STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345465	A. BUILDING _____ B. WING _____	C 10/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYVIEW NURSING & REHAB CENTER	3003 KENSINGTON PARK DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 10/18/12. Event ID# KIBM11.	F 000		

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

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.

received 11/13/12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure a privacy bag was utilized for 1 of 6 residents with a urinary catheter. Findings include: 1. Resident # 25 was admitted to the facility on 10/4/08 with a diagnoses of neurogenic bladder and urinary retention requiring placement of a suprabpubic catheter. The annual Minimum Data Set (MDS) assessment of 1/2/12 indicated Resident # 25 had severe cognitive deficits and required all aspects of care rendered by staff. Observations on 10/15/12 at 3:06 PM revealed Resident # 25 lying in bed. The urinary catheter bag was attached to the bedframe on the side of the bed facing the door of the room. The uncovered catheter bag contained urine and was visible from the hall. Observations on 10/15/12 at 5:11 PM revealed Resident # 25 being assisted from the bed to a wheelchair by Nursing Assistant (NA) # 1. When Resident # 25 was seated, NA # 1 placed the urinary catheter bag into a privacy bag hanging from the back of the wheelchair. NA # 1 stated a privacy bag was not used unless a resident was in a wheelchair. During an interview on 10/18/12 at 2:42 PM with the Administrator and the Director of Nursing (DON), the Administrator stated there was usually	F 241	DISCLAIMER Bayview Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Bayview Nursing and Rehabilitation. The facility reserves the right to submit documentation to refute the stated deficiencies through informal appeals procedures and/or other administrative or legal proceedings. ALLEGATION OF COMPLIANCE The plan of correction is submitted as written allegation of compliance. F 241 For the resident cited * Resident #25: On October 15, 2012 a catheter privacy bag was fitted to the bed frame, for use when the resident is in bed. This resident already had a privacy bag which was / is in use when she is up in a wheelchair For all residents * On October 15, 2012, all other residents in the facility who have catheters were audited to ensure they had catheter privacy bags while in bed and while in a chair. All had privacy bags except for Resident #25 who was missing a bag for use when in bed. Staff continues to ensure that a privacy bag is being utilized for each of these residents at all times while in bed or in a chair.	10.15.12 10.15.12

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

Debbie Combs-Jones Administrator, Dir. of Operations 11.10.12

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F 241	Continued From page 1 a privacy bag on both sides of the bed as well as on a wheelchair for a resident with a urinary catheter. The Administrator stated the catheter bag should be in a privacy bag whether the resident was in or out of bed. During the interview, the DON stated that utilizing a privacy bag was included in the instructions to staff on care of a catheter. The DON stated the expectation was for the urinary catheter bag to be covered. During an interview on 10/18/12 at 3:05 PM, the Staff Development Coordinator (SDC) stated that during orientation, new nursing assistants were instructed in dignity related to the use of privacy bags to cover urinary catheter bags whether the resident was in or out of bed.	F 241	System changes * A column was added to the Admission Checklist indigating a catheter privacy bag was provided to all new residents who enter the facility with a catheter. The DON or designee is reviewing all New Admission Checklists on a daily basis to ensure a catheter privacy bag(s) has been provided. * The Restorative C.N.A. as provided with a list of all residents in the facility with catheters and this list will be updated for new / discontinued catheters each day during the Morning Stand-up meeting. Using this list, the Restorative C.N.A is monitoring each resident with a catheter to ensure privacy bags are being utilized at all times, and is reporting results to the Director of Nursing on a daily basis. * Nursing staff were inserviced on the importance of ensuring that all residents who have catheters have a catheter privacy bag(s) and that the privacy bag is utilized at all times while the resident is in bed or in a chair. The importance of maintaining each resident's dignity was also reviewed.	10.20.12 10.20.12 10.20.12
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and family and staff interviews, the facility failed to notify the responsible party when a resident was moved to a different room, for one of one resident (Resident #2). Findings include: Resident #2 was admitted 1/03/12 with a diagnosis of Alzheimers Disease. The Minimum Data Set (MDS) dated 9/12/12 noted resident as being severely cognitively impaired. She needed extensive assistance with all Activities of Daily Living (ADLs).	F 247	Monitors * The DON or designee is making rounds on a daily basis to ensure catheter privacy bags are being utilized for all residents in the facility with catheters. This audit will be done daily for two weeks; weekly for four weeks and then ongoing quarterly audits. * The DON or designee will continue to audit Admission Checklists on a daily basis to ensure catheter privacy bags have been provided to all residents with catheters * Results of the audit will be reported to the QAPI Committee during their monthly meetings for three months, and changes to the plan will be initiated if improvement is not sustained. F 247 next page	10.20.12 10.20.12 11.12.12

