PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7.11. 20.22.11.10		С
		345279	B. WING		07/28/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 000	INITIAL COMMENT	S	F 000		
		was conducted from 07/25/18 Past-noncompliance was			
		F600 at a scope and severity J F686 at a scope and severity J			
	The tags F600and F Quality of Care.	686 constituted Substandard			
	_	F600 at a scope and severity J F686 at a scope and severity J			
F 600 SS=J		d Neglect	F 600		8/16/18
	Exploitation The resident has the neglect, misappropr and exploitation as a includes but is not li corporal punishmen	om Abuse, Neglect, and e right to be free from abuse, iation of resident property, defined in this subpart. This mited to freedom from t, involuntary seclusion and mical restraint not required to nedical symptoms.			
	§483.12(a) The facil	ity must-			
	physical abuse, corp involuntary seclusio This REQUIREMEN by: Based on record re Representative (RR	se verbal, mental, sexual, or poral punishment, or n; IT is not met as evidenced view, staff and Resident) interviews, and Nurse w, the facility neglected to		Past noncompliance: no plan of correction required.	
ABORATORY		WSUPPLIER REPRESENTATIVE'S SIGNATUR	?E	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/17/2018

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.

Electronically Signed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345279	B. WING _			C 07/28/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	CODE	0772072010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 600	neglected to attempt address a resident's 3 residents reviewed (Resident #3). The fawounds and address allow wound treatme maggots developing wounds. Resident #3 present in the pressuleg and was transferrevaluation and treatme to the second was re-admitted to from an acute long to diagnoses of chronic the bone) of left ankled vascular disease (a but A review of Resident revealed no assessming pressure ulcers on according to the pressure ulcer on leg in the following magging the pressure ulcer on leg in the following magging with wound clean of dressing), every Mancessary (prn).	altiple pressure ulcers and alternate measures to refusals of treatment for 1 of for pressure ulcers acility's failure to treat the the resident's refusals to into as ordered resulted in in one of the resident's was observed with maggots are ulcer on his right upper red to the hospital forment. Cal record revealed Resident of the facility on 7/6/2018 arm care hospital with active osteomyelitis (infection of e and foot and peripheral plood circulation disorder). #3's medical record nent of the resident's dmission to the facility on 1/6/2018, to treat the resident's right upper reanner; cleanse right upper ser. Apply duoderm (a type londay and Friday and when	F6	500		
	for treatment of each	of the resident's pressure of cleanser and frequency of				

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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	ODE	0.720,20.10	
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F 600	listed individually. varied but all 22 w they were not trea The Admission Mi assessment dated was severely impa 1-3 days out of 7 dassistance for all A with the physical a MDS indicated Reulcers and had a pbed and chair, and manage skin prob Area Assessment dated 7/13/18 indiulcers and the face	were a total of 22 treatments The frequency of treatment ere to be checked on the days	Fé	500			
	(dated 5/1/18) reviarea of pressure uperipheral vascular pressure ulcers with reduction in size/s next review. The contract treatment as order assessment of workinges as indicated 5/31/18) rearea which address treatments at all till Resident #3 will rechoices and prefer the interventions	and #3's current plan of care ealed it contained a "Focus" ealed it contained a "Focus" ealed it contained a goal of: It show positive healing with tage of pressure ulcer through eare plan interventions included; ered by physician. Weekly end/ulcer. Notify physician of ted. Resident #3's current care plan evealed it contained a "Focus" es the resident's refusals of all eres. The goal specified eceive care within resident's rences through next review. included: Document care being a protocol and notify physician					

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F 600	implications of not coregimen. Elicit family resident. Allow for flex refuses care, try again. A review of Resident Administration Record 7/16/18 revealed the upper leg and his oth documented as being occasion which was a specified Resident #3 his other pressure uld to check any of his profollowing dates; 7/7/1 7/12/18, 7/13/18, 7/14 The reverse side of the initials and signature documentation that a on the dates noted at Representative and For the resident's refuse A review of the progrewritten on 7/11/2018, a Skin/Wound/Treatm of Resident #3's preswounds. The docume (upper) unstageable; cm with 100% brown tissue surrounded by intact; no signs/symptime; cleanse area with santyl foam and absord day and when necess wound assessment for the resident for the resident for the resident signs/symptime; cleanse area with santyl foam and absord day and when necess wound assessment for the resident for the resident for the resident signs/symptime; cleanse area with santyl foam and absord day and when necess wound assessment for the resident signs for	ar. Discuss with resident implying with therapeutic input for best approaches to kibility in routines. If resident in later. #3's Treatment d (TAR) from 7/6/18 to pressure ulcer on his right er pressure ulcers were in treated only on one on 7/11/18. The TAR is refused treatment to all of the saure ulcers on the lates. #4,78/18, 7/9/18, 7/10/18, 7/10/18, 7/15/18 and 7/16/18. The resident's TAR noted the of Treatment Nurse #1 and littreatments were refused bove and that the Resident's Physician were notified of all sals. #5 and the saure ulcers and other entation included: Right leg 2.5 cm (centimeters) x 1.5 slough (a layer of dead living tissue); peri wound toms (s/s) of infection at this th wound cleanser and apply orbent dressing every other sary. This was the only	F 6			

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		345279	B. WING				C 28/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 369 HUNTER HILL ROAD OCKY MOUNT, NC 27804	1 011	20/2010
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F 600	A progress note date Treatment Nurse #1, #1 discussed the imp dressing changes wit verbalized understan refused and stated "r continued with the RI resident's refusals via she would come talk A progress notes dat Director of Nurses (D was transferred to the wound debridement a Representative was in A review of hospital in was transported to a Department (ED) on ED records revealed Services (EMS) that the ED reported the f maggots found in one ulcers. Resident #3 v	d 7/14/2018, written by specified Treatment Nurse portance of receiving th Resident #3, and he ding, however, Resident #3 maybe tomorrow." The note R was made aware of the atelephone and indicated to Resident #3. ded 7/17/18, written by the pone in the pone		600			
	stated she and Treati Resident #3's room of treatments because at the facility. The QI the dressing off of Re (the QI Nurse indicate outer upper area of the stated the dressing w	O AM, the Quality urse was interviewed and ment Nurse #2 went into on 7/17/2018 to do his Treatment Nurse #1 was not Nurse indicated she took esident #3's right upper leg ed the area to be on the he thigh/leg). The QI Nurse was loose and soiled heavily hage. The QI Nurse stated "I					

