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 _____	11/15/2013

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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to assess the circumstances surrounding falls so that effective interventions could be implemented for one of three residents sampled (Res.#142). The facility also failed to ensure a safe water temperature in 3 of 4 residents' rooms (rooms #10, #14, #31) where the temperature exceeded 116 Farenheit. Findings included: Resident #142 was admitted 8/27/13 with diagnoses of hemiplegia after stroke, personal history of falls, urine retention, abnormality of gait, and depressive disorder. The admission 5 day Minimum Data Set (MDS), dated 9/3/13 noted Res. #142 was cognitively intact, and was extensive assistance for all Activities of Daily Living (ADLs), with the physical assistance of one person. A review of the admission Care Area Assessment (CAA) dated 9/5/13 noted Res. #142 had a recent fall without injury, but was at risk for injurious falls, and that a	F 323	Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction. F 323 Affected Resident: 1. For resident 142, the history of falls and the circumstances of those falls were reviewed and a root cause analysis (RCA) was conducted to determine the primary cause of incidents. After the RCA, the resident was included in a discussion regarding his expectations of facility staff, his frustration with living in a nursing home, and his suggestions for preventing falls. Based on the RCA and the discussion	12-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/05/13

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.

SWX

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
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F 323	Continued From page 1 care plan would be developed, and was signed by the MDS coordinator and dated 9/5/13. Care plan dated 9/7/13 noted a focus of requiring assistance for ADL care secondary to resident ' s general debility/decline. The goal was that the resident would become independent with ADLs by next review. Approaches included: allow the resident rest breaks between tasks, physical or occupational therapy as ordered, one person to assist the resident with toileting/transfers every day and as needed. A review of the care plan noted no care plan for falls. A review of the falls incident reports for Resident #142 revealed that there were falls on: 9/20/13 An unobserved fall in the resident ' s bathroom, the resident was encouraged to ask for assistance. 10/12/13 The resident fell in his room while trying to transfer from bed to the wheelchair. Resident stated that he slipped. Urinal offered to keep at bedside and encouraged to call for assistance. 10/18/13 The resident fell in the bathroom and requested to go to the Emergency Room. It was determined in the Emergency Room that Res. #142 had a sprained knee. Facility offered the resident a bed/chair alarm, which he refused. The resident continues to transfer self to toilet without assistance. 10/23/13 A fall in the resident bathroom occurred when the resident was on the commode, trying to transfer to the wheelchair and fell. The bathroom was assessed and report noted that assist bar was on appropriate side (unaffected side). A	F 323	with the resident, cause-specific interventions were developed, written into the plan of care, and communicated to the staff. Since these interventions include the resident's input, and an RCA of the history of falls, they should be effective in preventing further falls by this resident. The resident has had no further falls. 2. The mixing valve was adjusted on 11-13-2013 and water temperature dropped to 113 degrees throughout the facility wide. This corrected the problem. Other Residents: 1. For each resident with a history of fall(s), a team reviewed the circumstances surrounding the falls and conducted a root cause analysis to ensure interventions implemented	

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	345465	A. BUILDING _____ B. WING _____	11/15/2013

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F 323	Continued From page 2 second rail could not be added due to the structure of the bathroom. 10/26/13 The resident was attempting to transfer himself from the bed to the wheelchair, slipped on the call bell cord and fell on his bottom. All cords were removed from the floor. 10/28/13 The resident was found on the floor of his room. The resident stated that the wheel chair went out from under him. No injuries noted. Facility will offer a bed/chair alarm. Remind the resident to lock brakes. The resident was placed on a list for psych services on 11/11/13, for any recommendations related to erratic moods and frequent falls. On 11/14/13 at 9:30 AM, in an interview, Res.#142 stated that he sometimes has to wait for help to the bathroom, because it is hard for him to maneuver in the bathroom in his wheelchair. His right side is his "good" side and the grab bar is on the right, but on the other side of the toilet. He states that sometimes he can not wait to go to the toilet and he goes into the bathroom himself. Res. #142 stated that the Nurse Aide (NA) came into his room and told him that sometimes he would have to wait for someone to help him. Res. #142 stated that he asked the NA " Ma ' am, do you want me to go in my pants? " Res. #142 has had 6 falls since Sept. 20, and he stated that he had another fall yesterday, and hit his shoulder. On 11/14/13 at 10:00 AM, in an interview, Nurse #1 stated that Res. #142 did fall on 11/13/13 and an x-ray was taken of his shoulder. A review of the x-ray report revealed that there were no fractures or damage to the shoulder.	F 323	were addressing the primary cause of the falls. If current interventions were modified, the care plans were updated and the staff was informed. In addition, Fall Prevention Care Plans for all residents, regardless of risk, will be developed at each resident's next MDS/Care Plan review, or at the time of a significant change or fall. 2. The mixing valve was adjusted on 11-13-2013 and water temperature dropped to 113 degrees throughout the facility wide. This corrected the problem. System Changes: 1. It is now the policy of this facility that all residents will be assessed for fall prevention on admission, quarterly, annually, with significant change and if a fall occurs. The assessment will	

