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 09/10/2019

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 000	INITIAL COMMENTS A complaint investigation survey was conducted with an on site revisit on 09/09/19 through 09/10/19. There was one allegation investigated and it was substantiated and cited. Event ID# 0R2U11.	F 000		
F 600 SS=G	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; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to protect a resident's right to be free from physical abuse when a resident was physically grabbed by a Nurse Aide (NA) for 1 of 3 residents reviewed for abuse (Resident #1). NA #1 grabbed Resident #1 by both wrists and held his arms above his head. Resident #1 yelled for the NA to let him go as he struggled to free himself. Following the physical abuse Resident #1 was observed to be visibly upset and had red bruises to both wrists and forearms and had puncture wounds to his left wrist and left forearm	F 600	1. On May 8, 2019 at 2:00 AM Nurse Aid (NA) #1 was witnessed to have abused Resident #1, pulling him backwards in his wheelchair and then found by Nurse #1, NA #2 and NA #3 to be holding his wrists above his head causing redness and small puncture wounds. Nurse #1 immediately instructed NA #1 to step away from the resident and to go home. Resident #1 was allowed time to calm down and fell asleep in his wheelchair and staff then assisted him to bed. NA #1	9/19/19

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

Electronically Signed | 09/26/2019

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F 600	Continued From page 1 that were bleeding from the NA's fingernails digging into his skin. Resident #1's injuries were treated at the facility. After NA #1 physically abused Resident #1 the facility failed to determine if NA #1 had abused any other residents in the facility. The findings included: Resident #1 was admitted to the facility on 09/14/18. Resident #1's diagnoses included schizoaffective disorder, dementia with behavior disturbances, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated 02/07/19 indicated Resident #1 was severely cognitively impaired and was independent with bed mobility, transfers, and locomotion on/off unit. No behaviors or rejection of care were noted during the assessment reference period. Review of a care plan developed on 04/30/19 read in part, Resident #1 was at risk for elopement related to cognitive impairment and mobility. The goal of the care plan read, Resident #1 would remain safe within the facility unless accompanied by staff or another authorized person. The interventions included: if Resident #1 was wandering in potentially unsafe or area or situation redirect to safer area, leave safe and reassess regularly. Review of an incident report dated 05/08/19 at 2:15 AM read in part, Resident #1 was at the end of the hall near the exit door and was upset and cursing. Nurse Aide (NA) #1 was standing behind Resident #1 holding his wrists/forearm causing a 0.5-centimeter (cm) skin tear and 1.5 cm red area	F 600	was terminated May 10, 2019 following the investigation of the allegation of abuse. The initial allegation and five day workday report were submitted timely as was the HCPR. The review of this investigation did show that although 100% education was done with all staff, there had been no formal audits to insure the facility attempted to identify other residents who may have been abused by NA #1 or any other staff. 2. All residents have the potential to be adversely affected by this deficient practice. On September 9, 2019 DON, SDC and SW began to round the building using an Abuse/Neglect Questionnaire to interview all cognitive, alert and oriented residents. The interviews were completed September 9, 2019 and revealed no further residents who felt that they had been abused or neglected either by NA #1 in the past or by any staff thus far. Skin assessments were completed on Sept 9, 2019 by the Minimum Data Set (MDS) nurses, Staff Development Coordinator (SDC), Director of Nursing (DON), Assistant Director of Nursing (ADON), and Wound Nurse on all cognitively impaired residents. Residents were assessed for signs of injury related to physical abuse with no obvious major concerns noted. Several residents were found to have random minor bruising and after investigations were conducted all were proven related to resident self-inflicted scratching, resident to object contact, a recent fall, or recent lab draws. Incident reporting will be completed on any issues discovered September 10, 2019.	

