

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 000	Initial Comments	D 000		
D 056	<p>10A NCAC 13F .0305(f)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use;</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observation, record review and interview, the facility failed to ensure cleaning supplies were monitored by staff while in use resulting in 1 resident (Resident #6) ingesting an unspecified amount of a cleaning agent.</p> <p>The findings are:</p> <p>Review of Resident #6's record revealed a current FL2 dated 9/09/15 revealed diagnoses of Schizophrenia, Chronic Paranoia and Diabetes.</p> <p>Record review of a hospital discharge summary for Resident # 6 dated 8/31/15 revealed: -Resident #6 presented with bizarre paranoid behavior earlier in the month and was seen at a local medical center and treated for a urinary tract infection.</p>	D 056		

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 056	<p>Continued From page 1</p> <ul style="list-style-type: none"> <li>-Resident #6 began acting similarly 5 days prior to this admission and the urine tests returned unremarkable.</li> <li>-Resident #6 was presenting with religious delusions and irregular behavior earlier in the day of admission.</li> <li>-Resident #6 drank an unspecified amount of a cleaning agent.</li> <li>-The resident was transferred from the facility to a local hospital emergency department (ED) on 8/30/15.</li> <li>-The resident was then transported and involuntarily admitted to the psychiatric unit on 8/31/15 with symptoms of persistent Schizophrenia which lead to threatening suicide via overdosing on a cleaning agent.</li> <li>-The resident was discharged from the psychiatric unit back to the facility on 9/10/15.</li> </ul> <p>Review of the nurses notes in Resident #6's Record revealed:</p> <ul style="list-style-type: none"> <li>-On 8/30/15 at 3:00 pm Resident #6 ingested a cleaning agent that was poured into a cup.</li> <li>-Resident #6 reported to staff she drank the cleaning agent "because I wanted to".</li> <li>-Resident #6 reported to staff she had ingested a "mouthful".</li> <li>-Resident #6's breath and the cup smelled of the cleaning agent.</li> <li>-Resident #6 was transported to the emergency department.</li> <li>-Resident #6 was then transported to a psychiatric unit in a different hospital.</li> <li>-There was no documentation that the Poison Control Center was contacted.</li> </ul> <p>Interview with housekeeper on 9/24/15 at 10:24 am revealed:</p> <ul style="list-style-type: none"> <li>-She was the housekeeper on duty at the time Resident #6 ingested the cleaning agent on</li> </ul>	D 056		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 056	<p>Continued From page 2</p> <p>8/30/15.</p> <ul style="list-style-type: none"> <li>-Resident #6 removed it from the housekeeper's cart telling the housekeeper she needed it to clean.</li> <li>-The housekeeper went into Resident #6's room and saw Resident #6 lowering a cup from her mouth.</li> <li>-The cup and Resident #6's breath smelled of the cleaning agent but did not know how much she drank.</li> <li>-She reported to Supervisor.</li> <li>-The Supervisor reported to the Resident Care Coordinator and was instructed to send Resident #6 to the emergency department.</li> </ul> <p>Interview with Resident Care Coordinator on 9/24/15 at 10:35 am revealed:</p> <ul style="list-style-type: none"> <li>-She was informed that Resident #6 ingested the cleaning agent and instructed staff to call 911 and The Poison Control Center.</li> <li>-Resident #6 was treated for a urinary tract infection earlier in the month and her unusual behavior subsided.</li> <li>-She was aware of recent unusual behavior of Resident #6 and reported to psychiatrist on 8/25/15 during on-site visit by the psychiatrist.</li> <li>-Resident #6 was seen by their on-site Psychiatric Physician 8/25/15 whereby urinalysis with culture and sensitivity (a test to diagnose and then treat a urinary tract infection) and a medication increase was ordered.</li> </ul> <p>Review of Resident #6's record revealed:</p> <ul style="list-style-type: none"> <li>-Resident #6 was seen in the local emergency department 8/04/15 with a diagnosis of urinary tract infection and prescribed treatment with Septra DS (amedication used to treat bacterial infections) 1 tablet every 12 hours for 10 days.