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 _____	**08/05/2015**

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
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. In the exit conference all deficiencies noted were discussed and acknowledged with administration. Stories: 1 Construction Type III (211) Constructed: 4/16/1993 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 90 Census = 73 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 025 SS=F	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 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a)	K 025	K025	10/3/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/09/2015

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 025	Continued From page 1 Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) The smoke walls located on the 200 and 400 hall holes and/or penetrations that were not sealed in order to maintain the fire resistance rating of the wall. There are also PVC penetrations in the smoke wall that were not equipped with UL Rated fire assemblies. NFPA 101, 19.3.7.3 NFPA 101, 8.3.6.1 This deficiency affected four of approximately seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025	Correction for the items noted as smoke walls on 200 and 400 hall smoke barriers had holes or penetrations that were not sealed and PVC penetrations that were not equipped with UL rated fire assemblies: -Is to seal penetrations with approved sealant and install UL Listed fire rated assemblies for replacement of PVC penetration fire rated assemblies as needed. The Maintenance Director will survey the remainder of the facility smoke barriers for like instances and repair upon discovery. Rechecks of the assemblies will continue monthly for the next three months to maintain integrity of repairs, with repeated observation to identify and remedy any further repairs needed. A summary of all findings and repairs will be presented to and discussed during the facility¿s monthly Safety Committee meetings for the next three months, with continued reviews quarterly until next annual survey. Correction date is 10/3/15	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015	K 038	K038 Correction for the item noted as exit doors equipped with delayed egress will relock	10/3/15

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K 038	Continued From page 2 at approximately 9:30 AM onward, the following deficiencies were noted: 1) The exit doors in the facility are equipped with delayed egress and when tested the doors would relock after the door is opened with use of keypad after the irreversible process of delayed egress locking system has been initiated. Doors shall not relock once the process of opening the door has started even if a keypad is used to speed up the opening of the delayed egress door. NFPA 101: 7.2.1.6.1 NFPA 101: 19.2.1 The deficiency affected the entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	and interrupt irreversible process when door is opened with use of keypad: -Is to change locks to standard electromagnetic locking system and utilize an emergency door release switch located within 36 inches of each exit door, and not more than 48 inches above finish floor. All existing signage designating delayed egress will be removed. The Maintenance Director will survey and test all facility exit doors equipped with electromagnetic locking devices for uniformity and proper operation of device. The Maintenance Director will test emergency door release switches during regular door checks daily for the next four weeks, then, emergency door release switch testing will then continue weekly ongoing. This will also include an ongoing monthly check of all master door releases at nurse¿s stations. A summary of all findings and results will be presented to and discussed during the next three monthly Safety Committee meetings, with continued reviews quarterly thereafter until next annual survey. Completion date is: 10/3/15	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by:	K 047		10/3/15

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K 047	Continued From page 3 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) An additional exit directional sign is needed in the service corridor to the exit corridor on 200 hall. 2) There was not an exit directional signage at any exit door from the interior courtyard. NFPA 101 19.2.10.1 This deficiency affected two of approximately seven smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 047	K047 Correction for the items noted as: (1) An additional exit directional sign is needed in the service corridor to the exit corridor on 200 hall, was to install the additional sign as needed. (2) An exit sign was installed at one of the three exit doors leading out of the courtyard. The Maintenance Director will survey the remainder of the building to locate any other areas needing exit directional signs and consult DHHS Construction section or local AHJ before installation if any others are needed. A summary of the findings and outcomes will be provided to and discussed during the facility's monthly Safety Committee meetings for the next three months with quarterly reviews ongoing until next annual survey. Completion date is 10/3/15.	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) The smoke duct detectors located in the HVAC	K 054	K054 Correction for the item noted as the smoke duct detector located in the kitchen HVAC unit was not maintained clean and in good operating condition: -Duct detector was cleaned and serviced as needed. The Maintenance Director will	10/3/15

