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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING ____ B. WING ____	C 12/02/2011

JAN 1 0 2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 4 errors out of 63 opportunities for error, resulting in an error rate of 6.3%, for 3 or 10 residents observed during medication pass (residents #8, #26, #30). Findings include: 1. Resident #26 was admitted to the facility on 9/19/02 with multiple diagnoses including glaucoma. Review of the resident's clinical record revealed physician orders dated 9/19/02 for Levobunolol 0.5% two drops in each eye daily. Levobunolol is an ophthalmic agent used for the treatment of glaucoma. Observation of medication pass on 12/1/11 at 8:10AM revealed nurse #1 administered one drop of Levobunolol 0.5% solution in each eye. Review of the resident's current medication administration record (MAR) revealed instructions to administer two drops of Levobunolol 0.5% solution in each eye. In an interview on 12/1/11 at 2:22PM, nurse #1 stated she received training on medication administration with other nurses on the floor when she was hired. She stated the pharmacy	F 332	F332 The facility will continue to ensure that it is free of medication error rates of five percent or greater. Nurse # 1 reviewed current physician orders for Resident #26 on 12-1-11 to ensure that medication record reflected correct transcription of physician orders. Resident #26 attending physician and responsible party were notified of the medication variance on 12-1-11 and documented on a medication variance report. Nurse #1 reviewed current physician orders for Resident #8 to ensure that medication record reflected correct physician orders and don't crush was in body of the physician orders on 12-1-11. Resident #8 attending physician and responsible party notified of the medication variance on 12-1-11 and documented on a medication variance report.	1/6

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luther Fritts   TITLE: Administrator   (X6) DATE: 01/05/12

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 332	Continued From page 1 conducted medication pass observations at least every quarter. Nurse #1 reviewed the resident's MAR and confirmed she had administered one drop of Levobunolol in each eye instead of two drops as ordered. Nurse #1 stated she usually administered two drops but was nervous today. In an interview on 12/1/11 at 5:15PM, the staff development coordinator (SDC) stated she completed medication pass observations on the nurses during orientation before they were released to work on the floor. The new staff also precepted with the other nurses on the floor. The SDC stated she repeated med pass observations at least yearly. The pharmacist conducted quarterly med pass observations. The SDC stated the staff should triple check the orders when medications were administered to ensure the right dosage was given. In an interview on 12/1/11 at 6:17PM, the Director of Nursing (DON) stated the staff was trained on medication administration by the SDC during orientation. The pharmacist also conducted training for the nursing staff. The SDC and pharmacist conducted periodic medication pass observations. Her expectation was for the staff to follow the correct procedures and triple check the MARS and labels when administering medications. 2. Resident #8 was admitted to the facility on 6/3/05 with multiple diagnoses including dysphagia and percutaneous endoscopic gastrostomy (PEG). Review of the resident's clinical record revealed physician orders dated 3/26/10 for Omeprazole 20mg (milligram) capsule, delayed release, one capsule per PEG	F 332	Nurse # 2 reviewed current physician orders for Resident #30 on 12-1-11 to ensure that medication record reflected the resident correct medication on medication record. Resident # 30 attending physician and responsible party were notified of the two medication variance on 12-1-11 and documented on medication a variance report. The facility current resident's physician orders and medication record were reviewed to ensure that orders were transcribed per physician orders to medication record on Dec 2- Dec 30, 2011 by Director of Nursing, staff development coordinator, and Administrative nurses. Each new admission physician orders will be reviewed in morning meeting to ensure that orders have been implemented and transcribed correctly to including do not crush medication and eye drops.	1/6

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F 332	Continued From page 2 daily, do not crush. Omeprazole is proton pump inhibitor indicated for treatment and prevention of ulcers, gastroesophageal reflux disease, and esophagitis. The delayed release capsules contain an enteric coated granule formulation of omeprazole, so that the absorption begins only after the granules leave the stomach. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Omeprazole - Administration: Capsule: do not crush." In an observation of medication pass on 12/1/11 at 8:16AM, nurse #1 prepared resident #8's medications for administration per PEG tube. Nurse #1 opened the omeprazole capsule and poured the contents into a plastic sleeve with the resident's other medications, placed them into a crushing device, and crushed the medications. Nurse #1 dissolved the crushed medications with 30 ml (milliliter) of water. The nurse flushed the PEG tube with 30ml of water and attempted to administer the medications by gravity flow. The nurse milked the PEG tube several times but the medications did not flow freely. Nurse #1 administered the medications by slowly pushing them through the tubing with a syringe. The tube was flushed with 30 ml of water after the medications were given. Review of the resident's current MAR revealed "do not crush" instructions for omeprazole. In an interview on 12/1/11 at 2:22PM, nurse #1 stated she received training on medication administration with other nurses on the floor when she was hired. She stated the pharmacy conducted medication pass observations at least	F 332	The facilities current licensed nurse's each have completed a medication observation and medication test on 12/ 12/11, 12/13/11 and 12/22/11 by facility staff development coordinator. The facilities current licensed nurses were provided re- education regarding medication administration to include medications that cannot be crushed, timeliness of medication and administration of correct dosage of medication prescribed on 12/12/11, 12/13/11 and 12/22/11 and completed on 1/06/12 by facility staff development coordinator. Any Nurses that have not been in serviced Will have the test completed by SDC Before going to the floor and SDC Will monitor the Medication pass Observation before Nurse gives medication by them self.	1/6

