						APPROVED
		& MEDICAID SERVICES		TIDI		. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CON	E SURVEY IPLETED
		345140	B. WING			C 18/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
PRICUT	MOOR NURSING CEN	ITER		6	10 WEST FISHER STREET	
DRIGHT	WOOR NURSING CEN	IIER		S	ALISBURY, NC 28145	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 0	000		
F 278 SS=B	complaint investiga 483.20(g) - (j) ASSI	re cited as a result of the tion. Event ID #1YLS11. ESSMENT RDINATION/CERTIFIED	F 2	278		10/1/14
	The assessment m resident's status.	ust accurately reflect the				
	A registered nurse in each assessment with participation of heat					
	A registered nurse assessment is com	must sign and certify that the pleted.				
		o completes a portion of the ign and certify the accuracy of ssessment.				
	willfully and knowing false statement in a subject to a civil mo \$1,000 for each ass willfully and knowing to certify a material resident assessment	d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each				
	Clinical disagreeme material and false s	ent does not constitute a statement.				
	by:	NT is not met as evidenced				
	Based on record re	eview and staff interviews, the			THIS FACILITYHS RESPONSE TO THIS	
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE	(X6) DATE
	ically Signed					10/06/2014

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.

DEDADTMENT OF LIEALTH AND LUMANN SEDVICES

PRINTED: 10/14/2014

	CONTRACT	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(¥2) MILL	тю	E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
				-		()
		345140	B. WING			09/1	8/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTI	MOOR NURSING CEN	NTER			10 WEST FISHER STREET ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 278	Continued From pa	age 1	F 2	78			
	Data Set (MDS) to Preadmission Scre (PASRR) determini identified as Level	eurately code the Minimum reflect results of the Level II eening and Resident Review ation for 4 of 8 residents II PASRR residents (Resident Resident #14 and Resident			REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; DOES IT CONSTITUTE AN ADMIS THAT ANY STATED DEFICIENCY ACCURATE. WE ARE FILING THI BECAUSE IT IS REQUIRED BY LA	E NOR SSION IS E POC	
		as initially admitted to the			" F:278 ADDRESS HOW CORRECTIVE A (S) WILL BE ACCOMPLISHED FO	R	
		and re-admitted on 7/18/14 agnoses which included bipolar			THOSE RESIDENTS FOUND TO H BEEN AFFECTED BY THE DEFIC PRACTICE:		
	(MDS) assessmen indicated the reside state Level II Pread Resident Review (I serious mental illne Determination of a made by an in-dep	nt #36 's Minimum Data Set t (Section A) dated 8/14/14 ent was not considered by the dmission Screening and PASRR) process to have a ess and/or intellectual disability. Level II PASRR resident is th evaluation. The results of			On 09/17/2014 Resident #36, Resid #11, Resident #14, and Resident #2 were reviewed by the MDS Nurse, Services Supervisor, and Administr along with the other residents to en that the MDS accurately reflects the Level 2 PASSR information on the l	24 Clinical ator sure eir	
	determination of ne appropriate care se recommendations individual's plan of	for services to help develop an care.			ADDRESS HOW CORRECTIVE AN WILL BE ACCOMPLISHED FOR T RESIDENTS HAVING POTENTIAL BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	HOSE	
	residents revealed	ility ' s list of Level II PASRR that Resident #36 was e residents named on the list.			Any resident has the potential to be affected by this practice.	•	
	Level II PASRR wri from the state date	nt #36 ' s records included a itten verification of approval d 1/13/14. Resident #36 ' s mber included the letter code "			On 09/17/2014 Resident #36, Resid #11, Resident #14, and Resident #2 were reviewed by the MDS Nurse, Services Supervisor, and Administr along with the other residents to en that the MDS accurately reflects the	24 Clinical ator sure	

