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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness Plan which described the facility's comprehensive approach to meeting health, safety, and security needs for their staff and resident population during an emergency or disaster situation. The facility failed to address how the facility would coordinate with local officials during an emergency or disaster, failed to show evidence of a community based test of their Emergency	E 001	The facility failed to establish maintain a comprehensive Emergency Preparedness Program (EPP) to comply with State and Federal guidelines. The Administrator was educated by a licensed Nursing Home administrator that has successfully completed and initiated the Emergency Preparedness Plan (EPP) The Emergency Preparedness Program describes the facility's comprehensive approach to meeting the health, safety	5/10/18

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

Electronically Signed | 05/04/2018

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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 001	Continued From page 1 Preparedness Plan and failed to provide evidence of staff training of the Emergency Preparedness Plan. The findings included: Review of the Emergency Preparedness Plan (EPP) manual provided by the facility with policies and procedures was conducted. The manual contained a template of how to organize the manual but no written established policies and procedures. The manual did not contain a written comprehensive EPP that met the federal requirements. An interview conducted on 04/12/18 at 3:52 PM with the Administrator revealed she had been at the facility for one month and did not realize the EPP had not been completed. She stated she had been in touch with the local emergency management to participate in a community based activity but did not have a date yet.	E 001	and security needs for the staff and resident population. The EPP will guide the facility during an emergency, disaster or an event that effects Deer Park and surrounding area. The administrator will be in charge of maintaining the EPP and keeping it up to date. The facility staff to include housekeeping, maintenance, social services, admissions, nursing, dietary and therapy, were educated on the Emergency Preparedness Plan. The emergency preparedness plan will be reviewed and updated with any changes impacting the facility and or Community as outlined in the EPP. The EPP will be discussed and reviewed with QAPI meetings quarterly for 12 months to ensure the EPP remains updated.	
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID# V48111	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		5/10/18

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 657	Continued From page 2 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to develop a baseline care plan that included minimum healthcare information to provide effective, person-centered care for a resident with clostridium difficile (abbreviated as C-diff and meaning a contagious bowel infection) and diabetes for 1 of 4 (Resident #257) residents reviewed for baseline care plan. Findings included: Resident #257 was admitted to the facility on 4/7/18 from the hospital with diagnoses including C-diff, peripheral vascular disease, diabetes, cellulitis, and anxiety. An entry tracking record Minimum Data Set (MDS) was opened but had not been completed at the time of the survey.	F 657	The facility failed to create a baseline care plan that included the mini8mum healthcare information to provide effective, person-centered care. The baseline care plan for resident # 257 was reviewed and updated on 4/12/2018 to meet the needs of the resident. The Administrator educated the licensed and non-licensed staff on completing the baseline care plan according to our policy and procedure and the timeline set forth by Federal and State guidelines. A review of the baseline care plans for other residents admitted to the facility was conducted and found to meet the resident's needs. Each new admitted and re-admitted resident will have their chart brought to morning meeting to review and ensure	

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 657	Continued From page 3 An observation of the resident's room on 4/9/18 at 11:45 am revealed a sign on the door stating the resident was on contact isolation. There was also an isolation cart with gowns and gloves outside the resident's room. A review of physician orders for April 2018 revealed an order for contact isolation precautions. A record review on 4/12/18 at 3:10 pm revealed the baseline care plan dated 4/7/18 for Resident #257 had the resident's name, date, and room number but was otherwise blank. An interview conducted with an MDS nurse on 4/12/18 at 3:12 pm revealed that the baseline care plan should not have been blank and should have been completed at the time of admission or within 48 hours of admission. An interview conducted with the Director of Nursing (DON) on 4/12/18 at 3:15 pm revealed that a baseline care plan is expected to be completed for every newly admitted resident within 48 hours of admission. An interview conducted with the Administrator on 4/12/18 at 4:55 pm revealed that her expectation was that baseline care plans were to be completed within 48 hours for every newly admitted resident.	F 657	that baseline care plans have been established. The DON or designee will audit the baseline care plan on new admissions. Each admission record will be brought for review of the IDT team at the next morning to ensure compliance. Care plan audits will be conducted to ensure facility staff follows; Facility, Federal and State guidelines. Audits will be conducted with each new admission for 4 weeks, then monthly for 3 months. Audit results will be reported to the QAPI committee along with the actions of the developed and implemented audits.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		5/10/18