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F 332	Continued From page 3 every quarter. Nurse #1 acknowledged the resident's MAR read "do not crush." She stated the omeprazole would not go through the tube unless it was crushed. Nurse #1 checked the front of her MAR for a "do not crush" list but found none. In an interview on 12/1/11 at 5:15PM, the SDC stated she completed medication pass observations on the nurses during orientation before they were released to work on the floor. The new staff also precepted with the other nurses on the floor. The SDC stated she repeated med pass observations at least yearly. The pharmacist conducted quarterly med pass observations. The SDC stated "do not crush" lists were posted in the front of all the MARS. She stated the staff should be familiar with which medications not to crush. In an interview on 12/1/11 at 6:17PM, the DON stated the staff was trained on medication administration by the SDC during orientation. The pharmacist also conducted training for the nursing staff. The SDC and pharmacist conducted periodic medication pass observations. The DON stated the nurses had a "do not crush" list on each medication cart and had received in-services on crushing medications. Her expectation was for the staff to know which medications could or could not be crushed. 3a. Resident #30 was admitted to the facility on 3/22/07 with multiple diagnoses including esophageal reflux. Review of the resident's clinical record revealed physician orders dated 11/5/10 for omeprazole 20mg tablet delayed	F 332	The facility Director of Nursing will report findings of weekly audits to the QA&A Committee weekly x 4 then bi- monthly x 1. Data will be reviewed and analyzed for patterns and trends. The QA&A committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	1/6

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F 332	Continued From page 4 release one tablet by mouth daily at 8:30AM for indigestion 30 minutes prior to breakfast. Omeprazole is proton pump inhibitor indicated for treatment of gastroesophageal reflux disease. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Omeprazole - Should be taken on an empty stomach; best if taken before breakfast." Observation of medication pass on 12/1/11 at 9:05AM revealed nurse #2 administered one omeprazole 20mg capsule with applesauce. Review of the resident's current MAR revealed an administration time of 8:30AM for omeprazole. In an interview on 12/1/11 at 1:40PM, Nurse #2 stated she was trained on medication administration when hired. Her last medication pass observation had been conducted in June 2011. She reviewed the MAR and acknowledged that omeprazole had been given after the meal. She stated the resident had just finished breakfast. Nurse #2 stated omeprazole was supposed to be given 30 minutes before breakfast but she was running a little late today. In an interview on 12/1/11 at 5:15PM, the SDC stated she completed medication pass observations on the nurses during orientation before they were released to work on the floor. The new staff also precepted with the other nurses on the floor. The SDC stated she repeated med pass observations at least yearly. The pharmacist conducted quarterly med pass observations. The SDC stated the staff should triple check the orders when medications were	F 332		

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F 332	Continued From page 5 administered to ensure they were given at the right time. In an interview on 12/1/11 at 6:17PM, the DON stated the staff was trained on medication administration by the SDC during orientation. The pharmacist also conducted training for the nursing staff. The SDC and pharmacist conducted periodic medication pass observations. Her expectation was for the staff to follow the correct procedures and triple check the MARS and labels when administering medications. 3b. Resident #30 was admitted to the facility on 3/22/07 with multiple diagnoses including benign prostatic hypertrophy and urinary frequency. Review of the resident's clinical record revealed physician orders dated 6/11/10 for oxybutynin ER (extended release) 10mg daily. Oxybutynin is a urinary antispasmodic agent used to treat urinary frequency. Lexicomp's Drug Information Handbook, 14th edition, stated in part: "Oxybutynin - Administration: Extended release tablets must be swallowed whole; do not crush." Observation of medication pass on 12/1/11 at 9:05AM revealed nurse #2 prepared resident #30's medications for administration. Nurse #2 placed one oxybutynin ER 10mg tablet into a plastic sleeve with the resident's other medications, placed them into a crushing device, and crushed the medications. The crushed medications were mixed in applesauce and administered to the resident.	F 332		