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F 600	Continued From page 2 to the left forearm. Nurse #1 asked NA #1 to release Resident #1's arms and move away from the resident. NA #1 was asked to leave the facility and Resident #1 was left alone to cool down. Director of Nursing was (DON) notified. The incident report was signed by Nurse #1. Review of a nurses note dated 05/08/19 at 2:15 AM read in part, NA "notified nurse resident was hitting staff and pushing the exit door, going in other resident room at the end of the hall." Nurse went to hall and NA #1 held resident's wrist and forearm areas due to resident being combative. Resident had 1.5 cm red area to left forearm and a 0.5 cm skin tear to left hand. The note was written by Nurse #1. Review of a statement provided by NA #1 and dated 05/09/19 read in part, on 05/07/19 I was scheduled to work from 9:00 PM to 4:00 AM and was caring for Resident #1. At approximately 2:15 AM Resident #1 was roaming around in his wheelchair (WC) and was going in and out of other resident rooms. I tried to talk to Resident #1 "tried to redirect him to come out of there room, he was hitting, kicking, swinging, and cussing." In the process of kicking, hitting, swinging he was hitting the doorframe and WC armrest he took his feet and shoved the WC back and it slammed me back against the glass door. Resident #1 pinned me against the glass door by rolling his WC back and forth. Resident #1 was still hitting, swinging, and kicking and I put my hand in front of my face to keep him from hitting me in the head and face. I told NA #2 to please get Nurse #1 to help get him off me. Nurse #1, NA #2 and NA #3 came down hall and Nurse #1 stated "you know you are not supposed to approach an agitated patient" and I replied, when it started Resident #1 was not	F 600	Additionally, the DON reviewed incident reports and 24 hour reports from May 2019, looking for any documentation that would show potential abuse or neglect. Nothing egregious was found. 3. On September 9, 2019, the DON, Nursing Home Administrator (LNHA), charge nurses and Administrator in Training (AIT) initiated small group trainings with 100% of staff present including nursing, dietary, housekeeping, laundry, and maintenance. They were instructed on the facility policy and procedures on abuse, abuse reporting, who to report to, definition of abuse, mistreatment of residents, staff responsibility to report, and zero tolerance of any resident abuse. No staff was allowed to report for work until participating in a training on the definition of abuse, mistreatment of residents, staff responsibility to report abuse, and to whom they should report. This training will be included in our new hire orientation and provided to any agency staff when used. Training was completed September 10, 2019 with all staff being contacted in person or by phone and prior to their next shift. Starting September 10, 2019, the Social Worker (SW) or designee initiated weekly rounds asking 25% of interviewable residents if they feel they are being treated respectfully, with dignity, and without any abusive behavior from staff. These interviews will continue weekly for three months and be reported monthly to QAPI for further discussion and/or recommendations. Facility initiated ongoing resident interviews scheduled in	

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F 600	Continued From page 3 agitated. Nurse #1 began assessing Resident #1 and I went down the hallway and was sent home at 2:30 AM by Nurse #1. "At no point did I put my hands on him." The document was signed by NA #1. Review of the facility's completed investigation dated 05/10/19 read in part, The Corrective Action Following the incident read, 100% staff education was provided on abuse and neglect. Definitions of abuse as well as how and when to report were highlighted in this Inservice. Resident #1 was discharged from the facility on 06/23/19. Attempts to speak to NA #1 on 09/09/19 were unsuccessful. An interview was conducted with Nurse #1 on 09/09/19 at 2:11 PM. Nurse #1 confirmed that she was working on 05/08/19 when NA #1 held Resident #1's wrist and forearms above his head. Nurse #1 stated that Resident #1 had been up wandering on the unit for most of the shift and at one point had wandered into another resident's room. Nurse #1 stated that she had gone outside to take her break at around 2:15 AM. NA #2 came outside and stated NA #1 and Resident #1 were fighting. She added that she could tell that it was not good by the urgency in NA #2's voice. Nurse #1 stated that she and NA #3 both jumped up and ran into the building and as she rounded the corner, she witnessed NA #1 standing behind Resident #1's WC at the end of the hall near the exit door. NA #1 had both of her hands wrapped around Resident #1's wrist/forearm area. She stated that Resident #1 was hollering, "Let me go. I don't wanna fight you." The resident was flailing	F 600	sync with the resident's MDS quarterly reviews to monitor for any issues regarding the resident feeling ill at ease with any issues of being treated in a manner that may be considered abusive. These interviews will be done by the SW in conjunction with the required OBRA MDS quarterly assessments. Starting September 11, 2019 administrative nursing staff or designee will monitor direct resident care and observe residents for any injuries of unknown origin. 10% of non-interviewable residents will be observed daily over various shifts for 4 weeks, then weekly for three months to ensure that no abuse is occurring. These observations will be reported to QAPI monthly for discussion and further recommendations. 4. On September 10, 2019 the LNHA and DON notified the Medical Director of this plan and he approved. The interviews and observations beginning September 10 and 11, 2019 will be reviewed weekly by the DON and LNHA, and brought to monthly QAPI meetings for additional review and recommendations. The role of the QAPI team in this plan of correction includes implementation and monitoring to ensure our interventions are effective. 5. Deer Park Health and Rehabilitation alleges compliance as of September 19, 2019.	

