PRINTED: 12/28/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION 1 0 2012	(X3) DATE SURVEY COMPLETED	
		345265	B. WING		C 12/02/2011	
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA	В/ҮА	10	EET ADDRESS, CITY, STATE, ZIP CODE 086 MAIN STREET NORTH ANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 332 SS≃D	RATES OF 5% OR N		F 332	F332		
	The facility must ensumedication error rates	ire that it is free of s of five percent or greater.		The facility will continue to that it is free of medication or rates of five percent or great	error	16
	by: Based on observation interviews, the facility medication error rate by 4 errors out of 63 of resulting in an error rate in the facility medication error rate by 4 errors out of 63 of resulting in an error rate in the facility in the f	less than 5% as evidenced opportunities for error, ate of 6.3%, for 3 or 10 oring medication pass 10). Findings include: admitted to the facility on diagnoses including the resident's clinical record ders dated 9/19/02 for or original original original original original at the diagnoses on 12/1/11 at the #1 administered one drop solution in each eye.		Nurse # 1 reviewed current products for Resident #26 on 1 to ensure that medication recorded reflected correct transcription physician orders. Resident #2 attending physician and responsition of the medication variance on 12-1-documented on a medication variance report. Nurse #1 reviewed current plorders for Resident #8 to ensure medication record reflected cohysician orders and don't crun body of the physician order 12-1-11. Resident #8 attending the physician and responsible parametrified of the medication variance report.	2-1-11 cord n of 26 onsible -11 and nysician ure that orrect ush was rs on ng rty	
and the second s	stated she received tradministration with other she was hired. She state of the sta	aining on medication ler nurses on the floor when ated the pharmacy				
ABORATORY I	DIRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURI	-	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 wing 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 s 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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
l	i	345265	B. WIN		.,,,	С	
MANEORDE	201000000000000000000000000000000000000	340200				12/0	2/2011
	ROVIDER OR SUPPLIER ENTER HEALTH & REHAI	В/ҮА		10	EET ADDRESS, CITY, STATE, ZIP CODE 086 MAIN STREET NORTH ANCEYVILLE, NC 27379		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 332	conducted medication every quarter. Nurse MAR and confirmed s drop of Levobunolol ir drops as ordered. Nu administered two drop In an interview on 12/development coordinate completed medication nurses during orientate released to work on the precepted with the oth SDC stated she repeat at least yearly. The plant of the state of	pass observations at least #1 reviewed the resident's he had administered one neach eye instead of two rse #1 stated she usually so but was nervous today. 1/11 at 5:15PM, the staff ator (SDC) stated she pass observations on the ion before they were he floor. The new staff also her nurses on the floor. The sted med pass observations harmacist conducted	F	3332	Nurse # 2 reviewed current orders for Resident #30 on to ensure that medication rereflected the resident correct medication on medication on Resident # 30 attending phy and responsible party were rof the two medication variant 12-1-11 and documented on medication a variance report. The facility current resident'	12-1-11 cord t ecord, sician notified nce on	1/6
and the second s	when medications were the right dosage was of	triple check the orders re administered to ensure given.			physician orders and medica record were reviewed to ensu- orders were transcribed per p	tion ure that physician	
İ	of Nursing (DON) state medication administration. The pharm training for the nursing pharmacist conducted observations. Her expfollow the correct proc MARS and labels whe medications.	staff. The SDC and periodic medication pass ectation was for the staff to edures and triple check the n administering			2- Dec 30, 2011 by Director Nursing, staff development coordinator, and Administra nurses. Each new admission	r of ative	
	6/3/05 with multiple dia dysphagia and percuta gastrostomy (PEG). Re clinical record revealed 3/26/10 for Omeprazol	ineous endoscopic eview of the resident's I physician orders dated			physician orders will be revenued morning meeting to ensure to orders have been implement transcribed correctly to inclinot crush medication and ey	that ted and uding do	

