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 _____	11/08/2012

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 No deficiencies were cited as a result of the complaint investigation of 11/8/12 Event ID# GTQZ11	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 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 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 on staff interviews and record reviews, the facility failed to develop a care plan for 1 (Resident #146) of 2 sampled residents receiving anticoagulant (medications received for prevention of blood clotting) medications Findings include	F 279		

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

Rebekah Kurka NHA — 12/7/12

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 _____	11/08/2012

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 1 Resident #146 was re-admitted to the facility on 5/25/11 Documented diagnosis from the hospital discharge summary included left lower extremity pain secondary to recurrent left lower extremity deep venous thromboses (blood clot), a history of pulmonary embolism (blood clot in the lungs), and peripheral vascular disease Review of the physician ' s orders for November 2012 revealed the resident received Fragmin (medication used to prevent blood clotting) 20,000 units sub-cutaneously every night at bedtime The medication was ordered beginning 5/25/12. Review of the resident ' s current care plan revealed no care plan for the use of an anti-coagulant medication. During an interview with the Minimal Data Set Nurse #1 on 11/7/12 10:31 AM, the reported she completed Resident #146 ' s last quarterly assessment on 9/12/12. The nurse stated she didn't address Fragmin as an anticoagulant. She stated she prepared care plans for Coumadin (oral anti-coagulant medication) use in the past and this resident should have had a care plan due to the use of Fragmin. During an interview on 11/7/12 at 2 26 PM with the Director of Nursing (DON), the DON stated she expected the use of Fragmin would have been addressed on the resident's care plan with a week after the order was written	F 279	Care plan for resident #146 was updated to include resident receiving anticoagulant medication on 11/7/2012 by Minimum Data Set Nurse. All other residents receiving anticoagulant therapy have been reviewed and Care Plans updated as appropriate on 11/30/2012 by Minimum Data Set Nurse. Interdisciplinary Care Plan team in serviced re: updating Care Plan with anti-coagulant therapy as appropriate for residents receiving anticoagulant medication on 11/30/2012 by Director of Nursing. Nurse Managers will review Physician orders 3 times per week and forward any identified orders for anticoagulant therapy to the Minimum Data Set Nurse for Care Plan update as appropriate. A QI audit tool will be utilized by the Director of Nursing/ Nurse Managers to monitor Care Plan updates for residents receiving anticoagulant therapy weekly x 4 weeks then monthly X 3 months with follow-up occurring as needed.	12/4/12
F 315 SS=D	483 25(d) NO CATHETER PREVENT UTI, RESTORE BLADDER	F 315	Continued...	

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 _____	11/08/2012

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 315	Continued From page 2 Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by Based on observation, staff interview, and record review, the facility failed to obtain a diagnosis for the use of an indwelling urinary catheter and failed to obtain orders for care of the catheter for 1 (Resident #8) of 2 sampled residents with an indwelling urinary catheter Findings include: Resident # 8 was re-admitted to the facility on 10/29/12 with diagnoses to include hematuria, urinary tract infection, Chronic Kidney Disease Stage IV, and retention of urine. Review of re-admission physician ' s orders of 10/2912 revealed the orders included "foley cath (indwelling urinary catheter) " . The orders did not indicate specific orders for a size of the catheter, no diagnosis for use, care, and no orders for changing the catheter or drainage collection set Review of the November 2012 physician's orders revealed there were no orders for a catheter, a	F 315	Results of the QI audit tool will be forwarded to the facility Quality Improvement Committee monthly for review and the identification of trends, development of action plans as indicated to determine the need and/ or frequency of continued QI monitoring. F 315 Indwelling urinary catheter for resident # 8 was discontinued on 11/8/2012 by Charge Nurse. All other residents with indwelling urinary catheters have been reviewed for appropriate diagnosis for the use of indwelling urinary catheters and MD orders have been obtained for the care of the catheter on 12/03/12 by Nurse Managers. All nurses have been in serviced re: obtaining diagnosis for the use of an indwelling urinary catheter and obtaining orders for the care of the catheter for residents with an indwelling urinary catheter by the Staff Development Coordinator by 12/03/ 2012. Any new nurses hired after the completion date will receive training during the orientation program.	12/4/12