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		345279	B. WING			l	28/2018
	ROVIDER OR SUPPLIER	EHABILITATION CENTER	•	736	REET ADDRESS, CITY, STATE, ZIP CODE 69 HUNTER HILL ROAD OCKY MOUNT, NC 27804	, <u> </u>	-0.2010
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F 600	saw about 15 maggo Nurse stated she known and she covered the Treatment Nurse #2. Director of Nursing (In no other wounds had not taken care of Resworked the upper had not taken care of Resworked the upper had not taken care of Resworked the upper had not have and loose. Not the wound had not have an odd infected. Nurse #1 all maggots in the wounds he and a Nurse sup and re dressed all of ulcers. A telephone interview Treatment Nurse #1 The Treatment Nurse #1 The Treatment Nurse #1 The Treatment Nurse #1 The Treatment Nurse #1 Resident #3 multiple to the facility on 07/0	g on his right upper leg and its in the wound." The QI is what maggots looked like wound and she and went out and called the DON). The QI nurse stated I maggots in them and no ainage or loose dressings, were treated as ordered. 27/2018 at 9:30 AM, stated on 07/17/18 she and Resident #3's room and told are and he agreed to the it Nurse #2 stated she had sident #3 because she lis of the facility. Treatment of the dressings on Resident to 17/11/18. Treatment Nurse is upper leg dressing was are #1 stated the pressure for but did not appear to be so noted she observed d, the DON was notified and dervisor came and cleaned the resident's pressure W was attempted with the on 7/27/2018 at 11:00 AM. It is answered and then stated did at the facility, she had been	F	600			

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F 600	take the bathing suppressing to do his bath a agreeable when she she started providing while giving Resident 7/16/18 she noticed the were still dated 7/11/1 working on 7/17/18 at bath that morning and afternoon and he refused good. NA #3 statt 7/16/18 the dressings. In a telephone interview. Nurse #2 stated NA # dates on Resident #3 Nurse #2 stated she with that she told the Treathere that day. On 7/27/2018 at 4:00 interviewed and state had been terminated documents that were The Administrator state documentation for Recare Treatment Nurse resident's refusals to dressing changes or pressure ulcers. The expectations were all completed as ordered. In an interview on 7/2 Resident Representa resident's readmission she had only received.	A #3 indicated she would blies in and tell him she was and he was always would let him know before the bath. NA #3 stated #3 his bed bath on Monday he dressings on his body 18. NA #3 stated she was and Resident #3 refused his dishe went back in the used and stated he did not ed she had told Nurse #2 on a were dated 7/11/18. Bew on 7/27/2018 at 3:40 PM, 13 did tell her about the 1's dressings on 7/16/18. Was not sure, but thought the threatment Nurse #1, who was 1. The threatment Nurse #1 relating to falsifying unrelated to Resident #3. It is ted she could not verify the esident #3 was valid for the element #3 was valid for the allow staff to perform check the resident's Administrator stated her treatments would be	F	600			

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F 600	The RR stated she 7/16/18 because R being treated. The Resident #3 refuse educate him, but co. On 7/27/2018 at 4:3 Nurse Practitioner (Resident #3 for ma ulcers to the wound physician when he recall if she was no refusals of treatmen Resident #3 on 7/1 treatment. The NP about Resident #3 temperature on 07/agreed the resident	fused his wound treatments. had filed a grievance on esident #3's wounds were not RR indicated she was told if d his treatment, the staff could ould not force him. 20 PM, in an interview, the (NP) stated she had referred nagement of his pressure d clinic and Infectious Disease was admitted. The NP did not tified about his Resident #3's nt, but did say she spoke to 6/2018 about his refusing stated she spoke to the MD having an elevated 16/18 and the physician t would be started on an estated she did not look at the	F6	500		
	following plan of co date of 7/24/2018: On 7/17/18 at 2:55 the QI nurse entereresident #3 dressin the QI nurse began wounds. Dressing to noted to be secure not secured at the foremoving resident #2 thigh, white larvae in the wound was no	ne facility provided the rrection with a compliance of the resident #3 room to change gs. Treatment nurse #2 and to undress resident #3 or resident #3 right upper thigh at the base of the dressing but top of the dressing. Upon #3 dressing to right upper approximately 0.5cm in length oted. The QI nurse exited and notified the DON of the				

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F 600	and assessed and memory and order was recovered to the Emergent On 7/18/18 Resident hospital with a diagnory decubitus ulcers. A thorough investigat 7/17/2018 to identify the residents wound. Was found that reside assessed on admissi provided once in elever 41 prior to larvae being was determined by the cause was the failure continuously seek altencouragement of recovered to failure of educating the process of actions to refuse care or treatment of the reasons. Corrective Actions On 7/23/18, all alert a interviewed regarding and Social Workers. Indings. All current residents wassessed on 7/18/20 7/20/18 by the Quality West Wing Treatment	and physician reasured the wound by 8:15 believed by the physician to be converted by the physician to the root cause of fly larva in the physician by the physician it that #3 wounds were not converted by the physician to the physic	F 60	0		

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		345279	B. WING				20/2040
NAME OF P	ROVIDER OR SUPPLIER	0.02.0		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 077	28/2018
10 10 1	NOVIDEN ON OUT FEET				69 HUNTER HILL ROAD		
HUNTER I	HILLS NURSING AND RE	EHABILITATION CENTER			OCKY MOUNT, NC 27804		
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F 600	Continued From page		F	600			
	worsening of wounds and documented in e record. No issues we On 7/20/18 a 100% a progress notes x 30 c Wound Consultant to had been refusing wo other residents identithat refused wound con 7/21/18 a 100% a Treatment Administration of June and July, was of Nursing to identify There were three other fused wound care a notes. The care planthe MDS nurse to add the encouragement of care. A head to toe assess 100% of all residents Director of Nursing and the record of the second	All wounds were measured ach resident's electronic are identified. Judit of all current residents days was completed by the determine if any resident and care. There were no fied in the progress notes are. Judit of all current residents are. Judit of all current residents are are. Judit of all current residents are are are any refusals of wound care. For eresidents identified that at times in the progress was updated on 7/21/18 by dress alternatives to aide in a fresident allowing wound are and RN Supervisor to identify					
	been addressed. The assessed, documente initiated and the phys representative was not treatment nurse. On 7/21/18, a questi SF with 100% of all limedication aides to vunderstanding of step refuses wound care, by the SF during the any identified areas of On 7/23/18, an in-ser	ith wounds that had not two identified wounds were ed, measured, treatment ician and resident office on 7/21/18 by the conseinance was initiated by the cense nurses and alidate knowledge and os to take when a resident Retraining was completed time of the questionnaire for office concerns.					

