STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 2567 Amended 12-22-11. Corrected Resident identifier in F280 to Resident #131.	F 000	Disclaimer Statement Hunter Hills Nursing and Rehabilitation Center acknowledges the receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Hunter Hills Nursing and Rehabilitaton's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute as admission that any deficiency is accurate. Further, Nash Rehabilitataion and Nursing Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set Assessment for 2 (Residents #185 and # 110) of 2 sampled residents with a significant change in condition. The findings include: 1. Resident # 185 was admitted to the facility on 08/20/11 and had diagnoses including Cardiomegaly, Congestive Heart Failure, Atrial Fibrillation, Edema, Hypertension, Cerebrovascular Accident, Dysphasia, Hyperlipidemia and Dementia.	F 274		

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

NHA — 12/27/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 1 The Admission Minimum Data Set (MDS) Assessment dated 08/29/11 showed that the resident had short and long term memory loss and had poor decision making skills requiring cues and supervision. The MDS showed that the resident required limited assistance with bed mobility, transfers, toileting and personal hygiene. The MDS showed a that the resident weighed 150 pounds. The Care Area Assessment (CAA) for Cognitive Loss/Dementia, dated 08/29/1,1 showed that the resident had mild dementia and required moderate assistance from the staff with activities of daily living (ADLs). The CAA showed that ADLs would be care planned to monitor for a decline in cognitive status and that the resident was at risk for a decline in ADLs. A review of the medical record revealed a progress note, dated 09/02/11, that showed the resident had moderate edema of the lower extremities. The progress note, dated 09/12/11, showed 3 plus to 4 plus pitting edema of bilateral feet and ankles. The resident's weight was recorded as 176 pounds on 09/14/11. The resident's weight was recorded as 189 pounds on 09/20/11. A progress note, dated 09/20/11, stated the resident had a weight gain and that the resident's diuretic had been increased to 20 mg (milligrams) twice a day (from 20 mg once a day). The physician's telephone orders also showed a one time dose of 40 mg of the diuretic. A progress note, dated 09/20/11,read: " Feet and legs are very edematous and shiny feet. Some clear fluid noted seeping from legs in very small amounts. " There was a progress note dated 09/25/11 that read: " 4+ (plus) edema to LEs	F 274	Resident # 185 & # 110 had a significant change in condition Minimum Data Set Assessment completed on 12/23/2011 by the MDS Nurse. A 100% audit of MDS's to be completed by 12/30/2011 to verify if any resident triggered for a Significant Change in condition by the Administrative Nurses The Interdisciplinary Care Plan Team was inserviced on 12/21/2011 regarding requirements for a Significant Change in Condition per the RAI Manual by the Administrator. The DON and/or MDS Nurses / Adminstrative Nurses will review resident changes in condition with each assessment due to determine if a significant change in the resident's condition is appropriate utilizing RAI Guidelines and a QI audit tool. Areas identified in the audit will be forwarded to the MDS nurse for assessment completion. The QI audit tool will be reviewed by the Administrator weekly for 4 weeks, and then monthly for 3 months to assure the monitoring system is functioning appropriately	1/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 2 (lower extremities). " The resident's weight was recorded as 192 pounds on 09/26/11. A progress note dated 09/27/11 read: " Severe edema to LEs. " There was a physician's telephone order dated 09/27/11 to give 40 mg of the diuretic twice a day for 3 days and then resume the 20 mg twice a day. A progress note dated 10/01/11 read: " Edema LEs. Noted improvement. " A progress note dated 10/09/11 read: " Severe edema LEs. " The resident ' s weight was recorded as 185 on 10/09/11. A progress note dated 10/11/11 read: " Current wt (weight) 185.2 lbs. Has 3-4+ pitting edema of bilateral lower extremities and feet. ' Name of diuretic ' dosage increased. " A progress note dated 10/14/11 read: " Severe edema to LEs. " There was a physician ' s telephone order dated 10/22/11 to increase the diuretic to 60 mg twice a day and to start another diuretic 5 mg, 30 minutes before the morning dose of the 60 mg diuretic on 10/23/11 and every Monday, Wednesday and Friday. The resident's weight was recorded as being 192 on 10/24/11. A progress note dated 10/25/11 read: " Increased weeping to bilateral extremities. ' Name of diuretic ' increased. " The resident ' s weight was recorded as 204 pounds on 10/25/11. There was a physician ' s telephone order dated 10/28/11 to give an additional 40 mg of the diuretic every day for 3 days. The resident's weight was recorded as 181 pounds on 11/03/11. A progress note dated 11/07/11 read: " Edema has decreased. No longer weeping. " The resident ' s weight was recorded as 164 pounds on 11/07/11. A progress note dated 11/08/11 read: " Swelling has decreased enough to BLE (bilateral lower extremities) and (resident) is able to wear slippers".	