STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLL IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NH0332			B. WING		12/14/2011		
NAME OF PRO	OVIDER OR SUPPLIER		STREET ADDRES	S, CITY, STATE	, ZIP CODE	1	
COVENANT VILLAGE, INC			1351 ROBINWO GASTONIA, NO				
(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)		5) LETE TE
L 043	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2209(D) INFECTION CONTROL 10A-13D.2209 (d) The facility shall ensure communicable disease screening, including tuberculosis, prior to admission of all patients being admitted from settings other than hospitals, nursing facilities or combination facilities; prior to or upon admission for all patients admitted from hospitals, nursing facilities and combination facilities; and within seven days upon the hiring of all staff. The facility shall ensure tuberculosis screening annually thereafter for patients and staff as required by 10A NCAC 41A, "Communicable Disease Control" which is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained at no charge by contacting the N.C. Department of Health and Human Services, Division of Public Health, Tuberculosis Control Branch, 1902 Mail Service Center, Raleigh North Carolina 27699-1902. Identification of a communicable disease does not, in all cases, in and of itself, preclude admission to the facility. This Rule is not met as evidenced by: Based on observations, staff inlerviews and record reviews facility staff failed to remove gloves and wash hands after providing incontinence care for two (2) of five (5) residents observed during incontinence care. (Resident #4 and #3).			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BI TAG CROSS-REFERENCED TO THE APPROPRIA		sistants or hand utlined in d sted by cted the ded of dures for aff give any ient in lowing one NA sen to eport any sing. nator will hose who end of tor of to deds to be to be s. The a specific his an issue. those	1/2012
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Tom Hower, Executive Director

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/A AND PLAN OF CORRECTION IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLIER/A		A. BUILDING		COMPLETED			
NAME OF PRO	OVIDER OR SUPPLIER	1	STREET ADDRE	SS, CITY, STATE	ZIP CODE		
			1351 ROBINY				
COVENANT	r village, inc		GASTONIA, N				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		Ю	PROVIDER'S PLAN OF COI	RRECTION	(X5)
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TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		' 1	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	DATE	
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L 043	.2209(D) INFECTION	CONTROL	Ì	L 043			
	10A-13D.2209 (d) The	facility shall	1	ł			
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1	admitted from hospitals	<u>-</u>	ı				ļ
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	is incorporated by refer		ļ	j			
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	at no charge by contac Department of Health a						
	Division	ind riuman services,					
	of Public Health, Tuber	culosis Control Branch					
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	27699-1902.	•	i				
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	disease does not, in all	cases, in and	ľ	1			1
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	This Rule is not met as	evidenced by:					
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L	gloves and wash hands						
	_	vo (2) of five (5) residents					
1		inence care. (Resident #4	1	<u> </u>			1
	and #3).	•		1			
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBE			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
NH0332			B. WNG		12/14/2011				
NAME OF PROVIDER OR SUPPLIER COVENANT VILLAGE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 ROBINWOOD ROAD GASTONIA, NC 28054						
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE			
L 043	.2209(D) INFECTION C	ONTROL		L 043					
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	upon admission for all p admitted from hospitals, facilities and combination								
	and within seven days u of all staff. The facility s ensure tuberculosis scre	rpon the hiring hall							
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	is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained								
	at no charge by contacti Department of Health at Division	nd Human Services,							
	of Public Health, Tubero 1902 Mail Service Center, Ra								
	27699-1902. Identification of a comm disease does not, in all	cases, in and				:			
	of itself, preclude admis facility.	sion to the							
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		o (2) of five (5) residents nence care. (Resident #4		i					

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LAUR DIAMAR AGREEMENT		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
				A. BUILDING B. WING	<u> </u>	1 .		
		NH0332				1	2/14/2011	
NAME OF PROVIDER OR SUPPLIER COVENANT VILLAGE, INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1351 ROBINWOOD ROAD GASTONIA, NC 28054					
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
L 043	.2209(D) INFECTION C	CONTROL		L 04 3				
£ 043	ensure communicable of including tuberculosis, padmission of all patients admitted from settings of hospitals, nursing facilitic combination facilities; proportion of all padmitted from hospitals, facilities and combination and within seven days to of all staff. The facility sitensure tuberculosis sore thereafter for patients an required by 10A NCAC. "Communicable Disease is incorporated by refere including subsequent ar Copies of these Rules in at no charge by contactin Department of Health and Division of Public Health, Tubero 1902 Mail Service Center, Ra 27699-1902. Identification of a commidisease does not, in all of itself, preclude admissingly. This Rule is not met as a Based on observations, record reviews facility st gloves and wash hands incontinence care for two	facility shall lisease screening, prior to s being other than lies or rior to or patients In nursing In facilities; Inpon the hiring Inall Isening annually Ind staff as Ind staff as Ind Human Services Ind Human Services Ind Horth Carolina Unicable Island Services or Ind Horth Carolina Unicable Island Services or Isl		L 043				
	and #3).			;				
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