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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 An onsite revisit was conducted on 11/16/18. Tags F-677 and F-732 were corrected as of 11/16/18. However new tags were cited as a result of the recertification survey and complaint investigation that was conducted at the same time as the revisit. The facility is still out of compliance.	F 000		
F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623		12/14/18

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

Electronically Signed | 12/07/2018

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 1	F 623		

this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 2 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the Ombudsman of resident discharges to the hospital for 6 of 6 residents reviewed (Residents #58, #123, #100, #112, #53, and #104) for hospitalization. Findings included: 1. Resident #58 had been admitted on 2/1/16. Her diagnoses included cerebrovascular accident, deep vein thrombosis and hypertension.	F 623	Hunter Hills Nursing and Rehabilitation acknowledges 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 Corrections is submitted as a written allegation of compliance.	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 3 A Minimum Data Set had been completed on 7/13/18 and indicated she was cognitively intact. Nursing documentation dated 9/1/18 indicated Resident #58 had been discovered on the floor of her room. A red bump was observed on her left temple. Emergency Medical Services had been notified for transfer to the hospital and Resident #58's daughter had also been notified. Resident #58 had been readmitted on 9/4/18 with diagnoses including fractured left femur, urinary tract infection, cerebrovascular disease, deep vein thrombosis and hypertension. On 11/15/18 at 12:19 PM an interview with the SW was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else had sent the information to the ombudsman. On 11/15/18 at 4:26 PM an interview with the Director of Nursing (DON) was conducted. She stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she had been unaware the SW here did not know that and had not been sending the required information. The DON stated it was her expectation of staff to know and understand the regulations. 2. Resident # 123 was admitted to the facility on 11/11/15 with diagnoses of pulmonary embolism, coronary artery disease, dementia, hypertension, diabetes mellitus and end stage liver disease. A review of Resident #123's most recent	F 623	Hunter Hills Nursing and Rehabilitation response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Hunter Hills Nursing and Rehabilitation 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. The process that led to the deficiency was the facility failed to notify the Ombudsman of discharges for residents #58, #123, #100, #112, #53 and #104. The Ombudsman was notified on 12-6-2018 by the Social Worker (SW) of resident #58, #123, #100,#112,#53 and #104 discharge to the hospital. 100% audit was initiated on 11-15-2018 by the Director of Nursing (DON) for the last 30 days of resident discharges to the hospital to ensure that the Ombudsman was notified. All areas of concerns were corrected by the SW by 12-07-2018. In-servicing was completed on 12-3-2018 by the Facility Nurse Consultant with the Administrator, DON, and SW□s in regards to notifying the Ombudsman monthly via email for all discharges to	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 4 Minimum Data Set (MDS) dated 10/24/18 identified her as having severely impaired cognition. A review of Resident # 123's medical record dated 10/12/18 revealed while at the dialysis center she had delayed response, weakness in extremities and was sent to the hospital. No written notice of transfer was documented to have been provided to the Ombudsman. On 11/15/2018 at 12:19 PM an interview with the Social Worker (SW) was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else had sent the information to the ombudsman. On 11/15/2018 at 4:26 PM an interview was conducted with the Director of Nursing (DON). The DON stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she had been unaware the SW did not know that and had not been sending the required information. The DON stated it was her expectation of staff to know and understand the regulations. On 11/16/2018 at 10:23 AM, an interview was conducted with the Ombudsman who stated she had not received any information from the facility about resident transfers to the hospital. 3. Resident # 112 was admitted to the facility on 4/27/18 with diagnoses of acute chronic respiratory failure, hypertension, heart failure, chronic obstructive pulmonary disease, anxiety and depression.	F 623	hospital. Any newly hired Administrator, DON or SW will be in-serviced during orientation by the Staff Facilitator (SF) on notifying the Ombudsman via email for all discharges to the hospital. 100% of all residents discharges from the facility will be monitored by the SW s monthly X 3 months utilizing a Discharge QI (Quality Improvement) audit tool to ensure the Ombudsman was notified of all discharges to the hospital. All areas of concerns will be corrected by the SW during the audit. The Administrator will review and initial the Discharge QI Audit tool monthly X 3 months to ensure completion and that all areas of concerns addressed. The Administrator will forward the results of the Discharge QI audit tool to the Executive QA Committee monthly x 3 months. The Executive QA committee will meet monthly and review the Discharge QI audit tools and address any issues, concerns, and/or trends and make changes as needed to include continued frequency of monitoring monthly x 3 months.	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 5	F 623		

A review of Resident #112's most recent Minimum Data Set (MDS) dated 10/18/18 identified her as cognitively intact.