F 274	The results of the QI audits will be reviewed in the Quality Improvement Committee meeting monthly and will follow-up as deemed necessary for identified concerns and to determine the need for &/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 3 The resident ' s Care Plan was last updated on 11/09/11 and contained no information related to the resident's edema or use of diuretics. The resident ' s medical record showed that on 11/11/11 a Quarterly MDS was done. The MDS showed that the resident required total assistance for transfers, bed mobility, toileting and personal hygiene. The MDS showed that the resident's weight was 181 pounds. There was no significant change assessment done. The resident's weight was recorded as 153 pounds on 11/15/11. There was a physician's telephone order dated 11/15/11 to increase the diuretic to 80 mg twice a day. A progress note dated 11/23/11 read: " Has had bilateral LE edema in which his ' name of diuretic ' was increased. Edema has decreased significantly. " The resident's weight was recorded as 147 on 11/27/11. A progress note dated 11/30/11 read: " Weight warning Wt 146.6. Resident edema has decreased. Takes 'name of diuretic' 80 mg BID (twice a day). " A progress note dated 12/02/11 read: " Wt 147. Started on double portions at meals d/t (due to) being hungry. " On 12/02/11 the resident's weight was recorded as 147 pounds and the resident was receiving 80 mg of a diuretic twice a day plus the second diuretic of 5 mg on Monday, Wednesday and Friday. MDS Nurse #1 stated in an interview on 12/07/11 at 11:00 AM, that a significant change MDS should have been done for this resident. MDS Nurse #2 stated in an interview on 12/07/11	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 4 at 11:15 AM, that she thought that certain things had to be in place before a significant change assessment could be done. Stated that she thought that ADLs would trigger a significant change if the resident went from being mobile to being immobile or verbal to non-verbal. Stated that she now knows that a significant change assessment could have been done. An interview was conducted with the Director of Nursing (DON) and the Administrator on 12/08/11 at 3:10 PM. The DON stated that she had conducted an in-service with MDS Nurse #2 on 12/07/11. The DON stated that the Nurse was having trouble understanding when a significant change in status MDS should be done. 2. Resident #110 was admitted to the facility on 07/28/11 and had diagnoses of Traumatic Subdural Hematoma, Diabetes Mellitus, Cerebrovascular Accident (stroke) with Right Hemiparesis (paralysis), Hypertension, Chronic Kidney Disease, Dementia with Agitation, Depression and Anxiety. The Admission Minimum Data Set (MDS) Assessment dated 08/01/11 showed that the resident had short and long term memory loss and was severely cognitively impaired. The assessment showed that the resident had no behaviors and was on no psychoactive medications, therefore there was not a Care Area Assessment for behaviors or psychoactive medications. A progress note dated 08/18/11 showed that the resident was fidgety and restless, disrobing, throwing covers, pillows and a diaper on the floor.	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 5 Progress Notes dated 09/01/11, 09/06/11 and 09/29/11 showed that the resident had episodes of agitation and frequently disrobing. The Medication Administration Record (MAR) showed that the resident received 0.25 mg of a benzodiazepine on an as needed basis for agitation in September and October of 2011. A benzodiazepine was a psychoactive drug used to treat anxiety and agitation. A progress note dated 10/02/11 read: " Agitated today. ' name of benzodiazepine ' given with some effectiveness. Res (continues) to strip padding off siderail and disrobe. " A progress note dated 10/03/11 read: " Res (resident) given ' name of benzodiazepine ' this AM as (resident) is disrobing and fidgety. " A progress note dated 10/07/11 read: " Resident was fidgety and pulling at his shorts. He is redirected by staff when removing shorts or clothes and when kicking off socks and covers". The resident ' s medical record showed that on 10/07/11 (observation end date) a Quarterly MDS was completed. The MDS showed no behaviors and that the resident was on an anti-anxiety medication. There was a physician's telephone order dated 11/15/11 for the benzodiazepine