accepted.

JUL 06 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING ______ B. WING ______	06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/DURHAM	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that facial hair was removed for 1 of 1 sampled residents (#31). The findings include: Resident #31 was admitted to the facility on 10/21/11 with cumulative diagnosis that included Hypertension, S/P (status post) GI (gastrointestinal) bleed, Cervical Stenosis, Coronary Artery Disease and Anemia. The resident was coded on the most recent MDS (minimum data set) dated 04/19/12 to be moderately impaired cognitively. The resident was coded as requiring limited assistance with her ADL's (activities of daily living). The MDS did not identify any mood or behaviors or of rejection of care by the resident. The resident's CAA's (care area assessments) dated 11/01/11 indicated the resident required "assistance with her ADL's, was a very pleasant female and was alert and oriented x 2." A review of the resident's care plan dated 05/16/12 indicated under the problem "cognitive impairment impaired ability to make decisions" an intervention "anticipate ADL needs." During an observation of the resident on 06/19/12 at 8:56 AM, the resident was noted to have hairs	F 241	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* *This Plan of Correction is the facility's credible allegation of compliance.* **F241** Corrective action has been accomplished related to the alleged deficient practice for resident #31. Resident #31 had facial hair removed on 6/21/12 and Certified Nursing Assistant was re-educated in regards to female residents in need of facial hair removal. Female residents are at risk to be affected by the same alleged deficient practice. On 6/21/12 the Director of Nursing (DON) and Assistant Director of Nursing (ADON) completed an audit of female residents to ensure no other residents were in need of removal of facial hair. Systemic measures implemented to ensure the same alleged deficient practice does not recur are as follows: Direct care staff will be re-educated regarding the need to remove female facial hair.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/5/12

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.

T.E. A.G. A.P. M.P. Ske.W.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 1 across her upper lip and around her mouth. The resident indicated that she used to take care of that herself but doesn ' t do it any more. The resident stated " the girls don't do it for me. It seems that the hair is getting more and more. I don't like how it makes me look." The resident was observed again on 06/20/12 at 3:00 PM with hair across her upper lip and around her mouth. The resident was observed again on 06/21/12 at 9:30 AM with hair across her upper lip. During an interview with a nurse aide on 06/20/12 at 10:30 AM it was revealed " we should check facial hair every time we care for a resident and shave the resident if needed and if the resident will let us. The nurse aide agreed that the resident had facial hair that needed to be taken care of. During an interview with the Assistant Director of Nursing (ADON) on 06/20/12 at 11:15 AM it was revealed " she (resident #31) tries to be as independent as she can. I would expect staff to try to provide the care and if she refuses it should be documented and then we would need to update her care plan."	F 241	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law.* ***This Plan of Correction is the facility's credible allegation of compliance.*** **F241-cont** The DON/ADON will complete an audit of 10 female residents weekly times 12 weeks. Negative findings will be addressed immediately. Resident Ambassadors will conduct weekly rounds and observe for facial hair on female residents. Negative findings will be taken to the Director of Nursing or Assistant Director of Nursing and appropriate interventions will be implemented. The results of the audits and observation rounds will be taken thru the Quality Assessment and Assurance (QA&A) meeting monthly times 3 months. The QA&A Committee will evaluate the effectiveness of the plan based on trends identified and develop and implement additional interventions as needed to ensure continued compliance.	7/6/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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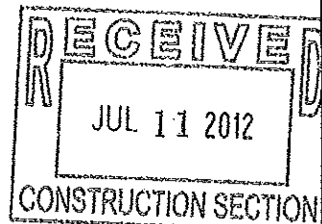
	345149	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	06/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

(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 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) Additional illumination is need at the right rear exit discharge door and the pathway to the public way. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. 42 CFR 483.70(a)	K 045	K045 1. Correction for the alleged deficient practice noted as additional lighting needed at the right rear exit discharge door and the pathway to the public way. Installed floodlights in rear of building to illuminate exit and the pathway to public way. Floodlights were tied into the backup generator for emergency egress lighting. 2. Site review to see if other areas deficient. 3. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of July 2, 2012.  RECEIVED JUL 11 2012 CONSTRUCTION SECTION	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K052 1. Correction for the alleged deficient practice noted of the Fire Alarm pull station located next to the break room rear exit door not working. Pull station next to break room rear exit door repaired and working. 2. Tested all pull stations for potential problems.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/9/12

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K 052	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) The Fire Alarm pull station located next to the breakroom rear exit door did not operate when tested.	K 052	3. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of June 26, 2012	
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) In the kitchen in front of the hood there are sprinkler heads in the facility rated for	K 056	K056 Correction for the alleged deficient practice noted of 1. In the kitchen in front of the hood there are sprinkler heads in the facility rated for intermediate temperature classification, Glass Bulb Color of Green temperature rating of (200 degree F) in place of ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155 degree F). Sprinkler heads Bulb Color of Green (200 degree F) replaced with Bulb Color of Red temperature rating of (155 degree F). Correction date of August 6, 2012. 2. Sprinkler heads installed in the Therapy Room smoke compartment were a mixture of glass bulb standard response heads and standard fused heads. Facility will need to verify that the heads are equal in response time and temperature. Sprinkler heads or head replaced to match per NAPA 101, 4.6.12.1 Correction date of August 6, 2012.	

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K 056	Continued From page 2 Intermediate Temperature Classification, Glass Bulb Color of Green temperature rating of (200° F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). 2) Sprinkler heads installed in the Therapy Room smoke compartment were a mixture of glass bulb standard response heads and standard fused heads. Facility will need to verify that the heads are equal in response time and temperature or replace heads to match each other.NAPA 101, 4.6.12.1 Every required sprinkler system shall be continuously maintained improper operating condition. NFPA 13, 5-3.1.5.2 3) Sprinkler heads will need to be installed both rear entrances. (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) 42 CFR 483.70(a)	K 056	3. Sprinkler heads need installed at both rear entrances. Sprinkler heads installed at both rear entrances per NFPA 13 section 5-13.8.1 4. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of August 6, 2012.	