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 867	Continued From page 4 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the recertification/complaint survey of 03/02/17. This was for one deficiency originally cited 03/02/17 and was subsequently recited on the current recertification/complaint survey of 04/12/18. The two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F 880: Infection Control: Based on observations, record review, and interviews the facility failed to follow isolation precautions (Resident #257) and failed to initiate contact isolation precautions (Resident #35) for 2 of 2 resident's reviewed for infection control. During the recertification and complaint survey of 03/02/17, the facility was cited for failure to follow the facility infection control policy to reduce the risk of acquiring and transmitting infections by not following droplet and contact isolation precautions for 3 of 5 residents reviewed on isolation precautions (Resident's #39, #43, and #76). An interview conducted on 04/12/18 at 4:56 PM	F 867	The Administrator was educated by the Regional Director of Operations on the facilities Quality Assurance Performance Improvement program (QAPI) on 5/2/2018. The education included: Identifying areas of continuous quality monitoring and the tools to be used. The Administrator educated facility staff regarding the policy and procedures on the QAPI program. Education also included; monitoring activities, a focus on the processes that effect resident outcomes and performance improvement. Ongoing monitoring will be used to re-establish the facilities outcomes. The Administrator is accountable for the overall implementation and functioning of the QAPI program. The QAPI committee will meet monthly to continue to monitor and identify areas of improvement to include survey deficiencies. The Committee will address the identified areas, examine and improve the identified needs through improvement, action plans and monitoring the effectiveness of such plans. The regional director of operations (RDO) will review the facility QAPI Committee meeting minutes for up to 6 months to ensure ongoing compliance.	

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 867	Continued From page 5 with the Administrator revealed she had only been at the facility for a month and has not had a Quality Assurance meeting yet. She stated the committee will meet monthly but no less than quarterly and as needed based on any new concerns.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		5/10/18

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 880	Continued From page 6 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to follow contact isolation precautions (Resident # 257) and failed	F 880	The facility failed to follow the posted signage on an isolation room without applying the appropriate personal	

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 880	Continued From page 7 to initiate contact isolation precautions (Resident #35) for 2 of 2 resident's reviewed for infection control. The findings included: 1. Resident #257 was admitted to the facility 4/7/18 with diagnoses including clostridium difficile (abbreviated as C-diff and meaning a contagious bowel infection), diabetes, cellulitis, sacral wound, and peripheral vascular disease. An entry tracking record Minimum Data Set (MDS) for Resident #257 was opened but had not been completed. An observation on 4/9/18 at 11:45 am of Resident #257's door revealed a sign indicating the resident was on contact isolation precautions and there was a cart outside the resident's room with isolation gowns and gloves. An observation on 4/9/18 at 11:47 am revealed the facility's maintenance director gave Resident #257 the portable facility telephone per the resident's request. After Resident #257 completed her telephone call the maintenance director was observed taking the telephone from the resident, placing the telephone back on the charging base, and walking down the hall way. An interview on 4/9/18 at 11:50 am with the maintenance director revealed he had seen the isolation sign and cart outside resident's room. The maintenance director stated he wasn't sure why he had not cleaned the telephone after use. The maintenance director also stated he always washed his hands.	F 880	protective equipment. Resident # 257 and # 35 are no longer on isolation precautions. Monitoring daily lab results, obtaining MD orders and initiating isolation precautions on positive labs results timely while implementing and educating for the benefit of the resident's requiring isolation, staff and visitors. Facility staff to include housekeeping, maintenance, social services, admissions, nursing, dietary and therapy have been in-serviced on the infection control policy and procedure. The clinical team reviews initial results and physician's orders to verify implemented isolation requirements. DON or Designee will be responsible to in service and educate new hires according to our policy and procedure on infection control. Observation audits will be conducted to ensure facility staff follows isolation and infection control policies when entering and exiting an isolation room. Observation audits will be conducted five days per week for 4 weeks, then monthly for 3 months. Audit results will be reported to the QAPI committee with the actions of the developed and implemented audits. An audit will be conducted by the DON or designee to ensure the implementation of isolation precautions was put in place as required. Audits will be conducted five days per week for 4 weeks, then monthly for 3 months. Audit results will be reported to the QAPI committee with the actions of the developed and implemented audits.	