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F 332	Continued From page 6 In an interview on 12/1/11 at 1:40PM, Nurse #2 stated she was trained on medication administration when hired. Her last medication pass observation had been conducted in June 2011. Nurse #2 acknowledged she had crushed the oxybutynin ER. She was unaware that it should not be crushed. She reviewed the "do not crush" list in the front of her MAR and found the brand name (Ditropan XL) for oxybutynin listed. In an interview on 12/1/11 at 5:15PM, the SDC stated she completed medication pass observations on the nurses during orientation before they were released to work on the floor. The new staff also precepted with the other nurses on the floor. The SDC stated she repeated med pass observations at least yearly. The pharmacist conducted quarterly med pass observations. The SDC stated "do not crush" lists were posted in the front of all the MARS. She stated the staff should be familiar with which medications not to crush. In an interview on 12/1/11 at 6:17PM, the DON stated the staff was trained on medication administration by the SDC during orientation. The pharmacist also conducted training for the nursing staff. The SDC and pharmacist conducted periodic medication pass observations. The DON stated the nurses had a "do not crush" list on each medication cart and had received in-services on crushing medications. Her expectation was for the staff to know which medications could or could not be crushed.	F 332		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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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 4:30p.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 cup; water ran off the bowls and cups. The dietary manager acknowledged the condition of the dome lids, bowls and cups. The Dietary Manager said that " they were cleaned, wet, and ready to be used for the dinner meal. In an interview with the dietary aide on 12/1/11, at 5:05 p.m., she stated, " I do not know who stored the bowls wet on the cart."	F 371	F371 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 re-education 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 observed the storage of dishes to ensure that each stored dry daily x 30 days and bi monthly times two.	

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F 371	Continued From page 8 In an interview on 12/1/11, at 5:10 p.m., with the Dietary manager, she stated, " I cannot say why the dome lids, bowls and cups were wet. " She further indicated, " everyone is nervous and rushes to get things done because the State is in the building."	F 371	The facility Dietary Manager will report findings of weekly audits to the QA&A Committee weekly x 4 then bi- monthly x 1. Data will be reviewed and analyzed for patterns and trends. The QA&A committee will evaluate the results and implement additional interventions as needed to ensure continued compliance.	

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	345265	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/20/2011

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K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was 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 sealed in order to maintain the required fire resistance rating of the ceiling.. 2) The ceiling expansion joint located near room 402 is separating from the ceiling and is not properly secured to the ceiling. 3) The ceiling radiation damper located in the laundry room was not maintained clean and in good condition. 42 CFR 483.70(a)	K 012	K012 Corrections for the alleged deficient practices noted as: (1) **Top layer of sheetrock in attic area over exit corridor has holes and penetrations not sealed:** Is to engage a contractor to remove and replace sections or patch as needed to maintain required one hour fire resistance rating over corridors. (2) **Ceiling expansion joint separated and not properly secured to ceiling:** Is to engage contractor to remove and replace or repair section as needed to maintain required one hour fire resistance rating of the corridor ceiling. (3) **Ceiling radiation damper located in laundry room was not maintained clean and in good condition:** Is to clean affected damper and verify proper operation or replace if necessary The Maintenance Director will immediately survey the remainder of the building to identify any other like issues pertaining to the above mentioned items (1), (2), (3), then again once per month for the next 3 months with repair upon discovery or engage contractor to perform any needed repairs or cleaning if needed.	1/28
K 014 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at	K 014		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Luther Smith   TITLE: Admin   (X6) DATE: 12/31/11

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K 014	Continued From page 1 approximately 8:00 AM onward the following was noted: 1) In tthe 500 hall there is carpet on the wall and the facility at the time of the survey coud not provide documentation that the material has a flame spread rating of Class A or Class B.	K 014	K012 (cont) Any negative findings will be reported to the facility Administrator immediately and all findings and results will be reported to and discussed in monthly Safety Committee meetings for the next 3 consecutive months and then continue quarterly thereafter until next annual survey. K014 Correction for the alleged deficient practice noted as "Carpet on the wall of 500 hall without documentation of flame spread rating of Class A or Class B": Is to engage contractor to remove carpet to expose properly rated 5/8 sheetrock base to be finished and painted. The Maintenance Director will immediately survey the remainder of the building to identify any other like instances and remedy any additional findings with 500 hall. All findings will be reported to and discussed at the next three consecutive Safety Committee meetings, then continuing quarterly thereafter until next annual survey.	1/28

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			K029 Corrections for the alleged 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.	1/28
K 029 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted: 1) The door to the dry storage room did not close, latch and seal at the time of the survey. 2) The storage room on the 600 hall near the nurse station did not close, latch and seal.	K 029	Are: Adjust, repair, or replace if needed to maintain a one hour construction rating for the two hazardous areas named. The Maintenance Director will immediately survey the remainder of the building to identify any other like instances and repair upon discovery or list for replacement if needed. These hazardous area door surveys will continue weekly for the next three months with any negative findings reported immediately to the Administrator. All findings will be reported to and discussed in the next three consecutive Safety Committee meetings and then continue quarterly thereafter until next annual survey.	
K 061 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have	K 061	K061 Correction for the alleged deficient practice noted as accelerator line valve not supervised in 500 wing sprinkler room will be to install an approved type tamper switch to monitor the shut off valve. The Maintenance Director	1/28