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F 247	Continued From page 2 A review of the nurse notes revealed that on 9/2/12 Resident #2 was moved to a different room because of a medical condition. This move occurred on the 3PM to 11PM shift. On 10/16/2012 at 9:30 AM, in a family interview, Resident #2's Responsible Party (RP) stated that the facility moved the resident into a different room due to a medical condition, and that she was not notified. In an interview on 10/18/12 at 9:00 AM the Social Worker stated that she was the person who would go over the admission packet with the families, and explained that if there was a room change the RP must be notified. She stated that if a resident was moved in the middle of the night, the facility may wait until the next day and notify the RP, but otherwise the RP would be notified the same day. She stated that her expectation would be that the nurse would also chart that the RP was notified. The Social Worker stated that she was aware that the RP was not notified and that the RP came into the facility and spoke to the nurse. On 10/18/12 at10:45 AM, in an interview, the Director of Nursing (DON) stated her expectation was that the nurse should notify the RP and chart that she notified the RP. The DON also stated that the RP may not be notified until morning, but that it should be charted. She also stated that the nurse should notify the family. On 10/18/12 at 11:40 AM, Nurse #1 stated that the floor nurse who was assigned to that resident	F 247	F 247 For the resident cited * Resident #2: Social Services met with the responsible party (RP) who had not received notice of Resident #2's room change. This RP was assured that if, in the future, a room change was warranted for a medical reason she would promptly be notified on the intent to move this resident. For all residents * The charts of all other residents who had a room change within the past quarter were reviewed to determine if any family or RP hadd not been notified regarding a room change. None were identified. System changes * Nursing staff was inserviced on the facility policy regarding Room Change/Roommate Assignment. The current policy states that RPs will be given advanced notice of such change, whenever possible or as soon after the room change as possible. This policy will continue to be enforced at this facility. * Nursing staff was inserviced regarding the importance of notifying the RP of any resident whose condition warrants a room change. Staff has been instructed that prior to moving a resident to a different room the Manager on Duty MOD) will be notified. The MOD will then verify with the Charge Nurse that the RP has been notified. All room changes will be reviewed for notification of RRP at the daily morning meeting. Monitors * The Social Service Director will audit the charts of residents who have had a room change to ensure the RP has been notified. This will be done daily for two months. * Results of the audit will be reported monthly to the QAPI Committee for three months and changes to the plan will be initiated as needed.	10.15.12 10.20.12 10.20.12 10.20.12 10.20.12 11.12.12

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F 247	Continued From page 3 would be responsible for notifying the responsible party.	F 247	F 441 For the resident cited * Resident #25: A privacy catheter bag has been provided for Resident #25 and the catheter bag is attached to the bed in such a way that it does not touch the floor while the resident is in bed.	10.15.12
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an 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 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	F441	For all residents * All other residents with catheters were audited to ensure that catheter bags were covered and kept from touching the floor, even when the resident had a low bed. In the audit, we found no other instances where a catheter privacy bag was touching the floor when attached to a bed or when the resident was in a chair. System changes * Nursing staff was inserviced regarding the importance of ensuring that the catheter bags of residents who have catheters are not touching the floor when the resident is in bed or in chair. They were also educated on how to attach a catheter privacy bag to a low bed so that it is not touching the floor Monitors * The DON or RCNA is monitoring all residents in the facility with catheters to ensure that the catheter bags are not touching the floor and that acceptable infection control practices are being utilized. This audit will be done daily for two weeks; monthly for two months and quarterly, thereafter. Random audits will also be conducted. * Audit results will be reported to the QAPI Committee during their monthly meetings for three months and changes to the plan will be initiated if improvement is not sustained.	10.15.12 10.20.12 10.20.12 11.12.12

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F 441	Continued From page 4 infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to ensure a urinary catheter bag was kept off the floor for 1 of 6 residents (Resident # 25). Findings include: 1. Observations on 10/15/12 at 3:06 PM revealed Resident # 25 lying in bed. The bed was in the lowest position. A urinary catheter bag was attached to the bedframe and was touching the floor. Observations on 10/15/12 at 5:11 PM revealed Resident # 25 being assisted from the bed to a wheelchair by Nursing Assistant (NA) # 1. The urinary catheter bag was attached to the bedframe, with the bottom of the bag lying on the floor. When Resident # 25 was seated, NA # 1 picked up the urinary catheter bag from the floor and placed it into a privacy bag hanging from the back of the wheelchair. When asked how the catheter bag was kept from touching the floor with the bed in the lowest position, NA # 1 stated, "We just hang the bag from the bedframe." During an interview on 10/18/12 at 2:42 PM with the Administrator and the Director of Nursing (DON), the Administrator stated the urinary catheter bag should be positioned off the floor. During the interview, the DON stated, "We have conducted infection control inservices in the past that would have covered keeping the bag off the floor. That is included in the care of a catheter. The expectation is for the bag to be positioned off the floor." During an interview on 10/18/12 at 3:05 PM, the	F 441		