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 _____	11/08/2012

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 315	Continued From page 3 diagnosis, a size, care, or frequency of changing the catheter or drainage collection set. During an interview with Nurse #8 on 11/7/12 at 4:42 PM, the nurse reported she wrote part of the resident's admission orders for 10/29/12. The nurse stated her signature on the bottom of the physician's orders signified the orders were correct and she used the hospital discharge summary for transcribing the orders and medications. The nurse reviewed the resident ' s current order for a "foley catheter" and stated the size was missing from the order, the changing schedule, the care schedule, and reason for the catheter were all missing from the orders. An interview was conducted with the Director of Nursing (DON) on 11/7/12 at 5:10 PM. The DON reported the " foley cath " order for Resident #8 needed a size, change orders, care orders, and diagnosis for its use. The DON stated the resident ' s current orders were incomplete. Review of a Urology consult of 11/8/12 revealed there were no urologic concerns for a need of the foley cath. Recommendations were received to discontinue the use of the catheter.	F 315	Charge Nurses will document new orders for indwelling urinary catheters to include diagnosis and care of the indwelling urinary catheter. Nurse Managers will review the physician orders 3 times per week to ensure appropriate indwelling urinary catheter diagnosis and orders for the care of the catheter have been obtained. Any identified issues will be addressed with the unit nurse upon identification. An audit QI tool will be utilized by the Director Of Nursing/ Nurse Managers to monitor that indwelling urinary catheters have the appropriate diagnosis and physician orders for the care of the indwelling urinary catheter weekly x 4 weeks, then monthly x 3 months with follow-up occurring as needed. Results of the QI audit tool will be forwarded to the facility Quality Improvement Committee monthly for the review and the identification of trends, development of action plans as indicated to determine the need and/or frequency of continued QI monitoring.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents	F 323		

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 _____	11/08/2012

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 323	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to secure poured medications that were left on top of the medication cart for 2 (300 hall, 200 hall) of 2 medication carts observed to be unattended by facility nursing staff. Findings include: 1. An observation, on 11/07/12 at 5:13 PM, was made of the medication cart on the 300 hall. The cart was locked and was observed to have a plastic medication cup with 17 milliliters (mls) of red liquid, 2 pill packages with one tablet in one packet, and a half tablet in the other on top of the medication cart. The packages were sealed. No nurse was observed in the area. An observation, on 11/07/12 at 5:15 PM, Nurse #2 came from the nurse desk, located in the center of the facility, and approached the 300 hall medication cart. She indicated the liquid medications in the medication cup were Keppra and Phenobarbital (anti-seizure medications). She stated the pills were Lamictal (anti-seizure medication). Nurse # 2 stated she was called away from the cart to take a phone call and failed to lock up the poured medications in the cart. She indicated that medications should not have been left out when the nurse was not in view of the medication cart or at the cart. Per Lexi-Comp Geriatric Dosage Handbook 14th Edition, Keppra (Levetiracetam) was used in combination with other medications to treat certain types of seizures in people with epilepsy	F 323	F 323 Identified Charge Nurses for 200 and 300 hall in serviced to include securing poured medications and not leaving medications unattended by Administrator on 11/13/2012. All nurses in serviced on securing poured medications and not leaving medications unattended by 12/03/12 by the Staff Development Coordinator. Any new nurses hired after the completion date will receive training during the orientation program. Nurse Managers will review medication carts 3 times per week for any unsecured medication left unattended. The Nurse Manager will address any concerns with the unit nurse upon identification. An audit QI tool will be utilized by the Director Of Nursing/ Nurse Managers to monitor for any unsecured medications left unattended 3X's / week for 4 weeks, then weekly X 4 weeks, then monthly X 3 months with follow-up occurring as needed.	12/4/12