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU			MB NO.	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						(2
		345140	B. WING			09/*	8/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTI	MOOR NURSING CEN	ITER			10 WEST FISHER STREET ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 278	Continued From pa	ge 2	F 2	278			
	An interview was co	onducted on 9/17/14 at 3:45 Nurse #3 assumed			Level 2 PASRR information on the	MDS.	
	Minimum Data Set plans. During the in that she typically loc at the bottom of eac determine whether determined to be a that any letter code flag that the resider the MDS as a Leve inquiry, the nurse in way she would know PASRR was throug staff members. Nu official report. " An interview was co PM with the Clinica Clinical Nurse Supe for receiving PASR	mpletion of the facility 's (MDS) assessments and care nterview, Nurse #3 reported oked at the PASRR letter code ch resident 's face sheet to or not a resident was Level II PASRR. She noted other than an "A" was a nt would need to be coded on I II PASRR. Upon further ndicated that the only other w if a resident was a Level II h communication with other rse #3 stated, "I don 't get an onducted on 9/17/14 at 3:54 I Nurse Supervisor. The ervisor assumed responsibility R information for residents, ormation through the state, and			On 09-17-14, the facility Administra re-educated the Clinical Services Supervisor, and MDS Nurse conce any resident that has a Level 2 PA currently and any new admissions communicated to the MDS Coordin and Administrator by the Clinical S Supervisor to ensure the MDS is c correctly. They both were also give list of Authorization Codes and Corresponding Timeframes/Restric from the NC Provider Manual to er both understood what a Level II Co Letter represents. ADDRESS WHAT MEASURES W PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE TO THE DEFICIENT PRACTICE WILL OCCUR:	erning SRR will be nator ervices oded en the ctions osure ode	
	subsequently receiv Upon inquiry, the C indicated she was r PASRR information to the MDS Nurse. the processing info linked to the MDS in automatically popul Level II PASRR, wh An interview was co PM with the facility inquiry, the Adminis expectation was for	ving verification and approval. linical Nurse Supervisor not aware that the Level II needed to be communicated She reported that she thought rmation from the State was nformation so that it would ate and code the resident as a nen appropriate. onducted on 9/17/14 at 4:22 's Administrator. Upon strator indicated that her the Level II PASRR coded accurately on each			On 09-17-14, the facility Administra re-educated the Clinical Services Supervisor, and MDS Nurse conce any resident that has a Level 2 PA currently and any new admissions communicated to the MDS Coordin and Administrator by the Clinical S Supervisor to ensure the MDS is c correctly. They both were also give list of Authorization Codes and Corresponding Timeframes/Restric from the NC Provider Manual to er both understand what a Level II Co Letter represents.	erning SRR will be nator ervices oded en the ctions isure	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345140	B. WING			09/1) 8/2014
	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		0/2014
BRIGHTI	MOOR NURSING CEN	ITER	610 WEST FISHER STREET SALISBURY, NC 28145				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 278	Continued From pa	ge 3	F 2	78			
	6/3/2004 with cumu included intellect dis A review of Resider (MDS) assessment indicated the reside state Level II Pread Resident Review (F serious mental illne Determination of a made by an in-dept this evaluation are of determination of ne appropriate care se recommendations f individual's plan of A review of the facil residents revealed included among the A review of Resider resident had been a number/letter code. PASRR number inc	at #11 's Minimum Data Set (Section A) dated 8/11/14 ent was not considered by the Imission Screening and PASRR) process to have a ess and/or intellectual disability. Level II PASRR resident is th evaluation. The results of used for formulating a eed, determination of an etting and a set of for services to help develop an			The facility has created an audi called the MDS PASRR Audit. T will be used for every Resident completion of each MDS asses ensure that each PASRR has b correctly and will be completed facility Administrator/Designee. INDICATE HOW THE FACILIT TO MONITOR ITHS PERFORI MAKE SURE THAT SOLUTION SUSTAINED. THE FACILITY N DEVELOP A PLAN FOR ENSU THAT CORRECTION IS ACHIE SUSTAINED. THE PLAN MUS IMPLEMENTED AND THE CO ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUA ASSURANCE SYSTEM OF TH FACILITY. The facility has created an audi called the MDS PASRR Audit. T will be used for every Resident completion of each MDS asses	This audit upon seen coded by the Y PLANS MANCE TO NS ARE MUST IRING EVED AND ST BE RRECTIVE S S LITY IE it form This audit upon	
	PM with Nurse #3. responsibility for co Minimum Data Set plans. During the in that she typically loo	Nurse #3 assumed mpletion of the facility ' s (MDS) assessments and care nterview, Nurse #3 reported oked at the PASRR letter code ch resident ' s face sheet to			ensure that each PASRR has b correctly and will be completed facility Administrator/Designee. The QA Committee will review	been coded by the	

