STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/CH	**5939 REDDMAN ROAD** **CHARLOTTE, NC 28212**

(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 speical locking systems. In the exit conference all deficiencies noted were discussed with administration. Stories: One Construction Type III (211) Constructed: 1984 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 120 Census = 98 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The building separation was non-compliant, specific findings include: 1. The fire wall separating the facility surveyed	K 011	K011 Correction for the alleged deficiency was the Maintenance Director sealed the holes or penetrations as needed with approved fire stopping material to restore the fire	8/8/16

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

Electronically Signed | 08/05/2016

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K 011	Continued From page 1 and the adjacent building has holes and penetrations in the fire rated wall that were not sealed in order to maintain the required rating of the fire wall. NFPA 19.1.1.4.1, 19.1.1.4.2 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 011	wall to its required rating. The Maintenance Director will survey the remainder of the facility to locate and inspect any other like fire walls, and make any needed repairs upon discovery. All fire walls will be rechecked monthly for three months and any negative results reported immediately to the facility Administrator. A summary of all findings will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next three months. Continued reviews will be conducted quarterly thereafter until next annual survey.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The smoke walls are was non-compliant, specific findings include: 1. The smoke walls in the attic by sprinkler pipe located on the at Zone 2 by MDS office and	K 025	K025 Correction for the alleged deficiency was to remove non approved sealant from the smoke wall and replace with an approved sealant that would restore the smoke wall to its required one hour rating.	8/11/16

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K 025	Continued From page 2 smoke on 100 Hall have holes and/or penetrations in the block wall that were not sealed in accordance with an approved fire rated assemble in order to maintain the fire resistance rating of the wall. 2000 NFPA 101 Section 5.7 Maintenance. 2000 NFPA 101, 8.3.2* 2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 NFPA 101, 8.3.6.1. Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: 1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 025	The Maintenance Director will survey the remainder of the facility smoke walls for any like circumstance and make any necessary changes and repairs upon discovery with approved sealant if needed. Smoke walls will be inspected for continued integrity and proper sealant monthly for three months. A summary of all findings and any needed repairs will be presented to and discussed during the facility monthly Safety Committee (QAPI) meeting for three months with continued reviews quarterly thereafter until next annual survey.	

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K 025	Continued From page 3 This deficiency affected four 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		
K 038 SS=E	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: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The means of egress was non-compliant, specific findings include: 1. When exiting A or B wing through the courtyard where the residents smoke the exit gate is not marked and the latch to open the gate is not visible. The latch to open the gate is located on the outside of the gate and is not readably accessible. NFPA 19.2.1 This deficiency affected one six means of egress. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	K038 Correction for the alleged deficiency will be to post exit signs near the two affected gates to indicate location and direction of exit through each. Existing latches will be replaced with a latching mechanism visible from both sides requiring no special knowledge to operate or release gate. The Maintenance Director will survey the remainder of the facility to locate and identify any other like instances and remedy upon discovery. The Maintenance Director will do daily checks of these gates and their proper operation ongoing during normal required daily door checks and log accordingly. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next	8/12/16

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K 038	Continued From page 4	K 038	three months with continued reviews quarterly thereafter until next annual survey.	
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 will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The emergency egress lighting was non-compliant, specific findings include: 1. The facility at the time of the survey could not verify that emergency lighting was available in the interior courtyard outside the dining room. 2000 NFPA 101, 19.2.8, 7.9 Emergency Lighting, 7.9.2.1 Emergency illumination shall be provided for not less than 1-1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 Lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candles (6 lux) and, at any point, not less than 0.06 ft-candles (0.6 Lux) at the end of the 1 1/2 hours. A maximum- to minimum illumination uniformity ratio of 40 to 1 shall not be exceeded. This deficiency affected the interior courtyard.	K 045	K045 Correction for the alleged deficiency was to verify lighting power source of courtyard lighting and engage electrical contractor to connect to emergency power as needed. The Maintenance Director will confirm courtyard lighting connection to emergency panel, and label breaker for proper identification. The Maintenance Director will conduct weekly tests of courtyard lighting for the next four weeks to insure proper operation, then continue spot checks as part of daily lighting checks. A summary of all repairs and findings will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next three months, with continued reviews quarterly thereafter until next annual survey.	8/31/16

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K 045	Continued From page 5 Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 045		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The exit signage was non-compliant, specific findings include; 1. From standing inside the courtyard outside the dining room the exit signage was incomplete. The interior courtyard is greater than 2500 sq feet and did not have the minimum of two illuminated exit signs in the courtyard. Exit and directional signs are displayed in accordance with section 7.10 Ref: 2000 NFPA 101 19.2.10.1 This deficiency affected the courtyard only. 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 alleged deficiency was to install illuminated exit signage at each end of the courtyard area to provide direction to either of the two required exits. The Maintenance Director will survey the remainder of the facility to verify proper exit signage is in place. The Maintenance Director will then conduct regular weekly checks of facility exit signs and operation on an ongoing basis with results logged in the TELS system. A summary of all results and findings will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next three months, with continued reviews quarterly thereafter until next annual survey.	8/5/16
K 050	NFPA 101 LIFE SAFETY CODE STANDARD	K 050		8/10/16

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K 050 SS=D	Continued From page 6 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The staff familiar with location of fire alarm pull stations was non-compliant, specific findings include: 1. On housekeeping member in the facility when asked to pull a fire alarm pull station stated that she did not know where they were located. NFPA 19.7.1.2 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 050	K050 Correction for the alleged deficiency was to immediately inservice the member of housekeeping to inform of pull station locations. The facility will provide an all staff inservice showing locations of each pull station and reference facility evacuation plans on each hallway further indicating their locations. The Maintenance Director will also provide additional inservice on locations during the next three monthly facility fire drills during particular shifts following guidelines of one fire drill per shift per quarter. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next	

