was scheduled to have a shower on 7/18/19 however hadn't received one yet. Resident #7 further stated she had initially requested for her shower time to be changed 3 months prior to July 2019. Review of the activities of daily living (ADL) flowsheet dated 04/13/19 revealed Resident #7's	F 561	1.) Resident #7 voiced concerns that the facility had not honored her wishes regarding shower days and times. To correct the deficiency as it relates to this individual, the facility's Interdisciplinary team (IDT) met with Resident #7 to identify on what days and at what time she preferred to shower. A decision was made to move her shower times to second shift twice a week, to which she agreed, in an attempt to accommodate her desire to sleep in until 10 or 11 am each morning. Resident #7's shower sheet/ADL Flowsheet and care plan were adjusted to reflect her choices. 2.)All residents have the potential to be affected by this deficient practice. D.O.N. or designee has completed, as of July 25, 2019, 100% interview/audit using the present resident roster to establish/confirm the baseline wishes related to shower times and days for all residents appropriate for showers. Those residents who are inappropriate for showers related to physical condition will receive appropriate bed baths scheduled twice a week and as needed. Those residents who were unable to be interviewed have had their responsible party/family notified to be aware of their shower schedule and to make any change requests to it. This information has been documented on resident care plans, the shower sheets/ADL flowsheets and transcribed to the C.N.A's daily assignment sheets. The ADL Flowsheets have been placed in the shower rooms for the C.N.A.'s to document showers given	

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F 561	Continued From page 2 name had a note beside it which stated she wanted to take her shower later in the day. Review of Resident #7's April 2019 activities of daily living (ADL) flowsheet revealed it was documented she received showers on the dates of 4/15/19 and 4/24/19. The review revealed Resident #7 was documented as not receiving a shower on 28 days out of 30 for the month of April. Review of the daily assignment sheet for 4/17/19 revealed a list of residents receiving showers on this date. The review revealed beside of Resident #7's name was a blank line with no initial. Review of Resident #7's May 2019 activities of daily living (ADL) flowsheet revealed it was documented she received showers on the dates of 5/08/19, 5/23/19 and 5/30/19. The review revealed Resident #7 was documented as not receiving a shower on 28 days out of 31 for the month of May. Review of the daily assignment sheet for 5/04/19 revealed a list of residents receiving showers on this date. The review revealed beside of Resident #7's name was a blank line with no initial. Review of Resident #7's June 2019 activities of daily living (ADL) flowsheet revealed it was documented she received showers on the date of 6/13/19. The review revealed Resident #7 was documented as not receiving a shower on 29 days out of 30 for the month of June. Review of the daily assignment sheet for 7/04/19 revealed a list of residents receiving showers on	F 561	and any refusals. As residents voice any wishes to change their shower times or days, care plans and shower sheet/ADL Flowsheets will be adjusted as needed, reported to clinical staff and documented on the 24 hour report. All new admissions will be interviewed to establish their right for self determination of services and their requests documented to ADL flow sheets, C.N.A. assignments sheets and to care plans. 3.) To ensure this deficient practice does not recur, D.O.N. or designee completed on July 25, 2019,communication of the baseline wishes with ongoing teaching and training to 100% of the licensed and certified clinical staff regarding the fulfillment of the shower schedules as written. Included in this education, when a resident's shower is completed or refused, it is to be documented on the shower sheet/ADL Flowsheet, reported to charge nurse and communicated through the 24 hour report. This education will be included in new hire orientation and reviewed with any agency staff used. 4.) The facility will monitor this performance with weekly audits of the shower schedule sheets/ADL Flowsheets and the 24 hour report. These audits, begun the week of July 22, 2019, are to be completed by the D.O.N. or designees weekly for four weeks, then monthly for two months with the results of the audits being reported to QAPI meeting each month for three months to insure ongoing substantial compliance. 5.)Date of Compliance August 11, 2019	

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F 561	Continued From page 3	F 561		

this date. The review revealed beside of Resident #7's name a note which stated she wanted to take her shower later in the day on second shift.

Review of the daily assignment sheet for 7/07/19 revealed a list of residents receiving showers on this date. The review revealed beside of Resident #7's name a note which stated she refused and requested to be showered on second shift.

On 07/18/19 at 12:22 PM an interview was conducted with Nurse Aide (NA) #5 which revealed during first shift the facility had two NA's in the building to complete showers. NA # 5 stated there was no shower team for second shift and the NA's on the hall were responsible for any second shift showers, which was difficult to complete due to the task load. She stated the staff completed what they could. NA #5 further stated Resident #7 did not like to get up early in the mornings and had requested a second shift shower.