Facility ID: 923010

If continuation sheet Page 4 of 14

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION		E SURVEY
IND PLAN (JF GUKKEG HUN	IDENTIFICATION NUMBER:	A. BUILDING	G		C
		345140	B. WING			_ 18/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	Ē	
BRIGHT	MOOR NURSING CEN	ITER		610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 278	inquiry, the nurse ir way she would kno PASRR was throug staff members. Nu official report. " An interview was co PM with the Clinica Clinical Nurse Supe for receiving PASR processing this info subsequently receiv Upon inquiry, the C indicated she was r PASRR information to the MDS Nurse. the processing info linked to the MDS i automatically popul Level II PASRR, wh An interview was co PM with the facility inquiry, the Adminis expectation was for determination to be resident ' s MDS as 3) Resident #14 wa 8/6/12 with cumulat traumatic brain inju A review of Resider (MDS) assessment indicated the reside state Level II Pread	I I PASRR. Upon further ndicated that the only other w if a resident was a Level II h communication with other urse #3 stated, " I don ' t get an onducted on 9/17/14 at 3:54 I Nurse Supervisor. The ervisor assumed responsibility R information for residents, ormation through the State, and ving verification and approval. Clinical Nurse Supervisor not aware that the Level II n needed to be communicated She reported that she thought rmation from the state was nformation so that it would late and code the resident as a nen appropriate. Onducted on 9/17/14 at 4:22 ' s Administrator. Upon strator indicated that her r the Level II PASRR e coded accurately on each ssessment. as admitted to the facility on tive diagnoses which included	F 278	performance to ensure that co performance is achieved and s The QA Committee will review facilityHs progress weekly for effectiveness and revise or de measures as necessary to ens corrective action is integrated system is sustained or revised to achieve and maintain correct solutions.	sustained. the velop new sure that and the as needed	

Facility ID: 923010

If continuation sheet Page 5 of 14

	-	AND HUMAN SERVICES					FORM	APPROVED
		& MEDICAID SERVICES				O		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION			E SURVEY PLETED
			A. BUILDI	ING				С
		345140	B. WING					_ 18/2014
NAME OF F	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, Z	IP CODE		
BRIGHTI	MOOR NURSING CEN	ITER			610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	CORRECTION	١	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T			COMPLETION DATE
TAG	REGULATORTOR		TAG		DEFICIENC			
F 278	Continued From pa	ge 5	F 2	78				
	Determination of a	Level II PASRR resident is						
		h evaluation. The results of						
		used for formulating a ed, determination of an						
	appropriate care se							
	recommendations f	or services to help develop an						
	individual's plan of	care.						
	A review of the facil	lity ' s list of Level II PASRR						
		that Resident #14 was						
	included among the	e residents named on the list.						
		nt #14 ' s records included a						
		tten verification of approval d 1/21/14. Resident #14 ' s						
		mber included the letter code "						
	В. "							
	An interview was co	onducted on 9/17/14 at 3:45						
		Nurse #3 assumed						
		mpletion of the facility 's (MDS) assessments and care						
		nterview, Nurse #3 reported						
	that she typically loo	oked at the PASRR letter code						
		ch resident 's face sheet to						
		or not a resident was Level II PASRR. She noted						
		other than an "A" was a						
	flag that the resider	nt would need to be coded on						
		I II PASRR. Upon further						
		idicated that the only other wif a resident was a Level II						
	5	h communication with other						
	staff members. Nu	rse #3 stated, "I don ' t get an						
	official report. "							
	An interview was co	onducted on 9/17/14 at 3:54						
		Nurse Supervisor. The						
		ervisor assumed responsibility						