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K 050	Continued From page 7	K 050	three months, with continued reviews quarterly thereafter until next annual survey.	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The tamper alarms are non-compliant, specific findings include: 1. The sprinkler backflow preventor valves located in the hot box outside are equipped with electronically supervised tamper alarms but the devices did not provide a supervisory audible and visual signal at the Fire Alarm Control Panel (FACP) when the valves are closed. 2. The supervisory trouble audible/visual signal for the electronically supervised tamper alarms for the sprinkler control valves could be silenced at the Fire Alarm Control Panel (FACP) when the valves are closed on the sprinkler system. The supervisory audible/visual trouble signal for the the sprinkler control valves can not be silenced until the valves are restored back to the normal position. NFPA 101; 9.7.2.1 NFPA 72: 2-9	K 061	K061 Correction for the alleged deficiency was to immediately contact fire alarm contractor: (1) to diagnose and adjust tamper alarms at sprinkler valves to operate reliably. (2) to diagnose and reprogram fire panel as needed to provide an audible alarm that cannot be silenced until the sprinkler valves are returned to normal position. The Maintenance director will do weekly tests of both (1) and (2) for the next eight weeks, and continue with verification of proper operation during regular scheduled quarterly sprinkler system testing by outside contractor on an ongoing basis. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee (QAPI meetings for the next three months with continued reviews	8/19/16

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K 061	Continued From page 8 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	quarterly thereafter until next annual survey.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The smoking area was non-compliant, specific findings include: 1. The residents were not following smoking regulations. Ash trays and cigerates were being dumped in the trash can and the the ground and not properly disposed of. Resident were	K 066	K066 Correction for the alleged deficiency was to immediately inservice all residents that smoke, to the importance of using ashtrays provided in the area. The facility will purchase more approved, non combustible ash trays to insure	8/11/16

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K 066	Continued From page 9 observerd smoking and not using the ash tays and droping the ashes directly on the ground. This deficiency affected smoking area only. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 066	adequate supply. The facility will perform hourly spot checks during smoking times to insure compliance and cleanliness of the area, and also emptying ashtrays into the approved self sealing containers, for the next four weeks. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee(QAPI) meetings for the next three months with continued reviews quarterly thereafter until next annual survey.	
K 067 SS=F	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 This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The HVAC system was non-compliant, specific findings include: 1. Ceiling radiation dampers, required to maintain the one hour rating of the ceiling , were not provided for in the corridor on the HVAC return located outside outside the therapy room . NFPA 101, Section 8.2.3.2.4.1: Openings in fire barriers for air handling duct-work or air movement shall be protected in accordance with NFPA 101, Sections 19.5.2.1, 9.2.1. and NFPA 90 A, Section 3-3.2	K 067	K067 Correction for the alleged deficiency was to install radiation damper as required to provide one hour rating of ceiling assembly in HVAC return located outside therapy room. The maintenance director will survey the remainder of the facility to check for other HVAC returns missing radiation dampers and make repairs or installation upon discovery.	8/12/16

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K 067	Continued From page 10 2a. HVAC unit for the therapy area (Zone 3) and nurse station in B-hall did not shut down with fire alarm activation. 2b. The emergency shut down switch located in there they room did not shut down the HVAC when tested. NFPA 90A, 4-2 NFPA 90A 4-4.1 Testing. All automatic shutdown devices shall be tested at least annually. This deficiency affected two smoke compartments Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	The Maintenance director will perform weekly checks of HVAC returns for the next eight weeks to insure all are in compliance, and continue with monthly checks ongoing. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee (QAPI meetings for the next three months, with continued reviews quarterly thereafter until next annual survey.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on observations, on Thursday 7/21/2016 at approximately 8:30 AM onward, the following deficiencies were noted: The emergency power supply was non-compliant, specific findings include: 1. The emergency generator operational inspection and testing was non-compliant, specific findings include; documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. 2. The generator records were non-compliant,	K 144	K144 Correction for the alleged deficiency was to (1) immediately schedule a load bank test for generator. The Maintenance Director will be inserviced on calculating and recording percent of rated load and temperature rise to maintain compliance. If generator cannot reach a monthly load of 30%, load bank testing will be done annually ongoing as needed.	8/15/16

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BRIAN CENTER HEALTH & REHAB/CH	**5939 REDDMAN ROAD** **CHARLOTTE, NC 28212**

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K 144	Continued From page 11 specific findings include, documentation for weekly electrolyte testing was not being conducted. Reference 1999 NFPA 110 6-3.6 Storage batteries, including electrolyte levels, used in connection with Level 1 and Level 2 systems shall be inspected at intervals of not more than 7 days and shall be maintained in full compliance with manufacturer's specifications. Defective batteries shall be repaired or replaced immediately upon discovery of defects. Reference 1999 NFPA 110 A-6-3.6, NFPA 70, National Electrical Code, Section 700-4(c) Maintenance of batteries should include checking and recording the value of the specific gravity. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPSS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60	K 144	(2) The facility will use a specific gravity measuring device during weekly generator testing to monitor and record electrolyte levels in the generator logbook on an ongoing basis. A summary of all findings and their results will be presented to and discussed during the facility monthly Safety Committee (QAPI) meetings for the next three months, with continued reviews quarterly thereafter until next annual survey.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345243	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 12 minutes, for a total of 2 continuous hours. (load bank testing) This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144		