On 07/18/19 at 6:18 PM an interview was conducted with the Director of Nursing (DON). The interview revealed her expectations were for residents to receive a minimum of 2 showers per week and have a choice of what time during the day they would like to receive a shower. She stated she had staffed the facility with two Nursing Assistants to complete the daily showers. The interview revealed if Resident #7 refused a shower it should be documented using a "R" on the ADL flowsheet. She stated she listed the showers for the day on the daily staffing sheet in which the NA's documented completion of the showers for a double verification. She stated the assignment sheet should not have blank lines

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F 561	Continued From page 4 beside Resident #7's name and her shower time should have been changed to second shift when she initially requested it in April 2019.	F 561		
F 624 SS=D	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, and outside agency interviews, the facility failed to provide instructions for discharge and follow up home care, and, failed to call in medications to be taken at home to the pharmacy for 1 of 3 residents (Resident #1) reviewed for safe and orderly discharge home. The findings included: Resident #1 was admitted to the facility on 06/14/19 with diagnoses which included hypertension, dementia, and cerebrovascular accident (CVA). Resident #1 was discharged home from the facility with family on 07/04/19 and was to have home health follow up for nursing, speech therapy, physical therapy and occupational therapy. Review of Resident #1's admission Minimum Data Set (MDS) dated 06/21/19 revealed he was severely impaired for daily decision making and	F 624	1.)Facility failed to provide and/or document sufficient preparation and instruction to Resident #1 and his family upon discharge home July 4th, 2019, as evidenced by the incomplete Interdisciplinary (IDT) Discharge Summary Sheet, and the lack of proof regarding communication to the pharmacy and home health agency with discharge orders. Resident #1 was in good general condition upon discharge and has not returned to this facility. 2.) All discharging residents have the potential to be affected by the same deficient practice. Discharge planning begins upon admission with plans for expected length of stay, wishes to return home and/or other required placement being discussed and documented from the admission baseline and ongoing care planning process throughout the residents stay.	8/7/19

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F 624	Continued From page 5 required extensive assistance with 1 to 2 with most activities of daily living (ADL) except eating. The resident had impairment on one side of his upper and lower extremities and used a wheelchair for locomotion. Review of Resident #1's baseline care plan for discharge planning revealed he was admitted for short term rehab with the goal for appropriate placement pending MD order. The interventions included discussing discharge plans with resident/responsible party (RP) and assisting with referrals and arrangements as needed. Review of Resident #1's Interdisciplinary Discharge Summary revealed sections to be completed by Social Services, Nursing Services, Dietary Services, Activities and Rehab Services. Resident #1's Discharge Summary was completely blank except for admission and discharge dates, resident name and physician name. None of the sections had been completed by the appropriate disciplines. Review of Resident #1's medical record revealed an order for the resident to be discharged home on 07/04/19 with home health to follow for nursing, physical therapy (PT), speech therapy (ST) and occupational therapy (OT) signed by the Nurse Practitioner (NP). There was no other document in the record of the resident ' s discharge, instructions and medications to be taken at home and when the next dose was due to be taken at home. There was a discharge summary in the medical record that had been dictated by the NP indicating the medications to be continued at home and the need for the resident to be followed by home health for nursing, ST, PT and OT. There was also a copy	F 624	3.) To ensure that this deficient practice does not recur, teaching and training of 100% of licensed staff and the Interdisciplinary Team (IDT) regarding the requirements of a safe discharge was completed by the Staff Development Coordinator on July 25, 2019, which included completion of the IDT Discharge Summary Sheet being mandatory. This sheet documents any family and/or resident teaching, a home going list of medications, any need for durable medical equipment (DME), home health agency visits and/or outpatient therapy visits ordered by the residents physician of record. This training is done with all new hire licensed or IDT members at orientation and is reviewed with any agency staff used prior to working in the facility. The facility's Medical Director and ARNP team have elected to now write hard copies of any homegoing prescriptions given to discharging residents and/or family upon discharge to alleviate any miscommunication problems that might occur with phone or fax communication with pharmacy or home health agencies. Social Worker documents resident discharges on her tracking form and keeps copies of the discharge telephone orders, a copy of the IDT Discharge Summary Sheet and copies of the prescriptions given to the resident upon discharge. In addition to this present process, Social Worker will be tracking residents after discharge home or to another non skilled community setting with follow up phone calls on Day 3, 7 and 21 after they have been discharged to	

