JUL 1 5 2013

PRINTED: 07/01/2013
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING _____ B. WING _____	06/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

(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 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to implement its written policy related to screening by not ensuring a criminal background check was requested upon hire for 1 of 2 sampled contract employees (housekeeper #1.) Findings included: Review of the facility's policy on Background Screening Investigations (Revised June 2005) read in part, "The personnel director, or other person designated by the administrator, will conduct employment background checks, reference checks, drug testing, and criminal conviction checks (including fingerprinting as required by state law) on persons making application, for employment with this facility. Such investigation will be initiated prior to offer of employment." There was no documentation of a criminal background request available for housekeeper #1 (date of hire 6/10/2013) employee file upon request on 6/19/2013. On 6/19/2013 at 5:19 pm during interview, the	F 226	Haymount Rehabilitation and Nursing Center 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 plan of correction is submitted as allegation of compliance. The below response to the Statement of Deficiency and the plan of correction does not denote agreement with the citation by Haymount Rehabilitation and Nursing Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl M. Geddie | TITLE: Executive Director | (X6) DATE: 7/9/13

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.

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F 226	Continued From page 1 payroll director indicated the housekeeping department is a contracted service as of 6/1/2013. Review of the contract between the company and the facility made April 25, 2013 for environmental, laundry and maintenance services to the facility read in part in section XIII, "Contractor's employees are subject to the facility's policies regarding immunizations, drug screenings and background checks, if required, at the expense of the contractor." On 6/20/2013 at 2:40 pm during an interview with the housekeeping supervisor, he presented the criminal background request for housekeeper #1 dated 6/19/2013. Interview with housekeeping supervisor indicated criminal background checks are done at the corporate office. The housekeeping supervisor indicated "they are normally done right away at the corporate office."	F 226	F226 Background check was obtained for Housekeeper #1. An audit was completed by the Housekeeping Contract Director to ensure that all background checks were on file for all its contract employees for the facility. All contracted employee files (housekeeping, laundry, and dietary) were audited by the contract Human Resource Manager to ensure all contracted employees had a current background check on file. Administrator received copy from the Contract managers for housekeeping, laundry, and dietary services verifying that all contracted employees had a current criminal background check on file. Each Contract facility manager will will submit proof of all new hires criminal background check to the Administrator or Designees before new hire's first day of work. New hire folders will be audited by the Administrator/designee weekly x4, then monthly x3, then quarterly thereafter. Any and all findings will be submitted to the QA for review.	6/19/13 6/19/13 7/8/13 7/8/13 7/8/13 7/8/13
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	F 441		

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	345414	A. BUILDING ______ B. WING ______	06/21/2013

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F 441	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility policy review and staff interviews the facility failed to post a contact precaution sign for 1of 1 resident (Resident #21) on contact isolation. Findings include: Review of the facility's policy titled "Isolation-Categories of Transmission-based Precautions" read in part "Use color coded signs and/or other measures to alert staff and visitors of the implementation of Transmission-Based Precautions, while respecting the privacy of the	F 441	F441 A yellow sign for Contact Isolation was obtained from the N.C. State-wide Program for Infection Control & Epidemiology (SPICE) website by the HR Manager. The Contact Isolation sign was immediately posted on the out-side of resident's #21 room door by the Infection Control nurse. The Unit Coordinators completed an audit of all other residents who required contact isolation and placed the appropriate Contact Iso-lation sign (SPICE) on the door for the one resident identified. The isolation cart for resident #21 was placed outside the resident room door by the charge nurse. Nursing staff was in-serviced by the DON of proper location of isolation cart. Nursing, Therapy, Dietary, Activity and Laundry/ Housekeeping staff was in-serviced by the Infection Control nurse and RN supervisor on the Contact Iso-lation Policy and Procedure and the use of the new Spice form. Staff will be in-serviced upon ori-entation and annually on the policy procedure for contact isolation and appropriate posting.	6/19/13 6/19/13 6/24/13 6/21/13 7/8/13 7/8/13

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	345414	A. BUILDING ______ B. WING ______	06/21/2013