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F 323	Continued From page 3 On 11/14/2013 at 11:00 AM in an interview, the MDS nurse stated that falls are assessed and discussed in the accidents/incidents meetings that are held weekly. On 11/14/13 at 2:10 PM, the Director of Nursing (DON) stated that since Res. #142 is cognitively intact, he can make decisions about whether to try and transfer himself or not. The DON stated that the facility does encourage Res. #142 to call for assistance. 2. Record review of a facility policy entitled "Water Temperatures Patient Care Areas" dated 3/5/2003 indicated under policy statement "Water temperatures in hand sinks or bathtubs will be maintained at levels that will not scald or harm residents." The policy also indicated "To be acceptable, this reading should be between 100 and 116 degrees F (Farenheit). If the reading is not between 100 and 116 degrees F, all staff should be notified immediately and no hot water should be used in patient care areas until the temperature has been corrected. It will be the responsibility of the Administrator and Director of Nursing to notify oncoming staff of any problems related to water temperatures. After any problem with maintaining proper water temperatures is corrected, water temperatures will be taken and recorded every two (2) hours for the next 24 hours to ensure the problem has been corrected."	F 323	include physical, psychosocial and medical issues, and will include personal preferences. All residents will have a Fall Prevention Care Plan, based on the assessment, regardless of the risk of falls, and the Care Plan will include interventions aimed at affecting the specific risks for each resident. If a resident has a fall, the circumstances surrounding the incident will be reviewed by the Accident/Incident team, a root cause analysis will be conducted, and cause-specific interventions will be implemented, added to the resident's care plan, and communicated to the staff. 2. The mixing valve was repaired and a new policy requires the water temperatures be checked and logged daily.	

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F 323	Continued From page 4 A temperature observation with the Maintenance Director (MD) on 11/13/13 at 2:07pm on three separate resident halls, revealed the following room water temperatures in the residents' bathroom sinks with a calibrated thermometer: (Prior to sink water temperature checks, the MD placed the metal shaft of the thermometer into an ice bath and calibrated it to 32F. After the thermometer was calibrated to 32F, the MD placed the calibrated thermometer metal shaft into an empty cup, and placed the cup containing the thermometer into each of the resident's sink running hot water until the thermometer read its maximum temperature.) Rm 14 - 120F Rm 10 - 120F Rm 31 - 120F In an interview with the MD on 11/13/13 at 2:20 pm, the MD stated he documented in a log weekly water temperatures in resident rooms. The MD stated a new mixing valve was installed on 10/1/13. The mercury thermometer above the new mixing valve read 128F. When asked if the water was too hot, the Maintenance Director stated "yes, the water is too hot, it should be 110F-116F." In an interview with the Executive Director on 11/13/13 at 2:26 pm, the Director stated "if the water temperature is too high, we would adjust the water temperature until it was within range, and then we would stop the showers until the temperatures were back within safe range."	F 323	Quality Assurance: 1. Falls for all residents will be tracked and trended, and the data collected will include circumstances surrounding each fall. The data will be reviewed by the Quality Assurance Committee monthly, on an ongoing basis, to ensure that a reduction in falls per individual residents occurs, which will indicate that interventions have been effective. If falls per resident have not decreased, this plan will be reviewed and modified, by the Quality Assurance Team. 2. Water temperatures will continue to be monitored daily and the logs will be reviewed by the Quality Assurance Team each month for 4 months. If water temperatures do not remain in acceptable levels, further repairs to the water heater will be undertaken.	