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 _____	11/08/2012

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 323	Continued From page 5 Levetiracetam was in a class of medications called anticonvulsants and side effects included drowsiness, weakness, unsteady gait, and coordination problems Phenobarbital was used to control seizures; is also used to relieve anxiety, and side effects include drowsiness, headache, dizziness, nausea and vomiting. Lamictal (Lamotrigine) extended-release tablets are used with other medications to treat certain types of seizures in patients who have epilepsy and side effects include loss of balance, double vision, blurred vision An interview, on 11/08/12 at 8:30 AM, was conducted with Nurse #5. Nurse #5 reported when she was preparing medications and was needed somewhere else, she indicated when it was not an emergency, she finished giving those medication Nurse #5 stated that when it was an emergency, she locked the poured medications in the cart. An interview, on 11/08/12 at 9:08 AM, was conducted with Nurse #4 Nurse #4 stated when she was called away when she had medications poured for administration, she indicated once she knew the reason was not an emergency she finished giving the medications. Nurse #4 stated when it was an emergency she locked them in the medication cart An interview on 11/08/12 at 9 15 AM was conducted with Nurse #6 Nurse #6 stated when there was an emergency while she was preparing medication she locked the poured medication in the drawer and responded to the emergency Nurse #6 indicated the facility policy was to not leave any medication on top the medication care	F 323	Results of the QI audit tool will be forwarded to the facility's Quality Improvement Committee monthly for review and the identification of trends, development of action plans as indicated to determine the need and/ or frequency of continued QI 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 _____	11/08/2012

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 323	Continued From page 6 unattended. An interview, on 11/08/12 at 10:30 AM, was conducted with Director of Nursing (DON). The DON stated her expectation was that the nursing staff followed standards of practice and secured medication prior to leaving the medication cart. 2. An observation, on 11/08/12 at 8:30 AM, was made of crushed medications in applesauce in a plastic 30 ml medicine cup and a milky tan liquid poured in a 4 ounce plastic cup on top of the medication cart on the 200 hall. There was no nurse observed to be in the area. An observation, on 11/08/12 at 8:32 AM, was made as Nurse #3 turned the corner of the 200 hall, and returned to the medication cart. An observation, on 11/08/12 at 8:33 AM, was made of Nurse #3 as she entered Room 220 and administered the crushed medications in the applesauce to the resident. An interview, on 11/08/12 at 8:46 AM, was conducted with Nurse #3 Nurse #3 stated the medication that she had prepared in the applesauce were Aspirin, Aricept, Namenda, Colace, Miralax, Catapres, and a multivitamin. She indicated she had added Beneprotein to Prostat(protein supplement) in the plastic cup When Nurse #3 was asked about the medication being on top of the medication cart, she indicated she should have taken the medication with her or had another nurse watch the medication cart for her Per Lexi-Comp Geriatric Dosage Handbook, 14th	F 323		

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 _____	11/08/2012

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 323	Continued From page 7	F 323		

Edition, Aricept is used to treat dementia and the side effects include nausea, vomiting, and diarrhea. Namenda is used to treat symptoms of Alzheimer ' s disease and the side effects include dizziness and confusion. Catapres is used to treat hypertension and the side effects include fast heartbeat, tremors, or a slow heart rate.

An interview, on 11/08/12 at 8:30 AM, was conducted with Nurse #5. Nurse #5 reported when she poured medications and was needed somewhere else, she indicated when it was not an emergency she finished giving those medications. Nurse #5 stated that when it was an emergency, she locked the prepared medications in the cart.

An interview, on 11/08/12 at 9:08 AM, was conducted with Nurse #4. Nurse #4 stated when she was called away when she had medications poured for administration, she indicated once she knew the reason was not an emergency she finished giving the medications. Nurse #4 stated when it was an emergency she would lock them in the medication cart.

An interview, on 11/08/12 at 9:15 AM was conducted with Nurse #6. Nurse #6 stated when there was an emergency while she poured medications,, she locked the prepared medication in the drawer and respond to the emergency. Nurse #6 indicated the facility policy was to not leave any medication on top the medication care unattended

An interview, on 11/08/12 at 10:30 AM was conducted with Director of Nursing (DON) The DON stated her expectation was that the nursing

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 _____	11/08/2012

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 323	Continued From page 8 staff followed standards of practice and secured medication prior to leaving the medication cart.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by Based on staff interviews and record review the facility failed to monitor the blood pressure and pulse for the administration of a hypertensive medication for 1 (Resident #64) of 10 sampled residents whose medications were reviewed	F 329	F 329 The blood Pressure and pulse is being monitored daily per physician's order for resident #64 who is receiving hypertensive medication by the Charge Nurses. Residents receiving hypertensive medications audited by Director of Nursing/ Nurse Managers for Blood pressure and pulse monitoring as appropriate and documented on the MAR on 12/03/2012 All Nurses in-serviced re: monitoring blood pressure and pulse for any resident receiving the administration of hypertensive medication per physician's order by Staff Development Coordinator by 12/03/2012. Any new nurses hired after the completion date will receive training during the orientation program.	12/4/12