</li> <li>-Resident was seen by the psychiatrist 8/25/15 and a U/A C&amp;S was ordered as well as an</li> </ul>	D 056		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 056	<p>Continued From page 3</p> <p>increase in the medication clozapine (a medication used to treat schizophrenia) with an additional 25mg to be given in the morning. -No results of U/A C&amp;S post-dating 8/25/15 was found in the record.</p> <p>Review of the cleaning agents manufacturer's list of ingredients revealed: -The cleaning agent contained pine oil as the major ingredient. -Additional ingredients included Isopropanol (Isopropyl). -Pine oil contains 1-alpha-terpineol. -Isopropanol (Isopropyl) and 1-alpha-terpineol both are two major toxic ingredients in the cleaning agent.</p> <p>Review of the data from the Hazardous Substance Data Bank (HSDB) revealed: -Isopropanol (Isopropyl) is a nondrinking alcohol. If ingested, symptoms include, abdominal pain, coma, dizziness, low blood pressure, low blood sugar, nausea, and slowed breathing. -Pine oil causes hemorrhagic gastritis, central nervous system depression, hypothermia and respiratory failure, can cause acute pulmonary edema within 4 minutes and can be fatal. -8 ounces of "pine oil cleaner" was fatal in adults. -Even small ingestions can result in severe aspiration pneumonia, all ingestions should be considered potentially hazardous.</p> <p>Review of the Material Safety data Sheet (MSDS) provided by the facility revealed: -The cleaning agent ingested by Resident #6 contained 10% pine oil and 5% Isopropyl alcohol listed as hazardous ingredients. -In case of ingestion, call Poison Control Center or physician immediately, have the person sip a glassful of water, do not induce vomiting unless</p>	D 056		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 056	<p>Continued From page 4</p> <p>told to do so by a Poison Control Center (PCC) or physician.</p> <p>Observation of the cleaning cart on 9/24/15 at 9:52 am revealed:</p> <ul style="list-style-type: none"> <li>-The lockable compartment of the cleaning cart was unlocked and contained one 60 fluid ounce bottle of bleach stored in an unlocked compartment of cleaning cart.</li> <li>-A caddy of cleaning products located on the bottom, front side of the cart, away from the lockable compartment and readily accessible as follows: <ul style="list-style-type: none"> <li>-One 32 fluid ounce bottle of Multi-Purpose Degreaser which was 1/2 full.</li> <li>-One 32 fluid ounce bottle of Multi-Purpose and Glass Cleaner which was 1/2 full.</li> <li>-One 32 fluid ounce bottle of Heavy duty Acid Bathroom Cleaner which was 3/4 full.</li> <li>-One 19 fluid ounce bottle of a Disinfectant that was 1/4 full.</li> <li>-One 32 fluid ounce bottle of a Tile Cleanser that kills mold and mildew which was 1/2 full.</li> <li>-One 60 fluid ounce bottle of the same cleaning agent that was ingested by Resident #6 which was 3/4 full.</li> </ul> </li> </ul> <p>Observation of cleaning cart in hallway on 9/24/15 from 9:54 am to 10:23 am revealed:</p> <ul style="list-style-type: none"> <li>-The housekeeper was cleaning a resident's room and going back and forth to cart which was left in the hallway.</li> <li>-The cleaning cart was parked to the left of the room and out of the view of the housekeeper.</li> <li>-The housekeeper retrieved items from the cart and returned to the room to clean.</li> <li>-The cart was left unattended on 11 different occasions while the housekeeper cleaned this room.</li> </ul>	D 056		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 056	<p>Continued From page 5</p> <ul style="list-style-type: none"> <li>-The time the cart was left unattended ranged from 33 seconds to 6 minutes and 11 seconds.</li> <li>-7 of the 11 occasions ranged from 1 minute to 6 minutes and 11 seconds.</li> <li>-Residents passed the cleaning cart on three occasions while cart was unattended and out of view of the housekeeper.</li> </ul> <p>Interview with housekeeper on 9/24/15 at 10:28 am revealed:</p> <ul style="list-style-type: none"> <li>-Since the incident with Resident #6 the safety of chemical products was reviewed with housekeeping staff by the administration.</li> <li>-Since this occurrence the housekeeper usually made sure chemicals were locked up in the carts.