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STATEMENT	OF PERIODICAL	THE OCITATION				OWIR M	<i><u>J. 0938-0391</u></i>
AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345265	B. Wil	ИG		l l	C 2/2011
NAME OF P	ROVIDER OR SUPPLIER			ere	DEET ADDRESS OFFI STATE VID OOD	12/0	2/2011
BBIANC	-NTCD IMALTIL & BELLA			1	REET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH		
DRIAN CI	ENTER HEALTH & REHA	B/YA			YANCEYVILLE, NC 27379		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					1
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F 332	Continued From page	. 2					
				332			
	inhibitor indicated for	meprazole is proton pump treatment and prevention of			1		
	Ulcers, dastroesonbar	Jeal reflux disease, and	!		The facilities current lices	nead niveo?a	
	esophagitis. The dela	yed release capsules					if
	contain an enteric coa	ited granule formulation of			each have completed a n	nedication	176
•	omeprazole, so that th	ne absorption begins only	i		observation		16
	after the granules leav	e the stomach.	!		and medication test on 12	2/12/11,	
	1				12/13/11 and 12/22/11 by	facility	
	Lexicomp's Drug Infor	mation Handbook, 14th			staff development coording	nator.	
	edition, stated in part: Administration: Capsu	"Omeprazole -					
	Administration. Capst	ille. do not crush."					
	In an observation of m	edication pass on 12/1/11			The facilities current licer	ised mirses	
	at 8:16AM, nurse #1 p	repared resident #8's			were provided re- education		
	medications for admin	istration per PEG tube.	1		regarding medication adm		
	Nurse #1 opened the	omeprazole capsule and			to include medication at the	mistration	
	poured the contents in	to a plastic sleeve with the	4		to include medications tha		
	crushing device and c	ations, placed them into a rushed the medications.	1		crushed, timeliness of med		Į.
	Nurse #1 dissolved the	crushed medications with			and administration of corr	ect dosage	j
	30 ml (milliliter) of water	er. The nurse flushed the			of medication prescribed of	on	1
	PEG tube with 30ml of	water and attempted to			12/12/11, 12/13/11 and 12	/22/11 and	İ
	administer the medicat	tions by gravity flow. The			completed on 1/06/12 by f	acility	-
	nurse milked the PEG	tube several times but the			staff development coordin	ator Any	ĺ
ļ	medications did not flo	w freely. Nurse #1			Nurses that have not been	in somissal	İ
	them through the Medic	cations by slowly pushing g with a syringe. The tube					
	was flushed with 30 ml	g with a synnge. The tube	1		Will have the test complete	ed by SDC	ĺ
1	medications were give	n water alter the	!		Before going to the floor a	nd SDC	ļ
	•				Will monitor the Medication	on pass	
	Review of the resident'	s current MAR revealed	1		Observation before Nurse	gives	
	"do not crush" instructio	ons for omeprazole.	1		medication by them self.		
	In an interview on 12/1	/11 at 2:22PM, nurse #1		,		1	
	stated she received tra	ining on medication	İ				
1	administration with other	er nurses on the floor when				ŀ	
] :	she was hired. She sta	ited the pharmacy					[
	conducted medication p	pass observations at least	<u> </u>				-
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STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUI	
		345265	B. WING		C 12/02/2011	
	OVIDER OR SUPPLIER	В/УА	10	EET ADDRESS, CITY, STATE, ZIP CODE 186 MAIN STREET NORTH ANCEYVILLE, NC 27379	1 120	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	every quarter. Nurse resident's MAR read "the omeprazole would unless it was crushed front of her MAR for a none. In an interview on 12/stated she completed observations on the medications on the medications on the floor. Trepeated med pass of the pharmacist conductors on the floor. Trepeated med pass of the pharmacist conductors were posted in the She stated the staff she medications not to crush an interview on 12/stated the staff was transfer and the staff was transfer and the staff. The She conducted periodic medications. The DC "do not crush" list on enhad received in-service medications. Her expeknow which medications crushed. 3a. Resident #30 was 3/22/07 with multiple desophageal reflux. Resident #30 expenses the staff was transfer to the staff was tran	#1 acknowledged the do not crush." She stated in not go through the tube. Nurse #1 checked the "do not crush" list but found 1/11 at 5:15PM, the SDC medication pass urses during orientation ased to work on the floor. In the SDC stated she observations at least yearly. In the SDC stated she observations at least yearly. In the state of the second of all the MARS. In the state of	F 332	The facility Director of Nurreport findings of weekly at the QA&A Committee weethen bi- monthly x 1. Data reviewed and analyzed for and trends. The QA&A cowill evaluate the results and implement additional intervas needed to ensure continucompliance.	udits to kly x 4 will be patterns mmittee l	16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REH		108	ET ADDRESS, CITY, STATE, ZIP CODE 36 MAIN STREET NORTH INCEYVILLE, NC 27379	12/02/2011	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
indigestion 30 minus Omeprazole is proto treatment of gastroes. Lexicomp's Drug Infedition, stated in pataken on an empty subreakfast." Observation of med 9:05AM revealed not omeprazole 20mg of Review of the reside administration time of the stated she was train administration when pass observation has 2011. She reviewed that omeprazole had She stated the reside breakfast. Nurse #2 supposed to be given breakfast but she was train administration when pass observations on the before they were released she complete observations on the before they were released med pass. The pharmacist contobservations. The States is protocolors and the states of the pharmacist contobservations. The States is protocolors and the states of the pharmacist contobservations. The States is protocolors and the states of the pharmacist contobservations. The States is protocolors and the states is protocolors.	tes prior to breakfast. on pump inhibitor indicated for esophageal reflux disease. formation Handbook, 14th rt: "Omeprazole - Should be stomach; best if taken before dication pass on 12/1/11 at tarse #2 administered one apsule with applesauce. The standard of the stomach of 8:30AM for omeprazole. 2/1/11 at 1:40PM, Nurse #2 ed on medication hired. Her last medication di been conducted in June of the MAR and acknowledged if been given after the meal. The entire of the stated omeprazole was in 30 minutes before as running a little late today.	F 332			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	ULTIPLE DING	CONSTRUCTION	(X3) DATE SU COMPLE	
		345265	Į.	G		į.	C 02/2011
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA	AB/YA		1086	T ADDRESS, CITY, STATE, ZIP CODE 5 MAIN STREET NORTH NCEYVILLE, NC 27379	1200)2/20 1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	right time. In an interview on 12 stated the staff was to administration by the The pharmacist also nursing staff. The SE conducted periodic mobservations. Her extended follow the correct pro MARS and labels who medications. 3b. Resident #30 war 3/22/07 with multiple prostatic hypertrophy Review of the resider physician orders date (extended release) 10 urinary antispasmodic frequency. Lexicomp's Drug Information, stated in part: Administration: Extended whole; do complete the complete distribution of medical groups.	In they were given at the In they were given at the In the DON	F	332			