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 _____	11/08/2012

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 329	Continued From page 9 Findings include: 1. Resident #64 was admitted to the facility on 10/02/05 and readmitted on 06/08/11. Cumulative diagnoses included hypertension, diabetes mellitus, and congestive heart failure. Review of a physician order, dated 10/05/12, revealed an order that read in part: "Cozaar 25 milligrams per mouth everyday for renal benefit due to hypertension and diabetes mellitus co-morbidities. Hold for systolic (reading when your heart is working to push blood through the blood vessels) blood pressure less than 100, diastolic (reading when your heart is resting between beats) blood pressure less than 65, and heart rate (pulse) less than 60." Per the manufacturer ' s information, "Cozaar is used to treat high blood pressure (BP). Cozaar is also used to slow long-term kidney damage in people with type2 diabetes who have high blood pressure. " Per Tabors Medical Dictionary "Type 2 diabetes is a chronic condition that affects the way the body metabolizes sugar (glucose)." Review of the Medication Administration Record sheet (MARs) for October 2012 revealed Resident #64's BP had been taken on 10/16/12, 10/17/12, and 10/31/12. Further review of the MARs did not have any documentation or information regarding the pulse rate Review of the MARS for November 1 through November 7, 2012 revealed no documentation for the BP or P	F 329	Residents requiring the administration of hypertensive medication to include resident #64 will have Medication Administration Record checks 3 times per week conducted by Director of Nursing/ Administrative Nurses/Charge Nurses by 12/3/2012. Any identified concerns will be immediately addressed with unit nurse. An audit QI tool will be utilized by the Director Of Nursing /Administrative Nurses to track appropriate monitoring of blood pressure and pulse with the administration of hypertensive medication 3X's / week X 4 weeks, then weekly X's 4 weeks, then monthly X 3 months with follow-up occurring as needed. Results of the QI audit tool will be forwarded to the facility Quality Improvement Committee monthly for review and the identification of trends, development of action plans as indicated to determine the need and/ or frequency of continued QI 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 _____	11/08/2012

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 329	Continued From page 10 An interview, on 11/07/12 at 10:40 AM, was conducted with Nurse #1, who had administered Resident #64 ' s morning medications. She reviewed the MARs and stated she was not aware the BP and P were needed prior to giving the medication and held if outside the values the physician gave. Nurse #1 continued that the order was clear on the MARS that the BP and P needed to be taken and that she had not done that. She relayed that the nurse who transcribed the physician ' s order should have placed the order on the MARs and should have also indicated on the MARs that the bloood pressure and pulse needed to be taken and the medication held if outside the vaules the physician gave. An interview on 11/07/12 at 10:55 AM, was conducted with the Director of Nursing (DON). The DON reviewed the MARs and indicated the nurse receiving the order should have created spaces on the MARs to indicated that the BP and P needed to be taken daily. She also relayed that during the change of the MARs monthly, this issue should have been identified by the nurse checking the monthly orders and created the means to document the BP and P. The DON stated it would have made the nurses more aware of the criteria to check the BP and P daily. When asked if pharmacy would have been expected to identify the need for the BP and P monitoring, she indicated they should but sometimes it is missed and the nurse reconciling the monthly orders should have noticed the error and corrected it. The DON stated it was her expectations that the BP and P should have been checked prior to giving the Cozaar and held if needed	F 329		

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 _____	11/08/2012

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 329	Continued From page 11 An interview, on 11/08/12 at 6:04 PM, was conducted with Nurse #7, who had taken and transcribed the order on 10/05/12 for Cozaar. She reviewed the order for Cosaar on 10/05/12 and reviewed the MARs. Nurse #2 relayed that when she transcribed the order she should have made the MARs reflect that the BP and P needed to be taken and the perimeters followed. She relayed she failed to do that and the resident had not had her BP and P taken per the physician's order.	F 329		