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NAME OF PR	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	1 017.	20/20 10
HUNTER I	HILLS NURSING AND RE	HABILITATION CENTER			O HUNTER HILL ROAD CKY MOUNT, NC 27804		
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F 600	Continued From page	e 10	F 6	800			
	keeper, social worker regarding Neglect to	•					
	Admission Assessme admitting nurse asses all residents with wou	nt form to ensure the ss, document, and measure inds on admission.					
	Wound Nurse Consul the Director of Nursin Facilitator (SF) in reg	n 7/19/18 an in-service was initiated by the found Nurse Consultant for the Administrator, e Director of Nursing (DON), and Staff acilitator (SF) in regards to the revised Nursing dmission Assessment to include:					
	full skin assessment of location, description,						
	skin assessment to vadescription and meas document on the app						
	Admission assessme	ompleted by 7/19/18. Ards to the revised Nursing Int was initiated with all other Clude agency nurses on					
	was completed by 7/2 On 7/18/18 a 100% ir	n service for all licensed					
	the DON in regards to include:	ncy nurses was initiated by Notification of refusals to ations, treatments, or any					
	form of care is refuse reported to the RR ar 2. Nurses must doo	d by a resident it must be nd the provider. cument all refusals of care to					
	include notification of This in-service was co On 7/21/18 an in-serv						

AND DUAN OF CODDECTION IDENTIFICATION NUMBERS		(X2) MUL1 A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 600	Continued From pag	ge 11	F	600			
	license nurses to ind Medication Aides re residents that resist was completed by 7 included: " People may ref others " Give clear explaas necessary " Work at building individual, showing a person and not just task " Ensure that we which the person feare respecting their possible. " When necessar resident trust to enc " Family involved to coresident. Ask family the resident to agree " Explain the risk care to residents " Explore if reside " Be patient, allow requests or tasks to answer " Assess for pain adequate pain control " Notify MD for pain and pain of pain not medication. " Psych consult " Wound clinic resisted to resident."	clude agency nurses and garding Alternatives for wound care. This in-service //22/18. This in-service use help from some but not anations and repeat ourselves a a closer relationship with the that they are valued as a seen as a focus for a care are going at a pace with els comfortable and safe, and modesty as much as ry seek a staff member that ourage wound care nent-notify family and get one and encourage the for ideas that will motivate ento to wound care. If actors of not allowing wound ent is fearful and reason why we the resident time to process be complete or questions to and ensure resident has oil prior to treatment/care ain orders if resident of relieved with prn pain					

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F 600	Continued From p	page 12	F 6	600		
	care was made of and Director of Nil wounds will be produced and Director of Nil wounds will be produced and Director of Nil wound ulcer flow ADON, SF, RN S Improvement Nur weekly x 4 weeks utilizing a Wound ensure all wounds care has been con alternatives attend that refuses, no last symptoms of worse concern identified addressed during Supervisor, or Quinclude providing DON will review a Tools weekly x 12 ensure all areas of The Quality Improcontacted by the Regional Vice 7/27/18 for assists steps to be taken staff position/title the steps, timeline steps, specific meevaluate the plant monitoring the eff The DON will present Care Audit Tools of Assurance (QA) of The Executive QA for 3 months and	conitor the system for wound in 7/22/2018 by the Administrator cursing. 25% of residents with sysically assessed and in the TAR, progress notes and sheet will be reviewed by the supervisor, or Quality se 3 x per week x 4 weeks, then monthly x 1 month. Care Audit Tool. This audit is to shave been identified, wound impleted per physician's orders, upted to encourage residents arvae and no signs and sening of wounds. Any areas of during the audits will be the audit by the ADON, SF, RN ality Improvement Nurse to additional staff training. The and initial the Wound Care Audit weeks for completion and to off concern were addressed. Every administrator as witnessed by a President of Operations on ance in evaluation of specific to address neglect and training, designated to be responsible for the for accomplishment of the ethodology to be used to success, and frequency of ects of the plan initiation. Sent the findings of the Wound to the Executive Quality committee will meet monthly review the Wound Care Audit at terends and/or issues that may be a considered to the success that may are and the success that may are addressed and the success that may are and the succ				