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K 054	Continued From page 4 unit for the kitchen was not maintained clean and in good operating condition. Location - HVAC unit in the attic area for kitchen. NFPA 90 A 4-4.4.1 This deficiency affected the kitchen unit only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 054	survey all other duct smoke detectors in the facility and have cleaned and serviced as needed. The Maintenance Director will do monthly duct smoke detector checks for the next three months to determine frequency of cleaning and service needs. The Maintenance Director will verify cleaning, service, and proper operation during annual fire alarm certification to maintain continued compliance. A summary of all results will be presented to and discussed during the facility's monthly Safety Committee meetings for the next three months with continued reviews and observations quarterly until next annual survey. Completion date is 10/3/15	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) The audible Supervisory signal for the closure of a sprinkler control valve can not be permanently silenced. When testing the valves for the sprinkler system only one provided an	K 061	K061 Correction for the items listed as: (1) The audible supervisory signal for the closure of a sprinkler valve cannot be permanently silenced. (a) Was to contact the fire alarm service provider to test system and reprogram as necessary to obtain an audible alarm that will recur after a short period of time. -When testing the valves for the sprinkler	10/3/15

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K 061	Continued From page 5 audible/visual signal at the fire alarm panel. 2) The accelerator lines have valves installed in the line that are equipped with unapproved tamper alarm. NFPA 101: 9.7.2.1 NFPA 72 This deficiency affected the entire facility. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 061	system only one signal was provided for two systems at fire panel. (b) Was to contact the fire alarm service provider to install a separate module for each dry pipe system so each would alarm independent of each other at fire alarm panel. (2) The accelerator lines have valves installed in the lines with unapproved tamper alarm: -Was to engage fire alarm service provider to install micro switch type tamper devices on each valve and verify operation. The Maintenance Director will test each valve and module for audible and visual alarm weekly for the next four weeks and note separation of the two, and timing and recurrence of audible signal from each. Further testing will then continue during normal quarterly sprinkler inspections and be verified by the Maintenance Director. A summary of all findings and results will be presented to and discussed during the facility's next three monthly Safety Committee meetings with quarterly reviews to continue until next annual survey. Completion date is 10/3/15.	
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		10/3/15

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K 067	Continued From page 6 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) An access door for the smoke duct detector located in the attic above the kitchen was not provided for in order to clean inspect and maintain the device. NFPA 90A, 2-3.4.1 This deficiency affected the kitchen unit only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	K067 Correction for the item listed as: An access door for the duct smoke detector located in the attic above the kitchen was not provided for in order to clean inspect and maintain the device. -Was to install an access door in duct to clean, inspect and maintain. The Maintenance Director will survey the remainder of the building to locate all HVAC units with duct detectors to verify access doors are in place. The Maintenance Director will check these monthly during duct detector checks and verify during annual fire alarm certification. A summary of all findings and results will be presented to and discussed during the monthly Safety Committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date is: 10/3/15	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted:	K 130	K130 Correction for the item listed as: Staff in the kitchen when questioned , were not familiar on how to operate the Ansul system in case of emergency.	10/3/15

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K 130	Continued From page 7 1) Staff in the kitchen when questioned were not familiar on how to operate the Ansul System in case of an emergency. NFPA 96: 8-1.4 "Instructions for manually operating the fire-extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed periodically with employees by the management." This deficiency affected kitchen only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 130	-Was to immediately in service staff on the location of system release and proper timing and use of the system. The Maintenance Director will continue with random in services on an individual basis during daily rounds to reinforce training. A summary of all training , results and continued compliance will be presented to and discussed during the monthly Safety Committee meeting for the next three months with continued reviews and in servicing quarterly thereafter. Correction date is 10/3/15.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on Wednesday 5, 2015 at approximately 9:30 AM onward, the following deficiencies were noted: 1) The staff at the time of the survey could not verify recepticales connected to emergency power on 400 hall. Staff will need to verify electrical panel connected on emergency panel and insure that they are properly labeled and verify the location of emergency recepticales in the resident rooms on 400 hall. NFPA 70, National Electrical Code. 9.1.2 This deficiency affected the entire building.	K 147	K147 Correction for the item listed as: The staff at time of survey could not verify receptacles connected to emergency power on 400 hall. -Was to immediately begin the process of receptacle and breaker identification. All emergency powered receptacles will be located, verified and identified with a red duplex receptacle for easy identification, and proper identifying label inside panels. All four emergency panels located on the hallways will be identified with red lettering or nameplates to be easily identified as such. The Maintenance Director will then do a monthly check of panels to maintain	10/3/15

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K 147	Continued From page 8 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 147	compliance and identification. Emergency receptacles in facility will be monitored during daily rounds and routine room checks for damage and replaced as needed with hospital grade receptacles. A summary of all findings and results will be presented to and discussed during the monthly Safety Committee meetings for the next three months and continue quarterly thereafter until next annual survey. Completion date is 10/3/15	