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 02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER HILLS NURSING AND REHABILITATION CENTER	POST OFFICE 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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to cover the Medication Administration Record (MAR), when leaving the medication cart to pass medications for 2 of 6 medication passes,(nurse #2 and #4), and 1 observation during tour, which exposed patient	F 164	Nurse #2, 3, & 4 were in-serviced re: not exposing patient personal information to include covering the MAR when leaving the medication cart on 2/11/2016 by the RN DON. On 2/11/2016 100% audit was completed	2/22/16

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

Electronically Signed | 02/17/2016

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F 164	Continued From page 1 information, (nurse #3). The findings included: On 2/11/2016 at 6:13 AM a medication pass was observed with Nurse #2. The nurse left the MAR open on top of the medication cart and entered the room 208. The resident ' s bed was positioned so that the nurse turned her back to the door to assist the resident to take the medication. An interview was conducted with the nurse after exiting the room. The nurse stated she would only cover the MAR on 3rd shift if someone was in the hall. On 2/11/2016 at 6:21 AM, an unlocked medication cart was observed outside of room 514, with the MAR opened. Upon exiting the room, an interview was conducted with the nurse, (nurse #3). The nurse stated she didn ' t know anyone was in the hall. She indicated she usually covered he MAR, but didn ' t know why she had not covered it this time. On 2/11/2016 at 8:55 AM, an unlocked medication cart was observed outside of room 607. The nurse (nurse #4) exited the room and continued to dispense medication. At room 609 the nurse entered the room and left the MAR open. The nurse turned her back to the door to assist the resident. An interview was conducted at after exiting the room. The nurse stated she only covered the MAR when she walked away from it. When questioned if she considered the cart to be with in her eye line when her back was to it, the nurse stated she guessed her eyes were not directly on it. An interview was conducted with the Director of Nursing (DON) on 6/11/2016 at 11:09 AM. The DON stated she expected her nurses to cover the MAR if they walked away from the cart.	F 164	by the RN facility consultant re: assuring that patients identifying confidential information to include the Medication Administration Record is protected when not in direct supervision of the medication cart. No concerns were identified during the audit. A 100% in-service to all licensed nurses and Medication Aides to include Nurse #2, 3, & 4 was completed by RN DON on 2/17/2016 re: exposing resident information to include assuring that patients identifying confidential information including the Medication Administration Record is protected when the Nurse and / or Medication Aide is not in direct supervision of the medication cart. Any nurse who has not received this in-service will not be allowed to work until in-service has been provided. All newly hired licensed nurses and Medication Aides will be in-serviced upon orientation by the RN DON or RN ADON on not exposing resident□s confidential information to include covering the Medication Administration record when the medication cart is unattended. The Medication/Treatment Cart Security QI Audit tool will be completed by the RN ADON, LPN QI nurse and LPN Treatment Nurses, to include nights and week-ends, daily for 7 days, 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 3 months to ensure no resident information is exposed. Any identified areas will require the nurse or med aide to be reeducated by RN DON or RN ADON up to including disciplinary action up to termination by the	

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F 164	Continued From page 2	F 164	Administrator. The RN DON will review and initial the Medication/Treatment Cart Security QI Audit Security tool daily for 7 days, then weekly for 8 weeks then monthly for 3 months for completion and to assure all areas of concerns were identified were addressed. The Administrator will review with Executive QI committee Medication Cart Security tool monthly X□s 6 months to determine issues and trend to include continued monitoring frequency.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 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. The facility must provide separately locked,	F 431		2/22/16

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F 431	Continued From page 3 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 observations and staff interviews the facility failed to lock the 2 of 7 medication carts, (600 hall cart and 500 hall cart) during tours of the facility, and during 2 of 6 medication pass observations with 2 nurses (Nurse #2 and #4). The findings included: On 2/10/2016 at 9:37 AM, the 600 hall cart was found to be unlocked in front of room 614. Upon exiting the room, an interview was conducted with the nurse, (nurse #1). The nurse stated she usually locked the cart, but had to take the temperature of the resident in the room. On 2/11/2016 at 6:13 AM a medication pass was observed with Nurse #2. The nurse left the cart unlocked and entered the room 208. The resident ' s bed was positioned so that the nurse turned her back to the door to assist the resident to take the medication. An interview was conducted with the nurse after exiting the room. The nurse stated she did not lock the medication cart if it was just outside the resident ' s room. On 2/11/2016 at 6:21 AM, an unlocked medication cart was observed outside of room 514. Upon exiting the room, an interview was conducted with the nurse, (nurse #3). The nurse stated she didn ' t know anyone was in the hall.	F 431	Nurse #1, 2, 3, & 4 were in-serviced re: locking and securing the medication cart at all times when left unattended on 2/11/16 by the RN DON. On 2/11/2016 a 100% audit was completed by the RN facility consultant to ensure all medication carts were locked when left unattended by the licensed nurse/ Medication Aides. Immediate retraining was conducted by the Facility Consultant with the license nurse/Medication Aide for all identified areas of concern on 2/12/2016. 100% in-service to all licensed nurses and Medication Aides to include nurse # 1, 2, 3 & 4 was completed by the RN DON, RN ADON on 2/17/2016 on locking the medication cart when unattended. Any nurses who have not received this in-service will not be allowed to work until the in-service has been provided. All newly hired licensed nurses and Medication Aides will be in-serviced upon orientation by RN DON or RN ADON re: locking and securing the Medication Cart while leaving the medication cart	

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F 431	Continued From page 4 She indicated she left the cart unlocked if it was by the resident ' s door. On 2/11/2016 at 8:55 AM, an unlocked medication cart was observed outside of room 607. The nurse (nurse #4) exited the room and continued to dispense medication. The nurse entered room 609, after leaving the medication cart unlocked. The nurse turned her back to the door to assist the resident. An interview was conducted after the nurse exited the room. The nurse stated she left the cart unlocked when entering a resident room, if the cart was within her eye line. When questioned if she considered the cart to be with in her eye line when her back was to it, the nurse stated she guessed her eyes were not directly on it. An interview was conducted with the Director of Nursing (DON) on 6/11/2016 at 11:09 AM. The DON stated she expected her nurses to lock the cart if they walked away from the cart. When passing medication, the DON indicated, if the cart was pulled up to the resident door and the cart remained in the nurse ' s eye site, it did not have to be locked. The DON stated if their back was turned to the cart, the cart should be locked.	F 431	unattended. The Medication/Treatment Cart Security QI Audit tool will be completed by the RN ADON, LPN QI nurse and LPN Treatment Nurses, to include nights and week-ends, daily for 7 days, 3 times a week X□s 4 weeks, then weekly X□s 4 weeks then monthly X□s 3 months to assure no unattended medication carts are left unlocked. Any identified areas will require the Nurse or Medication Aide to be reeducated by the RN DON or RN ADON, or Administrator up to and including disciplinary action to include termination by the Administrator. The DON will review and initial the Medication/Treatment Cart Security QI Audit tool daily for 7 days then weekly for 8 weeks then monthly for 3 months for completion and to assure all areas of concerns that were identified were addressed. The Administrator will review with Executive QI committee Medication Cart Security tool monthly X□s 6 months to determine issues and trend to include continued monitoring frequency.	