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	,	0.720,20.10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 677 SS=D	determine the need for monitoring. The decise of wound care during committee meeting we Administrator and Dir 7/22/2018. Final date of compliant The Administrator and for the implementation include all 100% audit monitoring related to Validation of the above correction was complextended survey. Validate interviews regarding residents refusing the regarding Admission are viewed. In-service for refusals. Staff were in-service for neglect care audit tools were are used 3 x per wee weeks, then monthly plan of correction. The validated as the facility ADL Care Provided for CFR(s): 483.24(a)(2) A residual out activities of daily I services to maintain gersonal and oral hygorogeness.	tions put into place and to or further frequency of sion to review the monitoring the quality assurance ras made by the rector of Nursing on the ector of Nursing on the is 7/24/2018. In DON will be responsible of corrective actions to fits, in services, and the plan of correction. The referenced plan of reted on 7/28/2018 during an idation included staff residents refusing care and atments. In-services assessments were for staff regarding notification in interviewed regarding and for notification. Wound reviewed that will be and k for 4 weeks, weekly x 4 x 1 month as stated in the e date of 07/24/18 was ty's date of compliance. The proposed in the receives the necessary good nutrition, grooming, and	F 6			8/17/18	
	by:	is not met as evidenced		Hunter Hills Nursing and Rehab	ilitation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345279	B. WING _			1	C 28/2018	
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F 677 Continued From page 14		e 14	F	677				
F 6//	interviews, the facility incontinence care in a during perineal care in (Resident #2) dependence. Findings included: Resident #2 was re-attendence was re-attendent #2 was re-attendence was revealed Resident #2 impaired, and require assistance for all Acti Resident #2 was alway urine. A care plan initiated a sasistance required for impaired cognition, included ADLs/Perso with staff support as a achieve highest pract Interventions included bathing, personal hydrought and she apper (Nursing Assistant #1 brought Resident #2)	refailed to provide a front to back manner for 1 of 3 sampled residents dent on staff for incontinent admitted to the facility 7/2/18. If MDS (Minimum Data Set-a residents) dated 7/9/18 are severely cognitively and extensive to total vities of Daily Living (ADLs). The area incontinent of stool and and area will be completed appropriate to maintain or cical level of functioning.		677	acknowledges receipt of the Statement Deficiencies and proposes this Plan of Correction to the extent that the summ of findings is factually correct and in or to maintain compliance with applicable rules and provisions of quality of care or residents. The Plan of Corrections is submitted as a written allegation of compliance. Hunter Hills Nursing and Rehabilitation response to this Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Hunter Hills Nursing and Rehabilitation reserve the right to refute any of the deficiencies on this Statement of Deficiencies throu Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. The process that led to this deficiency was the facility failed to provide incontinent care in a front to back manduring perineal care for 1 of 3 sampled residents. On 8/16/18 Resident #2 was provided perineal care utilizing appropriate technique by the assigned nursing assistant. On 8/15/18 Nursing Assistant #2 (NA) in-serviced in regards to Perineal Care include providing incontinent care in a front to back manner with return	ary der of cies		
		ation was conducted from OPM of incontinent care,			demonstration by the Staff Facilitator. On 8/10/18 a 100% Resident Care Aud	dit		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 677	Continued From page	ge 15	F 6	677			
F 677	bathing and ADL caresident was transfer and was undressed hands, donned glov NA #2 washed the property washed to front) using a circular mote. An interview was considered from the ward dry. Then cover washeloths and do are last. Always was back. First wipe down the middle. Never grand back to front." An interview was considered from the ward dry. Then cover washeloths and do are last. Always was back. First wipe down the middle. Never grand back to front." An interview was considered from the ward dry. She stated shathe and dress a result to do it today and all incontinent care and today. She stated she perineal area in circular from the ward of the perineal area in circular from the ward of the perineal area in circular from the ward of the perineal area in circular from the ward of the perineal area in circular from the ward of the perineal area in circular from the perineal area in circular from the perineal difference of the perineal area in circular from the perineal from the perineal area in circular from the perineal from the	re by NA #1 and NA #2. The erred from the chair to the bed by NA #2. She washed her es, and bathed the resident. Derineal area using a circular the rectal area to the vaginal and back and forth again ion. Inducted with NA #1 on She stated, "You wash from You keep the resident aist down, wash the top, rinse or the resident, change the bottom. The private areas she the privates from front to the each side, then go down to in a circle and never go Inducted with NA #2 on She stated with NA #2 on She stated she had not care because she was at she knew the proper way to esident, but was too nervous so correctly described to bathing but was too nervous he washed Resident #2's les and back to front." Inducted with the Director of 1/25/18 at 6:55 PM. She stated curing orientation on proper avoid a potential urinary tract erved by more senior NA's on period, and were	F	577	of Incontinent Care to include NA #2 ar resident #2 was initiated by the Staff Facilitator, Nurse Managers and Qualit Assurance nurse (QA) with all nurses at NAs to ensure staff are utilizing appropriate technique when providing perineal care. All areas of concern we immediately addressed by the Staff Facilitator, Nurse Managers and QA not to include retraining of staff. Resident of audits will be completed by 8/23/18. On 8/10/18 an 100% in-service was initiated by the Nurse Managers with a nurses and NAs to include NA #2 in regards to Perineal Care to include: 1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area with soap and water or pericare products a. For the female resident: cleanse to labia with strokes from top to bottom the rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean globefore continuing care 8. Apply clean brief/clothes 9. Make resident comfortable In-service will be completed by 8/23/18. All newly hired nurses and NAs will be	ty and re urse care	
	in-serviced annually also stated her expe	on period, and were or and as needed. The DON ectation was for all NA's to care in a way to prevent			All newly hired nurses and NAs will be in-serviced by the Staff Facilitator durir orientation in regards to Perineal Care include:	ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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TVAINE OF T	NOVIDEN ON OUT FEEL			7369 HUNTER HILL ROAD			
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F 677	F 677 Continued From page 16		F 6	.77			
	potential urinary tract	e infections by cleansing the back and not in a circular or		1. Explain procedure to resident 2. Provide privacy 3. Expose perineal area 4. Wash perineal area with soap water or pericare products a. For the female resident: clean labia with strokes from top to botto rinse b. For the male resident: cleanse penis then rinse 5. Discard soiled items in appropic containers 6. Removed soiled gloves 7. Wash hands and reapply clean before continuing care 8. Apply clean brief/clothes 9. Make resident comfortable 10% Resident Care Audits of Incord Care will be completed by the Staff Facilitator, Nurse Managers, and Care Assurance Nurse (QA) with nurses NAs to include NA #2 and resident utilizing the Resident Care Audit Tool-Incontinent Care to ensure stautilizing appropriate technique whe providing perineal care weekly x 8 then monthly x 1 month. The Direct Nursing will review and initial the Real Care Audit Tool-Incontinent Care was weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the rof the Resident Care to the Executomittee monthly x 3 months. The Committee monthly x 3 months.	se the m then the the driate attinent for a second the second th		

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 677	Continued From page	e 17	F 6'	Executive QA Committee will r monthly x 3 months and review Resident Care Audit Tool-Incor to determine trends and / or is may need further interventions place and to determine the need further and / or frequency of m	w the ntinent Car sues that s put into ed for	е	
F 686 SS=J	CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressur Based on the compreresident, the facility in (i) A resident receives professional standard pressure ulcers and of ulcers unless the indification demonstrates that the (ii) A resident with preferencessary treatment with professional star promote healing, preference ulcers from deve	grity Irre ulcers. Shensive assessment of a must ensure that- is care, consistent with the does not develop pressure vidual's clinical condition bey were unavoidable; and essure ulcers receives and services, consistent and ards of practice, to went infection and prevent	F 68	86		8/16/18	
	Based on record rev Representative (RR) Practitioner interview and monitor multiple implement measures refusals of treatment for pressure ulcers (F not treat and change ordered and did not no prevent maggots from When the resident rev	iew, staff and Resident interviews, and Nurse, the facility failed to treat pressure ulcers and did not to address a resident's for 1 of 3 residents reviewed Resident #3). The facility did pressure ulcer dressings as nonitor a pressure ulcer to a developing in the wound. fused treatment the facility sident's representative as		Past noncompliance: no plan correction required.	of		