Facility ID: 923010

If continuation sheet Page 6 of 14

PRINTED: 10/14/2014

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	: 10/14/2014 APPROVED : 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345140	B. WING				C 18/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHT	MOOR NURSING CEN	ITER			10 WEST FISHER STREET ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	for receiving PASRI processing this info subsequently receiv Upon inquiry, the C indicated she was r PASRR information to the MDS Nurse. the processing info linked to the MDS in automatically popul Level II PASRR, wh An interview was co PM with the facility inquiry, the Adminis expectation was for determination to be resident ' s MDS as 4) Resident #24 wa facility on 11/25/11 cumulative diagnos schizophrenia. A review of Resider (MDS) assessment indicated the reside state Level II Pread Resident Review (F serious mental illne Determination of a made by an in-dept this evaluation are n determination of ne appropriate care ser recommendations f	R information for residents, ormation through the state, and ving verification and approval. Clinical Nurse Supervisor not aware that the Level II in needed to be communicated She reported that she thought rmation from the State was nformation so that it would late and code the resident as a nen appropriate. onducted on 9/17/14 at 4:22 's Administrator. Upon strator indicated that her r the Level II PASRR e coded accurately on each ssessment. as initially admitted to the and re-admitted on 5/2/14 with ses which included nt #24 's Minimum Data Set t (Section A) dated 7/21/14 ent was not considered by the dmission Screening and PASRR) process to have a ess and/or intellectual disability. Level II PASRR resident is th evaluation. The results of used for formulating a eed, determination of an etting and a set of for services to help develop an	F 2	78			

Facility ID: 923010

If continuation sheet Page 7 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345140	B. WING				C 18/2014
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
DDIGUT	MOOR NURSING CEN			6	10 WEST FISHER STREET		
DRIGHTI	WOOR NURSING CEN	IIER		S	SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 7	F2	278			
		that Resident #24 was residents named on the list.					
	resident had been a number/letter code.	nt #24 ' s records revealed the assigned a Level II PASRR Resident #24 ' s Level II luded the letter code "B."					
	PM with Nurse #3. responsibility for co Minimum Data Set plans. During the in that she typically loo at the bottom of eac determine whether	mpletion of the facility 's (MDS) assessments and care nterview, Nurse #3 reported oked at the PASRR letter code ch resident 's face sheet to or not a resident was					
	that any letter code flag that the resider the MDS as a Leve inquiry, the nurse in way she would know PASRR was throug	Level II PASRR. She noted other than an "A" was a at would need to be coded on I II PASRR. Upon further dicated that the only other w if a resident was a Level II h communication with other rse #3 stated, "I don't get an					
	PM with the Clinica Clinical Nurse Supe for receiving PASRI processing this info subsequently receiv Upon inquiry, the C indicated she was r PASRR information to the MDS Nurse. the processing info linked to the MDS in	onducted on 9/17/14 at 3:54 I Nurse Supervisor. The ervisor assumed responsibility R information for residents, rmation through the state, and ving verification and approval. linical Nurse Supervisor not aware that the Level II needed to be communicated She reported that she thought rmation from the State was nformation so that it would ate and code the resident as					

Facility ID: 923010

If continuation sheet Page 8 of 14

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	10/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		345140	B. WING	·			C 18/2014
NAME OF F	PROVIDER OR SUPPLIER		-	ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHT	MOOR NURSING CEN	TER			610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	An interview was co PM with the facility inquiry, the Adminis expectation was for determination to be	enever appropriate. onducted on 9/17/14 at 4:22 ' s Administrator. Upon trator indicated that her ' the Level II PASRR coded accurately on each	F 2	278	3		
F 431 SS=D	LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in s accurate reconciliat records are in order		F 4	431			10/1/14
	labeled in accordan professional princip appropriate accesse instructions, and the applicable. In accordance with facility must store a locked compartmen controls, and permit have access to the The facility must pro- permanently affixed controlled drugs list	e expiration date when State and Federal laws, the Il drugs and biologicals in its under proper temperature t only authorized personnel to					

