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 10/17/2019

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 10/14/19 through 10/17/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #9X8111.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/14/19 through 10/17/19. Event ID# 9X8111. 0 of the 23 complaint allegations were not substantiated.	F 000		
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 the Minimum Data Set (MDS) Assessment for 1 of 3 residents reviewed for hospitalization (Resident #124). The findings included: Resident #124 was admitted to the facility on 7/25/19 and had diagnoses that included myocardial infarction (heart attack), sepsis and pulmonary embolism (blood clot in the lung). Review of the Discharge MDS dated 8/12/19 noted the resident was discharged and return not anticipated. Section A2100 of the MDS noted the resident was discharged to an acute hospital.	F 641	The Minimum Data Set (MDS) assessment for resident #124 was modified by the MDS nurse on 10/16/19 to reflect the correct discharge status. 100% audit of all current resident most current MDS assessment was initiated on 10/21/19 by the Facility MDS Nurse Consultant utilizing a MDS Accuracy Audit tool to ensure all completed MDS□s were accurately coded to include the correct discharge status. Any identified areas of concerns were corrected to include modifications by the MDS Nurses during the audit. Audit completed on 10/22/19.	11/6/19

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

Electronically Signed | 10/29/2019

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F 641	Continued From page 1 Review of a social worker progress note dated 8/12/19 revealed the following: "Resident d/c (discharged) home today with scheduled home health services. The resident was discharged at 5:15 PM with POA (Power of Attorney) present." An interview was conducted with MDS Nurse #1 on 10/16/19 at 2:30 PM. The MDS Nurse was observed to review the clinical record and stated the resident was discharged home and the MDS was coded that the resident was discharged to the hospital. The MDS Nurse stated the MDS was not accurate and she would do a correction for the MDS. On 10/17/19 at 2:30 PM the Administrator stated in an interview that it was her expectation the MDS be coded correctly.	F 641	On 10/22/2019 an in-service was completed by the Facility MDS consultant with the MDS Nurses in regards to accurately coding the MDS, to include accurate discharge status. 10% of completed MDS□s, will be reviewed by the Assistant Director Of Nursing and or the Registered Nurse (RN) supervisors to ensure all MDS□s are accurately coded to include accurate discharge status utilizing an MDS Accuracy QA Tool weekly for 8 weeks and monthly X 1 month. Any identified areas of concern will be immediately addressed by the ADON and/or the RN Supervisor to include additional training and modifications to assessment as indicated. The DON will review and initial the MDS Accuracy QA Tool weekly for 8 weeks and then monthly for 1 month for accuracy and to ensure all areas of concerns have been addressed. The Administrator will forward the results of the MDS Accuracy QA Tool to the Executive QA Committee monthly x 3 months. The Executive QA Committee will meet monthly x 3 months to review the MDS Accuracy QA 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.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance.	F 867		11/6/19

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F 867	Continued From page 2 §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility's Quality Assessment and Assurance (QA) Committee failed to maintain implemented procedures and monitor interventions that the committee put into place in November 2018. This was for a deficiency that originally was cited on 11/16/2018 and was subsequently recited on the current recertification survey of 10/17/2019. The repeated deficiency was Minimum Data Set (MDS) accuracy. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain and effective Quality Assurance program. The findings included: This tag is cross referenced to: F641: Accuracy of Assessments: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) Assessment for 1 of 3 residents reviewed for hospitalization (Resident #124). During the previous recertification survey on 11/16/2018, the facility was cited a deficiency at F641 for failure to accurately assess and code 2 residents' MDS (Resident # 97 and Resident # 129). The facility was re-cited during the current 10/17/2019 annual recertification/complaint investigation survey for the same issue of inaccurate coding on MDS assessments.	F 867	The Administrator, DON and QI Nurse were educated by the Facility Consultant on the QA process, to include implementation of Action Plans, Monitoring Tools, the Evaluation of the QA process, modification and correction if needed to prevent the reoccurrence of deficient practice identifying issues that warrant development and establish a system to monitor the corrections and implement changes when the expected outcome is not achieved and sustaining an effective QA program on 10/29/2019. The Director of Nursing (DON) completed 100% audit of previous citations and action plans within the past year to include to prevent accidents and to implement appropriate interventions to prevent further accidents to ensure that the QA committee has maintained and monitored interventions that were put into place. Action plans were revised and updated and presented to the QA Committee by the DON on 10/29/2019 for any concerns identified. All data collected for identified areas of concerns to include implementing appropriate interventions to prevent further accidents will be taken to the Quality Assurance committee for review monthly x 6 months by the Quality	

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F 867	Continued From page 3 During an interview on 10/17/2019 at 11:10 AM the Administrator stated that the QAPI-Inaccuracy of MDS was an oversight because that MDS nurse does mostly Medicare and this nurse was also in the process of training for upcoming changes. The Administrator further stated she would expect accurate MDS coding.	F 867	Assurance Nurse. The Quality Assurance committee will review the data and determine if plan of corrections are being followed, if changes in plans of action are required to improve outcomes, if further staff education is needed, and if increased monitoring is required. Minutes of the Quality Assurance Committee will be documented monthly at each meeting by the Administrator. The Facility Consultant will ensure the facility is maintaining an effect QA program by reviewing and initialing the Executive committee Quarterly meeting minutes and ensuring implemented procedures and monitoring practices to address interventions, to include implementing appropriate interventions to prevent further accidents, and all current citations and QA plans are followed and maintained Quarterly x 2. The Facility Consultant will immediately retrain the Administrator, DON and QA nurse for any identified areas of concern. The results of the Monthly Quality Assurance meeting minutes will be presented by the Administrator and/or DON to the Executive Committee Quarterly x 2 for review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued monitoring.	