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION		(X3) DATE S	ETED
1		345265	B. WIN	۱G .	,		40	C
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA	В/ҮА		s	STREET ADDRESS, CITY, STATE, ZIP CODI 1086 MAIN STREET NORTH YANCEYVILLE, NC 27379	E	1 12:	/02/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOU	LD BE	(X5) COMPLETION DATE
F 371	In an interview on 12/1 stated she was trained administration when he pass observation had 2011. Nurse #2 acknown the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September of the oxybutynin ER. September oxybutyni	d on medication ired. Her last medication been conducted in June owledged she had crushed he was unaware that it. She reviewed the "do not of her MAR and found the XL) for oxybutynin listed. I/11 at 5:15PM, the SDC medication pass urses during orientation ised to work on the floor. cepted with the other servations at least yearly. cted quarterly med pass C stated "do not crush" in front of all the MARS. ould be familiar with which ish. I/11 at 6:17PM, the DON ined on medication poss N stated the nurses had a ach medication cart and s on crushing ctation was for the staff to s could or could not be URE,	F 3	71				
SS=D	STORE/PREPARE/SEI	ORE, RVE - SANITARY	F 3	71				

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MAND PLAN OF CORRECTION IDENTIFICATION MARKED 345265 MAKE OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHABIYA STREET ADDRESS, CITY, STATE, JP CODE 1088 MAIN STREET NORTH 1089 MAIN STREET NORTH 1089 MAIN STREET NORTH 1089 MAIN STREET NORTH 1080 MAIN STREET N	CEATEMENT		MEDICAID SERVICES				OMB N	O. 0938-039
STREET ADDRESS, CITY, STATE, AP CODE 1807/2011 1808/ANN STREET ADDRESS, CITY, STATE, AP CODE 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1808/ANN STREET NORTH 1809/ANN STREET NORTH 1	AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1			(X3) DATE SU	RVEY
BRIAN CENTER HEALTH & REHABIYA (AS JID SUMMARY STATEMENT OF DEHICIENCIES (EACH DEHICIENCY MUST BE PRECEDED BY FULL REGULTIONY OR LISC DEMITTENING INCORMATION) F 371 Continued From page 7 The facility must (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility 1) failed to air-dry 30 dome lids, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups were observed to the ron the serving line, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups were observed stacked on top of each other on a cart in the dish rom. When the dictary manager lifted the racks with bowls and cup; water ran off the bowls and cups. The Dietary Manager said that "they were cleaned, wet, and ready to be used for the dinner meal. STREET ADDRESS, CITY, STATE, APP CODE 188 MAN STREET NORTH YANCEYVILLE, NC 27378 PROMITES FLAME TO FORTH YANCEYVILLE, NC 27378 PROMITES FLAME TO FURTHER TO FORTH YANCEYVILLE, NC 27378 PROMITES FLAME TO FURTHER TO FORTH YANCEYVILLE, NC 27378 PROMITES FLAME TO FURTHER TO STATE AT EACH OF THE APPROPRIATE COMPANTE TO THE	<u> </u>		345265	B. WA	iG_		1	
F 371 Continued From page 7 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility 1) failed to air-dry 30 dome lids, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups. Findings included: During kitchen observation on 12/1/11, at 4:20p.m., 30 dome lids were stacked on top of each other on the serving line, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups were observed stored on top of each other on the serving line, 4 racks (64) of soup/salad bowls and cup; water ran off the bowls and cups. The Dietary manager lifted the racks with bowls and cup; water ran off the bowls and cups. The Dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary manager acknowledged the condition of the dome lids, soup/salad bowls and cups. The Dietary Manager or cook will	BRIAN CE	NTER HEALTH & REHA	ATEMENT OF DEFICIENCIES		1	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379 PROVIDER'S PLAN OF CORREC	TION	I
