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
	345140	A. BUILDING _____ B. WING _____	07/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 000	INITIAL COMMENTS The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B for Long Term Care Facilities (General Health Survey).	F 000		

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

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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	345140	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	* K 018 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The dry storage room door in the kitchen was provided with a latch suitable for keeping the door closed at all times. This allows the dry storage room door to remain latched when closed. The door to the housekeeping closet at the nurse's station now has fire/weather stripping around door frame to resist the passage of smoke. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The dry storage room door in the kitchen was provided with a latch suitable for keeping the door closed at all times. This allows the dry storage room door to remain latched when closed. The other doors in the facility have been inspected by the Maintenance Supervisor to determine if any other doors do not have a suitable means of remaining closed at all times. None were found. The door to the housekeeping closet at the nurse station has been placed with fire weather stripping around the door frame allowing resist passage of smoke. The other doors in the facility have been inspected to determine if any other doors have a gap between the door and the frame. None were found.	8-30-13

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

Darlene Williams — RN — 9-6-13

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.

GW

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

The facility has been inspected to determine if other doors are found not to able to latch at all times. None were found.

On a monthly basis for three months and quarterly thereafter the Maintenance Supervisor will inspect all doors and document on a log sheet that all doors are able to be latched. If any are found that do not latch properly the Maintenance Supervisor will repair at that time and document on the log.

The facility has been inspected to determine if other doors are found to have a gap between the door and the frame. None were found.

On a monthly basis for three months and quarterly thereafter the Maintenance Supervisor will inspect all doors and document on a log sheet that all doors do not have a gap between the door and the frame. If any are found that do not latch properly the Maintenance Supervisor will repair at that time and document on the log.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION MONITORED FOR ITS EFFECTIVENESS. THE [illegible] ASSURANCE SYSTEM OF THE FACILITY:

The Maintenance Supervisor will be responsible for ensuring that all doors latch at all times.

The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.

The Maintenance Supervisor will be responsible for ensuring that all doors do not have a gap between door and frame.

The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.

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	345140	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliance, specific findings include: 1. dry storage room door in kitchen would not latch. 2. door to housekeeping closet at nurse station has a gap between the top of door and the frame. 42 CFR 483.70(a)	K 018	~~K 038~~ ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The bathroom door in the employee break room had a door knob that was not a two hand motion. A new door knob has been replaced that requires a one hand motion. This allows the exit to be readily accessible at all times. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	8-30-13
K 038 SS=D	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	K 038	The bathroom door in the employee break room had a door knob that was not a two hand motion. A new door knob has been replaced that requires a one hand motion. This allows the exit to be readily accessible at all times. None were found. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:	
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliance, specific findings include: bathroom door in employee breakroom requires two motion of hand to open door. 42 CFR 483.70(a)		The facility has been inspected to determine if other doors are found not to be readily accessible. None were found. On a quarterly basis the Maintenance Supervisor will inspect all doors and document on a log that all doors have a one hand motion and are readily accessible. If any are determined not to be, the Maintenance Supervisor will repair at that time and document on a log.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

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K 062	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliance, specific findings include: 1. per sprinkler contractor inspection report sprinkler system has not having a 5 year obstruction investigation in past 5 years. 2. also, 3 year full flow test. 3. sprinkler heads under canopy have corrosion on heads. 4. no sprinkler wrench provided in box sprinkler box. 42 CFR 483.70(a)	K 062	INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Maintenance Supervisor will be responsible for ensuring that all doors in the facility are readily accessible at all times. The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis. The QA committee will be responsible to ensure compliance is achieved and sustained.	
K 066 SS=F	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.	K 066	• K 062 SEE THE ATTACHED LETTER REQUESTING A WAIVER.	9-3-13

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K 066	Continued From page 3 (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: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliance, specific findings include: facility failed to provide proper ashtrays and metal container with self-closing cover in smoking area.	K 066	ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The nurses were in serviced on 9-1-13 by the Clinical Services Supervisor that all oxygen cylinders must be stored under the appropriate signage. Only oxygen cylinders that are empty to be placed under the empty signage and full oxygen cylinders are to be placed under the full signage. New bright signage has been placed in the med rooms to help nurses better read and follow the appropriate signage. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The nurses were in serviced on 9-1-13 that all oxygen cylinders must be stored under the appropriate signage. Only oxygen cylinders that are empty have to be placed under the empty signage and full oxygen cylinders have to place under the full signage. New bright signage has been placed in the med rooms to help nurses better read the signage	
K 076 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are 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:	K 076	The facility has been inspected to make sure all oxygen cylinders are placed under the correct signage. None were found. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The facility has been inspected to determine to make sure all oxygen cylinders are placed under the correct signage. None were found.	9-2-13

• X 066

ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

The areas outside where smoking is permitted, now has an ashtray of noncombustible material and safe design. Along with a metal container with a self-closing cover device in which the ashtrays can be emptied.

ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

The areas outside where smoking is permitted, now has an ashtray of noncombustible material and safe design. Along with a metal container with a self-closing cover device in which the ashtrays can be emptied.

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

The Maintenance Supervisor will do a QA round every two weeks times for one month then once a week times one month then quarterly thereafter to inspect all permitted smoking areas. He will document on a log that an ashtray of noncombustible material and a metal container with self-closing cover is readily available in all permitted smoking areas. If any noncompliance is found the Maintenance Supervisor will replace immediately with appropriate materials and document on a log.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THIS POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The Maintenance Supervisor will do a QA round every two weeks times for one month then once a week times one month then quarterly thereafter to inspect all permitted smoking areas. He will document on a log that an ashtray of noncombustible material and a metal container with self-closing cover is readily available in all permitted smoking areas. If any noncompliance is found the Maintenance Supervisor will replace immediately with appropriate materials and document on a log.

The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.

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K 076	Continued From page 4 Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliance, specific findings include: at time of survey, full oxygen cylinders were stored under signage for empty cylinders. 42 CFR 483.70(a).	K 076	On a weekly basis for one month, then three times weekly for one month and then quarterly thereafter the Maintenance Supervisor will inspect all oxygen cylinders to make sure they have been placed under the correct signage and he will document on a log. If any oxygen tanks are found to be noncompliant the Maintenance Supervisor will remove at that time and document on a log. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: On a weekly basis for one month, then three times weekly for one month and then quarterly thereafter the Maintenance Supervisor will inspect all oxygen cylinders to make sure they have been placed under the correct signage and he will document on a log. If any oxygen tanks are found to be noncompliant the Maintenance Supervisor will remove at that time and document on a log. The Administrator will present the Maintenance Supervisor's log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis. The QA committee will be responsible to ensure compliance is achieved and sustained.	