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PRINTED: 04/11/2013 FORM APPROVED OMB NO. 0938-0391

OVIDER OR SUPPLIER TH POST-ACUTE CARE	345357	A. BUILDING_ B. WNG		Ċ
	345357	B. WING		
				.03/21/2013
	NEUSE	. 1	REET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560	
(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
SPREAD, LINENS		F 441		
Infection Control Pro safe, sanitary and co to help prevent the d	gram designed to provide à omfortable environment and evelopment and transmission		does not constitute admission (of the
The facility must estandary which are facility must estandary (1) Investigates, continuous facility; (2) Decides what proshould be applied to (3) Maintains a reco	ablish an Infection Control h it - trols, and prevents infections ceedures, such as isolation, an individual resident; and rd of incidents and corrective		F: 441 It is the intent of the facility the current CDC approved isolation signage be posted on the doors	ection.
(1) When the Infection determines that a reprevent the spread control isolate the resident. (2) The facility must communicable disease from direct contact will train the control of the c	on Control Program sident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted		ion that requires isolation. Residents # 57 and #185 was to provided with proper isolation precautions. On 3/21/13 the incorrect signal.	ge
		Act of the state o	On 3/21/13 all incorrect signage was destroyed.	je
	SPREAD, LINENS The facility must esta Infection Control Prosafe, sanitary and control Prosafe, sanitary and control Prosafe, sanitary and control The facility must esta Program under whice (1) Investigates, continuous in the facility; (2) Decides what prosahould be applied to (3) Maintains a reconactions related to infection (b) Preventing Spread (1) When the Infection determines that a reprevent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (5) The facility must hands after each direct contact will trace (6) Linens Personnel must hand transport linens so a infection.	(2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	SPREAD, LINENS The facility must establish and maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	SPREAD, LINENS The facility must establish and maintain an ansafection Control Program designed to provide a safe, sanitary and comfortable environment and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (b) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

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.

Event1D:NTXY11 Facility ID: 923514

11,

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE : COMPI	
_			755,25		•	·	;
- +1		345357	B. WNG			03/2	21/2013
	OVIDER OR SUPPLIER TH POST-ACUTE CARI	E-NEUSE		130	EET ADDRESS, CITY, STATE, ZIP CODE 03 HEALTH DRIVE EW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE ·	(X5) COMPLETION DATE
F 441	 Continued From pa	ge 1	F	441			
	This REQUIREMEN	NT is not met as evidenced.		1	Licensed staff was in-serviced	on	
	by:				3/21/13 re: "Isolation Precau	tions "	
	Based on observat	tions, record review and staff		l	Reviewing the approved CDC	i	
	interviews, the facil	ity failed to post the proper		1			
		s for Disease Control (CDC) 3 residents observed on	•		identifying: Airborne, Drople	č j	
	isolation (Residents	s # 57 & 185). The findings			and/or Contact Isolation.		
	included: `				Dark decidents in the collection		
	1. Resident # 57 ha	ad a diagnosis of recurrent	1.		Both resident's #'s 57 and 185	i	
		colitis (C-diff) (an infection of			taken off of isolation on 3/22,	/13.	
	1110 001011 000000 2	,			Ol Nursa /Designed will monit	av sian	
		sician readmission orders dated			Ql Nurse/Designee will monit)	ļ. ·
		a diagnosis of sepsis		- [age for any resident(s) requir		
	secondary to clost	idrium colitis.	-	[isolation weekly until they no	longer	
<u>-</u>	Poviou of a physic	ian 's progress note dated		ĺ	require isolation.		
		ne resident had recurring C-diff	.			,	
		ancomycin (anti-infective) on			Any identified issues will be to	akan ta	
	3/24/13.	•					
					the Monthly Performance Im	prove-	
		/18/13 at 8:20 AM, 3/19/13 at PM and 3/20/13 at 9:10 AM			ment Committee for review.		-
		as posted on the resident's door				į	*
		on-Please check with nurse	1				
	before entering."	•			All issues identified will be co	rrected '	Miller
	A 5 t	Nurse #1 on 3/20/13 at 11:22			maintain compliance.	•	פוסוןד
		esident was on isolation for			• • •	ν (
,		urned from the hospital on		•		•	
		her stated that the resident's				* * * -	
	isolation would be	discontinued that afternoon					1 .
		ent no longer had loose stools.	1				
	In an interview wit	h Infection Nurse (ICN) #1 on		•			1
		M she stated that resident #57 off isolation for C-diff.				•	-