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F 624	Continued From page 6 of a prescription for Norco 10-325 milligrams (mg) 1 tablet every 6 hours as needed for pain with 20 tablets to be dispensed and no refills. The copy stated the original hard script had been sent home with the resident's family member at discharge and was signed by Nurse #1. Further review of the medical record revealed a nursing note that read: 07/04/19 at 2:00 PM - Resident discharged home with wife at this time. Hard script for Norco 10/325 mg sent with wife. Left in good general condition. The note was signed by Nurse #1. An interview on 07/18/19 at 9:00 AM with Resident #1's family member revealed he had been discharged from the facility on 07/04/19 without any prescriptions or discharge instructions. The family member stated she only had one prescription for the resident and that was his pain medication and stated she dropped it at the pharmacy on her way home with the resident. The family member stated she went back to the pharmacy to pick up his medications to find that none had been called in to the pharmacy by Deer Park. The only prescription the pharmacy had for the resident was his pain medication that she had dropped off earlier. The family member stated the next day on 07/05/19 she had called Deer Park when home health had not shown up and talked with the Social Worker and she told the family member that home health had been set up and should come out that day. The family member stated she also told the Social Worker that the pharmacy had not received his medications and stated the Social Worker told her she would have the nurse fax the orders for his medications to the pharmacy. She stated she called the pharmacy and the orders they had received from Deer Park were not valid. The	F 624	insure all discharge needs (ie: medications, DME, home health visits) have been met timely and to inquire as to any ongoing concerns or needs the resident and/or family may have identified once home. 4.) To insure these solutions are sustained, D.O.N. or designee will audit 100% of all IDT Discharge Summary Sheets weekly for four weeks, beginning the week of July 22, 2019. Random audits of discharge summaries will be done weekly for two more months, ending in October, to ensure ongoing compliance to established policy and procedure. Reports of all audits will be brought to QAPI for three months. Social Worker will provide D.O.N. or designee with her Discharge Tracking forms beginning the week of July 22, 2019, for four weeks and report same to QAPI each month , ending in October, to insure ongoing substantial compliance. 5.) Date of Compliance August 11, 2019	

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family member stated she had to go to Deer Park on 07/05/19 and get a copy of his medications. She stated she had gotten the copy from Nurse #2 and took them to the pharmacy. The home health nurse had not shown up on 07/05/19 as expected, but stated she came out on 07/06/19. The family member stated the nurse would not admit Resident #1 to their services because there were no orders for care and no medications. The Home Health Nurse recommended to the family member the resident be transferred back to the hospital for evaluation as he had not had any of his medications for 2 days. The family member stated she called EMS and had him transported to the local hospital where they admitted him. She stated he was admitted for 6 days but had been discharged and was home now receiving Home Health services.

A review of the hospital record revealed Resident #1 was admitted to the hospital on 07/06/19 with acute cystitis and acute kidney failure, moderate protein malnutrition, hypertension, onychomycosis (a fungal infection of the toe nail) and recent cerebral vascular accident (CVA). The resident was treated with intravenous (IV) fluids and antibiotics and had his nails trimmed by the podiatrist. Physical and Occupational therapies worked with him while he was hospitalized, and recommended services be continued on discharge. His chronic Foley catheter was replaced while inpatient by request of his family member. While inpatient Resident #1's Hemoglobin A1c was checked and was 6.3%, so the Physician discharged him home on Metformin instead of insulin. Resident #1 was discharged on 07/12/19 and advised to make an appointment with his primary care physician for follow up. He was discharged home with Home

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Health Nurse, Physical Therapy and Occupational Therapy and the agency was to call the family member to set up their initial visit on 07/13/19. The hospital Discharge Planner scheduled Durable Medical Equipment (DME) to be delivered on 07/12/19 which included a bedside commode, hospital bed and Hoyer lift. Resident #1 and his family member were given a list of medications to be continued at home with the date and time of the next dose due. Resident #1 was discharged home in the care of his family member.

An interview on 07/18/19 at 3:00 PM with Nurse #1 revealed she had taken care of Resident #1 and was the nurse that discharged him home on 07/04/19. When asked about the blank discharge instructions sheet, Nurse #1 stated she had completed another form and the one that was blank was optional as to whether it was filled out at discharge. Nurse #1 looked through the medical record but could not locate the form that she had completed for Resident #1's discharge. Nurse #1 stated she had called in the resident ' s medications to the pharmacy but could not remember which pharmacy it was called into but stated she had spoken with a person and had not left it on voicemail. She stated she had not completed a form with the medications he was to take at home but had read them off the Medication Administration Record (MAR). Nurse #1 stated she had not given a copy of the medications to Resident #1 or his family member on discharge but stated she probably should have. Stated she would have made a note in the chart about calling in the medications but when shown the notes she stated she guessed she had not made a note.

