

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345345	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/19/2015
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & RETIREMENT/MONROE			STREET ADDRESS, CITY, STATE, ZIP CODE 204 OLD HIGHWAY 74 EAST MONROE, NC 28112	
(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 000	INITIAL COMMENTS A 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. The facility is utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type II (222) Constructed: 1991 Fully Sprinkled - Yes At time of survey the: Certified Beds: Medicare/Medicaid - 80 Census - 63	K 000		
K 012 SS=D	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: 42 CFR 483.70 (a) Based on observations on 3/19/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The facility has areas of the one hour rated ceiling that were not maintained to protect the rating of the corridor ceiling.	K 012	Correction for the alleged deficiency noted as sheetrock in the attic space has holes that are not sealed in order to maintain the required rating of the ceiling in the center core area at two locations. Was to repair and seal areas as needed to obtain required rating with new drywall. The Maintenance Director will survey all like areas of the attic space and repair or	4/20/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

04/03/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 012	Continued From page 1 A. The sheetrock in the attic space that is part of the one hour fire rated corridors has holes that are not sealed in order to maintain the required rating of the ceiling in the center core area at two locations. 1. Attic hatch access just to the left near the TV room. 2. Attic hatch access just to the left near the 200 hallway bath. This deficiency affects 1 of approximately 6 such egress corridors in the facility. 2. The facility has unsealed penetrations in the one hour rated ceiling in the dietary department at the following locations. 1. The ceiling supports penetrating the rated ceiling for the air handling unit. 2. The conduit penetrating the rated ceiling at the dish washing station. Ref: NFPA 101 Section 19.1.6.2	K 012	replace drywall as needed. Any negative findings will be reported immediately to the facility Administrator and updates provided on progress of repairs as they occur. The Maintenance Director will continue with monthly inspections of the attic area for the next three months with all information presented and reviewed during the facility monthly Safety Committee meetings for those corresponding months. Attic inspections and reviews will continue quarterly thereafter until next annual survey. Completion date of April 20, 2015		
K 045 SS=D	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: 42 CFR 483.70 (a)	K 045	Correction for the alleged deficiency	4/20/15	

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K 045	Continued From page 2 Based on observations on 3/19/2015 at approximately 10:00 AM onward, the following deficiencies were noted: The facility has exit discharge lighting that were not complete as light bulbs at the required exits were not working properly. The exit discharge lighting in the following locations did not have one or both lit during the survey. 1. 300 hallway required exit discharge. 2. 100 hallway required exit discharge. 3. The service hallway required exit discharge This deficiency affects 3 of approximately 6 such required egress discharges in the facility. Ref: NFPA 101 Section 19.2.8	K 045	noted as exit discharge lighting that were not complete as light bulbs at the required exits were not working properly. Was to check and replace light bulbs and or fixtures as required to properly maintain exit discharge lighting. The Maintenance Director will survey all facility exit discharge lighting to ensure proper operation of lighting and fixtures with any negative findings repaired or replaced immediately. Lighting checks will then continue weekly on an ongoing basis for continued compliance. Any negative findings will be reported immediately to the facility Administrator and all findings will be presented to and discussed during the monthly Safety Committee meeting for the next three months with continued reviews quarterly until next annual survey. Completion date of April 20, 2015		
K 052 SS=E	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		4/24/15	

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

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K 052	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)</p> <p>Based on observations on 3/19/2015 at approximately 10:00 AM onward, the following deficiencies were noted:</p> <p>It was determined under direct observation that the facility failed to provide a Fire Alarm Control Panel (FACP) in proper working order.</p> <p>The automatic dialer audible and visual alert did not activate when the automatic dialer was disconnected from the main fire alarm panel.</p> <p>This deficiency affects the entire facility in case of phone line communication failure.</p> <p>Ref: NFPA 70 and 72 NFPA 101 Section 9.6.1.4</p>	K 052	<p>Correction for the alleged deficiency noted as The automatic dialer audible and visual alert did not activate when the automatic dialer was disconnected from the main fire alarm panel.</p> <p>Was to immediately contact fire alarm contractor to diagnose and then replace dialer for reliability. The Maintenance Director will then continue with weekly checks thereafter as scheduled on facility TELS system for ongoing compliance.</p> <p>The results of replacement and ongoing weekly tests will be presented to and discussed during the facility monthly Safety Committee meetings for the next three months with continued summary and reviews quarterly until next annual survey. Completion date of March 24, 2015</p>		