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
345357			B. WING	B. WING			C 03/21/2013		
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST-ACUTE CARE-NEUSE				STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560					
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 441	Continued From page	∋ 2	F	441					
	she stated that the isd #57 should have had the doors. The nursed have noticed that the In an interview with 10	CN #2 at 9:30 AM on 3/21/13 plation rooms for resident contact precaution signs on and supervisor should incorrect signs were posted. CN #1 on 3/21/13 at 9:50 AM ct isolation signs should the resident's door.							
	Review of the nurses	d a diagnosis of shingles. ' notes dated 3/13/13 was placed on isolation for					,		
	Review of the Infection noted that resident # isolation.	on Report dated 3/13/13 185 required contact							
	9:00 AM and 1:00 PM 3/21 at 9:30 AM revel the resident's door wl	i/13 at 8:20 AM, 3/19/13 at I, 3/20/13 at 9:10 AM and aled a sign was posted on nich read "Isolation-Please ore entering." The type of dentified on the sign.							
	she stated that the is 0 for resident #185 st precaution signs on the	CN #2 at 9:30 AM on 3/21/13 colation room. nould have had contact he doors. The nurses and we noticed that the incorrect				•			
	In an interview with I	ON #1 on 3/21/13 at 9:50 AM							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
		345357	B. WING		i	C /21/2013	
NAME OF PROVIDER OR SUPPLIER UNIHEALTH POST-ACUTE CARE-NEUSE			STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE NEW BERN, NC 28560				
(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 CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	An interview with the AM on 3/21/13 revea set up the isolation rothat the residents we. In an interview with the 3/21/13 she stated the did not place the sign. An interview with Nur 3/21/13 revealed she signs were posted on An interview with the on 3/21/13 at 11:17 A	ct isolation signs should the resident's door. 100 hall supervisor at 10:14 led a Nursing Assistant (NA) reconcent isolation. The NA #1 at 10:20 AM on the set up the rooms but is on the doors. The #2 at 10:24 AM on the incorrect in the isolation rooms. Director of Nursing (DON) am revealed her expectation ting the type of precautions	F 441				

PRINTED: 04/08/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED -**IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 APR 24 2013 04/03/2013 345357 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1303 HEALTH DRIVE UNIHEALTH POST-ACUTE CARE-NEUSE NEW BERN, NC 28560 PROVIDER'S PLAN OF CORRECTION (X5). COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 Submission of this Plan of Correction This Life Safety Code (LSC) survey was does not constitute admission of the conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing under-signed that the deficiency was Health Care section of the LSC and its referenced correctly cited or required correction. publications. This facility is Type protected. construction utilizing North Carolina Special locking arrangements, and is equipped with a K: 29 complete automatic sprinkler system. It is the intent of the facility that the the combustion chamber of the gas CFR#: 42 CFR 483.70 (a) K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 fired dryers be free from any SS≍E Build-up of dust and lint. One hour fire rated construction (with 34 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 On 4/3/13 the lint and dust was and/or 19.3.5.4 protects hazardous areas. When removed from the combustion the approved automatic fire extinguishing system option is used, the areas are separated from chamber of the dryer. other spaces by smoke resisting partitions and All other dryers were cleaned. doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed On 4/3/13 the PM schedule was 48 inches from the bottom of the door are permitted. 19.3.2.1 reviewed and the monitoring for lint and dust was changed from bi-weekly to weekly. This STANDARD is not met as evidenced by: The PM tool was revised on 4/4/13. Based on the observations and staff interview during the tour on 4/3/2013 the following item was observed as noncompliant, specific findings Maintenance Director/designee include: The facility had a buildup of dust and lint will monitor weekly. in the combustion chamber of the gas fired dryers in the laundry.... CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD K 056 (X6) DATE TITLE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Facility ID; 923514