The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility 1) failed to air-dry 30 dome lids, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups. Findings included: During kitchen observation on 12/1/11, at 4:30p.m., 30 dome lids were stacked on top of each other on the serving line, 4 racks (64) of soup/salad bowls and 3 racks (63) of cups were observed stacked on top of each other on a cart in the dish room. When the dietary manager lifted the racks with bowls and cups, The Dietary Manager said that "they were cleaned, wet, and ready to be used for the dinner meal. Findings included: During kitchen observation on 12/1/11, at 4:30p.m., 30 dome lids were stacked on top of each other on a cart in the dish room. When the dietary manager lifted the racks with bowls and cups, The Dietary Manager said that "they were cleaned, wet, and ready to be used for the dinner meal. Fig 71 The Dietary Manager immediately removed all dishes to include dome lids, soup/salad bowls and cups on 12-1-11 that were observed stored wet. Each of the items were placed in the dish machine to completed entire cycle. The facility dishes to include dome lids, soup/salad bowls, cups, glasess and plates were observed to ensure that each were stored dry on 12-1-11 by Dietary Manager. The Dietary Staff were provided reeducation regarding procedures for unloading dishes, storage of dishes to include cups, domes / bowls and dishwasher procedures on 12-1-11 and completed on _12/1/11_by Dietary Manager. The Dietary Manager or cook will		REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	Į.		CROSS-REFERENCED TO THE APPR	JLD BE OPRIATE	COMPLETION
5:05 p.m., she stated, "I do not know who stored the bowls wet on the cart." 5:05 p.m., she stated, "I do not know who stored the bowls wet on the cart." 6:05 p.m., she stated dry daily x 30 days and bi monthly times two.	t a b t ti	The facility must - (1) Procure food from considered satisfactor authorities; and (2) Store, prepare, dis under sanitary condition of the cond	sources approved or y by Federal, State or local tribute and serve food ons is not met as evidenced s, staff interviews, and cility 1) failed to air-dry 30 of soup/salad bowls and 3 ation on 12/1/11, at were stacked on top of ing line, 4 racks (64) of 3 racks (63) of cups were up of each other on a cart in the dietary manager vis and cup; water ran off e dietary manager littion of the dome lids, lietary Manager said that " and ready to be used for dietary aide on 12/1/11, at 1 do not know who stored	F		The Dietary Manager immeremoved all dishes to includids, soup/salad bowls and of 12-1-11 that were observed wet. Each of the items were the dish machine to comple cycle. The facility dishes to includids, soup/salad bowls, cups and plates were observed to that each were stored dry on by Dietary Manager. The Dietary Staff were proveducation regarding procedu unloading dishes, storage of include cups, domes / bowls dishwasher procedures on 12 and completed on _12/1/11_Dietary Manager. The Dietary Manager or cool observed the storage of dishe ensure that each stored dry disheres.	de dome cups on stored cplaced in ted entire de dome glasess ensure 12-1-11 ided re- ures for dishes to and 2-1-11 by k will es to aily x 30	

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STATEMENT	OF DEFICIENCIES	I SERVICES				OMB	NO. 0938-039
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	JLTIPLE CONST DING	RUCTION	(X3) DATE	
		345265	B. WIN	3			С
	ROVIDER OR SUPPLIER ENTER HEALTH & REHAI	BIYA		1086 MAIN S	ESS, CITY, STATE, ZIP CODE STREET NORTH ILLE, NC 27379	1:	2/02/2011
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F 371	Dietary manager, she the dome lids, bowls a further indicated, " ev	8 1/11, at 5:10 p.m., with the stated, "I cannot say why and cups were wet." She veryone is nervous and one because the State is in	F3	The report the Q then I review and to will e imple as nee	facility Dietary Mart findings of week (A&A Committee bi- monthly x 1. Dowed and analyzed frends. The QA&A evaluate the results ament additional integration of the contiliance.	ly audits to weekly x 4 ata will be for patterns committee and	