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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
	345265	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
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 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 CFR 483.70(a)	K 061	K061 (cont) Survey the remainder of the building 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 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.	1/28
K 062 SS=D	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: 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 Siamese 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	K 062	K062 Correction for the alleged deficient practices noted as: (1) **No "FDC" sign at Siamese connection**- will be to install a sign in location as needed. 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**	1/28

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	345266	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
K 062	Continued From page 3 inspection could not provide documentation at the work has been completed. CFR#: 42 CFR 483.70 (a)	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. Results of both (1) and (2) will be reported to and discussed in the next three Safety Committee meetings with contractor sprinkler inspection documentation presented and discussed during each quarterly corresponding month until next annual survey.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following 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 #1 located at the nurse station did not operate at the time of the survey. 42 CFR 483.70(a)	K 144	K144 Corrections for the alleged deficient practices noted as: (1) **Indicator lights for transfer switch in 500 mechanical room and (2) generator #1 annunciator panel at nurses station did not operate are:** Contacting the generator service contractor to repair indicator lights and annunciator 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 three months with continuing reports quarterly thereafter until next annual survey.	1/28

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	345265	A. BUILDING 02 - BLDG 02 OF 02 B. WING ________	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1068 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.2.5.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was 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 sealed in order to maintain the required fire resistance rating of the ceiling. 42 CFR 483.70	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 1 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 meetings. Survey of the attic will then continue monthly with quarterly reports to the Safety Committee ongoing until next annual survey.	1/28
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by. Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted: 1) The corridor door to the clean linen room did not latch due to a sock jammed into the door strike plate.	K 029	K029 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.	1/28

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Luther Fritts	Admin	12/31/11

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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	345265	A. BUILDING 02 - BLDG 02 OF 02 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1005 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
K 029	Continued From page 1 .42 CFR 483.70	K 029	K029 (cont) The Maintenance Director will survey the remainder of the building at a minimum of weekly, during regular rounds, for three months, to identify any like instances and remedy upon discovery. Any negative outcomes will be immediately reported to the Administrator and then a summary of all weekly outcomes will be reported to and discussed at the next three monthly Safety Committee meetings. These reports will then continue quarterly until next annual survey.	1/28
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following 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. (Location 600 wing sprinkler riser room) 42 CFR 483.70(a)	K 061	K061 Correction for the alleged deficient practice noted as accelerator line valve not supervised in 600 wing sprinkler riser room will be to install approved type tamper switch to monitor the shut off valve. The Maintenance Director will survey the remainder of the building 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 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.	1/28

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	345265	A. BUILDING 02 - BLDG 02 OF 02 B. WING ______	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

(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
K 029	Continued From page 1 42 CFR 483.70	K 029	K061 (cont) All findings will be reported to and discussed during the next three Safety Committee meetings and then continue quarterly with each corresponding inspection until next annual survey.	1/28
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following 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. (Location 600 wing sprinkler riser room) 42 CFR 483.70(a)	K 061	K075 Correction for the alleged deficient practice noted as soiled linen tub left in corridor unattended at resident room 618: Was to remove tub and store in proper hazardous storage location. The Maintenance Director and Environmental Services Director will survey the remainder of the building to identify any other like situations and remedy upon discovery. These surveys will continue for four weeks during normal daily rounds to provide consistency, and all results will be reported weekly at morning stand up meeting, then change to monthly during Safety Committee meetings. These reports will continue for three consecutive months and then quarterly thereafter until next annual survey.	1/28
K 075	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq. ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9 sq. m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 18.7.5.5	K 075		

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	345265	A. BUILDING 02 - BLDG 02 OF 02 B. WING	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/YA	1086 MAIN STREET NORTH YANCEYVILLE, NC 27379

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K 075	Continued From page 2 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) A soiled lined tub was left unattended and found stored in the corridor next to resident room 618 and was not properly stored. 42 CFR 483.70	K 075	K104 Correction for the alleged deficient practice noted as: "smoke damper in attic near resident room 601 was not operational during survey."- is to engage a mechanical contractor to test and diagnose functions of affected damper and repair or replace as needed. The Maintenance Director will survey the remainder of the building for other smoke dampers and verify proper function, marking their location on a floor plan for future reference. These surveys for proper operation of smoke dampers will continue monthly during regular scheduled fire drills with a summary of results presented to and discussed during monthly Safety Committee meetings for the next three months and then continue quarterly thereafter until next annual survey.	1/28
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. 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 smoke damper located in the attic in the smoke wall near resident room 601 was not operational at the time of the survey. 42 CFR 483.70	K 104		