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F 441	Continued From page 3 resident." Resident #21 was admitted to the facility on 11/15/12 and readmitted on 3/8/2013 with diagnoses which included Dementia, Alzheimer's, decubitus ulcers, and MRSA. During an interview at 8:30 am on 6/21/13 with nurse #6 (who identified herself as the infection control nurse), she revealed resident # 21 was on isolation precautions. An observation was made on 6/21/13 at 8:40 am of resident #21's room which revealed the room did not have a visible sign indicating the resident was on isolation precautions. There was not a sign visible on the outside of resident #21's room door. Visible from the hall was a plastic container three feet tall with the drawers facing toward the room door. The container was across the room from the room door. Located on top of this container was a package containing yellow items. Upon entrance to the room the package of yellow items was identified as a package of isolation gowns. Additional in-room inspection revealed an orange sign taped to the right hand side of the container. No writing was visible as the container was 6-9 inches away from the closet located on the right hand side of the room. The sign was facing the closet. When the container was moved it was noted that the sign read contact isolation. During an interview with Nurse #3 on 6/21/13 at 8:55 am regarding contact precautions, she stated she had one resident on contact precautions. She also stated that if a resident was on contact precautions, an isolation cart was put	F 441	F441(cont) Signs will be monitored on daily rounds by the charge nurse, and extra forms will be accessible at each nursing station. Residents on isolation will be reported and reviewed at the QA meeting monthly x3 and then quarterly thereafter.	7/8/13 7/8/13

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F 441	Continued From page 4 in the resident's room and a sign was taped on the cart stating what type of the precautions was needed. She further added that the facility doesn't post signs on the resident room door because "the Director of Nursing" (DON) told us not to post any signs on the door because it is a violation of the resident's privacy." Nurse #3 also indicated if a visitor came in the room they would know the resident was on contact precautions by the sign on the isolation cart in the room. During an interview at 9:00 am on 6/21/13, nursing assistant (NA) #2 reported that she knew a resident was on contact precautions when there was a sign posted on the door and that the sign indicated to wear apron (gown) and gloves. The procedure was to put the soiled items in a bag and in a container prior to leaving the room. She stated if a yellow gown was there you know they are on contact precautions. She reported that she had not cared for resident #21 this week. She later stated that resident #21 was on her assignment for that day. In an interview at 9:15 am on 6/21/13, NA #3 reported she was employed at the facility less than 2 weeks. NA #3 stated she received infection control education during an online course on day 2 of her orientation. She reported that the information about isolation precautions was located in the kiosk (facility's computer documentation screen) that is used by the NAs for obtaining information on residents. This information included but was not limited to behaviors, skin care and safety devices needed. She was unable to demonstrate the ability to locate any information about contact precautions	F 441		

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F 441	Continued From page 5 for resident #21 in the kiosk. An interview was conducted with the DON at 2:45pm on 6/21/13 regarding contact precautions. The DON stated that when isolation precautions are needed she would check on the roommate to determine if that resident could remain in the room with the resident who is on the precaution. She would check to see the type of isolation needed. She reported that an isolation kit with gowns, gloves and a trash collection container would be located inside the room. She defined the kit as a two drawer cart in the room with all the equipment in it. She stated different placards are used for different types of isolation and the placard was located on the side of the isolation kit inside the room.	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
JUL 26 2013
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345414	A. BUILDING 03 - MAIN BUILDING B. WING ____	07/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYMOUNT REHABILITATION & NURSING CENTER, INC	2340 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	Haymount Rehabilitation and Nursing Center 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 plan of correction is submitted as allegation of compliance. The below response to the Statement of Deficiency and the plan of correction does not denote agreement with the citation by Haymount Rehabilitation and Nursing Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	
K 038 SS=D	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. 18.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 7/9/2013 the following Life Safety item was observed as noncompliant, specific findings include: The door release mechanism in the cooler and freezer in dietary were not able to be seen in all levels of light in the case of an emergency. CFR#: 42 CFR 483.70 (a)	K 038	**K038** **The Maintenance Director has placed glow in the dark tape on the door release mechanism in**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl M. [signature]
TITLE: Executive Director
(X6) DATE: 7/25/13

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.

K038 (cont)	Date of Completion
in the cooler and freezer in the dietary department.	7/25/13
2. All other exits were inspected by the Maintenance Director to ensure that they are readily accessible at all times. No other exits identified.	7/25/13
3. All dietary employees and employees utilizing the cooler and freezer in the dietary department have been in-serviced by the Maintenance Director on the access to the release.	7/25/13
4. The door release will be checked weekly by the Maintenance Director to ensure door remains lighted and accessible.	7/25/13
5. Maintenance will report any and all findings at the monthly QA x3 months, and then quarterly thereafter.	7/25/13