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 01 - BUILDING 0101 B. WING	DEC 27 2012 12/06/2012

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 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The sheet rock in the attic on 600 hall and in the main area by the nurse station has holes that were not repaired and maintained in good condition in order to maintain the rating of the ceiling. 42 CFR 483.70(a)	K 012	Hunter Hills Nursing and Rehabilitation Center 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 Correction is submitted as a written allegation of compliance. Hunter Hills Nursing and Rehabilitation Center's 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 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. K012 The Maintenance Director repaired the sheet rock in the attic on 500 hall and in the main area of the nurses station on 12-21-2012 to assure areas are maintained in good condition in order to maintain rating of ceiling.	1-20-13
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at	K 029	An audit was completed on 12-7-2012 by the Maintenance Director to identify any other holes in sheet rock. Any areas identified will be repaired as appropriate. The Regional Director inserviced the Maintenance Staff on 12-20-2012 on preventative maintenance rounds including checking sheet rock walls and ceilings to assure they are in good condition. The Maintenance Director and/or Assistant will audit the facility walls and ceilings for holes and needed repairs monthly for three months then quarterly ongoing thereafter utilizing a Preventative Maintenance QI Audit Tool. Results of the Preventative Maintenance QI Audit Tool will be submitted to the Monthly Executive Quality Improvement Committee for review, recommendations of monitoring, and continued compliance in this area.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Regional Director — (X6) DATE: 12/20/2012

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 rogram participation.

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 01 - BUILDING 0101 B. WING	12/06/2012

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 029	Continued From page 1 approximately 8:30AM onward the following was noted: 1) The door between the kitchen and dining room at the dishwashing area was tied open preventing the door from closing. 42 CFR 483.70(a)	K 029	K029 The door between the kitchen and dining room at the dishwashing area was untied by a dietary staff member on 12/6/2012 to allow door to close, latch, and seal. All other self closing doors in the facility were audited to ensure no impediments for proper closing, latch, and seal on 12/7/2012 by the Maintenance Director. Any doors identified were corrected by the Maintenance Director as appropriate.	1-20-13
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) Illumination of means of egress including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. The 400 hall discharge illumination to the public way noncompliant: Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	The Regional Director inserviced the Maintenance Staff on preventive maintenance rounds including checking self closing doors in facility to assure close, latch, and proper seal and no use of wedges or ties on 12-20-2012. The Director of Nursing inserviced the Dietary Staff and Central Supply Staff on 12-19-2012 regarding never using wedges, items, or ties to impede a self-closing door from proper close, latch, and seal. The Maintenance Director and/or Assistant Maintenance will audit facility doors monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	
	42 CFR 483.70(a)		K045 The Maintenance Director increased the wattage bulb in the existing light fixture to the 400 hall exit area to provide light from the exit discharge leading to the public way and will be connected to the emergency panel of generator.	1-20-13
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 054	The Maintenance Director audited the facility exits on 12/10/12 to ensure that failure of any single lighting fixture/bulb will not leave the area in darkness. Any areas identified will be corrected as appropriate.	

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 01 - BUILDING 0101 B. WING _____	12/06/2012

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 054	Continued From page 2 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The smoke duct detectors located in the HVAC units were not maintained clean and in good operating condition. Location - HVAC unit in the attic area, front area. 42 CFR 483.70(a)	K 054	The Regional Director inserviced the Maintenance Staff on preventive maintenance rounds including checking exits/areas of egress for appropriate illumination on 12-20-2012. The Maintenance Director and/or Assistant Maintenance will audit facility illumination at exits/areas of egress monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area. K054 The smoke duct detector located in the HVAC unit of the attic, front area was cleaned by an outside contractor on 12-18-2012.	
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: Based on observation on Thursday 12/6/2012 at	K 056	An audit was completed on 12-18-2012 by the Maintenance Director to assure that all other smoke duct detectors were clean and in good operating condition and the outside contractor cleaned all areas identified on 12-18-2012. The Regional Director inserviced the Maintenance Staff on 12-20-2012 on preventive maintenance rounds including checking smoke duct detectors to assure they are maintained in a clean and operating condition. The Maintenance Director and/or Assistant Maintenance will audit facility smoke duct detectors monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	1-20-13