Facility ID: 923010

If continuation sheet Page 9 of 14

		& MEDICAID SERVICES	(X2) MULT	PLE CONSTRUCTION	OMB NO.	E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
					(С	
		345140	B. WING _		09/18/2014		
NAME OF I	PROVIDER OR SUPPLIER						
BRIGHTI	MOOR NURSING CEN	ITER		610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 431	Continued From pa	age 9	F 43	11			
	abuse, except whe package drug distri	n the facility uses single unit ibution systems in which the ninimal and a missing dose can					
	by: Based on observation staff interviews, the expired medication manufacturer in 1 c (100/200 Hall); and place to ensure a re	NT is not met as evidenced tions, medical records and a facility failed to discard s as specified by the drug of 2 medication store rooms I failed to have a system in esident ' s home medications and securely stored for 1 of 1 t #40).		THIS FACILITYHS RESPONS REPORT OF SURVEY DOES DENOTE AGREEMENT WITH STATEMENT OF DEFICIENCI DOES IT CONSTITUTE AN AE THAT ANY STATED DEFICIEN ACCURATE. WE ARE FILING BECAUSE IT IS REQUIRED B	NOT THE ES; NOR DMISSION ICY IS THE POC		
	store room on 9/18 opened vial of Aplis injectable medication tuberculosis) was s vial was not labeled opened. The pharm that the Aplisol had on 7/14/14. The m	of the 100/200 hall medication /14 at 2:32 PM revealed an sol Tuberculin PPD (an on used as a screening test for stored in the refrigerator. The d with the date it had been macy label on the vial indicated been dispensed to the facility anufacturer 's product ed opened vials of Aplisol d after 30 days.		 F:431 ADDRESS HOW CORRECTIVE (S) WILL BE ACCOMPLISHED THOSE RESIDENTS FOUND BEEN AFFECTED BY THE DE PRACTICE: An audit was completed on to ensure all open medication versus labeled and dated. No others we unlabeled.) FOR TO HAVE FICIENT 09-17-14 <i>i</i> als were		
	2:35 PM, the nurse should have been I opened on the outs stated this vial wou it was not known w	with Nurse #1 on 9/18/14 at indicated the opened vial abeled with the date it was side of the vial. Nurse #1 Id need to be discarded since hen it had been opened.		All nurses have been re-educa 09-17-14,09-18-14, and 09-29- Director of Nursing on proper la open medications. On 09-17-14 and 09-18-14 the Nursing and Clinical Services S inspected the two (2) medication	14 by the abeling of Director of Supervisor		

Facility ID: 923010

If continuation sheet Page 10 of 14

	-	AND HUMAN SERVICES					APPROVEI 0938-039
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST		(X3) DATE COM	E SURVEY PLETED
		345140	B. WING			09/*	C 18/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET A	DDRESS, CITY, STATE, ZIP COD	E	
BRIGHT	MOOR NURSING CEN	ITER		610 WEST SALISBU			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 431	Continued From pa	ge 10	F4	31			
	storing medications	nal procedure for dating and s such as Aplisol. The DON vial should have been dated		home room	e prescriptions were in the s. No others were found.	e medication	
	when opened. In a on 9/18/14 at 2:55F she had contacted regarding the expira	follow-up interview conducted PM, the DON indicated that the facility 's pharmacy ation of an opened vial of nacy confirmed that a vial of		09-17 Direc Stora	urses have been re-educa 7-14,09-18-14, and 09-29 stor of Nursing on Proper age of home medications e prescriptions.	-14 by the Drug	
	store room refrigera revealed an opened injectable vaccine) manufacturer ' s ex Pneumovax-23 pro	of the 100/200 hall medication ator on 9/18/14 at 2:32 PM d vial of Pneumovax-23 (an was labeled with a piration date of 8/22/14. duct information indicated all carded after the manufacturer '		WILL RESI BE AI DEFI	RESS HOW CORRECTIV BE ACCOMPLISHED FO IDENTS HAVING POTEN FFECTED BY THE SAMI CIENT PRACTICE:	OR THOSE ITIAL TO E	
	2:35 PM, the nurse Pneumovax-23 sho	with Nurse #1 on 9/18/14 at indicated the vial of buld have been discarded by Nurse #1 stated this vial iscarded.		09-17 vials Direc Servi	spection was completed 7-14 to ensure all open m were labeled and dated l ctor of Nursing and the Cli ces Supervisor. No other d unlabeled.	edication by the inical	
	(DON) on 9/18/14 a that she had contac regarding the expira pharmacy confirme	with the Director of Nursing at 2:55 PM, the DON indicated cted the facility 's pharmacy ation of Pneumovax-23. The d that both unopened and		09-18 Nursi medio	urses were educated on 3-14 and 09-29-14 by the ing on proper labeling of c cations.	Director of open	
	manufacturer 's ex			Nursi inspe	9-17-14 and 09-18-14 the ing and Clinical Services ected the two (2) medicati	Supervisor on rooms to	
	hospital on 7/29/14 transferred from the facility on 8/1/14.	as admitted to an acute care Resident #40 was hospital for admission to the fer cumulative diagnoses		home room	re no home medications a e prescriptions were in the s. No others were found.	e medication	
		nd inferior left pubic ramus ture), rheumatoid arthritis, and			urses have been re-educa 7-14,09-18-14, and 09-29		

