## Statement of Deficiencies and Plan of Correction

### NAME OF PROVIDER OR SUPPLIER

**Hunter Hills Nursing and Rehabilitation Center**

### STREET ADDRESS, CITY, STATE, ZIP CODE

7369 Hunter Hill Road
Rocky Mount, NC 27804

<table>
<thead>
<tr>
<th>ID (X4)</th>
<th>PREFIX (X5)</th>
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<tbody>
<tr>
<td>F 658</td>
<td>SS=D</td>
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#### SUMMARY STATEMENT OF DEFICIENCIES

- **ID**: F 658
- **PREFIX**: SS=D
- **TAG**: Services Provided Meet Professional Standards
- **CFR(s)**: 483.21(b)(3)(i)
- **TAG**: §483.21(b)(3) Comprehensive Care Plans

**The services provided or arranged by the facility, as outlined by the comprehensive care plan, must:**

(i) Meet professional standards of quality.

This **REQUIREMENT is not met as evidenced by:**

- Based on record review, family and staff interviews the facility failed to follow physician's orders to perform dressing changes for 1 of 3 residents (Resident #1) reviewed for pressure ulcers, and failed to provide treatments for 1 of 3 Residents with wound care (Resident #3).

The findings included:

1. Resident #1 was admitted to the facility on 10/11/17 and had diagnoses of end stage peripheral artery disease and dementia.

The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 1/15/18 revealed the resident had short and long term memory loss and severe cognitive impairment. The MDS noted the resident required extensive to total assistance with activities of daily living. The MDS noted the resident had 3 unstageable pressure ulcers and had a pressure reducing device for the bed and chair and received pressure ulcer care.

The resident’s Care Plan dated 10/21/17 noted the resident had pressure ulcers and to do treatments as ordered. There was a physician’s order dated 12/19/17 for the following: Apply betadine to the right foot and heel and right great toe and wrap with Kerlix (gauze) daily. There was a physician’s order

**The process that led to this deficient practice on 02/06/2018 was that the assigned hall nurse failed to complete the treatments for Resident #1 and Resident #3 and the assigned hall nurse failed to initial the Treatment Administration Record (TAR).**

On 02/09/2018 Resident #1 had a skin check completed by the assigned hall nurse with no new issues identified. On 02/13/2018 the West Wing Treatment Nurse completed an assessment of resident #1 wounds with no new issues identified. On 02/05/2018 the East Wing Treatment Nurse and the Director of Nursing (DON) completed an assessment on resident #3 wounds and no new issues were identified. On 2/9/2018 Resident #3 had a skin check completed by the assigned hall nurse with no new issues identified. On 02/05/2018 the DON notified the physician of the lack of documentation of the completion of the treatment on the TAR for Resident #1 and Resident #3 and no new orders were received.

100% head to toe assessments was completed on all residents to include...
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dated 12/22/17 to apply skin prep to the left heel daily.

Review of the Treatment Administration Record (TAR) for December 2017 revealed an entry to Cleanse R great toe with wound cleanser apply betadine and wrap with Kerlix daily.” A separate entry noted to cleanse the right heel with wound cleanser and apply betadine and wrap with Kerlix daily. There was another entry to apply skin prep to the left heel daily. The TAR contained no initials for December 24 and 25, 2017 to indicate the treatments had been done as ordered.

On 2/6/18 at 10:02 AM, an interview was conducted with the Administrator and Director of Nursing (DON). The Administrator stated she received a grievance from the resident ‘s family member about Resident #1 ‘s treatments not being done consistently. The DON stated during the investigation they determined the 2 nurses that worked on December 24 and 25, 2017 did not do the treatments. The Administrator stated she spoke with the family and apologized and let them know the 2 nurses no longer worked at the facility.

On 2/6/18 at 2:15 PM, the Administrator stated in an interview they had provided in-services to the nursing staff regarding treatments and had monitored the TARs for Resident #1 to ensure her treatments were being done but had not looked at other residents with wounds to see if their treatments were being done.

2. Resident #3 was admitted to the facility on 12/17/17 with diagnoses of bilateral stasis dermatitis, hypothyroidism, hyperthermia, encephalopathy, hyperthermia, bradycardia and...
A. BUILDING ____________________________  
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345279  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X2) MULTIPLE CONSTRUCTION  
A. BUILDING ____________________________  
B. WING ____________________________  

(X3) DATE SURVEY COMPLETED  
02/06/2018  

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anemia.  
A review of the resident's admission Minimum Data Set (MDS) dated 12/29/17 revealed the resident was cognitively intact. He required extensive assistance with dressing, eating, toilet use, personal hygiene and totally dependent on staff for bathing.  
A review of the Physician's orders dated 12/18/17 read, "ABD pad (a sterile, highly absorbent dressing) re-wrapped with ace wrap and apply Lac-Hydrin lotion twice a day."  
A review of the Treatment Administration Record (TAR) for February 2018 revealed the resident did not receive treatments on 2/1/18, 2/2/18, 2/3/18, and 2/4/18 on first shift. On second shift, the resident did not receive the treatment on 2/1/18 and 2/4/18, and 2/5/18.  
On 2/5/18 at 3:20 PM a family member of Resident #3 stated that the resident's legs were dry and the physician had ordered lotion. The family member stated that she thought since his legs were so dry that she did not believe that staff were putting the lotion on his skin.  
On 2/6/18 at 10:47 AM the Treatment Nurse stated that she applied the lotion this morning (2/6/18) and stated that there was no documentation that the treatment was done on second shift on 2/5/18.  
On 2/6/18 at 11:20 AM the Administrator and the Director of Nursing (DON) stated that the nurses had missed the treatments during February 2018 and if they had done the treatments they failed to document that the treatments were done.  

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treatment, the nurse/med aide will initial the TAR indicating the treatment was completed. If the resident refuses the treatment, the nurse/med aide will initial the TAR, circle their initial, and indicate refusal on the back of the record. The physician and the Resident Representative (RR) will be notified and this will be documented in the medical record. A colored sheet of paper will indicate residents who have treatments that are to be completed more frequently than daily (i.e. BID treatments) to alert all nurses to ensure completion by all shifts if indicated. The treatment nurse will ensure this sheet remains current. If treatments are not completed, disciplinary action will be taken to be completed by 2/23/2018. All newly hired nurses will be educated by the SF during orientation.  
The East and West Wing Treatment Nurse will review the Treatment Administration Records weekly x 8 weeks then monthly x 1 month to ensure all treatments have been initialed as completed on the Treatment Administration Record utilizing the Treatment Administration Record Audit Tool. Any concerns will immediately be identified and addressed by the Director of Nursing with reeducation of the licensed nurse on completion and documentation of physician ordered treatments. The Administrator will review and initial the Treatment Administration Record Audit tool weekly x 8 weeks then monthly x 1 month to ensure completion and that all areas of concern were addressed.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<td>The Director of Nursing will forward the results of the Treatment Administration Audit Tool to the Executive Quality Improvement Committee monthly X 3 months. The Executive Quality Improvement Committee will meet monthly X 3 months and review the Treatment Administration Audit Tool to determine trends and/or issues that may need further interventions put into place and determine the need for further and/or frequency monitoring.</td>
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