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F 600	Continued From page 4	F 600		

his arms trying to break away from NA #1. Nurse #1 stated she instructed NA #1 to let go of Resident #1 and step away from the WC and she did so easily. Nurse #1 stated that there were visible red marks where NA #1's hands had been wrapped around his wrist/forearm area and there was some bleeding from where NA #1's fingernails had dug into Resident #1's arm. She stated that NA #1 went to the nurse's station and she proceeded to wipe the blood off Resident #1's arm but no further treatment was required. After NA #1 had left the area the rest of the staff let Resident #1 sit in his WC at the end of the hall and calm down and within about an hour, he had dozed off to sleep. Nurse #1 state that they let him sleep there for a bit then offered to lay him down and he accepted with no issues. NA #1 was instructed to leave the facility and did so as she was asked by Nurse #1 who also stated she notified the DON of the situation. Nurse #1 stated that she had worked with NA #1 before and never had any issues but stated she believed this was abuse and did not like the way NA #1 handled the situation. She stated that when she instructed NA #1 to let go of Resident #1 and move away from the WC she did so with ease and could have easily removed herself from the situation before it escalated. She added that it was not appropriate for NA #1 to place her hands on Resident #1 when he was agitated. Nurse #1 stated she should have walked away and approached him at a later time. She added that she had never witnessed Resident #1 being physically combative before, but it was usual for him to wander on the unit. Nurse #1 confirmed that following the incident she notified the DON, completed the incident report and documented in the medical record. She added that the DON began re-educating the staff immediately on

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abuse and neglect and how to properly respond to agitated residents but stated to her knowledge no resident assessments were completed following the incident.

An interview was conducted with NA #2 on 09/09/19 at 1:49 PM. NA #2 stated that on 05/08/19 she worked with NA #1 as that was only her second day of orientation at the facility. NA #2 stated that Resident #1 had been wandering into other resident rooms and NA #1 had gotten him out and placed him back in the hallway. She stated that NA #1 had removed Resident #1 from another room and was trying to push him up the hallway and Resident #1 put his feet down to stop the movement of the WC. NA #2 stated that NA #1 attempted to tilt Resident #1's WC back on 2 wheels and instructed her to pick up his feet so they could move him up the hallway. NA #2 stated she refused and told NA #1 that she was going to go and get Nurse #1. NA #2 stated that when she left NA #1 with Resident #1, she had a hold of his WC. NA #2 stated that she went outside where Nurse #1 and NA #3 were taking a break and told Nurse #1 that she needed her help right now. NA #2 stated that as Nurse #1, NA #3 and herself rounded the corner of the hallway they witnessed NA #1 standing at the end of the hallway behind Resident #1's WC. She stated that NA #1 had both of Resident #1's hand held tightly above his head and Resident #1 was flailing his arms to get loose from NA #1. She explained that Nurse #1 stated to NA #1 let him go and step away from the WC and NA #1 was very agitated and red in face and she stormed off from the incident and went to the nurse's station and sat down. NA #2 stated that Nurse #1 began assessing Resident #1 and she noted blood to his left wrist/forearm area along with red marks from NA #1's hand.