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED	
		345140	B. WING			C 18/2014
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	00,	10/2014	
BRIGHTI	MOOR NURSING CEN	ITER		610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CORRECTION(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			D BE	(X5) COMPLETIOI DATE
F 431	records included a Medications Brough The tracking tool we 8/1/14 to indicate the returned to her upo The list of medication medications (which substances and have noted) with each m container; 1 tablet of clonazepam (a con treatment of anxiety ER (a controlled su release formulation moderate to severe mg oxycodone (a c an immediate relea medication used fo The hospital Nursin	Ige 11 f the resident 's hospital signed form entitled, " nt from Home Tracking Tool. " as signed by resident #40 on he receipt of medications n discharge from the hospital. ons included: 9 prescription were not controlled d no count of the quantity edication stored in a separate of 0.5 milligrams (mg) trolled substance used in the y); 11 tablets of 20 mg Opana bstance which is an extended of oxymorphone used for e pain); and 24 tablets of 15 ontrolled substance which is se formulation of an opioid r moderate to severe pain). ng Discharge Summary dated tient was given prescription	F 43	 F 431 Director of Nursing on Proper Drug Storage of home medications and or home prescriptions. There are two (2) audit forms initiated by the Administrator to ensure the deficient practice does not recur. A. Med Inventory Audit, this form is completed on admission/re-admission by the Clinical Services Supervisor and DOI to make sure all home medication and on home prescriptions are stored properly. B. Weekly Expired Medication Audit, thi form is completed weekly by the Clinical Services Supervisor and DON to make sure all drugs are labeled properly. 		
	medications to tran An interview was co Administrator on 9/ interview, the Admin process of admittin Upon inquiry, the Admin Upon inquiry, the Admin be accepted by back home with low An interview was co Administrative Assis The Administrative process of admittin which included takin	sport. onducted with the facility ' s 16/14 at 4:43 PM. During this nistrator discussed the g a resident to the facility. dministrator indicated that brought into the facility would the facility and would be sent		ADDRESS WHAT MEASURES W PUT INTO PLACE OR SYSTEMI CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WIN OCCUR: There are two (2) audit forms init the Administrator to ensure the de practice does not recur. C. Med Inventory Audit, this form completed on admission/re-admis the Clinical Services Supervisor a	C THAT LL NOT iated by eficient is ssion by	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		B. WING			C 09/18/2014			
NAME OF PROVIDER OR SUPPLIER			I		STREET ADDRESS, CITY, STATE, ZIP CODE	03/10/2014		
BRIGHTMOOR NURSING CENTER					610 WEST FISHER STREET			
БКІОПІІ				S	SALISBURY, NC 28145			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET		
F 431	Continued From pa	age 12	F 4	131				
	was not allowed to keep home medications at the facility and reported that the nursing staff would			.01	home prescriptions are stored prop	erly.		
	give such medications to the family to take back				D. Weekly Expired Medication Au	dit. this		
	home. Upon further inquiry, the Administrative				form is completed weekly by the Cl	inical		
	Assistant indicated that Resident #40 reported				Services Supervisor and DON to m			
	bringing some home medications with her (from				sure all drugs are labeled properly.			
		facility) upon admission. The						
		stant stated that she herself, "						
	just saw a bagyou could hear pills in a bottle. " The Administrative Assistant reported, however,				INDICATE HOW THE FACILITY PI	ANS		
	that she did not actually see the bottle(s) of pills.				TO MONITOR ITHS PERFORMAN			
	The Administrative Assistant also reported that				MAKE SURE THAT SOLUTIONS A			
	Resident #20 's bag of home medications would				SUSTAINED. THE FACILITY MUS			
		to the floor nurse and then to			DEVELOP A PLAN FOR ENSURIN	IG		
	the Director of Nursing (DON) or Clinical Nursing				THAT CORRECTION IS ACHIEVE			
	Supervisor.				SUSTAINED. THE PLAN MUST B			
					IMPLEMENTED AND THE CORRE	ECTIVE		
	An interview was conducted with the facility 's				ACTION EVALUATED FOR ITS			
	DON on 9/17/14 at 10:18 AM. The DON recalled that when Resident #40 was admitted to the facility on 8/1/14, she had a bag of medications brought in with her. The DON stated that she told				EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALIT	~		
					ASSURANCE SYSTEM OF THE	I		
					FACILITY.			
	the resident the facility could not accept the							
		ey needed to leave the facility.						
	The DON reported	that she herself put the bag of			The DON and Clinical Services			
		ounter in the locked 200/300			Supervisor will complete Med Inver			
		oom. The DON indicated the			Audit upon admission/ re-admissio			
		ned on the counter of the			each resident to the facility. The Ex	pired		
	medication store room until the resident was discharged from the facility (on 8/22/14). Upon				Medication audit will be completed	ill bo		
					weekly. Any discrepancies noted w followed by re-education with the n			
	inquiry, the DON reported that an inventory of the medications in the bag had not been taken. The				by the Director of Nursing.	1363		
		d not know the types or						
		tions that were in the bag.			The QA Committee will review wee facilityHs progress towards	kly, the		
	An interview was co	onducted with Nurse #2 on			implementation of corrective action	(s) and		
		M. Nurse #2 was a staff nurse			the facilityHs performance to ensur	e that		
		200/300 hall. During the			corrective performance is achieved			
	interview, Nurse #2				sustained. The QA Committee will			