</li> <li>-The housekeeper did not know why the chemicals unattended today.</li> <li>-When the housekeeper left for the day the housekeeper locked the chemicals in the cleaning cart and parks the cart in the B Hall bathroom.</li> </ul> <p>Interview with Resident Care Coordinator on 9/24/15 at 10:38 am revealed:</p> <ul style="list-style-type: none"> <li>-The RCC and Adminstrator reviewed the policy of locking up chemicals with the housekeeping staff after the incident involving Resident #6.</li> <li>-The housekeepers were aware that the chemicals should be secured prior to the incident.</li> <li>-The policy was that the chemicals were to be locked on the carts or kept with the housekeepers at all times.</li> <li>-The policy was that once the housekeepers finished with the carts the chemicals were to be locked in the carts and the carts were to be stored in B Hall bathroom.</li> <li>-The housekeepers were responsible for making sure the chemicals were locked up at all times and unavailable to the residents.</li> <li>-No one routinely checked to see if the chemicals</li> </ul>	D 056		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>		
(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) COMPLETE DATE
D 056	Continued From page 6  were locked in the carts. -They did review this policy with the housekeeping staff after Resident #6 drank the cleaning agent. -There was no change in care plan after Resident #6 returned from involuntary admission to the psychiatric unit.  Interview with the Administrator on 9/24/15 at 10:40 am revealed: -She did have a meeting after the incident with both housekeepers and instructed that the carts be pulled into the residents rooms while in use or they are to take the chemical caddy in the room with them. -She emphasized to the housekeepers that the chemicals were not to be left unattended. -There were no routine checks on whether this policy was being implemented.  The facility provided a Plan of Protection on 9/24/15 as follows: - Immediately, the facility will in-service housekeeping staff the importance of keeping cart locked up with no exposed chemicals. -The cleaning cart will be locked up at all times or under direct supervision at all times. -The Maintenance Director will do random checks to make sure the cart is locked daily. -The Administrator is responsible for making sure this plan is executed. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2015.	D 056		
D 273	10A NCAC 13F .0902(b) Health Care  10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERSVILLE, NC 28070</b>
---	--

(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) COMPLETE DATE
D 273	<p>Continued From page 7</p> <p>to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews the facility failed to ensure physician notification for 3 of 8 sampled residents (#2, #7 and #8) with elevated blood pressures outside the ordered parameters.</p> <p>The findings are:</p> <p>A. Review of Resident #7's current FL-2 dated 9/01/15 revealed: -An admission date of 12/19/13. -Diagnoses included Alzheimer's dementia, hypertension, and hypercholesterolemia. -A physician's order for daily blood pressure (BP) checks with an order to fax results to physician's office every Wednesday. -A physician's order for Norvasc 10 mg daily (used to lower elevated BP), Catapres 0.1 mg patch (used to lower elevated BP) weekly on Saturdays, and Coreg 25 mg (used to lower elevated BP) twice a day.</p> <p>Review of Resident #7's standing orders signed and dated 6/04/15 revealed: -A physician's order to recheck BP after 30-60 minutes if systolic BP is greater than 150 and notify physician if systolic BP remains greater than 165. -A physician's order to recheck BP after 30-60 minutes if diastolic BP is greater than 95 and notify physician if diastolic BP remains greater</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 8</p> <p>than 105.</p> <p>Review of Resident #7's signed Move-In Verification of Orders dated 6/05/2015 revealed a physician's order to check BP once daily and call physician's office for results greater than 160/90, and to fax log on Wednesdays.</p> <p>Review of Resident #7's subsequent physician's orders signed and dated 9/03/2015 revealed an order for "BP checks once daily and call physician's office for results greater than 160/90 and fax log on Wednesdays".