<table>
<thead>
<tr>
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<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 332 SS=D</td>
<td>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</td>
<td>F 332</td>
<td>F332</td>
<td>1/6</td>
</tr>
</tbody>
</table>

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).

- 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...
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<tbody>
<tr>
<td>F 332</td>
<td></td>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>F 332</td>
<td></td>
<td></td>
<td>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 order when medications were administered to ensure the right dosage was given.</td>
</tr>
<tr>
<td>F 332</td>
<td></td>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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 3/28/10 for Omeprazole 20mg (milligram) capsule, delayed release, one capsule per PEG.

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<thead>
<tr>
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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
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</table>

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.
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. 


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

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.
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<tr>
<td>F 332</td>
<td>Continued From page 3 every quarter. Nurse #1 acknowledged the resident's MAR read &quot;do not crush.&quot; She stated the omeprazole would not go through the tube unless it was crushed. Nurse #1 checked the front of her MAR for a &quot;do not crush&quot; list but found none.</td>
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<td></td>
<td>In an interview on 12/1/11 at 6:15PM, 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 &quot;do not crush&quot; lists were posted in the front of all the MARS. She stated the staff should be familiar with which medications not to crush.</td>
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<td></td>
<td>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 &quot;do not crush&quot; 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.</td>
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<tr>
<td></td>
<td>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</td>
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</table>

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.
NAME OF PROVIDER OR SUPPLIER: BRIAN CENTER HEALTH & REHABILITA
STREET ADDRESS, CITY, STATE, ZIP CODE: 1086 MAIN STREET NORTH, YANCEYVILLE, NC 27379

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<tbody>
<tr>
<td>F 332</td>
<td>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: &quot;Omeprazole - Should be taken on an empty stomach, best if taken before breakfast.&quot; 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...</td>
<td>F 332</td>
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<tr>
<td>F 332</td>
<td>Continued from page 5 administered to ensure they were given at the right time.</td>
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<td></td>
<td>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.</td>
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<td>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.</td>
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<td>Lexicomp's Drug Information Handbook, 14th edition, stated in part: &quot;Oxybutynin - Administration: Extended release tablets must be swallowed whole; do not crush.&quot;</td>
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<td>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.</td>
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</table>
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

<table>
<thead>
<tr>
<th>(K1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:</th>
<th>(K2) MULTIPLE CONSTRUCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>345285</td>
<td>A. BUILDING</td>
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<tr>
<td></td>
<td>B. WANG</td>
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</tbody>
</table>

**DATE SURVEY COMPLETED**

| C | 12/02/2011 |

**NAME OF PROVIDER OR SUPPLIER**

BRIAN CENTER HEALTH & REHAB/IA

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1086 MAIN STREET NORTH  
YANCEYVILLE, NC 27379

**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) | **COMPLETION DATE** |
|-----------------|-------------------------------------------------|-----------------|----------------------------------------------------------------|------------------|
| 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 oxycodone 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 oxycodone 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 medication pass observations at least yearly. The pharmacist conducted quarterly medication 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.  
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| F 371           | 483.35(1) FOOD PROCURE,  
STORE/prepare/SERVE - SANITARY | F 371 | | |
F 371

Continued From page 7

The facility must -
(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities;
(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 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 4:30 p.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 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, 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."

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, glasses 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.
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."

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.
**K012**

**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 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 a contractor to remove and replace or repair section as needed to maintain one hour fire resistance rating of the corridor ceiling.
3) The ceiling radiation damper located in laundry room was not maintained clean and in good condition.

42 CFR 483.70(a)

**K014**

**NFPA 101 LIFE SAFETY CODE STANDARD**

Interior finish for corridors and egressways, 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 approximately 8:00 AM onward the following was noted:

The Maintenance Director will immediately survey the remainder of the building to identify any other 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 necessary.
**NAME OF PROVIDER OR SUPPLIER**

**URBIAN CENTER HEALTH & REHAB**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1000 MAIN STREET NORTH

YANCEYVILLE, NC 27379

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<thead>
<tr>
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<tbody>
<tr>
<td>K014</td>
<td>Continued From page 1 approximately 8:00 AM onward the following was noted: 1) In the 600 hall there is carpet on the wall and the facility at the time of the survey could not provide documentation that the material has a flame spread rating of Class A or Class B.</td>
</tr>
</tbody>
</table>

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>K014</td>
<td>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.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>ID PREFIX/PEA/FC</th>
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<tbody>
<tr>
<td>K014</td>
<td>[28]</td>
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</table>

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/l 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.
<table>
<thead>
<tr>
<th>K029</th>
<th>Corrections for the alleged deficiencies noted as:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>(1) Door to the dry storage room did not close, latch and seal.</td>
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<td></td>
<td>(2) Storage room on 500 hall near nurses station did not close, latch and seal.</td>
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</table>

**K029**

**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**
**K 061 (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 tamper and alarm and these tests will be supervised and verified by the 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.