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM A CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. (
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED						
345140			B. WING			C 09/18/2014						
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE								
BRIGHT	MOOR NURSING CEN	ITER	610 WEST FISHER STREET SALISBURY, NC 28145									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE					
F 431	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 13 medications had been stored on the counter of the 200/300 medication store room for Resident #40 during her stay at the facility. Upon inquiry, the nurse stated she did not know what types or amounts of medications were in the bag. A follow-up interview was conducted with the Administrator on 9/17/14 at 10:42 AM. During this interview, the Administrator stated she was not aware that Resident #40 had brought home medications into the facility upon admission nor that these medications had been stored within the facility during her stay. Upon inquiry, the Administrator stated that her expectation was, "If those meds were in here, administrator also indicated that an inventory should have made of all the medications and that the resident (if alert) should have been asked to sign off on the inventory confirming its accuracy and completeness. She indicated that an inventory of the medications would have been necessary to identify the proper means to store each medication. When asked where the medications should have been stored, the Administrator stated that all controlled substances would have needed to be stored behind two locks.		F 4	431	the facilityHs progress weekly for effectiveness and revise or develop measures as necessary to ensure to corrective action is integrated and to system is sustained or revised as in to achieve and maintain corrective solutions.	that he						

Facility ID: 923010

If continuation sheet Page 14 of 14