PRINTED: 12/22/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **抗紅食食油品** QMB_NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDENBUPPLIERICLM.
[DENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION A. BUILDING 10 DAIGHTUE MARY - 10 B. WING 345265 12/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1088 MAIN SYREET NORTH BRIAN CENTER HEALTH & REHABIYA YANCEYVILLE, NC 27379 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE BUMMARY STATEMENT OF DEFICIENCIES (XG) COMPLEYION DATE ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY K012 K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 Corrections for the alleged deficient SS≒F practices noted as: Building construction type and height meets one (1) Top layer of sheetrock in attic of the following. 19.1.6.2, 19.1.6.3, 19.1.8.4, area over exit corridor has holes 19,3,5,1 and penetrations not sealed: I to engage a contractor to remove and replace sections or patch as needed to maintain required one This SYANDARD is not met as evidenced by: hour fire resistance rating over Based on observation on Tuesday 12/20/2011 at corridors. approximately 8:00 AM onward the following was (2) Ceiling expansion joint noted: separated and not properly 1) The top layer of sheetrock in the attic area secured to ceiling: Is to engage above the corridors which is part of the one four exit corridor has holes and penetrations in the top contractor to remove and replace lay that were not sealed in order to maintain the or repair section as needed to required fire resistance rating of the calling.. maintain required one hour fire 2) The celling expansion joint located near (comresistance rating of the corridor 402 is separating from the ceiling and is not ceiling. properly accured to the ceiling. (3) Ceiling radiation damper 3) The ceiling radiation damper located in the located in laundry room was not laundry room was not maintained clean and in good condition. maintained clean and in good condition: Is to clean affected 42 CFR 483,70(a) damper and verify proper K 014 NFPA 101 LIFE SAFETY CODE STANDARD K 014 operation or replace if necessary SS≂D Interior finish for corridors and exitways, including The Maintenance Director will exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and immediately survey the remainder of ceilings has a flame spread rating of Class A or the building to identify any other like Class B. 19,3,3,1, 19,3,3,2 issues pertaining to the above mentioned items (1), (2), (3), then again once per month for the next 3 months with repair upon discovery of engage contractor to perform any This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/20:1 at needed repairs or cleaning if needed. LABORATORY PIRECTOR'S OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE 12, AAm

Any deficioncy statement ending with an asteriak (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that uthor sateguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosuble 80 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 disclosuble 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.

FORM CMS-2587(02-99) Praylous Varsions Obsolete

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TATEMEN	TOF DEFICIENCIES OF COURECTION	E & MEDICAID SERVICES (X1) PROVOERSUPPLIERCUA WENTINCATION NUMBER 345285	(X2) MILTIPL A DULLDING IL WING	OT - NOTOLISHED BY	OMB NO. COMPLE COMPLE	JRVEY
	rovder or supplier Enter Health & I	REHADIYA	108	et address, coly, state, zip cox I wain street north NCEYVILLE, NC 27970		
(XI) ID PREFEX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRESCRIPED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVOURS PLAN OF COR (EALH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DESCRIPCY)	SHOULD RE	DATE COPATEUO (KI)
K 014	noted: 1) In the 500 half the facility at the tip provide document	age 1 DAM onward the following was there is carpet on the wall and me of the survey coud not alion that the material has a g of Class A or Class B.	K 014	K012 (cont) Any negative findings reported to the facility immediately and all fin results will be reported discussed in monthly S Committee meetings for consecutive months an quarterly thereafter unt survey. K014 Correction for the alleg practice noted as "Carpof 500 hall without doe flame spread rating of Class B": Is to engage contractor carpet to expose proper sheetrock base to be fin painted. The Maintena will immediately surve of the building to ident like instances and reme additional findings will findings will be reported discussed at the next the Safety Committee meeting quarterly the next annual survey.	Administrator dings and to and afety or the next 3 d then continuit next annual ded deficient set on the wall sumentation of Class A or to remove thy rated 5/8 nished and ince Director y the remaind ify any other day any the reconsecutions, then	f 1/28 er

grant.

PRINTED: 12/22/2011 DEPARTMENT OF HEALTH AND HUMAN SERVICES: FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (XI) PROVIDER/SUPPLIET/CLIA (XXI) DATE BURVEY KOJLONJEKOO STANTONI (XX) STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING TO SMICLIUG MAIN - TO B. WING 846285 12/20/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CAY, STATE, ZIP CODE HTRON TSSRTE NAME MADE BRIAN CENTER HEALTH & REHABIYA YANCEYVILLE, NC 27379 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUBT BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION ID PREFIX COPALIBATON (XV) (XA) (0 PREFIX (EACH CORRECTIVE ACTION BHOULD BE DATE CHOSS-REPERENCED TO THE APPROPRIATE YAG TAG DEFICIENCY) K029 Corrections for the alloged deficiencies noted as: (1) Door to the dry storage room did not close, latch and seal. (2) Storage room on 500 hall near nurses station did not close, latch and seal. 42 CFR 483.70(a) K 029 NFPA 101 LIFE SAFETY CODE STANDARD Are: Adjust, repair, or replace if K 029 needed to maintain a one hour One hour fire rated construction (with % hour construction rating for the two fire-rated doors) or an approved automatic fire hazardous areas named. The extinguishing system in accordance with 8.4.1 Maintenance Director will and/or 19.3.5.4 protects hazardous areas. When immediately survey the remainder of the approved automatic fire extinguishing system the building to identify any other like option is used, the areas are separated from other spaces by smoke resisting partitions and instances and repair upon discovery or doors. Doors are velf-closing and non-rated or list for replacement if needed. These field-applied protective plates that do not exceed hazardous area door surveys will 48 inches from the bottom of the door are continue weekly for the next three permitted. 19.3.2.1 months with any negative findings reported immediately to the Administrator. All findings will be reported to and discussed in the next This STANDARO is not met as evidenced by: three consecutive Safety Committee Based on observation on Tuesday 12/20/2011 at meetings and thon continue quarterly approximately 8:00 AM onward the following was thereafter until next annual survey. noted: 1) The door to the dry storage room did not close K061 , latch and seal at the time of the survey. Correction for the alleged deficient 2) The storage room on the 600 hall near the nurse station did not close, latch and seal. practice noted as accelerator line valve not supervised in 500 wing sprinkler 42 CFR 483,70(a) room will be to install an approved NFPA 101 LIFE SAFETY CODE STANDARD K 081 K 081 type tamper switch to monitor the shit SS=D

