STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, record review and staff interview the facility failed to ensure a report of missing dentures was responded to for 1 of 1 sampled residents. (Resident # 133) Findings include: Resident #133 was admitted to the facility on 3/18/10 and re admitted on 4/12/10. Diagnoses included Paralysis agitans and esophageal reflux. A review of the Minimum data Set dated 3/14/11 revealed the residents cognition was intact. The oral/dental status indicated there were no difficulties. A review of a NN (Nurses Note) dated 3/19/11 at 6:10pm revealed the responsible party was in the facility and reported the residents dentures were missing. The supervisor was updated regarding missing dentures. A review of the Dental history and Record from the dentist revealed the resident was seen on 3/23/11. The documentation indicated broken dentures could not be found. An interview with Resident #133 on 4/5/11 at	F 166	F ~~166~~ 1. The Administrator followed up with resident #133 and the family member of this alleged deficient practice. New dentures were ordered on 4/22/11. 2. Facility residents with concerns have the potential to be affected by this alleged deficient practice. The facility Administrator reviewed the concern logs from January 2011 through current to verify that concerns have been resolved and followed up on with residents/family members. The facility Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and RN Supervisor inserviced staff on the Facility Policy and Procedure regarding concern reporting and prompt follow-up beginning 4/21/11. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The facility Administrator, Director of Nursing (DON), Staff Development Coordinator (SDC), and RN Supervisor inserviced staff on the Facility Policy and Procedure regarding concern reporting and prompt follow-up beginning 4/21/11. **" 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 provisions of federal and state law."**	04/15/11 04/15/11 04/29/11 04/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/29/11

A 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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	345362	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 166	Continued From page 1 10:35am revealed her teeth were broken and the dentist was to fix them. The resident indicated that she was suppose to get new dentures but she had not received them yet. Further discussion revealed that her dentures had a chip in them and that the dentist was going to fix them but when he came to the facility her dentures could not be found. The resident was laying in her bed neatly groomed without any dentures in place during the interview. On 4/6/11 5:44pm an interview with the social worker revealed that she was first aware of the residents dentures being missing was on 4/5/11 when the responsible party for the resident informed her of the dentures being missing. Further discussion revealed that "when the dentist came and said he could not find the teeth to fix them. I asked a nurse if they had seen them and they said the responsible party stated she was going to medicaid to get another pair. I did not follow up with her regarding the dentures" The social worker provided a concern report dated 4/5/11 which documented she had received communication from a nurse that the dentures were on the 300 hall medication cart and when the dentist was here the dentures were missing from the medication cart. The social worker could not remember which nurse had informed her that the dentures were missing from the medication cart, nor could she remember the date she was told. The social worker indicated she was aware the dentures were missing before the dentist came to the facility. The social worker stated it was her responsibility to follow up on the report that the dentures were missing and confirmed that she did not follow up on the dentures being missing.	F 166	Concerns will be reviewed and address in the morning meeting daily Monday – Friday by the Administrator. The facility RN Supervisor will review and address concerns voiced on the Weekends. Appropriate staff members will be assigned to investigate and follow up on concerns. Once the investigation and follow-up is completed the documentation will be given to the Administrator for review to ensure the concern was handled appropriately and resident/family member was notified regarding outcome. Concerns will be logged into The Concern Log and kept in the Administrator's office. 4. Quality Assessment & Assurance-QA&A The Administrator will review Concerns in the facility QA&A meeting weekly for four weeks and then monthly thereafter beginning 4/29/11. 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. **" 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 provisions of federal and state law."**	04/11/11 04/29/11 & ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING _____ B. WING _____	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