to be increased to 1 mg and to be given twice a day. There was a physician's telephone order, dated 11/26/11, for a second benzodiazepine 0.5 mg to be given three times a day as needed. There was a physician's telephone order dated 11/29/11 for an antipsychotic medication 0.25 mg to be given every morning. A progress note dated 12/02/11 read: " Constantly reaching and grabbing onto objects within close reach. He has even grabbed on to another resident's (wheelchair) and pushed	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 274	Continued From page 6 it some. " The resident's care plan (last updated on 12/05/11) did not include information related to the resident's behaviors or psychoactive medications. MDS Nurse #2 stated in an interview on 12/08/11 at 2:45 PM that there were no behaviors documented in the progress notes during the 7 day look back period and that if a significant change assessment needed to be done between MDS assessments, the nurses would need to communicate this to the MDS nurses. On 12/08/11 at 3:10 PM an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated the Resident #110 had definitely had a change in condition. The DON stated that the changes in behaviors were not documented on the quarterly MDS done on 10/07/11. The DON stated that the MDS nurse attend the morning meetings and the Medicaid meetings and there were discussions about this resident's status and that the MDS nurse should pick up significant changes in condition during these meetings as well as from the documentation in the progress notes.	F 274		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 279	Continued From page 7 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based upon resident and staff interviews and record reviews, the facility failed to develop comprehensive care plans for the following: 1 of 1 sampled Residents (Resident #114) with mental disorders and 3 of 4 sampled Residents (Resident #39 and Resident #44) receiving psychoactive medications. Findings Include: 1. Resident #114 was admitted to the facility on 10/28/11 with diagnoses of uncontrolled diabetes II and depressive disorder. The 5-day Minimum Data Set (MDS) dated 11/4/11 revealed Resident #114 mood patterns as the following: feeling down, difficulty sleeping, tiredness, low appetite, feeling bad about herself, trouble concentrating, speaking or moving slowing up to 5 days per week. Resident #114 was cognitively intact. The Care Area Assessment (CAA), dated 11/4/11, revealed Resident #114 triggered for mood state.	F 279	Resident #114 Care Plan was revised to address mood on 12/8/2011 by the MDS Nurse. Residents #39 & #44 Care Plan was revised to include psychoactive medications on 12/7/2011 by the MDS Nurse A 100% audit of the comprehensive care plans to ensure resident care plans are completed to include mood status and psychoactive medications as appropriate was completed on 12/29/2011 by the Administrative Nurses. The Interdisciplinary Care Plan team was inserviced re: developing and completing appropriate individualized comprehensive Care Plans on 12/21/2011 by the Administrator	1/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 279	Continued From page 8 The CAA indicated Resident #114 had some difficulty since her diagnosis of depression and was feeling bad about herself. The CAA indicated to proceed to care plan for mood and that she was at risk for unstable mood. A record review of Resident #114 care plan was conducted. There was no care plan for mood state. An interview with Resident #114 on 12/8/11, at 8:58 AM, revealed she felt more depressed since being here. She was not taking the same psychiatric medications that she was at home. She thought the home medications were working better. Her appetite comes and goes. She does not want to do anything. An interview with the Social Worker (SW) #1 on 12/8/11, at 9:29 AM, revealed she completes the MDS section for mood state. SW #1 indicated that she had met with Resident #114 family last week. Resident #114 felt like she had let herself down. Resident #114 had agreed to receive mental health services. SW #1 indicated she had missed to care plan for Resident #114 mood state and that she would work on a care plan. An interview with Director of Nursing (DON) and Administrator on 12/8/11, at 2:02 PM, revealed there was a meeting with Resident #114 and her family last week. Resident #114 was very tearful because of her diabetes and being young in a facility. She had received preadmission and resident review level II screening. She was diagnosed with bipolar disorder. Resident #114 should have been care planned for mood status.	