A review of Resident # 112's medical record dated 11/2/18 documented she was found sitting on the floor of her room. The medical doctor was in the facility, assessed the resident and sent her to the emergency room for evaluation. No written notice of transfer was documented to have been provided to the Ombudsman.

On 11/15/2018 at 12:19 PM an interview with the Social Worker (SW) was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else had sent the information to the ombudsman.

On 11/15/2018 at 4:26 PM an interview was conducted with the Director of Nursing (DON). The DON stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she had been unaware the SW did not know that and had not been sending the required information. The DON stated it was her expectation of staff to know and understand the regulations.

On 11/16/2018 at 10:23 AM, an interview was conducted with the Ombudsman who stated she had not received any information from the facility about resident transfers to the hospital.

4. Resident #104 was originally admitted to the facility on 3/23/18, with diagnoses including Hypertension, Heart Failure, Anemia, Neurogenic Bladder and Diabetes Mellitus. According to the most recent Quarterly Minimum Data Set (MDS) dated 10/16/18, Resident #104's cognition was

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 6	F 623		

intact. She required extensive assistance in most areas of activities of daily living.

Review of the record revealed Resident #104 was hospitalized on 9/2/18 through 9/11/18, 10/17/18 through 10/24/18 and 11/7/18 through 11/12/18.

During an interview on 11/15/18 at 2:35 PM, Staff Nurse #4 revealed when Resident #104 was discharged to the hospital she usually informed Resident #104's family by telephone call and documented it in the medical record. Staff Nurse #4 stated Resident #104 was discharged to the hospital on 11/7/18 through 11/12/18 because she was experiencing shaking and chills. She said Resident #104 was discharged to the hospital from 9/2/18 through 9/11/18 because she had pneumonia, high temperature and she was shaking and cold. Staff Nurse #4 stated Resident #104 was discharged to the hospital on 10/17/18 through 10/24/18 because she was shaking, having chills and had an elevated temperature.

On 11/15/18 at 12:19 PM an interview with the Social Worker was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else at the facility had sent the information to the ombudsman.

On 11/15/18 at 4:26 PM an interview with the Director of Nursing (DON) was conducted. She stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she was unaware the facility's Social Worker was not sending the required information regarding resident and transfer notifications to the Ombudsman.

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 7 During an interview on 11/16/18 at 10:44 AM, the Administrator revealed her expectation would be that when residents were discharged to the hospital, the Ombudsman would be sent monthly reports of residents discharged to the hospital by the facility Social Worker. 5. Resident #53 was admitted to the facility on 12/9/2010 with diagnoses to include pulmonary embolism, convulsions, cerebral vascular accident, diabetes, and end stage renal disease on dialysis. A Minimum Data Set (MDS) assessment dated 9/21/2018 revealed her cognition was moderately impaired. Nursing documentation dated 11/9/2018 indicated Resident #58 had vomited and was sleepy but arousable. Vitals signs were taken twice, and the Physician advised staff to send the resident to the hospital. Emergency Medical Services had been notified of the transfer to the hospital, and the Residents Responsible Party was made aware. Resident #58 had not been re-admitted to the facility at the time of the survey. On 11/15/2018 at 12:19 PM an interview with the Social Worker (SW) was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else had sent the information to the ombudsman.	F 623		

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 8 On 11/15/2018 at 4:26 PM an interview was conducted with the Director of Nursing (DON). The DON stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she had been unaware the SW did not know that and had not been sending the required information. The DON stated it was her expectation of staff to know and understand the regulations. On 11/16/2018 at 10:23 AM, an interview was conducted with the Ombudsman who stated she had not received any information from the facility about resident transfers to the hospital. 6. Resident #100 was admitted to the facility on 10/18/2017 with diagnoses to include hypertension, chronic kidney disease, diabetes and left lower leg amputation. A Minimum Data Set (MDS) assessment dated 9/13/2018 revealed his cognition was moderately impaired. Nursing documentation dated 10/14/2018 indicated the resident stated he did not feel well and he requested to go to the hospital because it was not normal. His Blood sugar and vital signs were taken. The Resident's daughter was contacted and requested to send the resident to the hospital also. Emergency Medical Services was notified to transfer the resident to the hospital and the Physician was made aware. Resident #100 had been readmitted on 10/22/2018 with diagnoses to include altered mental status, urinary tract infection and mass on the kidney.	F 623		