</p> <p>Review of Resident #7's BP log for July 2015 revealed:</p> <ul style="list-style-type: none"> <li>-BP checks were documented daily from 7/01/15 to 7/31/15 except for 7/28/15.</li> <li>-A handwritten entry on 7/28/15 "would not wake up. Not done".</li> <li>-Systolic BP ranged from 126 to 170.</li> <li>-Diastolic BP ranged from 86 to 117.</li> <li>-BP results were out of range of ordered parameters 26 of 30 results in July 2015.</li> <li>-Example of BP results that were out of range on the following dates:</li> <li>-On 7/02/15, BP was 153/111 and no documentation of a BP recheck or physician notification.</li> <li>-On 7/07/15, BP was 163/117 and no documentation of a BP recheck or physician notification.</li> <li>-On 7/12/15, BP was 148/105 and no documentation of a BP recheck or physician notification.</li> <li>-On 7/16/15, BP was 170/112 and no documentation of a BP recheck or physician notification.</li> <li>-On 7/28/15 there was no documentation of a BP check. It could not be determined if a BP recheck</li> </ul>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERSVILLE, NC 28070</b>		
(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) COMPLETE DATE
D 273	<p>Continued From page 9</p> <p>and physician notification was required or not.</p> <ul style="list-style-type: none"> <li>-No BP rechecks were documented from 7/01/15 to 7/31/15.</li> <li>-Handwritten and initialed "fax" entries noted on 7/01/15, 7/22/15, and 7/30/15.</li> <li>-Fax log sheets dated 7/01/15, 7/22/15, and 7/30/15 were attached to the July 2015 BP log.</li> </ul> <p>Review of Resident #7's BP log for August 2015 revealed:</p> <ul style="list-style-type: none"> <li>-BP checks were documented daily from 8/01/15 to 8/07/15 and 8/10/15.</li> <li>-Handwritten notations for "Home Visit" from 8/08/15 to 8/09/15 and 8/11/15 to 8/27/15.</li> <li>-No BP results or "Home visit" documented for 8/28/15 to 8/31/15. (The resident had knee surgery and was out of the facility during this time).</li> <li>-Systolic BP ranged from 120-194.</li> <li>-Diastolic BP ranged from 86-127.</li> <li>-BPs were out of range of ordered parameters 6 of 8 results in August 2015.</li> <li>-Example of blood pressures that were out of range of ordered parameters on the following dates: <ul style="list-style-type: none"> <li>-On 8/01/15, BP was 142/97 and no documentation of a BP recheck or physician notification.</li> <li>-On 8/05/15, BP was 162/118 and no documentation of a BP recheck.</li> <li>-On 8/07/15, BP was 145/106 and no documentation of a BP recheck or physician notification.</li> <li>-On 8/10/15, BP was 194/127 and no documentation of a BP recheck or physician notification.</li> </ul> </li> <li>-No BP rechecks were documented from 8/01/15 to 8/10/15.</li> <li>-A fax log sheet dated 8/05/15 was attached to the August 2015 BP log.</li> </ul>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 10</p> <p>Review of Resident #7's BP log for September 2015 revealed:</p> <ul style="list-style-type: none"> <li>-BP checks were documented daily from 9/05/15 to 9/23/15.</li> <li>-Handwritten line marked through 9/01/15 to 9/04/15.</li> <li>-Systolic BP ranged from 116 to 165.</li> <li>-Diastolic BP ranged from 82 to 109.</li> <li>-BP were out of range 16 of 19 results in September 2015.</li> <li>-Example of blood pressures that were out of range on the following dates:</li> <li>-On 9/8/15, BP was 159/100 and no documentation of a BP recheck or physician notification.</li> <li>-On 9/10/15, BP was 150/101 and no documentation of a BP recheck or physician notification.</li> <li>-On 9/13/15, BP was 158/107 and no documentation of a BP recheck or physician notification.</li> <li>-On 9/17/15, BP was 156/108 and no documentation of a BP recheck or physician notification.</li> <li>-On 9/20/15, BP was 165/96 and no documentation of a BP recheck or physician notification.</li> <li>On 9/22/15, BP was 134/103 and no documentation of a BP recheck or physician notification.</li> <li>-No BP rechecks were documented from 9/01/15 to 9/23/15.</li> <li>-Fax log sheets dated 9/09/15 and 9/16/15 were attached to the September 2015 BP log.</li> </ul> <p>Interview with the Resident Care Coordinator (RCC) on 9/24/15 at 9:00 am revealed:</p> <ul style="list-style-type: none"> <li>-The medication aide (MA) on first shift checked Resident #7's BP.