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F 686	input. Failure to treat pressure ulcers allo one of the resident' transferred to the hitreatment. Findings included: A review of the med #3 was re-admitted from an acute long diagnoses of chron the bone) of left and vascular disease (at A review of Resider revealed no assess pressure ulcers on 07/06/18. A review of Resider revealed an order, the pressure ulcer of leg in the following leg with wound cleat of dressing), every necessary (prn). The Admission Min assessment dated was severely impaid 1-3 days out of 7 days out of 7 days out of 7 days out of 7 days out of 8 days out of 9 days out of 8 days out of 9 days out of	dent's care plan to elicit their at and check Resident #3's awed maggots to be present in swounds. Resident #3 was ospital for evaluation and dical record revealed Resident to the facility on 7/6/2018 term care hospital with active ic osteomyelitis (infection of kle and foot and peripheral blood circulation disorder). In #3's medical record ment of the resident's admission to the facility on the resident's right upper manner; cleanse right upper manner; cleanse right upper manner; cleanse right upper manner. Apply duoderm (a type Monday and Friday and when finum Data Set (MDS) 7/13/2018 noted Resident #3 red for cognition, rejected care as and needed total civities of Daily Living (ADLs) is sistance of two persons. The ident #3 had multiple pressure essure reducing device for the that nutrition interventions to terms were in place. The Care	F	586				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 686	Continued From page 19 Area Assessment (CAA) for Pressure Ulcers		F	586			
	dated 7/13/18 indicated ulcers and the facility	ated a focus on pressure y would address the area of the residents' plan of care.					
	(dated 5/1/18) revea area of pressure uld	#3's current plan of care aled it contained a "Focus" ers related to chronic disease and a goal of:					
	reduction in size/sta next review. The ca Treatment as ordere	show positive healing with ge of pressure ulcer through re plan interventions included; ed by physician. Weekly and/ulcer. Notify physician of d.					
	(dated 5/31/18) reversible area which address treatments at all times Resident #3 will reconduces and prefere The interventions in resisted per facility profession of patterns in behaving implications of not coregimen. Elicit family	esident #3's current care plan ealed it contained a "Focus" the resident's refusals of all es. The goal specified eive care within resident's nees through next review. cluded: Document care being protocol and notify physician ior. Discuss with resident omplying with therapeutic y input for best approaches to exibility in routines. If resident ain later.					
	7/16/18 revealed the upper leg and his of documented as beir occasion which was specified Resident # his other pressure upper leg and the state of t	t #3's Treatment ord (TAR) from 7/6/18 to e pressure ulcer on his right her pressure ulcers were ng treated only on one on 7/11/18. The TAR #3 refused treatment to all of lcers or would not allow staff pressure ulcers on the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 686	7/12/18, 7/13/18, 7/ The reverse side of initials and signatur documentation that on the dates noted Representative and of the resident's refused from the resident's refused from the resident's refused from the resident #3's presentative and of the resident #3's presentative of Resident #3's presentative from the found (upper) unstageable cm with 100% brow tissue surrounded be intact; no signs/symtime; cleanse area as santyl foam and abstady and when necessing the same that the following signs in the following from the following changes were balized understated and stated continued with the foresident's refusals with the following from the from the following from the following from the following from the from the following from the from the following from the from the following fro	118, 7/8/18, 7/9/18, 7/10/18, 14/18, 7/15/18 and 7/16/18. The resident's TAR noted the e of Treatment Nurse #1 and all treatments were refused above and that the Resident's Physician were notified of all usals. Tress notes revealed a note B, by Treatment Nurse #1, as the thick that the Resident's result of the thick that the Resident's resident's resident's resident's resident's resident #3, and he res	F	586			
	Director of Nurses (was transferred to t	DON) revealed Resident #3 he local hospital for possible t and the Resident's					

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TED :		THA BUILTATION OF NITED		7369	HUNTER HILL ROAD		
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F 686		notified. ecords revealed Resident #3	F6	886			
	Department (ED) on ED records revealed Services (EMS) that the ED reported the finaggots found in one ulcers. Resident #3 w	local hospital Emergency 7/18/2018. The resident's the Emergency Medical transported Resident #3 to acility indicated there were to of the resident's pressure was admitted to the hospital posis, cellulitis and decubitus					
	stated she and Treatr Resident #3's room of treatments because The at the facility. The QI the dressing off of Resident and the outer upper area of the stated the dressing with wet, brown drain pulled off the dressing saw about 15 maggor Nurse stated she kne and she covered the Treatment Nurse #2 to Director of Nursing (En no other wounds had other wounds had drain but all of the wounds	rse was interviewed and ment Nurse #2 went into n 7/17/2018 to do his Treatment Nurse #1 was not Nurse indicated she took sident #3's right upper leg ed the area to be on the ne thigh/leg). The QI Nurse as loose and soiled heavily age. The QI Nurse stated "I g on his right upper leg and its in the wound." The QI w what maggots looked like wound and she and went out and called the DON). The QI nurse stated maggots in them and no ainage or loose dressings, were treated as ordered.					
	the QI nurse went to him why she was the	stated on 07/17/18 she and Resident #3's room and told re and he agreed to the Nurse #2 stated she had					

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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804			20/2010
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F 686	worked the upper had Nurse #2 stated all or #3's body were dated #2 indicated the right soiled and loose. Nur ulcer did have an odd infected. Nurse #1 all maggots in the woun she and a Nurse sup and re dressed all of ulcers. A telephone interview Treatment Nurse #1 all The Treatment Nurse #1 all The Treatment Nurse she no longer worked fired and ended the compact of the facility on 07/0 usually gave the resident #3 multiple to the facility on 07/0 usually gave the resident #3 agreeable when she she started providing while giving Resident 7/16/18 she noticed to were still dated 7/11/1/18 working on 7/17/18 all bath that morning an afternoon and he refuteel good. NA #3 stated 7/16/18 the dressings	sident #3 because she Ils of the facility. Treatment of the dressings on Resident of 7/11/18. Treatment Nurse of upper leg dressing was of the facility and the pressure of but did not appear to be of noted she observed of the DON was notified and dervisor came and cleaned of the resident's pressure of was attempted with the on 7/27/2018 at 11:00 AM. Of answered and then stated of at the facility, she had been of times since his readmission of 18. NA #3 stated she of the was always of the bath. NA #3 stated	F	686			
	afternoon and he refu feel good. NA #3 stat 7/16/18 the dressings	used and stated he did not ted she had told Nurse #2 on					