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A telephone interview on 07/18/19 at 4:10 PM with the Pharmacy that was to receive the medication orders revealed the Pharmacist working on 07/04/19 stated she had not received a call from Deer Park regarding medications for Resident #1. She stated there were no voicemail messages left on 07/04/19 and no messages from the Pharmacy Techs about medications being called in from Deer Park for Resident #1. She stated she had received a fax on 07/05/19 at 2:49 PM from the Assistant Director of Nursing (ADON) at Deer Park with orders for medications for the resident. The Pharmacist stated the Pharmacy had holiday hours that day and were only open on 07/04/19 from 10:00 AM to 6:00 PM. The Pharmacist stated if the resident's family member came in after 6:00 PM she would not have been able to get his medications until the next day. She stated his medications were filled on 07/05/19.

A telephone interview on 07/18/19 at 4:10 PM with the Home Health Agency Representative revealed they had received a fax on 07/05/19 at 6:56 AM regarding Resident #1's need for home care. The Representative stated they scheduled a Nurse to go out on 07/06/19. The Home Health Agency Representative stated when the Nurse went out on 07/06/19 she had not accepted Resident #1 into care because he had not had any orders for care and no medications and the Nurse felt like it was an unsafe situation and recommended to the family member that she call EMS and have the resident sent to the hospital for evaluation and treatment.

An interview on 07/18/19 at 4:32 PM with the Social Worker (SW) revealed she had discussed with Resident #1's family member his discharge

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plan on two occasions. The SW stated the family member had told her the only equipment the resident would need at discharge was a bedside commode. The SW stated she had emailed and texted with the Home Health Liaison regarding Resident #1 needing home health follow up for nursing, physical therapy, speech therapy and occupational therapy. The SW stated Resident #1 had used this home health agency before and wanted to use them again. The SW stated Nurse #1 was to call the prescriptions in to their pharmacy of choice and stated she thought everything was arranged for Resident #1 to go home. The SW stated the family member called her the day after discharge and told her Resident #1 ' s prescriptions had not been called in to the pharmacy and stated she asked the Assistant Director of Nursing (ADON) to fax them to the pharmacy and she had done that on 07/05/19 around 2:45 PM. The SW stated she was not aware until the resident told Nurse #2 on the evening of 07/05/19 that Home Health had not been to see Resident #1 on that day. The SW stated she had followed her normal process of contacting the Liaison with the Home Health Agency and stated she was not sure what had happened with the referral and why they had not gone out to Resident #1's home on 07/05/19.

A telephone interview on 07/18/19 at 5:10 PM with Nurse #1 revealed she could not recall who she had talked to at the pharmacy when she had called in the medications. Nurse #1 stated she was not sure where the paperwork that she had filled out was if it was not in the resident's medical record. Nurse #1 stated their typical process was to call the pharmacy and read the medications off the Medication Administration Record (MAR) and attach a copy to the discharge instructions.

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(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
F 624	Continued From page 11	F 624		

A telephone interview on 07/18/19 at 6:15 PM with Resident #1's family member revealed she had gone to the facility late afternoon on 07/05/19 to obtain a copy of the resident's medications to be taken at home. She stated she had received the copy of the medications from Nurse #2.

An interview on 07/18/19 at 6:15 PM with the Director of Nursing (DON) revealed their normal discharge planning process was for the SW to start the process on admission and she stated the SW was responsible for the majority of the discharge process. She stated the SW was responsible for arranging home health and durable medical equipment (DME) needs and the Nurse was responsible for filling out parts of the discharge form not completed by the other disciplines and calling in the medications to the resident's pharmacy of choice. A copy of the discharge instructions and medications should be sent home with the resident and his or her family according to their process. The DON stated the medications should indicate when the resident was to take his or her next dose. She looked through the medical record but was unable to locate a copy of the discharge instructions or a copy of the medications and when the resident was to take his next dose. There was only one form to be completed at the time of discharging a resident and Resident #1's was blank according to the DON. She stated it was her expectation the nurse discharging the resident complete the form and list his medications and the next dose due before discharging the resident; however, she could not find another discharge sheet in the medical record and stated the discharge sheet was not optional and should be completed on every resident discharged home. The DON also

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 07/18/2019

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stated it was her expectation the nurse calls the pharmacy 2 hours after calling in medications to ensure they were received and would be filled for the resident.

An interview on 07/18/19 at 6:25 PM with the ADON revealed the SW had received a call from Resident #1's family member on 07/05/19 stating his medications had not been called into the pharmacy on 07/04/19 as indicated by Nurse #1. She stated she had made a list of the medications and faxed to the pharmacy on 07/05/19 and confirmed around 3:00 PM they had received her fax. The faxed listing of medications was not located, but the ADON stated she had confirmed receipt of the list with the pharmacy. The ADON verified there was not a copy of the list in Resident #1's medical record.

An interview on 07/18/19 at 6:35 PM with Nurse #2 revealed he had given Resident #1's family member a list of his medications to be taken at home on the evening of 07/05/19.