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 623	Continued From page 9 On 11/15/2018 at 12:19 PM an interview with the Social Worker (SW) was conducted. She stated she had been unaware she was supposed to notify the ombudsman regarding discharges or transfers and was unaware if anyone else had sent the information to the ombudsman. On 11/15/2018 at 4:26 PM an interview was conducted with the Director of Nursing (DON). The DON stated she had been aware of the need to notify the ombudsman with discharge and transfer notifications. She stated she had been unaware the SW did not know that and had not been sending the required information. The DON stated it was her expectation of staff to know and understand the regulations. On 11/16/2018 at 10:23 AM, an interview was conducted with the Ombudsman who stated she had not received any information from the facility about resident transfers to the hospital.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code 2 of 38 Minimum Data Set (MDS) assessments reviewed (Resident #129 and Resident #97). Findings included: 1. Resident #129 had been admitted on 10/30/18.	F 641	The process that led to this deficiency was the Minimum Data Set Nurse (MDS) failed to code the MDS assessment accurately for resident # 129 and resident # 97. Resident # 129, Minimum Data Set (MDS) assessment was modified by the MDS	12/14/18

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 641	Continued From page 10 Diagnoses included fracture of left femoral neck, diabetes, hypertension and atherosclerotic heart disease. A 5 Day and Discharge Return Anticipated MDS assessment with an Assessment Reference Date (ARD) of 11/5/18 had been completed. A Death in the facility tracker with an ARD of 11/5/18 had also been completed. Hospital Emergency Department (ED) records were reviewed and indicated Resident #129 had been sent to the hospital for shortness of breath. The ED records indicated Resident #129 had expired on 11/6/18 at 1:37 AM. An interview with MDS nurse #1 was conducted on 11/15/18 at 2:41 PM. The nurse stated she was unsure why a death in the facility tracker had been completed or if it was necessary as a discharge assessment had been completed. She explained when a resident was out of the facility, had not yet been admitted to another facility and had died, a death in the facility tracker was appropriate to complete. She also stated the death in the facility tracker date should have been dated 11/6/18 and this had been an error. On 11/15/18 at 4:26 PM and interview with the Director of Nursing (DON) was conducted. The DON stated the MDS assessment should be accurate and reflect the resident condition. 2. Resident #97 had been admitted on 3/1/18. Diagnoses included cerebral infarction, diabetes, hypertension and atherosclerotic heart disease. A psychiatrist note dated 7/20/18 indicated	F 641	nurse on 11-15-2018 to reflect an accurate coding of the discharge assessment. Resident # 97, MDS assessment was modified by the MDS nurse on 11-15-2018 to reflect the Gradual Dose Reduction (GDR). MDS for Resident #129 was transmitted and accepted into the National Repository on 11-16-2018 and the MDS for Resident # 97 was transmitted and accepted into the National Repository on 11-16-2018. A 100% audit of all residents discharge MDS assessments and all residents currently receiving antipsychotics will be reviewed by the Registered Nurse (RN) Minimum Data Set (MDS) Consultant to include Resident # 129 and resident # 97 to ensure the most recently completed MDS assessments are coded accurately to include discharge assessments and if GDR occurred for residents on antipsychotic medications in look back period to be completed by 12-4-2018. This audit will be completed by the RN MDS Consultant utilizing a resident census. Modifications will be completed by the MDS nurses during the audit for any identified areas of concern with the oversight from the DON to be completed 12-04-18. An in-service was completed on 12-4-2018 for the MDS nurses, Director of Nursing (DON), and Assistant Director of Nursing (ADON) by the Registered Nurse MDS Consultant regarding the proper coding of MDS assessments as indicated in the Resident Assessment Instrument	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 641	Continued From page 11 Resident #97 ' s current regimen included Risperdal (an antipsychotic medication) 0.5 milligrams (mg) at bed time. Also noted "will consider .... Gradual Dose Reduction (GDR) of Risperdal" and "no medication changes today." Diagnoses included cognitive and communication deficits secondary to cerebral vascular accident, depression and anxiety. Resident #97 ' s September 2018 Medication Administration Record (MAR) indicated she had received Risperdal 0.5 mg at bedtime daily. A psychiatrist note dated 10/6/18 indicated "change Risperdal to 0.25 mg nightly." Diagnoses included cerebral infarction, major depressive disorder and anxiety disorder. A Physician order dated 10/6/18 to "decrease Risperdal to 0.25 mg nightly." A Health Status nursing note dated 10/6/18 indicated "Decrease Risperdal to 0.25 mg nightly per psych." Resident #97 ' s October 2018 MAR indicated she had received Risperdal 0.5 mg nightly through 10/6/18. The dosage had been noted as decreased on 10/6/18 to Risperdal 0.25 mg and the lower dosage had been started 10/7/18. A Pharmacist note dated 10/11/18 indicated the Risperdal dosage had been decreased on 10/7/18. Resident #97's most recent Quarterly Minimum Data Set (MDS) assessment dated 10/15/18 indicated she had received antipsychotic medications on a routine, daily basis. No GDR	F 641	(RAI) manual with emphasis that all MDS assessments are completed accurately. All newly hired MDS nurses will be provided the in-service during orientation by the Staff Facilitator (SF) regarding the proper coding of MDS assessments as indicated in the RAI manual. 10% of all current residents with discharge MDS assessments and residents currently receiving antipsychotics to include resident # 97, will be reviewed by the ADON or DON to ensure accurate coding of the MDS assessments, including discharge assessments and GDR and for residents on antipsychotic medications if occurring during look back period utilizing an MDS Monitoring QI (Quality Improvement) audit Tool weekly X 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the Director of Nursing (DON) to include additional training and modifications to the MDS assessment as indicated. The DON will review and initial the MDS Monitoring QI audit Tool weekly for eight weeks and then monthly for one month for accuracy and to ensure all areas of concerns have been addressed. The DON will forward the results of the MDS Monitoring QI audit Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the audit results of the MDS Monitoring QI Tool. Any issues, concerns, and/or trends identified will be addressed by	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 641	Continued From page 12 had been attempted and was noted as contraindicated by a physician note dated 7/20/18. On 11/15/18 at 2:24 PM an interview with the MDS nurse was conducted. She stated a GDR had occurred and should have been marked on this quarterly assessment. She stated she was unsure how the GDR had been missed. On 11/15/18 at 4:26 PM and interview with the Director of Nursing (DON) was conducted. The DON stated the MDS assessment should be accurate and reflect the resident condition.	F 641	implementing changes as necessary, to include continued frequency of monitoring.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident	F 661		12/14/18