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Required automatic sprinkler systems have

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off valve. The Maintenance Director

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

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

NAME OF PROVIDER OR SUPPLIER

BRIAN CENTER HEALTH & REHAB/YA

(X1) PROVIDER/SUPPLIERICLA
(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY
COMPLEYED

(X3) DATE SURVEY
COMPLEYED

(X3) DATE SURVEY
COMPLEYED

STREET ADDRESS, CITY, STATE, ZIP CODE
1088 MAIN STREET NORTH
YANCEYVILLE, NC 27879

	enter health & rehab/ya		YANCEYVILLE, NC 27878
(X4) 10 PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency Must be preceded by Full REGULATORY OR LEC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OFFICIENCY) (X6) COMPLETION COMPLETION CAYE
K 061	Continued From page 2 valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9,7.2,1	K 06	to identify any other like instances and schedule installation as needed. The Maintenance Director will then supervise installation and testing of installed tamper switch to insure proper operation and alarm at fire
K 062 88≃D	This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted: 1) The accelerator line to the dry side of the sprinkler riser has a valve that when closed will affect the operation of the system is not equipped with an electronically supervised tamper alarm, (Loaction 500 wing sprinkler riser room) 42 OFR 483,70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 06	panel. Regular quarterly sprinkler inspections include testing of tampers and alarm and these tests will be supervised and verified by Maintenance Director each quarter. All findings will be reported to and discussed during the next three monthly Safety Committee meetings and then continue quarterly with each corresponding inspection until next annual survey.
	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		K062 Correction for the alloged deficient practices noted as: (1) No "FOC" sign at Siamese connection- will be to install a sign in location as needed. The
	This STANDARD is not met as evidenced by. Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted: 1) The facility did not have a Fire Department. Connection "FDC" Sign at the Slamese connection at the right side parking lot location. 2) Upon review of the sprinkler inspection documentation it was noted that a 5 year internal inspection is due and the facility at the time of the		Maintenance Director will survey the remainder of the building to identify any other like instances and remedy upon discovery. This will be checked for location and visibility during each quarterly sprinkler inspection ongoing. (2) "5 year sprinkler system internal inspection is due and

FORM CMS-2687(02-88) Previous Versions Obsoluta

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA LIDENTIFICATION NUMBER: A GUILDING 01 - MAIN BUILDING ME OF PROVIDER OR SUPPLIER

BRIAN CENTER HEALTH & REHABIYA

STREET ADDRESS, CITY, STATE, ZIP CODE 1086 MAIN STREET NORTH YANCEYVILLE, NO. 27379

		YANCEYVILLE, NC 27379				
(X4) IO PREFIX TAG	Summary Statement of Deficiencies (Each Deficiency Must be preceded by Full Regulatory or LSC Identifying Information)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(XS) COMPLETION DATE		
	Continued From page 3 Inspection could not provide documentation at the work has been completed. CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD	K 062	K062 (cont) Facility could not provide documentation the work had been completed- is to engage sprinkler contractor to inspect system as necessary to insure proper operation.			
	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.		Results of both (1) and (2) will be reported to and discussed in the next three Safety Committee meetings wit contractor sprinkler inspection documentation presented and discussed during each quarterly corresponding mouth until next annusurvey.			
	This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted; 1) The indicator lights for the transfer switch located in the 500 wing mechanical room were not operation at the time of the survey. 2) The generator annunciator panel for generator		K144 Corrections for the alleged deficient practices noted as: (1) Indicator lights for transfer switch in 500 mechanical room and (2) generator #1 annunciator punel at nurses station did not operate are:	1/28		
	#1 localed at the nurse station did not operale at the time of the survey. 42 CFR 483.70(a)		Contacting the generator service contractor to repair indicator lights and amunciator panel as needed for proper operation. The Maintenance Director will test and observe each of these for proper function during each weekly generator test. All findings will be reported at the monthly Safety Committee meetings for the next thre months with continuing reports quarterly thereafter until next annual			