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F 441	Continued From page 5 Staff Development Coordinator (SDC) stated that during orientation, new nursing assistants were instructed on infection control related to urinary catheter bags, and the bags should not be on the floor.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC/special locking system. The deficiencies determined during the survey are as follows:	K 000	DISCLAIMER Bayview Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Bayview Nursing and Rehabilitation. The facility reserves the right to submit documentation to refute the stated deficiencies through informal appeals procedures and/or other administrative or legal proceedings.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: all cross corridor doors in smoke wall. re-engaged to magnate when fire alarm system was silenced.	K 027	ALLEGATION OF COMPLIANCE The plan of correction is submitted as written allegation of compliance. K 027 Actions to correct deficient practice * See System changes — 12.21.12 To determine if the deficient practice affects other areas * All cross corridor doors will be checked to ensure proper closely and programming changes will be made as needed. — 12.14.12 System changes * Programing changes will be made by the fire alarm company to ensure all cross corridor doors do not re-engage to magnate when the fire alarm is silenced. — 12.12.12 Monitors * Monthly fire drills will be conducted and appropriate closure of all doors will be verified. — 12.14.12 * Results of the audit will be reported monthly to the QAPI Committee for three months and changes to the plan will be initiated as needed. — 12.14.12	

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

Director of Operations — 12.10.12

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K 027	Continued From page 1 42 CFR 483.70(a)	K 027	K 038 Actions to correct deficient practice	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: exit doors 46 and 47 did not release when fire alarm system was activated.	K 038	* See system changes below To determine if the deficient practice affects other areas * All other exit doors were checked to ensure they released when the fire alarm system was activitated. System changes * Programing changes will be made by the fire alarm company to ensure all exit doors release when the fire alarm is activated. Monitors * Monthly fire drills will be conducted and appropriate closure of all doors will be verified. * Results of the audit will be reported monthly to the QAPI Committee for three months and changes to the plan will be initiated as needed.	12.21.12 12.14.12 12.21.12 12.14.12 12.14.12
K 045 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: exit door leading out of Riverwalk Hall to public way has only single light bulb fixture. The	K 045	K 045 Actions to correct the deficient practice * The light fixture at doors 46 and 47 was replaced with a wall pack fixture with 2 bulbs. To determine if the deficient practice affects other areas * All other exterior doors were reviewed to ensure they are lit by fixures with multiple bulbs. System changes * In the future, any new exterior light fixtures will be of the type that have at least two bulbs Monitors * Monthly rounds will include monitoring to ensure * Audit results will be reported to the QAPI Committee during their monthly meetings for three months and changes to the plan will be initiated if improvement is not sustained.	12.08.12 12.08.12 12.08.12 12.14.12 12.14.12

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K 045	Continued From page 2 failure of single bulb would leave area in darkness.	K 045		
K 052 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: on activation of fire alarm, horn/strobe devices on Lake and Bay Hall did not function on test.	K 052	K 052 Actions to correct the deficient practice * Williams Sprinkler Inc repaired wiring on Lake and Bay halls that was causing malfunction of the horn / strobe To determine if the deficient practice affects other areas * All other halls were reviewed to ensure horn / strobe proper functioning, and it was found that a similar problem was occuring on Riverwalk. It was also repaired. System changes * Williams Sprinkler Inc repaired wiring on Lake and Bay and Riverwalk halls that was causing malfunction of the horn / strobe Monitors * Monthly fire drills will I include monitoring of horn / strobe light functioning. * Audit results will be reported to the QAPI Committee during their monthly meetings for three months and changes to the plan will be initiated if improvement is not sustained.	12.08.12 12.08.12 12.08.12 12.14.12 12.14.12
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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BAYVIEW NURSING & REHAB CENTER	3003 KENSINGTON PARK DRIVE NEW BERN, NC 28560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1. sprinkler heads under canopy around facility have excessive lint on heat sensitive element. 2. also many sprinkler heads have excessive corrosion on heads. 3. facility could not provide proper documentation that a 3 year full flow trip test has been preformed. 4. facility could not provide proper documentation that a 5 year obstruction investigation has been performed. 42 CFR 483.70(a)	K 062	K 062 Actions to correct the deficient practice * See system changes below To determine if the deficient practice affects other areas * All sprinkler heads under the canopy are being replaced rather than simply the ones identified System changes * Sprinkler heads under the canopy will be replaced with new 5.6K 155 degree QR semi-recessed dry pendant sprinklers by Williams Fire Sprinkler Co. * The three year full flow trip test was completed in February 2012. * Contract with Williams Fire Sprinkler will be modified to include the 3 year full flow and the 5 year obstruction tests. Both tests will be completed in January 2012. Monitors * Monthly rounds will include a review of sprinklers under the canopy to ensure they are clear of lint or errosion. * Audit results will be reported to the QAPI Committee during their monthly meetings for three months and changes to the plan will be initiated if improvement is not sustained.	1.18.13 1.18.13 1.18.13 2.2012 1.18.13 1.18.13 1.18.13