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 661	Continued From page 13 representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to complete a recapitulation of stay for 1 of 1 residents reviewed for a planned discharge to the community. (Resident #4) The findings included: Resident #4 was originally admitted to the facility on 7/12/18 with diagnoses including Hypertension, Chronic Pain and Anemia. According to the most recent Admission Minimum Data Set (MDS) dated 7/19/18, Resident #4's cognition was impaired and she required extensive assistance in most areas of activities of daily living. Resident #4's expectation was to be discharged to the community. Resident #4 was discharged home on 8/1/18 and a review of the closed record revealed the facility failed to complete a recapitulation of the resident's stay. Review of a facility Social Worker note dated 8/1/18, read in part, "The Social Worker scheduled home health to include medical. Social Worker evaluation of the home setting for community resources, home health equipment, discharge plan of care, Medication Administration Record (MAR) listing and resident to follow up with Primary Care Physician after discharge	F 661	The process that led to the deficiency is the facility failed to complete a recapitulation of resident stay (discharge summary) for resident #4. Resident #4 no longer resides at the facility. Resident #4 physician reviewed the discharge summary on 12-7-18 and agreed with discharge to home. A 100 % audit was initiated on 11-15-2018 of all discharges in the past 30 days by the Director of Nursing (DON) and Assistant DON (ADON) to ensure that a discharge summary was completed. Any deficient findings were corrected by the Director of Nursing (DON) and Assistant DON (ADON) and current physician by 12/7/18. An in-service was initiated by the Facility Nurse Consultant with the Director of Nursing (DON), Assistant DON, Staff Facilitator (SF), Unit managers, Social Workers (SW) and nurses in regards to the requirement of completion of a discharge summary and discharge instruction\ plan of care in its entirety when a resident discharges from the facility. This will be completed by 12/7/18.	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 661	Continued From page 14 home. Resident to transport via non-medical emergency medical services (EMS) at expense of facility, hard prescriptions of medication." During an interview on 11/16/18 at 9:01 AM, facility Social Worker #1 revealed Resident #4 was admitted to the facility on 7/12/18 and was discharged on 8/1/18. She said the Social Work discharge summary included the code status, social history assessment and the equipment sent home with the resident. She said the final summary note included the equipment sent home with the resident, the code status, admission data form and social history were shared with other disciplines. She said discharge planning started on the first day. She revealed Resident #4 stayed in the facility for twenty days. Social Worker #1 said she was unaware she was supposed to complete a recapitulation of Resident #4's stay in the facility. During an interview on 11/16/18 at 10:15 AM, the Director of Nursing (DON) revealed she was not aware of the need to complete a recapitulation of a resident's facility stay when the resident had a planned discharge from the facility. During an interview on 11/16/18 at 10:41 AM, the Administrator revealed the recapitulation of stay would be completed for discharged residents and they would get it corrected going forward.	F 661	25% of all discharged residents will be audited by the Medical Records Manager weekly x 8 weeks then monthly x 1 month to ensure a recapitulation of resident stay (discharge summary) was completed by the assigned nurse and signed by the physician utilizing a Discharge Summary audit tool. The DON will be immediately notified by medical records for any identified areas of concern during the audit. The Director of Nursing will review and initial the Discharge Summary audit tool weekly X 8 weeks and monthly X 1 month to ensure completion and that all areas of concerns were corrected. The DON will forward the results of the Discharge Summary Audit Tool to the Executive Quality Assurance (QA) Committee monthly x 3 months. The Executive QA committee will meet and review the Discharge Summary Audit Tool and address any issues, concerns and\or trends and to make changes as needed, to include continued frequency of monitoring monthly x 3 months.	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		12/14/18