</li> </ul>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 11</p> <ul style="list-style-type: none"> <li>-If the BP was elevated the MA was to report it to the RCC to call to the physician's office.</li> <li>-"If I am busy, I tell the MA to contact the physician."</li> <li>-The BP logs sheets were faxed every Wednesday. The staff were to attach the fax log sheets to the BP log.</li> <li>-The staff was to recheck BP if elevated and document those results.</li> </ul> <p>Interview with MA on 9/24/15 at 9:10 am revealed:</p> <ul style="list-style-type: none"> <li>-She had worked at the facility for 2 years as a MA and supervisor.</li> <li>-She checked BP daily and "if it is up I give the scheduled meds and recheck it in 45 minutes. I don't always document it".</li> <li>-She knew there were parameters to watch for BP.</li> <li>-She reported elevated BP results to the RCC. "If she is too busy to contact the physician, I do it. I usually fax the results to the physician versus calling because we get a faster response".</li> <li>-Resident #7 was "out of the facility at the end of August and came back the first week of September", so the resident was not available for BP checks on the missing dates on the BP logs for August and September.</li> </ul> <p>Interview with Resident #7 on 9/24/15 at 9:55 am revealed:</p> <ul style="list-style-type: none"> <li>-The MA checked her BP every morning before she was given her medications, "sometimes when I'm standing up, but usually when I'm sitting on my bed".</li> <li>-The MA reported her BP reading to the resident.</li> <li>-The staff did not recheck the BP if elevated.</li> <li>-Her BP readings were about the same when she was at her physician's office.</li> <li>-She was on medications to lower her BP; both</li> </ul>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 12</p> <p>pill and patch.</p> <p>Interview with Resident #7's room-mate on 9/24/15 at 9:55 am revealed: -She was present during the interview of Resident #7 with the resident's permission. -"We look out for each other." -The MA checked BP at medication time in the mornings. -The staff rarely rechecked BP for Resident #7.</p> <p>Interview with Resident #7's primary care physician's office representative on 9/24/15 at 10:05 am revealed: -Resident #7's BP was "usually ok when she comes to the office. I'm not sure the facility's technique is good. I think they need to re-train the staff in taking BP". -Resident #7 saw a cardiologist who was adjusting her medications. -The facility was faxing the BP log sheet every week as ordered. -The facility needed to follow the orders on file to recheck BP when elevated.</p> <p>Observation of a BP check for Resident #7 was not available on 9/24/15 after the 10:05 am interview with her primary care physician's office representative. The resident was out of the facility.</p> <p>Refer to interview on 09/24/15 at 7:40 am with the Resident Care Coordinator.</p> <p>Refer to interview on 09/24/15 at 10:50 am with the Administrator.</p> <p>B. Review of Resident #2's current FL-2 dated 09/19/15 revealed: -The resident was admitted to the facility on</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 13</p> <p>05/26/15.</p> <p>-Diagnoses included pulmonary hypertension, diabetes mellitus type II, and schizophrenia.</p> <p>-An order for weekly blood pressures (BPs) on Mondays.</p> <p>Review of the Move-In Verification Of Orders dated 06/08/15 revealed:</p> <p>-An order for daily BP checks.</p> <p>-An order to implement the facility's standing orders.</p> <p>Review of the facility's standing orders dated 06/08/15 revealed:</p> <p>-If systolic BP was greater than 150, staff were to assist the resident to rest, recheck the BP in 30-60 minutes, and notify the physician if greater than 165.</p> <p>-If diastolic BP was greater than 95, staff were to assist the resident to rest, recheck the BP in 30-60 minutes, and notify the physician if greater than 105.</p> <p>Review of Resident #2's record revealed a physician's order dated 07/12/15 to change daily BPs to weekly.</p> <p>Review of the July 2015 Medication Administration Record (MAR) and blood pressure log revealed:</p> <p>-The standing order for BP parameters was transcribed to the MAR.