F 279	Care plans will be reviewed per quarterly assessment schedule by the Interdisciplinary Care Plan team. A QI audit tool will be completed by the DON/Administrative Nurse/Care Plan team to monitor completion of care plans. The results of the QI audits will be reviewed by the Administrator weekly x 4 weeks, then monthly x 3 months to ensure the facility's monitoring system is functioning appropriately. The results of the QI audits will be reviewed in the Quality Improvement Committee meeting monthly with follow-up as deemed necessary for the identified concerns and to determine the need for and/or frequency of continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 279	Continued From page 9 2. Resident# 39 was admitted to the facility on 8/23/11 with diagnoses of dementia, depressive disorder and anorexia. The significant change MDS dated 11/11/11, indicated Resident #39 mood patterns as the following: feeling down, tiredness and low appetite up to 5 days per week. The CAA dated 11/11/11 triggered for receiving psychoactive medications. The psychoactive medications were used for depression and dementia. It indicated her delirium to be in a worsening state. A record review for Resident #39 care plan revealed there was no care plan for psychoactive medications. During an interview with the Social Worker on 12-8-11 at 11:48 AM, revealed Resident #39 triggered for psychoactive medication and was supposed to be care planned. The MDS Coordinator #1 was not sure how she missed this. An interview with DON and Administrator on 12/8/11, at 2:02 PM, revealed that residents should be care planned, when triggered for psychoactive medications. 3. Resident #44 was admitted to the facility on 7/4/11 with diagnoses of insomnia, malaise and fatigue. The MDS, dated 11/25/11, indicated Resident #44 mood patterns as the following: having little interests in things, feeling down, tiredness and low appetite. The CAA dated 11/25/11 indicated Resident #44 triggered for psychoactive medication and was at risk for an unstable mood and difficulty sleeping. It indicated	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 279	Continued From page 10 she was receiving Ativan and Restoril medications and the facility would proceed to care plan for psychoactive medications. A record review of Resident #44 care plan was conducted. There was no care plan for psychoactive medications. An interview with MDS Coordinator #2 on 12/7/11, at 9:17 AM, revealed she would need to search for a psychoactive medication care plan for Resident #44. An Interview with the MDS Coordinator #1 on 12/7/11, at 9:27 AM, revealed there is a CAA completed for psychoactive medications, but a care plan needed to be completed for psychoactive medications. An interview with DON and Administrator on 12/8/11, at 2:02 PM, revealed that residents should be care planned, when triggered for psychoactive medications.	F 279		
F 280 SS=B	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	F 280	The Interdisciplinary Care Plan Team met with resident #25, #131 and #118 to review their plan of care on 12/23/2011 Social Worker will invite residents to their plan of care meetings quarterly and as needed per OBRA schedule and will be documented on a Care Plan Invitation Form.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 11 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to consistently invite alert and oriented residents to their care plan meetings for 3 of 17 alert and oriented residents interviewed (Resident #25, #131, and #118). The findings include: 1. Resident # 25 was admitted to the facility on 11/01/07 and had diagnoses including Diabetes, Hypertension, Hyperthyroidism, Anemia and Depression. A review of the resident's most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 10/05/11 showed that the resident was cognitively intact. During an interview on 12/06/11 at 9:00 AM, the resident stated that she was not invited to her care plan meetings. Review of the Interdisciplinary Care Plan Progress Notes revealed that on 03/20/11, the resident's care plan was reviewed and updated. There was no documentation that the resident was invited or attended the care plan review.	F 280	The Interdisciplinary Team to include the Social Workers have been inserviced on 12/21/2011 regarding resident right to participate and/or be invited to their plan of care meeting by the Administrator. A QI audit tool will be completed by the Social Worker and/or MDS nurse to ensure resident is invited to their scheduled care plan meeting. The QI audit tool will be reviewed by the Administrator weekly for 4 weeks, and then monthly for a minimum of 3 months to assure the monitoring system is functioning appropriately. The results of the QI audits will be reviewed in the Quality Improvement Committee meeting monthly with follow-up as deemed necessary for identified concerns and to determine the need for and/or frequency of continued monitoring	1/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER --	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 12	F 280		