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F 600	Continued From page 6	F 600		

She added that Resident #1 did calm down and allowed Nurse #1 to put him in the bed later that shift. She also stated that NA #1 was sent home and did not finish her shift. NA #2 stated that as she was still in orientation she had just been trained on abuse and neglect and when the DON arrived at the facility that night, she again received education about abuse and neglect. She stated that she had been trained to never restrain anyone and if a resident was agitated to let the nurse know and never touch a combative resident.

An interview was conducted with NA #3 on 09/09/19 at 11:07 AM. NA #3 stated that on 05/08/19 around 2:15 AM she and Nurse #1 were outside taking a break and NA #2 came outside and stated that she needed Nurse #1 now. NA #3 stated that they all ran to the unit and witnessed NA #1 at the end of the hallway standing behind Resident #1's WC and was firmly holding both of Resident #1's hands above his head. Resident #1 was hollering "let me go" and she could see red marks to both of his wrist area and some blood on the left wrist/forearm, he was very upset but allowed her to look at his arms. NA #3 stated that she had worked with NA #1 a couple of times and never had any issues with her but stated she felt like NA #1 abused Resident #1 and she should have not responded the way she did. We were trained that if a resident became combative to leave them alone and ensure their safety and approach them at a later time. She added that NA #1 easily removed herself from the situation when Nurse #1 instructed her to do so and she did not feel like she was trapped behind the WC. NA #3 further stated that following the incident that night the DON immediately re-educated the staff on abuse and neglect and how to handle combative

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residents.

An interview was conducted with the DON on 09/09/19 at 2:45 PM. The DON stated that on 05/08/19 she received a call around 2:15-2:30 AM from Nurse #1 who stated she had witnessed NA #1 holding Resident #1's arms above his head and she felt like it was a case of abuse. The DON stated approximately 20 minutes later she arrived at the facility and spoke to NA #2, NA #3, and Nurse #1 and they all 3 witnessed the same thing. They all stated they witnessed NA #1 holding Resident #1's wrists above his head as he struggled to free himself from NA #1. Resident #1 was yelling, "Let me go I don't want to fight you." NA #1 only released Resident #1 and stepped away from the situation when instructed to by Nurse #1. The DON stated that when she spoke to NA #1 on 05/09/19 she stated that Resident #1 had her pinned against the door and she could not get away from Resident #1. The DON stated that even if NA #1 was pinned against the door it was not appropriate for her to forcefully hold Resident #1's wrist above his head. She was trained to make sure Resident #1 was safe and then step away from the situation. Abuse and neglect training was started immediately with the staff members on duty which included the definition of abuse and how to deal with combative residents. She added that no formal audits were started at that time, but they did "more vigilant monitoring on the hallways." During the first week of September 2019 the facility had begun using an abuse questionnaire with the alert and oriented residents. The DON also confirmed that at the time of the incident no skin assessments or other measures had been completed to ensure that no further abuse had occurred. The DON stated that after she talked

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F 600	Continued From page 8 to the staff and reviewed their statements, she felt that NA #1 had abused Resident #1 and she substantiated the allegation and terminated NA #1 on 05/10/19. An interview was conducted with the Administrator on 09/10/19 at 11:09 AM. The Administrator stated she had been at the facility for 5 weeks but had learned of the situation with NA #1 and Resident #1 by reviewing the report and investigation. She stated that it concerned her because the event had occurred but was relieved when she read that NA #1 had been terminated which is exactly what she would have done. The Administrator stated that she was the abuse coordinator and very involved in the investigations that had occurred during her 5 weeks at the facility to ensure that all the pieces of the investigation and follow up were completed. The Administrator stated that abuse and neglect training had been completed at the time of the incident but was not aware of any further assessment or measure that were completed to determine if NA #1 had abused any other residents.	F 600		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §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 record review and staff interviews the facility's Quality Assessment and Assurance	F 867	The LNHA and Director of Nursing were educated by the Regional Director of	9/19/19