</p> <p>-BPs ranged from 130/76 to 150/108.</p> <p>-3 of 11 documented BPs were outside the ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Review of the August 2015 MAR revealed:</p> <p>-The standing order for BP parameters was transcribed to the MAR.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 14</p> <p>-BPs ranged from 116/75 to 129/108. -3 of 5 documented BPs were outside the ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Review of the September 2015 MAR revealed: -The standing order for BP parameters was transcribed to the MAR. -BPs ranged from 96/64 to 139/102. -2 of 3 documented BPs were outside the ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Examples of BPs outside the ordered parameters included: -On 07/11/15, BP was documented as 143/101. -On 07/12/15, BP was documented as 150/108. -On 08/03/15, BP was documented as 185/96. -On 08/17/15, BP was documented as 129/108. -On 09/14/15, BP was documented as 139/102.</p> <p>Interview on 09/24/15 at 7:35 am with a medication aide (MA) revealed: -She routinely checked Resident #2's BP in the mornings before the end of her shift. -She was not aware of what the BP parameters were without looking at the MAR. -She was not aware of the order to recheck the BP and did not do the rechecks.</p> <p>Interview on 09/24/15 at 8:50 am with Resident #2 revealed: -Night shift staff routinely checked his BP once weekly. -He did not know whether or not his BP was high because staff did not tell him the number. -He had chest pain at least once a month, but had not reported it to staff. -His chest pain was "enough to notice but not severe".</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 15</p> <p>-His chest pain went away when he lay down.</p> <p>Refer to interview on 09/24/15 at 7:40 am with the Resident Care Coordinator.</p> <p>Refer to interview on 09/24/15 at 10:50 am with the Administrator.</p> <p>C. Review of Resident #8's current FL-2 dated 01/27/15 revealed: -Diagnoses included hypertension, hyperlipidemia, and chronic obstructive pulmonary disease. -An order for weekly blood pressures (BPs) on Mondays.</p> <p>Review of Physician's Verification Of Orders form dated 04/10/15 revealed: -An order for daily BP checks. -An order to implement the facility's standing orders.</p> <p>Review of the facility's standing orders dated 08/14/15 revealed: -If systolic BP was greater than 150, staff were to assist the resident to rest, recheck the BP in 30-60 minutes, and notify the physician if greater than 165. -If diastolic BP was greater than 95, staff were to assist the resident to rest, recheck the BP in 30-60 minutes, and notify the physician if greater than 105.</p> <p>Review of the July 2015 Medication Administration Record (MAR) and BP log revealed: -The standing order for BP parameters was transcribed to the MAR. -BPs ranged from 102/77 to 161/116. -13 of 31 documented BPs were outside the</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 16</p> <p>ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Review of the August 2015 MAR and BP log revealed: -The standing order for BP parameters was transcribed to the MAR. -BPs ranged from 102/63 to 174/74. -4 of 31 documented BPs were outside the ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Review of the September 2015 MAR and BP log revealed: -The standing order for BP parameters was transcribed to the MAR. -BPs ranged from 120/76 to 160/114. -2 of 24 documented BPs were outside the ordered parameters with no documentation of a recheck in 30-60 minutes per the standing orders.</p> <p>Examples of BPs outside the ordered parameters included: -On 07/05/15, BP was documented as 161/116. -On 07/10/15, BP was documented as 143/115. -On 07/14/15, BP was documented as 154/111. -On 08/06/15, BP was documented as 174/74. -On 09/21/15, BP was documented as 160/114.</p> <p>Interview on 09/24/15 at 9:15 am with a medication aide (MA) revealed: -She checked Resident #8's BP daily before breakfast. -She had noticed a "couple of them" were high, so she documented the BP on the MAR and asked the resident if his head hurt or if he felt dizzy. -She did not realize the parameters ordered by the physician required a recheck of the BPs and she did not routinely recheck the BP.