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F 686	F 686 Continued From page 23		F 6	86			
	dates on Resident #3 Nurse #2 stated she that she told the Trea there that day. On 7/27/2018 at 4:00 interviewed and state had been terminated documents that were The Administrator sta documentation for R care Treatment Nurs	e unrelated to Resident #3. ated she could not verify the esident #3 was valid for the					
	dressing changes or pressure ulcers. The	check the resident's Administrator stated her I treatments would be					
	Resident Representaresident's readmissions she had only receive which was on 7/14/2 Resident #3 had refute The RR stated she had 7/16/18 because Resident #3 refused educate him, but course Practitioner (Name Resident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manulcers to the wound of the sident #3 for manual for the siden	D PM, in an interview, the IP) stated she had referred agement of his pressure clinic and Infectious Disease					
	physician when he w recall if she was noti refusals of treatment	ras admitted. The NP did not fied about his Resident #3's , but did say she spoke to /2018 about his refusing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 686	about Resident #3 temperature on 07/ agreed the resident antibiotic. The NP s pressure ulcers on On 7/28/2018 the fa plan of correction w 7/22/2018: On 7/17/18 at 2:55 the QI nurse entere change Resident # #2 and the QI nurse #3 wounds. Dressir thigh noted to be se dressing but not se dressing. Upon rem right upper thigh, w cm in length in the nurse exited Reside DON of the larvae. On 7/17/2018 the D and assessed and pm and order was re-	stated she spoke to the MD having an elevated 16/18 and the physician twould be started on an stated she did not look at the	F	586	ENCY)			
		nt #3 was admitted to the local nosis of Sepsis, cellulitis, and						
	7/17/2018 to identife the residents wound was found that Res	ation was initiated on y the root cause of fly larva in d. During the investigation it ident #3's wounds were not sion and wound care was only						