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 761	Continued From page 15 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain the temperature for 2 of 2 medication refrigerators reviewed (medication refrigerator #1 on the East wing and medication refrigerator #1 on the West wing), and failed to remove expired medications from 1 of 4 medication carts reviewed (700 hall medication cart). Findings included: 1. On 11/15/18 at 4:03 PM the East wing refrigerator #1 was observed with Nurse #3. The refrigerator temperature was observed to be 31 degrees Fahrenheit (F).	F 761	The process that led to this deficiency was the facility failed to maintain the temperature for 2 of 2 medication refrigerators reviewed (East Wing medication refrigerator #1 and West Wing medication refrigerator #1). Also facility failed to remove expired medications from 1 of 4 medication carts (700 hall). On 11-15-2018 a new refrigerator and a thermometer were placed in the East and West Wings by the Maintenance Director. On 11-15-2018 all refrigerated medications from the East and West wing medication refrigerators were removed, returned to pharmacy and reordered by	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 761	Continued From page 16 The temperature log indicated the refrigerator temperature range should be 36-46 degrees F. The temperatures recorded on the log revealed refrigerator temperatures ranging between 28-32 degrees F with the most recent temperature check completed on 11/15/18 AM. Medications in the East wing #1 medication refrigerator included: 4- Risperidone 25 milligram (mg) syringes. The medication packaging indicated to store between 36-46 degrees F. 14- Exenatide extended release 2 mg syringes. The medication packaging indicated to store between 36-46 degrees F. 1- Influenza afluria 5 milliliter (ml) vial. The medication packaging indicated to store between 36-46 degrees F. 5- Influenza syringes. The medication packaging indicated to store between 36-46 degrees F. 3- Vials detemir insulin. The medication packaging indicated to store between 35-46 degrees F. 4- Vials of Humulin regular insulin. The medication packaging indicated to store refrigerated. 2- Liraglutide insulin pens. The medication packaging indicated do not freeze. 2- Tuberculin purified protein injection 5/0.1 milliliter (ml) vial. The medication packaging indicated to store between 35-46 degrees F. An interview with Nurse #3 was conducted on 11/15/18 at 4:15 PM. The nurse stated the night shift usually checked the refrigerator temperatures. On 11/16/18 at 9:12 AM an interview with the	F 761	the nurse unit managers. On 12-3-2018 a 100% in-service was initiated by the Facility Nurse Consultant with all nurses to include the Staff Facilitator (SF) and nurse #3 in regards to Refrigerator Temperatures to include acceptable temperature ranges, requirements for documentation on the temperature logs, adjusting the temperatures, and notification of maintenance when temperatures are not within range. In-service will be completed by 12-06-18. All newly hired licensed nurses will be in-serviced during orientation by the Staff Facilitator in regards to Refrigerator Temperatures. 100% audit of refrigerator temperatures will be completed by the Administrative nurses 5 times a week x 4 weeks, weekly x 4 weeks then monthly x 1 month utilizing the Refrigerator Temperature Audit Tool to ensure all refrigerator temperatures are within acceptable ranges. All areas of concern will be immediately addressed by the Administrative nurses to include adjustment of refrigerator temperature to acceptable range, notification of Maintenance Director for any related repair/replacement, removal of medications if indicated and re-education of staff. The DON will review and initial the Refrigerator Temperature Audit tool weekly x 8 weeks then monthly x 1 month to ensure all areas of concern were	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 761	Continued From page 17 Director of Nursing (DON) was conducted. The DON stated it was her expectation of the nurses to check the refrigerator temperatures and to notify maintenance immediately if the temperatures were out of range. 