(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 166	Continued From page 2 On 4/6/11 at 5:50pm an interview with the administrator revealed that the first time he realized the dentures were missing was on 4/5/12 when the social worker provided him with the concern report. Further discussion revealed that the facility process was whom ever received the report of a concern or missing belonging usually would report the concern to the social worker who would write up the report and give it to him for an investigation. On 4/7/11 at 8:50am an interview with nurse #2 who routinely was assigned to the medication cart on 300 hall revealed that she remembers Resident #133's dentures being on the medication cart waiting for the dentist to repair them. Further discussion revealed that she remembers the dentures were missing from the medication but could not remember the date. Nurse #2 also indicated that the teeth being missing from the medication cart was reported. On 4/7/11 at 8:58am an interview with nurse aide #1 revealed that she was aware the residents dentures had a chip in it and needed to be repaired. The dentures were placed on the medication cart for safe keeping until the dentist came and fixed them. Further discussion revealed that the dentures have been missing for a while but could not remember the exact date.	F 166		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364		

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F 364	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on 3 of 3 sampled resident interviews, and a test tray observation, the facility failed to provide meals that were palatable and served at appropriate temperatures. (Residents #13, #249, #133). Findings included: Review of the Resident Council Meeting Minutes from January 2011 through March 2011 revealed no concerns with the temperatures and palatability of the foods served by the facility. During an interview on 4/4/11 at 4:30pm, Resident #13 stated the food did not taste good or look appetizing. During an interview on 4/04/11 at 5:05pm, Resident #249 stated that the food had no seasoning, the soup was salty, and the breakfast meals were always served cold. During an interview on 4/05/11 at 10:32am, Resident #133 revealed that she always requested a peanut butter sandwich because the food tasted bad, and the food was served cold during all meals. During an observation of the meal tray serving line in the kitchen on 4/6/11 at 11:50am, the temperatures of the hot food items ranged from 154 degrees Fahrenheit to 192 degrees Fahrenheit. The temperature of the milk was 39 degrees Fahrenheit. The dinner plates were maintained in a plate warmer next to the meal	F 364	F364 Palatable Foods Resident #13 was discharged from the facility prior to receipt of 2567. Resident #249 was interviewed by Assistant Dietary Manager on 4/25/11 and any food concerns were addressed. Resident #133 was interviewed by the Assistant Dietary Manager on 4/25/11 and any food concerns were addressed. The facility Meal Comment Card Program was implemented with Comment Cards delivered with meals beginning 4/18/11. Comment or concerns identified will be addressed by the Dietary Management Team. 2. Residents currently residing in the facility have the potential to be affected by this alleged deficient practice: The facility Resident Council met on 4/22/11 and residents were surveyed for meal concerns/preferences. Identified items were addressed by the Assistant Dietary Manager beginning 4/25/11. 3. Facility cooks were inserviced on Palatable Foods by the Dietary Manager on 4/20/11. The Dietary Management Team will complete Meal Test Tray three times per week for four weeks, then weekly thereafter, address any issues and report findings to the Facility QA&A Committee. **" 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 provisions of federal and state law."**	04/25/11 04/18/11 ongoing 04/25/11 04/20/11 04/18/11

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F 364	Continued From page 4 serving line until used. Each resident's plated meal was covered with a tray lid cover and bottom, and then placed on individual meal service trays. The meal service trays were placed in closed-sided stainless steel, multi-shelved delivery carts with the exception of the cart for the 300 residential hall. The meal delivery cart which transported meals to the 300 hall (last delivery) was also made of stainless steel; but open-sided. On 4/6/11 at 1:15pm, a meal test tray observation was conducted. The last meal tray was served to a resident on the 300 hall at 1:28pm. Temperatures were taken and food items of regular consistency were tested for palatability on a test meal tray at 1:30pm with the assistance of the Dietary Manager and the Activity Director (ham only). The temperatures of the ham, chicken and dumplings, green beans, corn, soup, and sweet potatoes ranged from 112 degrees Fahrenheit to 142 degrees Fahrenheit. During the taste testing, the Dietary Manager (DM) confirmed that the chicken and dumplings were salty; the green beans were lukewarm and had no seasoning/needed salt; and, the soup was lukewarm and had no flavor. However; the Activity Director disagreed that the ham was lukewarm and had no flavor. During an interview on 4/6/11 at 1:44pm, the DM revealed that meal test tray observations were conducted weekly, during alternating meal services. The DM also stated that the food service department did not usually receive many food complaints from residents.	F 364	Resident dietary likes and dislikes are updated by the Dietary Management Team upon admission, annually, and when concerns are identified. The facility Meal Comment Card Program was implemented with Comment Cards delivered with meals beginning 4/18/11. Comments or concerns identified will be addressed daily Monday through Friday by the Dietary Management Team. 4. Quality Assessment & Assurance-QA&A The Dietary Manager will review the Meal Comment Cards, and Test Tray findings weekly for four weeks and then monthly thereafter beginning 4/29/11. 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. " 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 provisions of federal and state law."	04/18/11 & ongoing 04/18/11 & ongoing 04/29/11 & ongoing
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining	F 411		