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 880	Continued From page 8	F 880		

An interview with the Director of Nursing (DON) conducted on 4/9/18 at 11:53 am revealed it was her expectation that all staff follow posted isolation precautions. The DON further stated the telephone should have been cleaned before being put back into use.

An observation on 4/9/18 at 11:58 am revealed Resident #257's meal tray was delivered to her room by a staff member from the business office. The staff did not place an isolation gown or gloves on before entering the room.

An interview on 4/9/18 at 12:00 pm with the staff member from the business office revealed she had seen the isolation sign on Resident #257's door and the isolation cart outside the resident's room. The staff member stated she should have followed isolation precautions and was not sure why she did not.

An interview was conducted on 4/9/18 at 12:05 pm with the DON and revealed it was her expectation that all staff follow posted isolation precaution signage any time the resident's room is entered.

An interview was conducted on 4/12/18 at 2:15 pm with the facility nurse practitioner and she revealed it was her expectation that all staff follow posted signage for isolation precautions and that any items coming out of an isolation room should be cleaned prior to being put back into use.

An interview was conducted with the Administrator on 4/12/18 at 4:55 pm and revealed it was her expectation that all staff follow posted signage for isolation precautions and that any items coming out of an isolation room should be

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 880	Continued From page 9 cleaned before being put back into use. 2. Review of Resident # 35's medical record revealed on 04/05/18 his urine was obtained for a urine culture. On 04/07/18 the final results indicated an organism greater than 100,000 colony forming units per milliliter (CFU/ML) of E-Coli, ESBL resistant and was started on an antibiotic for the UTI by Nurse Practitioner # 1. On 04/10/18 the final results of the urine culture was signed and dated by NP # 2. Observation of Resident # 35's room on 04/10/18 at 8:59 AM revealed no contact precautions had not been set up. Observation of Resident # 35's room on 04/11/18 at 10:57 AM revealed no contact precautions had not been set up. Observation of Resident # 35's room on 04/12/18 at 8:25 AM revealed no contact precautions had not been set up. Interview with NP #2 on 04/12/18 at 9:37 AM (who had the final results of the urine culture in her possession) revealed Resident # 35 should have been started on contact precautions on 04/07/18 when the final results of the culture were reported to NP #1, and added she herself should have realized contact precautions were not ordered and initiated it when she read the report on 04/10/18. Observation of Resident # 35's room on 04/12/18 at 10:30 AM revealed contact precautions had been set up.	F 880		

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 880	Continued From page 10 Interview with the Administrator on 04/12/18 at 4:55 PM revealed her expectation would be for Resident # 35 to have been started on contact precautions when the report came back with ESBL.	F 880		
F 926 SS=D	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident and staff interviews the facility failed to allow 4 of 14 residents assessed as safe smokers to smoke independently and unsupervised (Residents #15, #38, #61, #357). The findings included: Review of the facility Smoking Policy, revised 01/16 read in part: Smoking is allowed only during designated smoking times which are 10:00 AM, 1:00 PM, 4:00 PM, and 8:00 PM. No smoking will be permitted outside these designated time periods. Each smoking time will last for only 20 minutes. Facility administration reserves the right to modify smoking times as necessary due to inclement weather or other justifiable circumstance. Staff supervision is required during all smoking sessions to light all cigarettes, monitor safety, and to ensure all residents adhere to the policy.	F 926	The facility failed to allow residents that have been assessed and found to be a safe smoker the right to smoke independently without supervision at the time of their choosing. Residents # 15, 38, 61, and 357 were assessed for the ability to safely smoke independently without supervision. Each were found to meet the criteria to independently smoke at liberty. Their care plans were updated to reflect independent unsupervised smoking. Each resident wishing to smoke was re-evaluated by the DON for the ability to smoke independently without supervision and education on the smoking policy and procedure. The residents that are able to independently smoke will get the lighter and cigarette from the nurse on duty, upon entry back into the facility they will return the lighter to the nurse to maintain safety.	5/10/18