There were no signatures of the persons that attended the care plan review. The resident's clinical record showed that a Quarterly MDS assessment was done on 04/28/11. The Care Plan Progress Notes showed that on 05/11/11 a care plan meeting was held with Resident #25. The progress note was signed by the people that attended the meeting including Resident #25. The clinical record showed that the resident had a Quarterly MDS on 07/21/11. There was a note dated 08/02/11 that a care plan review was held. There was no documentation that the resident was invited or attended the meeting. There were no signatures of the persons that attended the meeting. The clinical record showed that a Quarterly MDS was done on 10/05/11. There were no further Care Plan Progress Notes on the chart. A review of the computerized Progress Notes for Resident #25 revealed no documentation regarding the resident being invited to care plan meetings.

The Social Worker stated in an interview on 12/8/11, at 11:00 AM, that alert and oriented residents were verbally invited to their care plan meetings. The Social Worker stated that in the past she documented on the care plan review sheet that the resident was invited and now documented this information in the computerized chart. The Social Worker stated that she did not remember if she invited the resident to the care plan meeting in October, 2011 but that she usually invited the resident to the care plan meeting.

The Administrator stated in an interview on 12/08/11, at 2:05 PM, that the social worker was expected to invite the resident a day or two before

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 13 or at the time of the care plan meeting. The Administrator stated the social worker should have documented in the computerized chart that the resident was invited to their care plan meeting, and if the resident attended, the resident signed the Interdisciplinary Care Plan Progress Notes at the time of the meeting. 2. Resident #131 was admitted to the facility on 04/05/10 and had diagnoses including Diabetes, Cerebrovascular Accident and Hyperlipidemia. A review of the resident's most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 10/26/11 showed that the resident was cognitively intact. On 12/05/11 at 3:15 PM Resident #131 stated in an interview that he was not invited to his Care Plan Meetings. A review of the resident's clinical record showed that an Annual Minimum Data Set (MDS) Assessment was done on 03/25/11. The Interdisciplinary Care Plan Progress Notes dated 04/06/11 showed that the resident and his spouse attended the care plan meeting. The Care Plan Progress notes were signed by the resident's spouse. The clinical record showed that a Quarterly MDS Assessment was done on 08/12/11. There was no documentation in the Interdisciplinary Care Plan Progress Notes or in the computerized progress notes to indicate that the resident was invited to the care plan meeting. The clinical record showed that on 10/26/11 a Quarterly MDS Assessment was done. There was no documentation in the Interdisciplinary Care Plan Progress Notes or in the computerized	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 14 progress notes to show that the resident was invited to his care plan meeting. The Social Worker stated in an interview on 12/08/11, at 11:00 AM, that on the week of the meeting she verbally invites alert and oriented residents to the care plan meetings and did document in the Interdisciplinary Care Plan Progress Notes and now documented in the computerized progress notes. The Social Worker stated that she sends the invitation to the resident's wife and if she comes he comes with her. The Social Worker stated that the resident was sometimes forgetful and if his wife does not come, he does not come. The Administrator stated in an interview on 12/08/11, at 2:05 PM, that the social worker was expected to invite the resident a day or two before or at the time of the care plan meeting. The Administrator stated the social worker should have documented in the computerized chart that the resident was invited to their care plan meeting, and if the resident attended, the resident signed the Interdisciplinary Care Plan Progress Notes at the time of the meeting 3) Resident #118 was admitted to the facility on 9-3-10 with diagnoses to include generalized weakness, hypertension, poor venous access, right lower extremity edema, severe pulmonary hypertension, acute renal failure, anemia, depression, and chronic back pain secondary to severe spinal stenosis. Review of the resident's annual Minimum Data	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 15 Assessment (MDS) assessment of 8-12-11, and quarterly MDS assessment of 10-28-11, revealed the resident was cognitively intact. During an interview with Resident #118 on 12-5-11 at 11:10 AM, the resident reported she was unaware of a "care plan meeting", and did not remember being invited to attend, or having had attended any kind of meeting "like that". Review of an " Interdisciplinary Care Plan Progress Note " , revealed a note written on 6-8-11 that documented "Care Plan Review today with (resident and Responsible Party) invited to attend, care plan updated". A note dated 9-28-11, revealed: " Care Plan review today, resident (and Responsible Party) invited to attend". Review of the facility's " Interdisciplinary Care Plan Progress" note dated 11-8-11, revealed no resident or Responsible Party (RP) signatures. Another note was written on 12-14-10 and documented: "Care plan review held today. (No) changes to care plan at this time". During an interview on 12-7-11 at 8:54 AM, with the Minimum Data Set (MDS) Nurse, #2, the Nurse reported the Social Worker (SW) invited the residents to the care plan meetings. The MDS nurse reported she started as the MDS nurse at the beginning of April 2011, and had not reviewed the resident ' s care plan with her one-on-one. The Nurse reported she spoke regularly with the resident during her rounds and kept up with any changes with her. If needed, the Nurse reported, she wrote a nurse note regarding any concerns and followed through with any changes.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 16 During an interview with SW #1, on 12-7-11 at 1:49 PM, the SW reported she sent out invitations to the RP for the care plan meetings, and verbally invited the resident when they were alert and oriented. The SW stated she documented on the care plan review notes that the RP was invited, and now she documented in the computerized record. The SW stated the resident hadn't been to a care plan meeting since she moved upstairs from the rehabilitation unit. The SW stated she did not remember the last invitation she gave to the resident, and the resident ' s RP lived out of town and had not attended any of the care plan meetings. Review of the resident's computerized record with the SW, revealed no documented invitation was provided to the resident or her RP for the last care plan meeting dated 11-9-11. The SW stated her prior care plan review would have been held in August and she had no documentation of the invitations to the resident or RP for that meeting. Review of the resident's physical medical record revealed the care plan review of 6-8-11 revealed the resident and the RP were invited. During the interview 12-7-11 at 1:49 PM, the SW stated according to the documentation, the only other time the resident and the RP were invited to a care plan meeting was 9-28-11. The SW stated she had not reviewed the care plan with the resident on a one-on-one basis at any time. The SW stated she tried to invite the alert and oriented residents to the care plan meetings, and were expected to notify the resident on a quarterly basis that their care plan meeting was coming up and to invite them to attend if they	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING _____ B. WING _____	12/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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 280	Continued From page 17 wanted to go. The Administrator stated in an interview on 12/08/11, at 2:05 PM, that the social worker was expected to invite the resident a day or two before or at the time of the care plan meeting. The Administrator stated the social worker should have documented in the computerized chart that the resident was invited to their care plan meeting, and if the resident attended, the resident signed the Interdisciplinary Care Plan Progress Notes at the time of the meeting	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING 01 - BUILDING 0101 B. WING	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19 3.5 This STANDARD is not met as evidenced by. A. Based on observation on 12/22/2011 the dry sprinkler system did not have a high and low air pressure alarm for the dry side of the system. 42 CFR 483.70 (a)	K 056	A high and low air pressure alarm for the dry side of the fire sprinkler system has been installed by an outside contractor on 1/9/2012 The fire sprinkler system has been assessed at the East and West Wing of the facility to ensure the dry sprinkler system has a high and low pressure alarm for the dry side of the system. This was completed by the maintenance Director and the outside contractor on 1/9/2012 The maintenance Director and /or designee will ensure quarterly fire sprinkler inspections are completed as incorporated into the facility's Quality Improvement Program	1/10/12