K 062
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
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<tr>
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<tbody>
<tr>
<td>K 062</td>
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<td>inspection could not provide documentation at the work has been completed.</td>
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<tr>
<td>CFR#:</td>
<td>42 CFR 483.70 (a)</td>
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<tr>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
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<tr>
<td>K 144</td>
<td>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99.</td>
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<td>3.4.4.1.</td>
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<tr>
<td>This STANDARD is not met as evidenced by;</td>
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<tr>
<td>Based on observation on Tuesday 12/20/2011 at approximately 8:00 AM onward the following was noted;</td>
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<tr>
<td>1) The indicator lights for the transfer switch located in the 500 wing mechanical room were not operation at the time of the survey.</td>
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<td>2) The generator annunciator panel for generator #1 located at the nurse station did not operate at the time of the survey.</td>
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<tr>
<td>42 CFR 483.70(a)</td>
<td>K 062</td>
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<tr>
<td>K062 (cont)</td>
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<tr>
<td>Facility could not provide documentation the work had been completed- is to engage sprinkler contractor to inspect system as necessary to insure proper operation.</td>
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<tr>
<td>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.</td>
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<td>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:</td>
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<td>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.</td>
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</table>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(NX) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER:
345285

(SX) MULTIPLE CONSTRUCTION
A. BUILDING 02 - BLDG 02 OF 02
B. WONG

(03) DATE SURVEY COMPLETED
12/20/2011

NAME OF PROVIDER OR SUPPLIER
BRIAN CENTER HEALTH & REHABILTY

STREET ADDRESS, CITY, STATE, ZIP CODE
1068 MAIN STREET NORTH
YANCEEVILLE, NC 27980

(KX) 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)

(K012) S5-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
NFPA 101 LIFE SAFETY CODE STANDARD

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.

(K029) S5-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 shock jammed into the door
strike plate.

K029
Correction for the alleged deficient
practice noted as door to clean linen
room did not latch due to a shock
jammed into the door strike plate; is
the Maintenance Director to verify
proper door close, latch and seal.

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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 patient(s). (See instructions.) Except for nursing homes, the findings stated above are delineable 30 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 delineable 14

PO9M 080738755 (02-00) Previous Version Obsolete

Event ID: 6590785
Facility ID: 835503
+/ continuation sheet
Page 1 of 3
**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.

**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 tamper's and alarm, and these tests will be observed and verified by the Maintenance Director each quarter.
**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**[Form Approved]**

**CMS NO. 0938-0591**

**STATE ADDRESS, CITY, STATE, ZIP CODE:**

1234 Main Street North
Yanceville, NC 27379

**DATE SURVEY COMPLETED:**

12/27/2011

**NAME OF PROVIDER OR SUPPLIER:**

Brian Center Health & Rehab

**K029**

Continued From page 1

42 CFR 483.70

K061

NFPA 101 LIFE SAFETY CODE STANDARD

56-D

Required automatic sprinkler systems have valves supervised so that if a local automatic 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 12/27/2011 at approximately 6:00 PM toward the following was noted:

1) The shower area to the dry side of the sprinkler head has a valve that when closed will affect the operation of the system is not equipped with an electronically supervised simplex alarm. (Location 609 wing sprinkler floor room 42 CFR 483.70(e)

K075

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/eq 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

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.

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.
<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>K075</th>
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<td>(X1) Provider/Supplier/Clinic Identification Number</td>
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<td>(X2) Multiple Construction</td>
<td>A. Building</td>
<td>B. Wing</td>
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<td>(X3) Date Survey Completed</td>
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<td>Name of Provider or Supplier</td>
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<tr>
<td>Street Address, City, State, Zip Code</td>
<td>1085 Main Street North</td>
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<td>Yanceyville, NC 27379</td>
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<th>Prefix Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>K075</td>
<td>Continued from page 2</td>
<td>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 lab was left unattended and found stored in the corridor next to resident room 618 and was not properly stored.</td>
<td>K104 Correction for the alleged deficient practice noted as: &quot;Smoke damper in attic near resident room 601 was not operational during survey,&quot; 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.</td>
<td>28</td>
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42 CFR 483.70 NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.