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
	345343	A. BUILDING **02 - BUILDING 02** B. WING ______	03/25/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH AND REHABILITATION/GOLDSBORO	**1700 WAYNE MEMORIAL DRIVE** **GOLDSBORO, NC 27534**

(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 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 Type III (211) construction, one story, with a complete automatic sprinkler system utilizing special locking. In the exit conference all deficiencies noted were discussed with administration. At time of survey the: Total Certified Bed Count =130 Census =115 The deficiencies determined during the survey are as follows:	K 000		
K 072 SS=D	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: 42 CFR 483.70 (a) Based on observations, on 3/25/15 at approximately 11 AM onward, the following deficiencies were noted: The means of egress was non-compliant, specific findings include: There were items stored on the corridor not in immediate use:	K 072	K072 Correction for the alleged deficient practice noted as There were items stored on the corridor not in immediate use; 1) Two file cabinets were stored outside of the chapel. 2) Fourteen, five gallon water bottles were stored outside the MDS coordinators	4/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/13/2015

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 072	Continued From page 1 1) Two file cabinets were stored outside the chapel. 2) Fourteen, five gallon water bottles were stored outside the MDS coordinators office. Reference NFPA 101, 7.1.10 This deficiency affected one smoke compartment. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 072	office. Was to immediately remove the items from the corridor and restore the means of egress. The Maintenance Director immediately surveyed the remainder of the egress corridors of the building and made any corrections as needed upon discovery. The facility will immediately conduct an in service with all Department Managers and staff to educate on importance of keeping exit corridors clear of obstructions at all times. The Maintenance Director, Facility Administrator and Department Managers will maintain observations during daily rounds with any negative findings immediately reported to the Facility Administrator. Daily reports will be given at morning stand up meetings for the next thirty days with an overall summary reported to and discussed during the next three monthly Safety Committee meetings. Reviews will then continue quarterly until next annual survey.	