Bayview Nursing & Rehabilitation Center
3003 Kensington Park Drive
New Bern, North Carolina 28560

Brian D. Joiner LNHA
Executive Director
administratorl@BayviewRehab.com
Tel: 252-638-1818 ext. 222

DEC 09 2013

BAYVIEW
NURSING AND REHABILITATION CENTER

December 5, 2013

Sheilah Wood, RN
NC Department of Health and Human Services
Division of Health Service Regulation
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711

Ms. Wood,
Attached is our Plan of Correction based on the cited deficiencies listed on the CMS-2567 from your visit on November 12-15, 2013. I hope you find this POC acceptable and that it covers all concerns noted on the CMS-2567. Please note that this POC has been submitted and postmarked by December 5, 2013 as stated on your letter. Based on receiving one citation at a level D, I am requesting a desk review to bring Bayview Nursing & Rehab Center back into compliance.

If you have any further questions, please do not hesitate on contacting me at (252) 638-1818.

Respectfully,

Brian D. Joiner LNHA
Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345485	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/03/2013

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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 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	Please see attached pages for Provider's Plan of Correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 12/20/13

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GW

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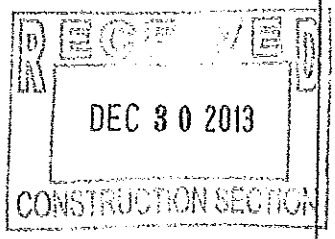
K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following item were noncompliant, specific findings include: door going to kitchen from service hallway and dry storage room door being held open with cardboard. Also beauty shop door would not close and latch. 42 CRF 483.70(a)	K 018		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following item were noncompliant, specific findings include: smoke barrier wall in attic near Living room and Activity room had unsealed penetrations that was not sealed to maintain the required the fire resistance rating of the smoke wall. 42 CFR 483.70(a)	K 025		

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K 062 SS=E	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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following item were noncompliant, specific findings include: closet in room 35 has storage within 18 inches of sprinkler head. 42 CFR 483.70(a)	K 062		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:00 am onward, the following item were noncompliant, specific findings include: GFCI in beauty shop did not trip on test. 42 CFR 483.70(a)	K 147		

Submission of this response to the statement of deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or correctly sighted and/or require correction.

K 018

Completion Date:
1/17/2014

1. Cardboard has been removed from propping open door going to kitchen from service hallway and dry storage room. Door handle to beauty shop was replaced.
2. Maintenance Director audited the facility doors for proper closing and latching and any doors found out of compliance were corrected. He also inspected to make sure no facility door was being propped open.
3. Maintenance Director will include in his weekly facility audit to inspect that facility doors close and latch appropriately and verify that facility doors are not being propped open.
4. Weekly audits will be brought to the monthly Quality Assurance Meeting for review for 4 months to make sure that the doors meet regulatory requirements.

K 025

Completion Date:
1/17/2014

1. Smoke barrier wall in attic near living room and Activity room hall has now been sealed properly to maintain the required fire resistance rating for smoke walls.
2. Maintenance Director inspected all smoke barrier walls in the attic to make sure they were sealed properly. If any smoke barrier walls were found to be out of compliance, the Maintenance Direct sealed the penetrations properly.
3. Maintenance Director will inspect all smoke barrier walls in the attic whenever there is work performed in the attic by an outside vender to make sure the smoke barrier walls are properly sealed to maintain the required fire resistance rating for smoke walls.
4. Maintenance Director will monitor all smoke barrier walls and notify the Quality Assurance Team if any walls are found to be out of compliance to meet regulatory requirements.

K 062

Completion Date:
1/17/2014

1. Storage in closet of room 35 has been removed and now has 18 inches of clearance from sprinkler head.
2. Maintenance Director will audit all resident closets to make sure that there is no storage within 18" of sprinkler heads. If any storage is found to be within 18" of the sprinkler head, the Maintenance Director will remove the storage to be within regulatory compliance.
3. Maintenance Director will include in his weekly facility audit to inspect resident closets to make sure there is an 18" clearance from the sprinkler head to meet regulatory requirements.
4. Weekly audits will be brought to the monthly Quality Assurance Meeting for review for 4 months to make sure that the resident closets meet regulatory requirements.

K 147

Completion Date:
1/17/2014

1. The GFCI in the beauty shop was replaced.
2. The Maintenance Director audited all the facility GFCI outlets to make sure they trip on test. If any GFCI outlet was found to not trip during test, the GFCI outlet was replaced.
3. Maintenance Director will include in his monthly facility audit to inspect facility GFCI outlets will trip on test.
4. Monthly audits will be brought to the monthly Quality Assurance Meeting for review for 4 months to make sure that the GFCI outlets meet regulatory requirements.