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 926	Continued From page 11 1. Resident #61 was admitted to the facility on 02/22/18 with diagnoses of high blood pressure and cirrhosis. Review of the facility Smoking Safety Evaluation dated 02/22/18 revealed Resident #61 was independent and did not need assistance with smoking. Review of the admission Minimum Data Set (MDS) dated 03/01/18 revealed Resident #61 was cognitively intact and used tobacco. An interview conducted on 04/11/18 at 11:48 AM with Resident #61 revealed he could only smoke at the supervised smoking times. He stated he would like to smoke more often but he wasn't allowed to go out to smoke unsupervised. An interview conducted on 04/11/18 at 3:05 PM with the Director of Nursing revealed all smokers had to be supervised even if they were assessed as a safe smoker. She stated that was the facility policy. An interview conducted on 04/11/18 at 5:15 PM with the Administrator revealed it was the facility policy for all residents assessed as safe or unsafe smokers to be supervised while smoking and they could only smoke at the scheduled times. She further stated residents assessed as safe smokers should have been able to smoke when they chose to smoke. 2. Resident #357 was admitted to the facility on 04/07/18 and assessed as alert and oriented and able to make his needs known. Review of Resident #357's Smoking Safety	F 926	The Administrator educated facility staff to include, housekeeping, maintenance, social services, admissions, nursing, dietary and therapy on the resident's right to smoke independently and unsupervised and the process in which they will obtain their cigarette and lighter. The DON or designee will complete the smoking assessment upon admission, MDS nurse will complete a quarterly smoking assessment and with any significant change in the resident condition. Audits will be conducted to ensure residents continue to smoke independently and unsupervised according to policy and procedure, 5 days a week for four weeks, then weekly for 4 weeks and monthly for 2 months. Audit results will be reported to the QAPI committee with the actions of the developed and implemented audits.	

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 926	Continued From page 12	F 926		

Evaluation dated 04/07/18 revealed he was independent and did not need assistance with smoking.

An interview conducted on 04/11/18 at 9:16 AM with Resident #357 revealed he could only smoke at supervised smoking times and he would like to smoke more often.

An interview conducted on 04/11/18 at 3:05 PM with the Director of Nursing revealed all smokers had to be supervised even if they were assessed as a safe smoker. She stated that was the facility policy.

An interview conducted on 04/11/18 at 5:15 PM with the Administrator revealed it was the facility policy for all residents assessed as safe or unsafe smokers to be supervised while smoking and they could only smoke at the scheduled times. She further stated residents assessed as safe smokers should have been able to smoke when they choose to smoke.

3. Resident # 15 was admitted to the facility on 04/21/17 with diagnoses which included Parkinson disease and depression.

Review of Resident #15's quarterly Minimum Data Set (MDS) dated 01/17/18 revealed he was cognitively intact and had no upper extremity impairment.

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 926	Continued From page 13	F 926		

Review of the facility's Smoking Safety Evaluation dated 02/28/18 revealed Resident # 15 was able to smoke independently and did not require supervision.

Interview with Resident # 15 on 04/10/18 at 11 :55 AM revealed he would like to smoke when he pleased.

An interview conducted on 04/11/18 at 3:05 PM with the Director of Nursing revealed all smokers had to be supervised even if they were assessed as a safe smoker. She stated that was the facility policy.

An interview conducted on 04/11/18 at 5:15 PM with the Administrator revealed it was the facility policy for all residents assessed as safe or unsafe smokers to be supervised while smoking and they could only smoke at the scheduled times. She further stated residents assessed as safe smokers should have been able to smoke when they chose to smoke.

4. Resident # 38 was admitted to the facility on 11/05/15 with diagnoses which included depression and chronic obstuctive pulmonary disease.

Review of Resident # 38's annual Minimum Data Set (MDS) dated 02/08/18 indicated he was cognitively intact, had no upper extremity impairment and tobacco use.

Review of the facility's Smoking Safety Evaluation dated 02/28/18 revealed Resident # 38 was able to smoke independently and did not require supevision.

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 04/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEER PARK HEALTH & 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
F 926	Continued From page 14 Interview conducted with Resident # 38 on 04/10/18 at 3:55 PM revealed he would like to be able to smoke when he wanted to. An interview conducted with the Director of Nursing revealed all smokers had to be supervised even if they were assessed as a safe smoker. She stated that was the facility policy. An interview conducted on 04/11/18 at 5:15 PM with the Administrator revealed it was the facility policy for all residents assessed as safe or unsafe smokers to be supervised while smoking and they could only smoke at the scheduled times. She further stated residents assessed as safe smokers should have been able to smoke when they chose to smoke.	F 926		