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	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	•	0172072010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	*	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 686	#1 prior to larvae be was determined by cause was the failu continuously seek a alternate treatment failure of educating process of actions trefuses care or treatment Nurse wother reasons. Corrective Actions All current residents assessed on 7/18/2 7/20/18 by the Qua Wing Treatment nurensure wounds care signs or symptoms wounds were meas resident's electronic identified. On 7//20/18 a 100% progress notes x 30 wound Consultant thad been refusing vother residents identified that refused wound. On 7/21/18 a 100% Treatment Administ of June and July, wof Nursing to identifications of June and July wof Nursing to identificatio	even days by treatment nurse eing discovered in a wound. It the Administrator that the re of treatment nurse #1 to alternatives to aide in the options due to a systematic the licensed nurses on the o take when a resident tments. as terminated on 7/24/18 for swith wounds were physically 018 and completed on lity Improvement nurse, West rese and Registered Nurse to be had been completed and no of worsening of wounds. All ured and documented in each corecord. No issues were audit of all current residents of days was completed by the of determine if any resident wound care. There were no utified in the progress notes	F	686				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
		345279	B. WING _			C 07/28/2018		
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804		0172072010		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 686	Continued From page	ge 26	F 6	886				
		ddress alternatives to aide in of residents allowing wound						
	100% of all resident Director of Nursing all residents with we residents identified been addressed. The assessed, document initiated and the physical	esment was completed on its on 7/21/18 by the Assistant and RN supervisor to identify bunds. There were two with wounds that had not ne two identified wounds were nted, measured, treatment ysician and resident notified on 7/21/18 by the						
	SF with 100% of all medication aides to understanding of storefuses wound care by the SF during the any identified areas On 7/19/18, the facil Admission Assessmadmitting nurse assall residents with wood on 7/19/18 an in-set Wound Nurse Consthe DON, and Staff	tionnaire was initiated by the licensed nurses and validate knowledge and eps to take when a resident a. Retraining was completed time of the questionnaire for of concerns. Ility revised the Nursing ment form to ensure the ess, document and measure bunds on admission. Envice was initiated by the ultant for the Administrator, Facilitator in regard to the mission Assessment to						
	include: 1. Upon admissio full skin assessmen location, description 2. The treatment of the stream	n, the admitting nurse will do a t of all wounds to include n, and measurements. nurse will complete a second validate or clarify location,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	<u> </u>	(X3) DATE SURVEY COMPLETED		
		345279	B. WING _			1	28/2018	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS 7369 HUNTER HIL ROCKY MOUNT				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACI	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD B I-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 686	document on the app This in-service was of The in-service in regard Admission assessment licensed nurses to inc 7/19/18 by the Staff R was completed by 7/2 On 7/18/18 a 100% in nurses to include age the DON in regards to include: 1. Each time medic form of care is refused reported to the RR and 2. Nurses must doc include notification of This in-service was of On 7/21/18 an in-service license nurses and M Alternatives for reside This in-service was of in-service included: "People may refus others "Give clear explat as necessary "Work at building individual, showing the person and not just st task "Ensure that we as	surement of all wounds and blicable flow sheet. completed by 7/19/18. ards to the revised Nursing ent was initiated with all other clude agency nurses on Facilitator. This in-service 22/18. In service for all licensed ency nurses was initiated by the one Notification of refusals to eations, treatments, or any end by a resident it must be not the provider. Cument all refusals of care to f RR and MD completed by 7/22/18. Indedication Aides regarding ents that resist wound care. Completed by 7/22/18. This lise help from some but not enations and repeat ourselves a closer relationship with the nat they are valued as a leen as a focus for a care. The provider of t	F	586				
	resident trust to enco	y seek a staff member that burage wound care notify family and get family						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345279	B. WING			C 07/28/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804	<u> </u>	0112012010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 686	Ask family for ideas to agree to wound "Explain the ris care to residents "Explore if residents "Be patient, allor requests or tasks to answer "Assess for pair adequate pain cont" Notify MD for promplains of pain redication. "Psych consult "Wound clinic redication. "Psych consult "Wound clinic redication. "The decision to more than the for resistance to other appropriate. The decision to more accordance on and Director of Nurwounds will be phy documentation on the wound ulcer flow side ADON, SF, RN Sul Improvement Nurse.	and encourage the resident. Is that will motivate the resident care. It factors of not allowing wound Ident is fearful and reason why ow the resident time to process to be complete or questions to an and ensure resident has trol prior to treatment/care pain orders if resident not relieved with prn pain eferrals ese alternatives can be utilized ther types of care as unitor the system for wound 7/22/2018 by the Administrator sing. 25% of residents with sically assessed and the TAR, progress notes and the tare will be reviewed by the pervisor, or Quality as 3 x per week x 4 weeks,	F 68	,		
	utilizing a Wound C ensure all wounds care has been com alternatives attemp that refuses, no lar symptoms of worse concern identified of addressed during to Supervisor, or Qua	then monthly x 1 month Care Audit Tool. This audit is to have been identified, wound upleted per physician's orders, ted to encourage residents wae and no signs and ening of wounds. Any areas of during the audits will be the audit by the ADON, SF, RN lity Improvement Nurse to dditional staff training. The				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		345279	B. WING				C 28/2018	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 69 HUNTER HILL ROAD OCKY MOUNT, NC 27804	<u> 1 011</u>	20/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	l l	ID PROVIDER'S PLAN OF CORRECTIO REFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPI DEFICIENCY)			(X5) COMPLETION DATE	
F 686	Tools weekly x 12 we ensure all areas of complete the DON will present Care Audit Tools to the Assurance (QA) composed the Executive QA Composed for 3 months and revision to determine the need further intervent determine the need further intervent determine the need for monitoring. The decisof wound care during committee meeting wound care audit too would all 100% audit monitoring related to wold wound care audit too and are used 3 x per 4 weeks, then monthal plan of correction. The validated as the facility would care audit too and are used 3 x per 4 weeks, then monthal plan of correction. The validated as the facility would care audit too and are used 3 x per 4 weeks, then monthal plan of correction. The validated as the facility would care audit too and are used 3 x per 4 weeks, then monthal plan of correction. The validated as the facility would care audit too and are used 3 x per 4 weeks, then monthal plan of correction. The validated as the facility was a constant of the province of the provin	nitial the Wound Care Audit eks for completion and to incern were addressed. The findings of the Wound e Executive Quality mittee monthly for 3 months. In mittee will meet monthly ew the Wound Care Audit ends and/or issues that may ions put into place and to or further frequency of sion to review the monitoring the quality assurance as made by the ector of Nursing on The isomorphism of corrections to tas, in services, and the plan of corrective actions to tas, in services, and the plan of correction. The referenced plan of eted on 7/28/2018 during an dation included staff residents refusing care and eatments. In-services Assessments were for staff regarding notification in interviewed regarding is that resist wound care. Is were reviewed that will be week for 4 weeks, weekly x y x 1 month as stated in the edate of 7/22/2018 was ty's date of compliance.		686				
F 880	Infection Prevention 8	& Control	F i	880			8/17/18	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345279	B. WING _			C 7/28/2018	
	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804		772072010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 880 SS=D	infection prevention a designed to provide a comfortable environmediseases and infection §483.80(a) Infection program. The facility must estate and control program a minimum, the following services un arrangement based unconducted according accepted national state §483.80(a)(2) Writter procedures for the probut are not limited to: (i) A system of surveit possible communical infections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trait to be followed to previous and trait to be followed to previous and trait and to who communicable disease reported; (iii) Standard and trait to be followed to previous and trait and to who communicable disease reported;	ntrol ablish and maintain an and control program a safe, sanitary and ment and to help prevent the asmission of communicable ans. prevention and control ablish an infection prevention (IPCP) that must include, at wing elements: tem for preventing, identifying, and controlling infections is eases for all residents, fors, and other individuals ander a contractual upon the facility assessment to §483.70(e) and following andards; a standards, policies, and ogram, which must include, allance designed to identify ole diseases or a can spread to other	F8	80			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		TE SURVEY MPLETED	
		345279	B. WING _			C 7/28/2018
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7369 HUNTER HILL ROAD ROCKY MOUNT, NC 27804		7720/2010
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	depending upon the involved, and (B) A requirement to least restrictive posticized contact with resider contact with resider contact will transmit (vi)The hand hygier by staff involved in §483.80(a)(4) A systidentified under the corrective actions to \$483.80(e) Linens. Personnel must has transport linens so infection. §483.80(f) Annual or The facility will concord residentified under the corrective actions to the facility will concord residentified under the corrective actions to the facility will concord residentified under the corrective action.	out not limited to: uration of the isolation, e infectious agent or organism nat the isolation should be the sible for the resident under the tes under which the facility eyees with a communicable skin lesions from direct ats or their food, if direct at the disease; and the procedures to be followed direct resident contact. Stem for recording incidents facility's IPCP and the taken by the facility. Indle, store, process, and tas to prevent the spread of teview. Induct an annual review of its their program, as necessary. In its not met as evidenced eview, observation, and staff ty failed to follow established delines for hand hygiene and the incontinent care was the sident	F8	The process that led to this de was facility failed to follow esta infection control guidelines for hygiene and changing gloves vincontinent care was provided residents. On 8/16/18 Resident #2 was provided in the continent care utilizing the aptechnique to include hand hygieness.	blished hand vhile for 1 of 3 rovided propriate	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С	
		345279	B. WING _			07	/28/2018	
NAME OF P	ROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	·		
				73	369 HUNTER HILL ROAD			
HUNTER	HILLS NURSING AND F	REHABILITATION CENTER		R	OCKY MOUNT, NC 27804			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 880	Continued From page	ge 32	F 8	380				
	•				changing gloves during incontinent car	P		
	Review of the Stand	dard Precautions section of			by the assigned nursing assistant.	C		
		Control Manual reads, in part,			by the designed hareing desistant.			
	,	ons are designed to reduce			On 7/27/18 Nursing Assistant (NA) #2	was		
		sion of microorganisms from			in-serviced in regards to Hand Washin			
		d unrecognized source of			Procedure to include removing gloves			
		are facilities. Standard			hand hygiene following incontinent car			
	precautions are use	ed for the care of all residents.			with return demonstration.			
	_	h hands after touching blood,						
	body fluids, secretic				On 7/25/18 100% Resident Care Audit			
		, whether gloves are worn or			Handwashing with return demonstration			
		mediately after gloves are			was initiated by the Director of Nursing	,		
		otherwise necessary to avoid			Nurse Managers, Staff Facilitator and Quality Assurance Nurse (QA) with all			
	_	anisms to other residents or may be necessary to wash			nurses and nursing assistants (NA) to			
		asks and procedures on the			include NA #2 to ensure staff were			
		event cross contamination of			following established infection control			
	-	as appropriate. Gloves- Wear			guidelines for hand hygiene to include			
	_	ng blood, body fluids,			changing gloves after providing			
	secretions, excretio	ns, and contaminated items.			incontinent care. All areas of concern			
	Change gloves betw	veen task and procedures on			were immediately addressed by the St	aff		
		fter contact with material that			Facilitator, Nurse Managers and Qualit	y		
	may contain a high				Assurance nurse (NA) to include			
		emove gloves promptly, before			retraining of staff. Audit will be complete	:ed		
	touching non-contai				by 8/23/18.			
		ices before going to another			On 7/05/40 4000/ in comittee in research	4-		
		hands to avoid transfer of			On 7/25/18 100% in-service in regards Hand Washing Procedure was initiated			
	microorganisms to o	other residents of			the Staff Facilitator with all nurses and	ь		
	enviioninents				NAs to include NA #2 to ensure all state	Ŧ		
	An observation of R	lesident #2 was made on			follow infection control guidelines for	•		
		She was observed leaned			handwashing to include:			
		icked chair in the dining room,			Technique for washing hands			
	_	esembled vomitus was seen in			2. When to wash hands			
	her lap, and she ap	peared to be sleeping. NA #1			a. When reporting to work and before)		
	(Nursing Assistant #	#1) was in the dining room and			going home			
	_	2 to her room. After the brief			b. Before and after contact with			
		was no sign of urinary			residents			
	incontinence and Re	esident #2 had a small			c. After coming in contact with any b	ody		

