

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL025035	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 07/29/2016
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NAME OF PROVIDER OR SUPPLIER NEW BERN HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 2915 BRUNSWICK AVENUE NEW BERN, NC 28562
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(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
C 000	<p>Initial Comments</p> <p>Report of a Complaint Investigation by Billy S. Bryant conducted on 07/29/2016.</p> <p>Records indicate this facility was first licensed on 03/01/1980. The facility is currently licensed for 108 Beds. Therefore the facility was surveyed for conformance with the applicable portions of the 2005 Rules for Licensing of Adult Care Homes of Seven or More Beds and applicable portions of the 1978 Edition of the North Carolina Building Code(s), Institutional Occupancy and the 1977 Rules for Licensing of Adult Care Homes of even or More Beds in effect at the time of initial licensure.</p> <p>The complaint stated the facility HVAC system was not operating and cooling the building down to the maximum temperature allowed in the corridors and the resident room temperatures were too high.</p> <p>The complaint was substantiated.</p>	C 000		
C 189	<p>Building Equipment Maintained Safe, Operating</p> <p>SECTION .0300 - PHYSICAL PLANT 10A NCAC 13F .0311 OTHER REQUIREMENTS (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. (k) This Rule shall apply to new and existing facilities with the exception of Paragraph (e) which shall not apply to existing facilities.</p> <p>This Rule is not met as evidenced by: 1. Based on observation and an interview with the</p>	C 189		

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

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C 189	<p>Continued From page 1</p> <p>facility's Director of Quality Assurance and a representative of an HVAC company on site the mechanical equipment was not kept in operating condition.</p> <p>Findings from 07/29/2016:</p> <p>a. Green Hall - The compressor to Unit #8 supplying central cooling air was not operating.</p> <p>b. Red, Blue, and Green Halls - A total of 8 temperature readings were taken in the corridors and 3 readings were above a temperature of 80°F with relative humidity in the mid 70's range.</p> <p>c. Red and Blue Halls - In 4 resident rooms with working central cooling systems 3 of 4 readings taken at the supply air vents showed cooling air temperatures were in the mid 70°F range indicating that the central cooling system was possibly not operating correctly.</p>	C 189		