PRINTED: 12/10/2012
FORM APPROVED
OMB NO. 0938-0391

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 01 - BUILDING 0101 B. WING _____	12/06/2012

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	Continued From page 3 approximately 8:30AM onward the following was noted: 1) The sprinkler head located in exit canopy on 500 hall was not rated for ordinary temperature classification, Glass Bulb Color of red temperature rating of (155°F). 2) A sprinkler head is need in the exit canopy located on 200 hall next to room 206 . (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) 42 CFR 483.70(a)	K 056	K056 An outside contractor will be replacing the sprinkler head located in exit canopy on 500 hall rated for ordinary temperature classification, glass bulb color red. An outside contractor will be installing a sprinkler head in the exit canopy located on 200 hall next to room 206. An audit was completed on 12-19-2012 by the Maintenance Director and Maintenance Assistant to ensure all other exit canopy areas have sprinkler heads under exterior roofs or canopies exceeding four feet. Any areas identified will be corrected by the outside contractor.	1-20-13
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1). The tamper alarm tested in the pit on the backflow device for the sprinkler system did not provide a signal at the fire alarm panel when tested. 2) The facility at the time of the survey could not provide documentation concerning the annual inspection on the backflow device for the sprinkler system. 3) Facility at the time of the survey could not provide documentation that a 5 year internal inspection has been conducted within the last	K 062	The repairs and/or additions made by the outside contractor will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area. K062 An outside contractor will be repairing the tamper alarm for the sprinkler system backflow device to provide a signal at the fire alarm panel when tested. The Administrator provided the surveyor with a copy of the annual inspection of the backflow device by fax on 12/7/2012. An outside contractor will be obtained to complete a five year internal investigation. The Regional Director inserviced the Maintenance Staff on assuring inspection records of the sprinkler system are stored in the facility where they can be easily accessed when requested by a inspector on 12-20-2012. The sprinkler outside contractor will test the tamper alarm in the pit on the back flow device quarterly ongoing to assure that it provides a signal to the fire alarm panel when tested and provide facility with written documentation of this test.	1-26-13

PRINTED: 12/10/2012
FORM APPROVED
OMB NO. 0938-0391

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 01 - BUILDING 0101 B. WING	12/06/2012

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 062	Continued From page 4 five years. 42 CFR 483.70(a)	K 062	The repairs made by the outside contractor for the tamper alarm and the quarterly tamper alarm check documentation will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	
K 135 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The Sterno cooking/hot holding fluid was not stored in NFPA 30 approved fire cabinet.	K 135	K-135 The sterno cooking/hot holding fluid was removed from the facility on 12/6/2012 by the Maintenance Director. An audit of the facility was completed by the Maintenance Director on 12/6/2012 to assure no other flammable or combustible liquids were stored outside of a approved fire cabinet. Any areas identified were corrected as appropriate. The Dietary staff and Maintenance Staff were inserviced on 12-20-2012 by the Director of Nursing on assuring that flammable/combustible liquids are stored in an approved fire cabinet or off site of the nursing facility. The Maintenance Director and/or Assistant Maintenance will audit the facility for storage of flammable/combustible materials monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	1-20-13
K 147 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was	K 147	K-147 The exhaust fans for the 500 hall resident bathrooms were replaced by 12-21-2012 by the Maintenance Director. The flow switch for the de-watering pump for the sprinkler pit was replaced by the Maintenance Director on 12-18-2012 to assure operation.	1-20-13

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 01 - BUILDING 0101 B. WING	12/06/2012

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 147	Continued From page 5 noted: 1) The exhaust fan for the 500 hall resident bathrooms was not operational at the time of the survey. 2) The de-watering pump for the sprinkler pit located outside did not operate and was not connected to emergency power. 42 CFR 483.70(a)	K 147	An outside contractor has been obtained to connect the de-watering pump to the emergency generator. A facility audit was completed by the Maintenance Director of exhaust fans to assure they were operational on 12-10-2012. Any fans identified will be repaired and/or replaced as appropriate. The Regional Director inserviced the Maintenance Staff on 12-20-2012 on preventive maintenance rounds including checking exhaust fans to assure they are operational. The Maintenance Director and/or Assistant Maintenance will audit facility exhaust fans monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	