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F 867	Continued From page 9 Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in February 2019. This was for one recited deficiency which was originally cited in February 2019 on an annual recertification and complaint survey and subsequently cited again during the facility's current follow up and complaint survey of 09/10/19. The deficiency was in the area of resident abuse and neglect. The continued failure of the facility during 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 referred to F 600 Resident Abuse: Based on record review and staff interview the facility failed to protect a resident's right to be free from physical abuse when a resident was physically grabbed by a Nurse Aide (NA) for 1 of 3 residents reviewed for abuse (Resident #1). NA #1 grabbed Resident #1 by both wrists and held his arms above his head. Resident #1 yelled for the NA to let him go as he struggled to free himself. Following the physical abuse Resident #1 was observed to be visibly upset and had red bruises to both wrists and forearms and had puncture wounds to his left wrist and left forearm that were bleeding from the NA s fingernails digging into his skin. Resident #1's injuries were treated at the facility. After NA #1 physically abused Resident #1 the facility failed to determine if NA #1 had abused any other residents in the facility. During the recertification and complaint survey of 02/01/19 the facility was cited for failing to protect a resident's right to remain free from physical	F 867	Operations (RDO) on the Quality Assurance Performance Improvement process (QAPI) including response to adverse events with development and implementation of action plans on 9/17/2019. This education included the requirement for facility to develop immediate action plans for adverse events such as allegations of abuse to identify and protect any resident from further potential of abusive behaviors. The LNHA, DON and facility department managers were also educated on 9/17/19 on the QAPI process and their respective assignments for QAPI reviewing, reporting and monitoring. The LNHA is accountable for ensuring the facility has implemented the QAPI program, including identifying and monitoring areas for improvement for indicators by departments. Action plans will be developed as needed for noted areas of improvement, including adverse events such as allegations of abuse. Ad Hoc QAPI meetings will be held with implementation of action plans for adverse events. The Administrator will ensure QAPI action plans and minutes reflect areas of improvement that the QAPI committee is monitoring. The QAPI committee will meet monthly to monitor progress of identified areas of improvement to include indicators for departments, noted survey deficiencies, and areas for improvement including adverse events identified through AdHoc QAPI meetings. The QAPI Committee will	

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F 867	Continued From page 10 abuse or neglect for 3 of 3 sampled residents reviewed for abuse and neglect. Nurse aide (NA) #1 grabbed Resident #38 by the arms, yelled at her and pushed her while seated in a wheel chair into a linen cart. Resident #38 was observed to have a new skin tear on her left forearm after NA #1 was observed to grab her arms. Staff neglected to assess and implement standing orders for Resident #90 who experienced shortness of breath and an elevated body temperature. Staff failed to prevent Residents #207 and #309 from engaging in physical and verbal altercations with each other. An interview was conducted with the Administrator on 09/10/19 at 11:09 AM. The Administrator stated that she had been at the facility for 5 weeks. She stated that she had learned of the incident with Resident #1 and Nurse Aide (NA) #1 by reviewing the report. She stated she was also aware of the resident abuse citation that the facility had received in February 2019 as part of orienting herself to the building. She stated that in her 5 weeks at the facility she had one Quality Assurance (QA) meeting on 08/14/19 and included herself, Director of Nursing (DON), Medical Director (MD), Social Worker, Business Office Manager, Dietary Manager, Minimum Data Set nurse, Activities Director, Admission Director, and the Corporate Consultant. The Administrator stated that they went over the previous months minutes and followed up on any issues that needed to be address, they also went over the current survey results and ensured that the audits were still in place. The Administrator stated that going forward she would be the Abuse Coordinator and would be highly involved in any abuse investigation to make sure all the pieces that needed to be	F 867	review results of action plans to identify progress and the need for revisions to ensure ongoing quality improvement is effective. Regional Director of Operations will review AdHoc QAPI action plans for allegations of abuse and the facility monthly QAPI Committee meeting minutes for the next 4 months to ensure compliance is maintained.	

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 09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 11 completed were completed timely. She added that she hoped that would be effective in achieving and maintaining compliance.	F 867		