FOTM CM6-2587(02-00) Previous Versions Objection

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENGLIA IDENTIFICATION NUMBER: 345265			(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BLDG 02 OF 02		COMPLETED	
		B. WING.		12/20/2011		
AME OF P	ROVIDER OR SUPPLIER			ELY ADDREGS, CITY, STAYE, ZIP CODE		
BRIAN C	ENTER HEALTH & R	ЕНАВ/УА	E E	88 MAIN STREET NORTH ANCEYVILLE, NC 27378		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ntement of deficiencies y must be preceded by full .sc identifying information)	id Prefix Tag	Provider's Plan of Corre (Each Corrective Action Sh Cross-Referenced to the Api Deficiency)	OULD BE	(X8) COMPLETION OATE
0±38	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18,1.6.2, 18.1.6.3, 18.2.6.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following viae noted: 1) The top layer of sheetrock in the attic area above the corridors which is part of the one hour exit corridor has holes and penetrations in the top lay that were not seeled in order to maintain the required fite resistance rating of the ceiling. 42 CFR 483.70 NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour lire-rated barrier, with a 3/4 hour fire-rated door,		K 012	Building 2 K012 Correction for the alleged deficient practice noted as top layer of sheetrock in the attic area with holes and penetrations not maintaining required resistance rating: Is to engage contractor to remove and replace, repair or patch as needed to maintain the required I hour resistance rating over the corridor area. The Maintenance Director will survey the remainder of the building to identify any other areas requiring attention and engage contractor or repair upon discovery. Once repairs are made the Maintenance Director will survey the attic areas monthly for the next three months to insure proper coverage and continuity. Any negative findings will be immediately reported to the Administrator and then monthly at Safety Committee		u x
	are self-closing of accordance with 7.1			meetings. Survey of the a continue monthly with que reports to the Safety Comongoing until next annual K029	ttic will the parterly mittee survey.	n
	approximately 8:00 AM onward the following was noted: 1) The corridor door to the cleen linen room did not latch due to a sock jammed into the door strike plate.		Wing.	Correction for the alleged deficient practice noted as door to clean linen room did not latch due to a sock jammed into the door strike plate: is the Maintenance Director to verify proper door close, latch and seal.		
DRATORY	confection's on provided the control of the control	erisuppuer representative's sign Antts	ATURE.	Admi		731

FORM CM6-2567(02-89) Provious Versians Obsolete

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Facility ID: 023000

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PRINTED: 12/22/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0898-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (K1) PROVIDENCIJA OCO MULTIPLE CONSTRUCTION DC) DAYE SURVEY SYNTEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED and plan of correction A BUILDING 02-BUDG 02707 02 A WANG 345266 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P CODE 1005 MAIN STREET NORTH ERIAN CENTER HEALTH & REHABIYA YANCEYVILLE, NC 27370 PROVIDENTE PLAN OF CORRECTION COMPLEXION (X2) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID FACH CORRECTIVE ACTION MICHAED BE CROSS-REFERENCED TO THE APPROPRIATE LEACH DEFICIENCY INDET BE PRECEDED BY FULL PREFIX PRÉFIX DAYE REGULATORY OR LSC IDENTIFYING INFORMATION) TOUS TAG DEFICIENCY K029 (cont) K 029 K 029! Continued From page 1 The Maintenance Director will survey .42 CFR 483,70 the remainder of the building at a NFPA 101 LIFE SAFETY CODE STANDARD K 081 K 061 minimum of weekly, during regular 0=38 rounds, for three months, to identify Required automatic sprinkler systems have valves supervised so that at least a local etanx; any like instances and remedy upon will sound when the valves are closed. NFRA discovery. Any negative outcomes 72, 9.7.2.1 will be immediately reported to the Administrator and then a summary of all weekly outcomes will be reported This STANDARD is not met as evidenced by: to and discussed at the next three Based on observation on Tuesday 12/20/2011 at monthly Safety Committee meetings approximately 8:00 AM onward the following was These reports will then continue noted: 1) The excelerator line to the dry side of the quarterly until next annual survey. sprinkler riser has a valve that when closed will effect the operation of the system is not equipped K061 with an electronically supervised temper elem;. Correction for the alleged deficient (Loadion 600 wing sprinkler riser room) practice noted as accelerator line valve 42 CFR 483,70(a) not supervised in 600 wing sprinkler riser room will be to install approved type tamper switch to monitor the shut off valve. The Maintenance Directo will survey the remainder of the building to identify any other like instances and schedulo installation a needed. The Maintenance Director will then supervise installation and testing of installed tamper switch to insure proper operation and alarm at fire panel. Regular quarterly sprinkler inspections include testing of tampers and alarm, and these tests will be observed and verified by the Maintenance Director each quarter. Event (0.1)981021 F##### \UV. 6530000 If continuation about Page FORM CRUS-2667 (UR DO) Pominus Versions Obsoleto