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F 411	Continued From page 5 routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to provident dental services to 1 of 3 sampled residents with dental issues. Resident #253. Findings included: Resident #253 was admitted to the facility on 3/21/11 with diagnoses which included: acute cerebrovascular accident, and hypertension. The review of the Admission Assessment (3/21/11), indicated the resident was alert and oriented with slurred speech; but was able to be understood. The Assessment also documented that the resident's full upper and lower partial dentures were lost at the hospital, prior to his admission to the facility. Review of the Nursing Summary Record dated 3/23/11 revealed Resident #253 complained to the first shift staff nurse of not being able to use	F 411	F411 - Dental Services 1. Resident #253, involved in this alleged deficient practice discharged home on 4/8/11. Emily Overcash, the facility Admissions Director, followed-up with the RN Case Manager at the hospital regarding the lost dentures on 3/25/11. 2. Current and future residents with Dental Services needs have the potential to be affected by this alleged deficient practice: Availability of Dental Services was reviewed at the Resident Council Meeting on 4/22/11. Identified Dental Service needs will be followed-up on by the Social Services Director. The Social Services Director began reviewing the "Ancillary Services Available" notice with current and newly admitted residents during the Social Services MDS Assessment and interview beginning 4/20/11. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Administrator developed an "Ancillary Services Available" notice. The Social Services Director began reviewing the "Ancillary Services Available" with current and newly admitted residents during the Social Services MDS Assessment and interview beginning 4/20/11 **" 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 provisions of federal and state law."**	04/08/11 04/22/11 04/20/11 04/20/11 04/20/11

See F 364

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F 411	Continued From page 6 his dentures which were left at the hospital. The staff nurse documented: "The Charge Nurse-Supervisor was made aware so it could be reported in the morning meeting". Review of the Dentist's scheduled visit to the facility on 3/23/11 did not include Resident #253. Review of the Nursing Summary Record dated 3/25/11 indicated someone from the facility's Admission's office would contact the hospital concerning Resident #253's missing dentures. On 3/31/11, Resident #253 was hospitalized due to right sided weakness, labored breathing, and in/out consciousness. The resident was re-admitted to the facility on 4/1/11. On 4/04/11 at 5:30pm, Resident #253 was observed working with the Speech Therapist. The resident had no teeth. The resident revealed that he was missing full upper dentures which were lost at the hospital prior to his admission to the facility. During an interview on 4/7/11 at 8:43am, the facility's SW (Social Worker) revealed Resident #253 was not seen by the dentist during last visit because the resident had no complaints of dental pain or inconvenience. The SW stated that she was aware that the resident's dentures were misplaced when he was in the hospital. The SW also stated that the resident's brother was in contact with the hospital who were trying to locate the dentures. During an interview on 4/7/11 at 9:02am, Resident #253 revealed that he was never asked by any of the facility staff if he wanted to be seen	F 411	Social Services Director has developed a Dental Services Tracking Program to track residents in need of dental services beginning 4/22/11. 4. Quality Assessment & Assurance-QA&A The Social Services Director will review the Ancillary Services Binder weekly for four weeks and then monthly thereafter beginning 4/29/11. 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. **" 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 provisions of federal and state law."**	04/22/11 04/29/11 & ongoing