2. On 11/15/18 at 4:22 PM the West wing refrigerator #1 was reviewed with the Staff Development Coordinator (SDC). The refrigerator temperature was observed to be 32 degrees Fahrenheit (F). The temperature log indicated the refrigerator temperature range should be 36-46 degrees F. There were four temperatures recorded on the log ranging between 28-32 degrees F with the most recent temperature check completed on 11/15/18, AM. Medications in the West wing #1 medication refrigerator included: 2- Exenatide extended release 2 milligram (mg) syringes. The medication packaging indicated to store between 36-46 degrees F. 18- Insulin aspart insulin prefilled syringes. The pharmacy label indicated to refrigerate. 3- Degludec insulin pens. The medication packaging indicated to store between 36-46 degrees F. 1- Degludec insulin vial. The medication packaging indicated to store between 36-46 degrees F. 1- Tube Becaplermin gel. The medication packaging indicated to store between 36-46 degrees F. 1- Vial of Humulin regular insulin. The medication packaging indicated to store refrigerated. 6- Insulin glargine pen. The medication packaging indicated to store between 36-46	F 761	addressed appropriately. A 100% audit of medication carts to include 700 hall was initiated on 11-15-2018 by the Administrative nurses to ensure no expired medications noted on the carts. For any identified areas of concern during the audit, the medication was immediately removed, discarded and reordered from pharmacy by the Administrative Nurses. 100% in-servicing was initiated on 12-03-18 by the SF with all licensed nurses and medication aides to include nurse # 3 in regards to removing expired medications from the medication cart to be completed on 12-06-18. The Administrative Nurses will monitor medication carts for expired medications utilizing the QI Audit tool Expired Medications weekly x 8 weeks and monthly x 1 month. All Licensed Nurses and Medication Aides will be re-educated by the Administrative Nurses for any identified areas of concern during the audit. The Director of Nursing (DON) will review and initial the QI Audit tool Expired Medications weekly x 8 weeks then monthly x 1 month for completion and to ensure all areas of concern were addressed. The DON will forward the results of the Refrigerator Temperature Audit tool and the QI Audit tool Expired Medications to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months and review the	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 761	Continued From page 18 degrees F. 1- Unopened box of Liraglutide syringes. The medication packaging indicated do not freeze. 3- Vials of pneumococcal vaccine. The medication packaging indicated to store between 36-46 degrees F. 1- Vial of influenza vaccine. The medication packaging indicated to store between 36-46 degrees F. 2- Tuberculin purified protein injection 5/0.1 milliliter (ml) vial. The medication packaging indicated to store between 35-46 degrees F. 13- Vials of hepatitis B vaccine. The medication packaging indicated to store between 36-46 degrees F. 1- Insulin glargine vial. The medication packaging indicated to store between 36-46 degrees F. 2-Liraglutide syringes. The medication packaging indicated to store between 36-46 degrees F. 1- Box of Alteplase 2mg. The medication packaging indicated to store between 36-46 degrees F. On 11/15/18 at 4:27 PM an interview with the SCD was conducted. She stated the refrigerator temperatures should be 36-46 degrees F. On 11/15/18 at 4:45 PM an interview with the Administrator (AD) was conducted. The AD stated the medication refrigerator temperatures were supposed to be checked twice daily. On 11/16/18 at 9:12 AM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the nurses to check the refrigerator temperatures and to notify maintenance immediately if the temperatures were out of range.	F 761	Refrigerator Temperature Audit tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and/or frequency of 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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 761	Continued From page 19 3. On 11/15/18 at 3:54 PM and observation of the 700 hall medication cart was conducted with Nurse #3. Two cartons of acetaminophen 650 milligram (mg) suppositories with an expiration date of 6/2018 were discovered. There were 11 suppositories in each carton. An interview with Nurse #3 was conducted on 11/15/18 at 3:54 PM. The nurse stated she was not sure how she had missed removing the expired acetaminophen from the medication cart. On 11/16/18 at 9:12 AM an interview with the Director of Nursing (DON) was conducted. The DON stated it was her expectation of the nurses to check their medication carts for expired medications and to dispose of them or send back to the pharmacy.	F 761		
F 880 SS=E	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	F 880		12/14/18