DEPÁRT	MENT OF HEALTH	AND HUMAN SERVICES					NPPROVED 0938-0391
CENTERS FOR MEDICARE & MEDICALD SERVICE STATEMENT OF DEPICIFICATE AND PLAN OF CORRECTION (M) PROVIDENSUPPLIENT IDENTIFICATION NUMBER (M) PROVIDENSUPPLIENT (M) PROVIDENSUPPLIE		(X1) PROVIDENSUPPLIENCIA IDENTIFICATION NUMBER:	I ,	W RAINDARE DS * BATHOL DS OF DS . COST MITTURE CORPUNICATION		DO) DATE SURVEY COMPLETED	
		345765	B. War			19/20	vin 1
1	ROVIDER ON BUPPLIER ENTER REALTH & R	EHABIYA 1/1:1		10	ETADORESS, CITY, STATE ZIP CODE: 16 MAIN STREET NORTH UNCEYVILLE, NC 27879		
(X4) ID PREFIX YAG	IFACH DPPORENC	TERENT OF DEFENERACES Y MUST BE PRECEDED BY FULL BC (DENTIFYING JUPORIZATION)	PRES YAG		UBJCEHAA) LENCH CONNECTINE VELICY OF COURTE LENCH CONNECTINE VELICY OF COURTE LENCH CONNECTINE VELICY LENCH CONNECTINE VELICY LENCH CONNECTINE VELICY LENCH CONNECTINE VELICY LENCH CONNECTINE VELICY LENCH CONNECTINE LENC	OULD BE	DAAR OONATEINOM OOD
	Continued From pa .42 CFR 483.70	:	<u> </u>	029	K061 (cont) All findings will be report discussed during the next	t three Safe	y/28
K 061 SS <d,< td=""><td colspan="3">NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local stannwill sound when the valves are closed. NFPA 72, 9.7.2.1</td><td>061</td><td>Committee meetings and continue quarterly with e corresponding inspection annual survey.</td><td>d then leach</td><td>/20</td></d,<>	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local stannwill sound when the valves are closed. NFPA 72, 9.7.2.1			061	Committee meetings and continue quarterly with e corresponding inspection annual survey.	d then leach	/20
K ons	This STANDARD Based on observa approximately 8:00 noted: 1) The accelerator sprinklor deer has affect the operation with an electronica (Loaction 600 wing 42 CFR 483.70(a) NFPA 101 LIFE 5/ Soiled linen or tree exceed 32 gal (12: density of contained does not exceed capacity of 32 gal any 64 sq ft (5.9 sc or tresh collection dreater than 32 gal	AFETY CODE STANDARD th collection receptacles do not L) in capacity. The average capacity in a room or space galveq. It (20.4 L/sq m). //, (121 L) is not exceeded within m) area. Mobile soiled liven receptacles with capacitles: 1 (121 L) are located in a room cardous area when not		076	K075 Correction for the allege practice noted as soiled I in corridor unattended at room 618: Was to remo store in proper hazardou location. The Maintenan and Environmental Serv will survey the remainded building to identify any situations and remedy up These surveys will continue weeks during normal dat provide consistency, and will be reported weekly stand up meeting, then a monthly during Safety Comeotings. These reports for three consecutive mediately thereafter until survey.	inen tub left resident we tub and s storage ce Director lees Director of the cother like pon discover mue for four ily rounds to all results at morning hange to committees will continue to the sould continue and the continue an	y. 28
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PRINTED: 12/22/2011.

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391§ CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER: (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 02 - BLDG 02 OF 02 B. WING 12/20/2011 345265 STREET ADDRESS, COY, STATE, ZIP CODE 🗽 NAME OF PROVIDER OR SUPPLIER 1686 MAIN SYREET NORTH BRIAN CENTER HEALTH & REHABIYA YANGEYVILLE, NG 27379 PROVIDER'S PLAN OF CORRECTION COMPLETION SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) (D (EACH CORRECTIVE ACTION SHOULD BE' PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG YAG DEFICIENCY) K104 K 075! K 075 Continued From page 2 Correction for the alleged deficient This STANDARD is not met as evidenced by: . practice noted as: "smoke damper in Based on observation on Tuesday 12/20/2014 at attic near resident room 601 was not approximately 8:00 AM onward the following was operational during survey."- is to noted: engage a mechanical contractor to test 1) A solled lined tub was left unattended and and diagnose functions of affected found stored in the corridor next to resident room damper and repair or replace as 618 and was not properly stored. needed. The Maintonance Director will survey the remainder of the 42 CFR 483,70 K 104 NFPA 101 LIFE SAFETY CODE STANDARD building for other smoke dampers and K 104 verify proper function, marking their SS=E Penetrations of smoke barriers by ducts are location on a floor plan for future protected in accordance with 8.3.6. reference. These surveys for proper operation of smoke dampers will continue monthly during regular scheduled fire drills with a summary This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at of results presented to and discussed approximately 8:00 AM onward the following was during monthly Safety Committee noted: meetings for the next three months 1) The smoke damper located in the attic in the and then continue quarterly thereafter smoke wall near residient room 601 was not until next annual survey. operational at the time of the survey. 42 CFR 483.70

Facility (0: 929000

FORM CMS-2687(02-80) Previous Varsions Obsolots

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