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F 411	Continued From page 7 by the dentist; but, if he had been made aware of the dentist's visit to the facility, he would have liked to have been seen by the dentist. The Director of Nursing was in attendance during this interview. During an interview on 4/7/11 at 9:14am, the facility's Admission's Staff confirmed that the facility was made aware of the missing dentures by the Resident #253. She revealed that a staff member from the facility's Admissions office went to the hospital on the next day to search unsuccessfully for the missing dentures. During an interview on 4/7/11 at 10:07am, the facility's ST (Speech Therapist) revealed that Resident #253's speech was slurred related to the cerebrovascular accident and was receiving dysarthria and dysphagia therapy. The ST also indicated if the resident had his dentures, his speech may have improved, but would not ameliorate the deficit.	F 411		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	431 Stored Drugs The TB vial and bottle of Prostat were removed and discarded by the facility Staff Development Coordinator on 4/7/11. 2. Current residents have the potential to be affected by the same alleged deficient practice: The facility Director of Nursing (DON), Staff Development Coordinator (SDC), and RN **" 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 provisions of federal and state law."**	04/7/11 04/8/11

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F 431	Continued From page 8 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview failed to dispose an open multidose TB vial and one bottle of Prostat. The findings are: On 4/7/11 at 10:45 am, the medication room refrigerator had one open and not dated TB vial. The medication room had one open and not dated multidose bottle of Prostat. During an interview, on 4/7/11 at 11:06 am, Nurse #1 stated all multidose bottles and vials should be dated when opened. Nurse #1 disposed the TB vial and the Prostat bottle.	F 431	Supervisor completed an audit of all medication carts, medication storage room, and the medication refrigerator on 4/8/11, for expired, undated or unlabeled medications. Items found were removed, discarded and replacements ordered. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The DON, SDC, and RN Supervisor inserviced the Licensed Nursing Staff on "Storage and Labeling of Medications" beginning 4/22/11. DON/SDC/RN Supervisor will verify Licensed Nurses are auditing Medication Carts, Medication Storage Room and Medication Refrigerator daily. 4. Quality Assessment & Assurance-QA&A The Facility Director of Nursing will review the Medication Cart, storage room and med room refrigerator audits weekly for four weeks and then monthly thereafter beginning 4/29/11. 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. **" 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 provisions of federal and state law."**	04/22/11 04/15/11 04/29/11 & ongoing

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	345362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

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BRIAN CENTER HEALTH & RETIREMENT/CABARRUS	250 BISHOP LANE CONCORD, NC 28025