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	<p>Continued From page 17</p> <p>-Resident #8 never complained of chest pain, headache, or dizziness.</p> <p>Interview on 09/24/15 at 9:10 am with Resident #8 revealed:</p> <p>-Staff checked his BP daily in the mornings. -His BP was high this morning; it was "178 over something". -Sometimes when his BP was high, staff would tell him to go eat breakfast so he could take his medications and the BP may come down. -Staff did not recheck his BP. -He has had chest pain "once or twice a year" but did not notify staff because it was "nothing major".</p> <p>Refer to interview on 09/24/15 at 7:40 am with the Resident Care Coordinator.</p> <p>Refer to interview on 09/24/15 at 10:50 am with the Administrator.</p> <p>Interview on 09/24/15 at 7:40 am with the Resident Care Coordinator (RCC) revealed:</p> <p>-It was the responsibility of the MA on duty to follow the ordered parameters for BPs. -She was not aware the MAs were not completing the BP rechecks per the physician orders.</p> <p>Interview on 09/24/15 at 10:50 am with the Administrator revealed:</p> <p>-She was not aware the MAs were not completing the BP rechecks per the physician's orders. -There was no specific monitoring system in place to ensure staff were completing the BP rechecks.</p> <p>On 09/24/15, the Administrator submitted a Plan of Protection as follows:</p> <p>-All staff would be re-educated regarding the BP parameters prior to their next scheduled shift.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 273	Continued From page 18  -The RCC would monitor BPs daily for one week, then monthly thereafter to ensure ongoing compliance.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2015.	D 273		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service  10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.  This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to assure therapeutic diets were served as ordered for 1 of 3 sampled residents (Resident #2) with physician's orders for a therapeutic diet (No Concentrated Sweets).  The findings are:  Review of Resident #2's current FL2 dated 09/19/15 revealed: -Diagnoses included diabetes mellitus Type 2, pulmonary hypertension, gout, obesity, arthritis, schizophrenia - paranoid type, and anxiety. -No diet order on the FL2. -An order to check blood sugars every morning.  Review of Resident #2's Resident Register revealed an admission date of 05/26/15.	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 310	<p>Continued From page 19</p> <p>Review of Resident #2's record revealed: -A physician's diet order dated 06/08/15 for a No Concentrated Sweets (NCS) diet. -Instructions for the NCS diet were to follow the regular menu plan with diabetic desserts and to avoid sugar sweetened foods and sugar. -Resident #2 had a hemoglobin A1c test on 07/05/16 with a result of 6.1. (An A1c is a test used to measure how well a person's diabetes is managed. A level of 7 or less is the target range for a person with diabetes.)</p> <p>Review of the diet list posted in the kitchen on 09/23/15 at 12:00 pm revealed Resident #2 was on a NCS diet.</p> <p>Review of the therapeutic diet menu for NCS diets served on 09/23/15 lunch meal revealed residents ordered a NCS diet were to be served: 3 ounces of Swiss steak with gravy, steamed rice, baby carrots, 1 wheat dinner roll or bread, 1 packet of margarine, a 2 x 3 square of diet rainbow cake, 8 ounces of milk, and 8 ounces of diet beverage of choice.</p> <p>Observation of the lunch meal on 09/23/15 from 12:00 pm to 12:30 pm revealed: -Resident #2 was at the dining room table with portable oxygen. -Resident #2 was served the following by Nurse Aide staff assisting with service in the dining room: 8 ounces of fruit punch, 8 ounces of milk, 6 ounces of water, Swiss steak with gravy, steamed rice, baby carrots, 1 wheat dinner roll, and a 2 x 3 square of diet rainbow cake. -Resident #2 fed himself the lunch meal. -Resident #2 consumed 100% of the meal, including the beverages. -Resident #2 was not to have been served sweetened fruit punch.