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 02 - BLDG 0202 B. WING	12/06/2012

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 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The smoke wall in the attic area on 800 hall have hole/penetration that was not sealed in order to maintain the required fire resistance rating of the smoke barrier. 42 CFR 483.70(a)	K 025	K-025 The Maintenance Director sealed the hole in the attic area on 800 hall to assure the required fire resistance rating of the smoke barrier on 12/19/2012. The Maintenance Director completed an audit of the smoke walls in the attic areas to identify any holes or penetrations on 12/10/2012. Any areas identified were repaired as appropriate. The Regional Director inserviced the Maintenance Staff on 12-20-2012 on preventive maintenance rounds including checking smoke walls to assure no holes or penetrations to maintain the required fire resistant rating. The Maintenance Director and/or Assistant Maintenance will audit facility smoke walls for holes/penetrations monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	1-20-13
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are	K 029	K-029 The wedge was removed from the corridor door to the extra storage room on 700 hall on 12-6-2012 by Mainenance Staff to allow door to close, latch, and seal. A self closing device was installed on the corridor door to the Central Supply located on 700 hall by the Maintenance Director on 12-21-2012. All other self closing doors in the facility were audited to ensure no impediments for proper closing, latch, and seal on 12/7/2012 by the Maintenance Director. Any doors identified were corrected by the Maintenance Director as appropriate. The Regional Director inserviced the Maintenance Staff on preventive maintenance rounds including checking self closing doors in facility to assure close, latch, and proper seal and no use of wedges or ties on 12-20-2012.	1-20-13

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

Regional Director 12/20/2012

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.

PRINTED: 12/10/2012
FORM APPROVED
OMB NO. 0938-0391

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 02 - BLDG 0202 B. WING	12/06/2012

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 029	Continued From page 1 permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The corridor door to the extra storage room on 700 hall was wedged open preventing the door from closing. 2) The corridor door to the central supply located on 700 hall was not equipped with a self closing device.	K 029	The Director of Nursing inserviced the Dietary Staff and Central Supply Staff on 12-19-2012 regarding never using wedges, items, or ties to impede a self-closing door from proper close, latch, and seal. The Maintenance Director and/or Assistant Maintenance will audit facility doors monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	
K 045 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) Illumination of means of egress including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. The 700/800 hall discharge illumination to the public way noncompliant: Lighting must be arranged to provide light from	K 045	K045 The Maintenance Director will install and additional 250 watt light to the 700/800 hall exit area to provide light from the exit discharge leading to the public way and will be connected to the emergency panel of the generator. The Maintenance Director audited the facility exits on 12/10/12 to ensure that failure of any single lighting fixture/bulb will not leave the area in darkness. Any areas identified will be corrected as appropriate. The Regional Director inserviced the Maintenance Staff on preventive maintenance rounds including checking exits/areas of egress for appropriate illumination on 12-20-2012. The Maintenance Director and/or Assistant Maintenance will audit facility illumination at exits/areas of egress monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	1-20-13

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

PRINTED: 12/10/2012
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	12/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	PO BOX BOX 8405 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 045	Continued From page 2 the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. 42 CFR 483.70(a)	K 045		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Thursday 12/6/2012 at approximately 8:30AM onward the following was noted: 1) The exhaust fan for the resident bathrooms on 600 hall was not operational at the time of the survey. 42 CFR 483.70(a)	K 147	K147 The exhaust fans for the resident bathrooms on 600 hall were replaced by 12-21-2012 by the Maintenance Director. A facility audit was completed by the Maintenance Director of exhaust fans to assure they were operational on 12/20/12. Any fans identified will be repaired and/or replaced as appropriate. The Regional Director inserviced the Maintenance Staff on 12-20-2012 on preventive maintenance rounds including checking exhaust fans to assure they are operational. The Maintenance Director and/or Assistant Maintenance will audit facility exhaust fans monthly for three months then quarterly thereafter ongoing utilizing a Preventative Maintenance QI Audit Tool. The results of the Quality Improvement Audit Tool will be submitted to the monthly Executive QI Committee for review, recommendations of monitoring, and continued compliance in this area.	1-20-13