If continuation sheet Page 1 of 3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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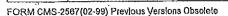
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	, ,	CONSTRUCTION 1 - MAIN BUILDING 01	(X3) DATE COMP	
		345357	B, WING	T-MAIN BRESING 9.	04/0	3/2013
	ROVIDER OR SUPPLIER	L	13	EET ADDRESS, CITY, STATE, ZIP CODE 03 HEALTH DRIVE EW BERN, NC 28560	-	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX: TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS	K 000	DEFICIENCY)		***
	This Life Safety C conducted as per at 42 CFR 483.70 Health Care section	ode (LSC) survey was The Code of Federal Register (a); using the 2000 Existing on of the LSC and its referenced facility is Type protected		Any identified issues will be taken to the monthly Performance Improvement Committee for review.	Appendigitation and the second	
	construction utilizi	ng North Carolina Special ents, and is equipped with a ic sprinkler system.		Identified issue will be corrected to maintain Compliance.		
K 029 SS=E	NFPA 101 LIFE S One hour fire rate fire-rated doors) of	AFETY CODE STANDARD d construction (with ¾ hour r an approved automatic fire em in accordance with 8.4.1	K 029		The form the Policy of the State of the	
	and/or 19.3.5.4 pr the approved auto option is used, the other spaces by s doors. Doors are field-applied prote	otects hazardous areas. When omatic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or active plates that do not exceed bottom of the door are			The second secon	
	permitted. 19.3					•
	Based on the ob- during the tour or observed as non- include: The faci	is not met as evidenced by: servations and staff interview 4/3/2013 the following item was compliant, specific findings lity had a buildup of dust and lint a chamber of the gas fired dryers				
K 056	1	SAFETY CODE STANDARD	K 056			
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE

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(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 04/03/2013 345357 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1303 HEALTH DRIVE UNIHEALTH POST-ACUTE CARE-NEUSE NEW BERN, NC 28560 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ÎD PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY K 056 K 056 Continued From page 1 SS=D If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the K: 056 Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully It is the intent of the facility to supervised. There is a reliable, adequate water supply for the system. Required sprinkler keep the sprinklers from being systems are equipped with water flow and tamper blocked so they will freely operate. switches, which are electrically connected to the 19.3.5 building fire alarm system. 4/3/13 the mattresses were removed. This STANDARD is not met as evidenced by: 4/4/13 supply clerk/designee were Based on the observations and staff interviews in-serviced on: "Sprinkler System: on 4/3/2013 the following Life Safety item was Keeping the sprinklers from being observed as noncompliant, specific findings include: The sprinkler in the nurses supply room blocked so they can work freely". on the right hand side of the back of the room was blocked by bed mattress stacked at that QI nurse/designee will monitor location. Bi weekly. CFR#: 42 CFR 483.70 (a) K 062 NFPA 101 LIFE SAFETY CODE STANDARD K 062 Any identified issues will be taken SS≍D Required automatic sprinkler systems are to the monthly Performance Imcontinuously maintained in reliable operating provement Committee for review. condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Identified issues will be corrected to maintain compliance.







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COMPLETED

04/03/2013

(X5) COMPLETION

DATE

DEPARTMENT OF HEALTH, AND HUMAN SERVICES **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 345357 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1303 HEALTH DRIVE UNIHEALTH POST-ACUTE CARE-NEUSE NEW BERN, NC 28560 -SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG' TAG DEFICIENCY) K 062 Continued From page 2 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/3/2013 the following item was observed as noncompliant, specific findings include: The sprinkler heads installed at the the men's and women's bathrooms just across from K062 the conference room in the egress corridor were a mix of a quick response head and a standard It is the intent of the facility to fused head, all sprinkler heads in a smoke maintain similar sprinkler heads compartment are required to be of the same type

CFR#: 42 CFR 483.70 (a)

13,5-3.1.5.2

so that the sprinkler system in that space can work in unison. Actual NFPA Standard: NFPA

in the smoke compartments so that all of the sprinklers will work in unison.

On 4/16/13 BFPE installed sprinkler heads at the men's and women's bathrooms across from the conference room making them similar so that they would work in unison.

All other sprinklers were monitored by the Maintenance Director.

Any identified issues will be taken to the monthly Performance Improvement Committee for review.

Identified issues will be corrected to maintain compliance.