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 20	F 880		

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 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.

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 21 §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 observation, record review, and staff interviews, the facility failed to disinfect glucometers per the manufacturer's recommendations after use to check blood sugars for 2 of 2 residents (Resident #76 and Resident #25) observed for blood sugar checks. The facility also failed to complete and document surveillance and data to track and trend infections in the facility during the previous 7 of 10 months (January, March, April, June, July, August and September 2018). The findings included: 1. The facility's policy titled Glucometer-Cleaning and Disinfection, revised on 9/4/2014 read: 3a) Use EPA-registered germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer, 3b) Then cover/wrap the entire glucometer with the wipe, and 3c) Place in a plastic disposable cup on the medication cart and allow full minutes exposure time according to the manufacturers product directions for disinfection of the glucometer. 4) After full minutes exposure time according to manufacturer's product directions, remove cloth wipe and discard. Return glucometer to plastic cup to allow it to thoroughly air dry.	F 880	The process that led to the deficiency was the facility failed to maintain infection surveillance of resident□s infections. Facility failed to disinfect glucometers per manufacturers recommendation□s for 2 of 2 resident (resident #76 and #25). The Facility Infection Control Surveillance Policy was initiated for September and October data by the Assistant Director of Nursing (ADON) which was completed on 12-6-18. The ADON will review all new orders for antibiotics and progress notes to identify residents with infections and document on the infection control surveillance monthly infection log which includes the resident name, date, name of infection, date of onset of infection, and signs and symptoms of infection for tracking and trending purposes. The Director of Nurses (DON) will review and initial the Infection Control Tools for completion and ensure all areas of concerns were addressed per the infection control surveillance protocol weekly x 8 weeks and monthly x 1 month to ensure completion and all identified areas of concerns are addressed.	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 22 The facility's germicidal disposable wipe included on the label "bactericidal, fungicidal, tuberculocidal and viricidal in 4 minutes." An observation of a blood sugar check was conducted on 11/14/2018 at 11:45 AM with Nurse #1 for resident #76. Nurse #1 gathered her supplies and took a glucometer wrapped in a tissue from the medication cart drawer. The nurse sanitized her hands, donned gloves and conducted the blood sugar check on Resident #76. The nurse then went back to the medication cart, removed her gloves, re-sanitized her hand, donned gloves and opened a wipe package labeled "bactericidal, fungicidal, tuberculocidal and viricidal in 4 minutes and wiped the glucometer off for approximately 10 seconds, then used the same wipe to wrap the glucometer up and set it in a plastic cup. The nurse stated she needed to leave the glucometer wrapped for 2 minutes and then it would be ready to use again. When the nurse was questioned about the 4 minutes on the label of the wipe, the nurse replied in a question, "maybe I should leave it for 4 minutes?" An observation of a blood sugar check was conducted on 11/14/2018 at 11:55 AM with Nurse #2 for resident #25. The nurse picked up 1 of 2 unwrapped glucometers sitting in a plastic cup on top of the medication cart, and then gathered her supplies for the blood sugar check. The nurse sanitized her hands, donned gloves and preformed the blood sugar check. The nurse went back to the medication cart, laid the glucometer on the cart and readied and gave insulin to resident #25. Then the nurse sanitized her hands, donned gloves and opened the wipe	F 880	The DON and the ADON, were in-serviced on 12-3-2018 by the Facility Nurse Consultant related to the responsibility of the facility to ensure an Infection Control Program is maintained and includes surveillance and data analysis of monthly infections. On 11-16-18 return demonstration of glucometer cleaning was initiated by the Registered Nurse Managers with all nurses and medication aides to include nurse #1 and nurse #2 utilizing a Glucometer Cleaning Audit tool. Any identified areas of concerns were addressed during the audit by the Registered Nurse Managers to include re-education. These audits were completed on 11-21-18. In-servicing was initiated on 11-14-18 by the Staff Facilitator (SF) with all nurses and medication aides to include nurse #1 and nurse #2 regarding Glucometer cleaning policy which include: Use EPA-registered germicidal disposable cloth/wipe to thoroughly wet the entire external surface of the glucometer, Then cover/wrap the entire glucometer with the wipe, and Place in a plastic disposable cup on the medication cart and allow full minutes exposure time according to the manufacturers product directions for disinfection of the glucometer. After full minutes exposure time according to manufacturer's product directions, remove cloth wipe and discard. Return glucometer	