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K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 RECEIVED MAY 20 2011 This STANDARD is not met as evidenced by: Based on observation and staff interview at 1:30 pm the following smoke barrier was observed as noncompliant: specific findings include the smoke wall on 300 and 400 hall bath, had penetration that was not sealed in order to maintain the required fire resistance rating of the smoke barrier. 42 CFR 483.70(a)	K 025	K – 025 1. The corrective action: The penetrations on the 300 and 400 hall bath attic smoke walls will be sealed with an approved fire rated sealant by the Facility Maintenance Director. 2. Identification of other areas of concern: The Facility Maintenance Director will complete a survey of the attic area to identify any other penetrations of concern. Repairs to these areas will be completed with an approved fire rated sealant. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Facility Maintenance Director will survey the attic area monthly for the next three months and after any work completed in the attic area. Any identified penetration of concern will be repaired with an approved fire rated sealant. 4. Quality Assessment & Assurance-QA&A The Facility Maintenance Director will report findings to the Facility Safety Committee (a sub-committee of the QA&A) for the next three 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. " 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 provisions of federal and state law."	06/03/11 06/03/11 06/03/11 06/15/11 & ongoing
K 056 SS=E	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	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 5/19/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345362	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 056	Continued From page 1 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 and staff interview at 1:30 pm the following tamper alarm was observed as noncompliant: specific findings include the tamper alarm located in maintenance shop did not give a audible or visual at fire panel on test. 42 CFR 483.70(A)	K 056	K – 056 1. The corrective action: The facility sprinkler system tamper switch was repaired by Carolina Fire Control on May 10, 2011. The switch is functioning properly. 2. Identification of other areas of concern: The Facility Maintenance Director will complete a survey of the other sprinkler system tamper switches to ensure proper functioning. Any concern identified will be resolved. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Facility Maintenance Director will test the Sprinkler System Tamper Switches monthly. Any concerns identified will be resolved.	5/10/11 05/20/11 05/20/11
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and staff interview at 1:30 pm the following was observed as noncompliant: specific findings include: med and food carts were stored on 300 and 400 halls decreasing the corridor width of path of egress. 42 CFR 483.70(a)	K 072	4. Quality Assessment & Assurance-QA&A The Facility Maintenance Director will report findings to the Facility Safety Committee monthly (a sub-committee of the QA&A) for the next three 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. " 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 provisions of federal and state law."	06/15/11 & ongoing
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are	K 076		

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K 076	Continued From page 2 protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview at 1:30 pm the following was observed as noncompliant: specific findings include: oxygen tank was lying in wheelchair. 42 CFR 483.70(a)	K 076	K – 072 1. The corrective action: The carts on the 300 and 400 hallways were removed. 2. Identification of other areas of concern: The Facility Maintenance Director completed a survey of the facility for any obstructions or impediments. Any identified concerns were addressed. 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Facility Staff were inserviced on maintaining clear means of egress. The Facility Maintenance Director and Management Staff will monitor regularly for the next three months and report finding to the Safety Committee. Any identified concerns will be immediately addressed. 4. Quality Assessment & Assurance-QA&A The Facility Maintenance Director will report findings to the Facility Safety Committee (a sub-committee of the QA&A) for the next three 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.	05/04/11 05/20/11 05/27/11 05/20/11 & ongoing 06/15/11 & ongoing
K 145 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2. This STANDARD is not met as evidenced by: Based on observation and staff interview at 1:30 pm the following was observed as noncompliant: specific findings include Emergency Generator when tested did not crank and transfer load within 10 seconds. 42 CFR 483.70(a)	K 145	**" 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 provisions of federal and state law."**	

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			K – 076 1. The corrective action: The oxygen tank was immediately removed from the wheel chair.	05/04/11
			2. Identification of other areas of concern: The Facility Maintenance Director completed a survey of the facility for any improperly stored oxygen containers. Any identified concerns were addressed.	05/20/11
			3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Facility Staff were inserviced on safe handling and storage of oxygen.	05/27/11
			The Facility Maintenance Director and Management Staff will monitor regularly for the next three months and report finding to the Safety Committee. Any identified concerns will be immediately addressed.	05/20/11 & ongoing
			4. Quality Assessment & Assurance-QA&A The Facility Maintenance Director will report findings to the Facility Safety Committee (a sub-committee of the QA&A) for the next three 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.	06/15/11 & ongoing
			" 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 provisions of federal and state law."	

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			K – 145 1. The corrective action: The facility Emergency Generator was repaired by Prime Power on May 5, 2011. The generator now cranks and transfers load within 10 seconds. 2. Identification of other areas of concern: no other generators 3. Measures put into place to ensure that the alleged deficient practice does not recur include: The Facility Maintenance Director will monitor Emergency Generator for proper crank and transfer of load weekly for the next two months. Any identified concerns will be immediately addressed. 4. Quality Assessment & Assurance-QA&A The Facility Maintenance Director will report findings to the Facility Safety Committee (a sub-committee of the QA&A) for the next three 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. " 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 provisions of federal and state law."	05/05/11 05/05/11 & ongoing 06/15/11 & ongoing