Facility ID: 923072

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345279	B. WING _				C		
NAME OF DE	ROVIDER OR SUPPLIER	040270	1	ς-	TREET ADDRESS, CITY, STATE, ZIP CODE	1 077	28/2018		
NAIVIE OF FI	COVIDER OR SUFFLIER								
HUNTER I	HILLS NURSING AND RE	HABILITATION CENTER			369 HUNTER HILL ROAD				
				K	OCKY MOUNT, NC 27804				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 880	Continued From page	e 33	F8	380					
	amount of stool in the	brief.			fluids-remove gloves after perineal care and wash hands	е			
	A continuous observation was conducted from 3:15 PM through 3:50 PM of incontinent care, bathing and ADL care by NA #1 and NA #2. The resident was transferred from the chair to the bed and was undressed by NA #2. She washed her				 d. After handling contaminated items (soiled incontinent briefs, linens, trash, etc.) 				
					e. Before and after eating or drinkingf. After using the bathroom				
		s, and bathed the resident.			g. After smoking				
	NA #2 used the same washcloth throughout care and washed the perineal area. Using the same cloth, NA #2 proceeded to wash Resident #2's lower back and thighs. NA #2 then touched all				h. After coughing, sneezing, or blowi	ng			
					your nose	d.			
					 i. Whenever your hands are obvious soiled. 	siy			
	•	de table, closet door, and			j. In between handling soiled linen a	nd			
		d clean linens and clothes,			clean linen	IIu			
		anged the contaminated	k. After leaving one resident room and			nd			
		entinent brief and clean			before entering the next resident room.				
		nt, and touched the bed			3				
	controls. She did not	change gloves or wash her			3. Use of alcohol hand sanitizer- an				
	hands at any time du	ring the care.			alcohol based hand sanitizer may be u unless the hands are visibly soiled. The				
	An interview was con-	ducted with NA #1 at 4:10			hands should be free of dirt and organi				
	PM. She stated, "You	wash from the top (face)			material when using an alcohol hand				
	down. You keep the r	esident covered from the			sanitizer. The hands should be washed	t			
		top, rinse and dry. Then			with soap and water after exposure to				
		ange washcloths and do the			blood or body fluids				
		reas are last. You have to							
		efore you touch the clean			4. Procedure for use of alcohol hand				
		and dry your hands, put			sanitizer				
	_	resident, dry the resident,			In-service will be completed by 8/23/18	5.			
		e off your gloves, wash your			All newly hired nurses and nursing	- 44			
	any of that. I tried to g	loves on. (NA#2) didn't do			assistants will be in-serviced by the Sta				
	couldn't. (Resident #2				Facilitator during orientation in regards Perineal Care to include:	iO			
		w because (NA #2) touched			Explain procedure to resident				
	-	n. The ADL and incontinent			Provide privacy				
	care was not properly				Expose perineal area				
	and had not proporty	- -			Wash perineal area with soap and				
	An interview was con-	ducted with NA #2 at 4:15			water or pericare products				
		ad not properly completed			a. For the female resident: cleanse the	ne			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345279	B. WING			1	20/2040
		EHABILITATION CENTER ATEMENT OF DEFICIENCIES	ID	ST 73	TREET ADDRESS, CITY, STATE, ZIP CODE 669 HUNTER HILL ROAD OCKY MOUNT, NC 27804 PROVIDER'S PLAN OF CORRECTION	1 077.	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 880	knew the proper way resident, but was too also correctly describ bathing but was too near she washed Resident gloves or washed her contaminated everyth touched everything was con Nursing (DON) on 7/2 staff were trained on orientation and annual had a hand washing sour skills fair. My exp to follow hand hygien she was nervous and perform hand hygienes	s nervous. She stated she to bathe and dress a nervous to do it today and ed incontinent care and lervous today. She stated to #2's had not changed here hands at all, and ling in the room when she lith gloved hands. ducted with the director of 25/18 at 6:55 PM. She stated hand hygiene during ally. She stated, "In fact, we station 2 weeks ago during lectation is for all employees e at all times. (NA #2) said	F	880	labia with strokes from top to bottom the rinse b. For the male resident: cleanse the penis then rinse 5. Discard soiled items in appropriate containers 6. Removed soiled gloves 7. Wash hands and reapply clean globefore continuing care 8. Apply clean brief/clothes 9. Make resident comfortable 10% Resident Care Audits-Handwashin will be completed by the Staff Facilitate Nurse Managers, and Quality Assurand Nurse (QA) with all nurses and NAs to include NA #2 and resident #2 utilizing Resident Care Audit Tool-Handwashing ensure staff are following established infection control guidelines for hand hygiene to include changing gloves following incontinent care weekly x 8 weeks, then monthly x 1 month. The Director of Nursing will review and initiate the Resident Care Audit Tool-Handwashing weekly x 8 weeks the monthly x 1 month to ensure all areas of concern were addressed. The Administrator will forward the result of the Resident Care Audit Tool-Handwashing to the Executive QA Committee monthly x 3 months. The Executive QI committee will meet mont x 3months and review the Infection Control Monitoring Audit Tools to determine trends and / or issues that meed further interventions put into place.	e oves ng or, ce the g to al nen of	

		OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET			345279	B. WING _					
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET					7369 HUNTER HILL ROAD	DE	011	10/2010	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	ON SHOULD BE IE APPROPRIA		(X5) COMPLETION DATE	
F 880 Continued From page 35 F 880 and to determine the need for further and / or frequency of monitoring.	F 880	Continued From page	ge 35	F 8	80 and to determine the need for	or further ar	nd		