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

Rochelle Batchelor RN, BSN, NHA 1/12/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING 02 - BLDG 0202 B. WING	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 12/22/2011 the dry sprinkler system did not have a high and low air pressure alarm for the dry side of the system. 42 CFR 483.70 (a)	K 056	A high and low air pressure alarm for the dry side of the fire sprinkler system has been installed by an outside contractor on 1/9/2012 The fire sprinkler system has been assessed at the East and West Wing of the facility to ensure the dry sprinkler system has a high and low pressure alarm for the dry side of the system. This was completed by the maintenance Director and the outside contractor on 1/9/2012 The maintenance Director and /or designee will ensure quarterly fire sprinkler inspections are completed as incorporated into the facility's Quality Improvement Program	1/10/12
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 12/22/2011 the tamper alarm on the back-flow preventer failed to sound an alarm when the valve was closed.	K 061	The tamper alarm on the back-flow preventer was installed by an outside contractor to sound an alarm when the valve was closed on 1/9/2012 to the fire alarm panel The Maintenance Director and / or designee will ensure quarterly tamper alarm inspections are completed as incorporated into the facility's Quality Improvement Program.	1/10/12

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

RN BSN RN, WNHA — 1/10/12

ıy deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ıys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

CD

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/28/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345279	A. BUILDING 02 - BLDG 0202 B. WING	12/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8495 ROCKY MOUNT, NC 27804

(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
K 061	Continued From page 1 42 CFR 483.70 (a)	K 061	Disclaimer Statement Hunter Hills Nursing and Rehabilitation Center acknowledges the receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Hunter Hills Nursing and Rehabilitaton's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute as admission that any deficiency is accurate. Further, Nash Rehabilitatalon and Nursing Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	