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 23 package labeled "bactericidal, fungicidal, tuberculocidal and viricidal in 4 minutes and wiped the glucometer off for approximately 10 seconds. The nurse threw the wipe away and set the glucometer in the cup without any wipe. The nurse stated she was to leave the glucometer in the cup for 5 minutes to kill all the germs and also let it air dry and then it was ready for use. The nurse did not respond when questioned what the 4 minutes on the label meant. On 11/15/2018 at 9:50 AM, an interview was conducted with the Staff Development Coordinator (SDC), who stated according to the facility's policy the glucometer should be wet for 3 to 5 minutes with the wipe for disinfection. After reading the wipe packaging, the SDC stated the glucometer should be wet for 4 minutes to disinfect the glucometer. The SDC stated she had not yet conducted an in-service on glucometer cleaning to the staff, as she had only recently started working at the facility. On 11/15/2018 at 10:14 AM, an interview was conducted with the Director of Nursing (DON) who stated she expected staff to wrap and leave the glucometer wet for 4 minutes before using it on the next resident. 2. Review of the facility's policy titled The Infection Prevention and Control Program, revised on 1/22/2018, included the following: Establish system for the prevention, identification, investigation, and control of infection of residents, staff and visitors. On 11/15/2018 at 12:30 PM, an interview was conducted with the Assistant Director of Nursing (ADON), who stated she received a report on all	F 880	to plastic cup to allow it to thoroughly air dry. The facility's germicidal disposable wipe included on the label "bactericidal, fungicidal, tuberculocidal and viricidal in 4 minutes." In-service was completed 11-21-18. All newly hired nurses and medication aides will be in-serviced regarding the glucometer cleaning policy during orientation by the Staff Facilitator. 10% of all nurses and medication aides to include Nurse #1 and Nurse #2 will be audited by the Registered Nurse Managers weekly x 8 weeks and monthly x 1 month utilizing the Glucometer Cleaning audit tool to ensure that the glucometer is being cleaned per the Glucometer cleaning policy. Any identified areas of concerns will be addressed by the Registered Nurse Managers during the audit to include re-education. The DON will review and initial the Glucometer cleaning audit tool weekly x 8 weeks and monthly x 1 month to ensure completion and all identified areas of concerns were addressed. The DON will forward the results of the Infection Control Monitoring Audit Tool and the Glucometer Cleaning Audit tool to the Executive QA Committee monthly x 3 months. The Executive QA committee will met monthly x 3 months and review the Infection Control Monitoring Audit and Glucometer Cleaning Audit to determine trends and/or issues that may need further interventions and determine further 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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 24	F 880		

the resident's receiving antibiotics from the pharmacy. The ADON stated she reviewed why the resident was on antibiotics, their symptoms, and laboratory work to make sure the correct antibiotic was ordered. The ADON further stated she would map the infections and monitor grouping for the problem areas and educate staff if needed. When asked about the October 2018 Infection Control tracking and trending, the ADON stated she was still working on it and had not been given a time limit to finish. The ADON stated she had only started in this position 2 weeks ago, and this was the first month she had worked on the Infection Control tracking and trending.

On 11/15/2018 at 12:40 PM, an interview was conducted with Unit Manager #2, who stated the previous ADON left the facility in September 2018, and Infection Control (IC) was a part of that position. The Unit Manger #2 further stated that she had been the ADON earlier in the year and when she stepped down from that position, she thought the next ADON had been doing the tracking and trending of infections.

On 11/15/2018 at 3:24 PM, a review of the Infection Control records for 2018 in the presence of the ADON revealed no tracking or trending information for the months of January, March, April, June, July, August and September. No information was available for October. February included 1 resident on the tracking and trending report, and May included 4 residents on the tracking and trending report. The ADON stated no further tracking or trending information could be found.

On 11/15/2018 at 4:26 PM, an interview was

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 _____	C 11/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	7369 HUNTER HILL ROAD 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 880	Continued From page 25 conducted with the Director of Nursing (DON) who stated she expected the IC/ADON nurse to monitor, track and trend accurately. The DON stated she and the ADON were both new to the positions and the previous IC/ADON no longer worked at the facility.	F 880		