</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 310	<p>Continued From page 20</p> <p>Interview with Resident #2 on 09/24/15 at 4:00 pm revealed: -He was a diabetic and his blood sugars average "about 100". -If his blood sugars dropped below 70 or were above 200, he began to have symptoms of high or low blood sugars. -The facility provided sugar free foods. -"I occasionally get drinks with sugar in them" when served by the facility. -He was not on insulin, but did take a tablet for his diabetes. -"My doctor says he is happy with how I am doing. He told me at my last visit and said he would see me in six months." -He had no complaints with the food he was served at the facility.</p> <p>Interview on 09/23/15 at 12:05 pm with a Nurse Aide (NA) who had served beverages to Resident #3 revealed: -"All of our drinks are unsweetened and residents who are not a diabetic can add sugar if they want to." -He served fruit punch, milk and water to Resident #3. -All residents, including diabetics, who wanted fruit punch received the same fruit punch. -The fruit punch was diet and did not contain any sugar. -The facility had a posted list in the kitchen on residents who were diabetics. -He "knew which ones were diabetics" because he had worked at the facility for "awhile".</p> <p>Observation on 09/23/15 at 12:20 pm at the serving station in the kitchen revealed: -A 3 gallon container containing concentrated fruit punch with a mixing ratio of 1 part concentrate to</p>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 310	<p>Continued From page 21</p> <p>7 parts water.</p> <ul style="list-style-type: none"> <li>-The recommended serving size was 4 ounces.</li> <li>-Ingredients on the label included filtered water and corn sweetener.</li> <li>-There were 13 grams of sugar for one serving size of 4 ounces.</li> <li>-A 3 gallon container containing concentrated tea that was unsweetened.</li> </ul> <p>Interview with the Dietary Manager on 09/23/15 at 12:23 pm revealed:</p> <ul style="list-style-type: none"> <li>-The facility served all of the residents the same fruit punch, including residents who were diabetics.</li> <li>-She was not aware that the fruit punch mix contained corn sweetener.</li> <li>-She thought all of the drink mixes were sugar free.</li> <li>-The staff served 8 ounces of the fruit punch because "that is how much we are supposed to serve".</li> <li>-She did not measure the fruit punch concentrate when preparing the beverages from the mixture, but demonstrated with a gallon container that she added approximately 20 ounces of the fruit punch concentrate to one gallon (128 ounces) of water.</li> <li>-She did not know what the 7:1 ratio on the label of the container meant in relation to preparation of the beverage.</li> <li>-She was responsible for identifying food and beverages to order for regular and therapeutic diets.</li> <li>-She would not have staff to serve the sweetened fruit punch to residents who were diabetic.</li> </ul> <p>Interview with the Administrator on 09/24/15 at 10:10 am revealed:</p> <ul style="list-style-type: none"> <li>-The Dietary Manager was responsible for determining what foods and beverages to purchase and serve, according to the residents'</li> </ul>	D 310		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE
D 310	Continued From page 22  diet orders. -She was unaware the fruit punch being served to diabetic residents was sweetened.	D 310		
D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations regarding health care and physical storage.</p> <p>The findings are:</p> <p>A. Based on observation, record review and interview, the facility failed to ensure cleaning supplies were monitored by staff while in use resulting in 1 resident (Resident #6) ingesting an unspecified amount of a cleaning agent. [Refer to Tag 056, 10A NCAC 13F .0305(f)(4)(B) Physical Environment (Type A2 Violation).]</p> <p>B. Based on observations, interviews and record reviews the facility failed to ensure physician notification for 3 of 8 sampled residents (#2, #7 and #8) with elevated blood pressures outside the ordered parameters. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).]</p>	D912		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL060014</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/24/2015</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>HUNTER VILLAGE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>111 S CHURCH STREET HUNTERVILLE, NC 28070</b>
---	---

(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) COMPLETE DATE