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

PRINTED: 10/28/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345332	B. WING			10/24/2013	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB			•	STREET ADDRESS, CITY, STATE, ZIP CODE 2501 DOWNING STREET SW WILSON, NC 27895			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE AC	TION SHOULD	BE	(X5) COMPLETION DATE
F 000	There were no def	iciencies cited as a result of urvey ending 10/24/13. The	F	000			
LABORATORY	ODRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	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 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.

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

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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB SUMMANY STATEMENT OF REPOSEDUP YFULL (EACH GENCHARY) MUST BE PROCEDED BY FULL (EACH GENCHARY) MUST BY FULL (EACH GENCHARY) MUST BE PROCEDED BY FULL (EACH GENCHARY) MUST BY FULL (EACH GENCHARY) (EACH GENCHARY) MUST BE PROCEDED BY FULL (EACH GENCHARY)	STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING ()1	(X3) DATE SURVEY COMPLETED		
BRIAN CENTER HEALTH AND REHAB SUMMARY STATEMENT O DEFICIENCY REGULATORY OR LSC IDENTIFYING INFORMATION) K 000 INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a), using the 2000 Existing Health Care section of the LSc and its referenced publications. This building is TypeV(111) construction, one story, with a complete automatic sprinker system. The deficiencies determined during the survey are as follows: K 011 SS=D If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: A. Based on observation on 11/14/2013 the fire doors near room 201 failed to latch upon activation of the fire alarm. 25 The Maintenance Director performed a check of the facility and no other fire doors sinaled to latch correctly upon activation of the fire alarm. The Maintenance Director performed a check of the facility and no other fire doors sinaled to latch correctly upon activation of the fire alarm system. This STANDARD is not met as evidenced by: A. Based on observation on 11/14/2013 the fire doors near room 201 failed to latch upon activation of the fire alarm. 42 CFR 483.70 (a) One hour fire rated construction (with ½ hour fire-rated doors) or an approved automatic fire exilinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the 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 in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system on its seed, the areas are separated from	345332		B. WING	B. WING		11/14/2013			
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	K 029 SS=D	A. Based on observed or snear room 20 activation of the fire 42 CFR 483.70 (a) NFPA 101 LIFE SAFONE hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3.5.4 protein approved automaption is used, the all	ration on 11/14/2013 the fire 1 failed to latch upon alarm. FETY CODE STANDARD construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When atic fire extinguishing system reas are separated from	K 02	audit all fire doors in months and then mo that they are latching Results of the audits monthly QA&A confurther follow up and K029 The closure to the dikitchen has been ins linen and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and the soiled room have been adjute the months and then months are the months and the months are the months and the months are	a the facility 2 x monthly x 2 monthly x 2 months to g correctly. will be brought to the maittee meeting for direcommendations. The storage room in the talled. Both the clean doors to the land.	nth x 2 ensure he an undry	11/25/13	

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: X0UJ21

Facility ID: 922992

If continuation sheet Page 1 of 2

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		& MEDICAID SERVICES				MID INC) <u>. 0938-039</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345332		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 11/14/2013		
							NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH AND REHAB
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOU		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D BE COMPLÉTIO	
	doors. Doors are so field-applied protect 48 inches from the l permitted. 19.3.2	K	029	of the facility and no other doors were found to have missing closures. The Maintenance Director also checked all the doors to make sure that they closed and latched appropriately. No other doors were found to be out of compliance. The Maintenance Director and/or designee will audit all the doors in the facility monthly x 3 months to ensure that they close and latch appropriately and that the closures are functioning properly. Results of the audits will be brought to the monthly QA&A committee meeting for			
	This STANDARD is not met as evidenced by: A. Based on observation on 11/14/2013 there was no closer on the door to the dry storage room in the kitchen. B. Both the clean linen and the soiled linen doors to the laundry failed to close and latch. 42 CFr 483.70 (a) 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: A. Based on observation on 11/14/2013 the generator cranked but failed to transfer the load. 42 CFR 483.70 (a)		K 1			144	11/25/13
					There are no other generators attached to the facility to check. The Maintenance Director and/or design will audit the generator weekly x 4 week and then monthly to ensure that the transfer of the load is working appropria and within the proper time frame. Results of the audits will be brought to the monthly QA&A committee meeting further follow up and recommendations.	nee ks ately	