PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		345140	B. WING		C 08/04/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/0-1/2010
DDIGUTA	200 MUDOINO OFNITED			610 WEST FISHER STREET	
BRIGHTM	OOR NURSING CENTER		;	SALISBURY, NC 28145	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE
F 253 SS=D	483.15(h)(2) HOUSEI MAINTENANCE SER		F 253		8/10/16
	The facility must provi	ide housekeeping and			
	-	s necessary to maintain a			
	sanitary, orderly, and				
	, ,				
	This REQUIREMENT by:	is not met as evidenced			
	Based on observation	ns_staff and resident		THIS FACILITY'S RESPONSE TO TH	ıs I
		review the facility failed to		REPORT OF SURVEY DOES NOT	
		ivacy curtain and walls		DENOTE AGREEMENT WITH THE	
		sidents. (Resident #12)		STATEMENT OF DEFICIENCIES; NOF	₹
	The findings included			DOES IT CONSTITUTE AN ADMISSIO	N N
		2016 at 11:12 AM revealed		THAT ANY STATED DEFICIENCY IS	
	Resident #12 was sea	ated in her wheelchair in her		ACCURATE. WE ARE FILING THE PO	oc
		of the wheelchair revealed		BECAUSE IT IS REQUIRED BY LAW.	
	•	n substance and dried food			
		of the wheelchair. The		ADDRESS HOW CORRECTIVE ACTION	ON
		served on the front corners		(S) WILL BE ACCOMPLISHED FOR	
		ne seat and on the sides of		THOSE RESIDENTS FOUND TO HAV	
		ons at this time included the		BEEN AFFECTED BY THE DEFICIEN	Τ
		of her bed and the privacy		PRACTICE:	
		dried brown flecks on the leadboard, and extending up		For Resident #12 the wheelchair and w	uall llev
	to and including the c	, , , , , , , , , , , , , , , , , , , ,		was cleaned. The privacy curtain was	/all
		he privacy curtain facing		removed and another clean curtain was	
	Resident #12 's bed.	ne privacy curtain racing		put back up on August 5, 2016.	·
	Observations on 8/3/2	2016 at 2:00 PM and		pat baok up on ragast o, 2010.	
		evealed the wheelchair,		ADDRESS HOW CORRECTIVE ACTION	on I
		ain had not been cleaned.		WILL BE ACCOMPLISHED FOR THOS	
	Interview on 8/4/2016			RESIDENTS HAVING POTENTIAL TO	
		revealed he was also over		BE AFFECTED BY THE SAME	
		es. Rounds were made with		DEFICIENT PRACTICE:	
		ctor in Resident #12 's		Each resident's room was checked by	the
	room. Interview with	the Maintenance Director		Administrative Staff to ensure that the	
		aware the wall and privacy		wall's were clean as well as the privacy	,
		ng. He further explained		curtains. There were no other issues	
	nursing was responsil	ble for the cleaning of the		noted. All resident wheelchairs were	
_ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed

08/26/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345140	B. WING _				C 04/2016
	ROVIDER OR SUPPLIER	!		61	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST FISHER STREET ALISBURY, NC 28145	1 007	04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 253	Interview with the Dir. 8/4/2016 at 9:25 AM scheduled was in platon night shift by nursi. Interview with the DC revealed she had cor. Assurance) on wheel Resident #12's wheel DON on 7/22/16. A whole completed by the sign a monitoring too was cleaned. Review revealed a nurse's ini wheelchair had been was on vacation durin unable to be reached observed Resident # "no, it's not clean". The dried, build-up food swheelchair. Interview on 8/4/2016 Administrator revealed prepared for Mainten housekeeping tasks.	the last month nursing had of the wheelchairs. ector of Nursing (DON) on revealed a cleaning ce to clean the wheelchairs ng. No on 8/4/16 at 11:05 AM expleted a QA (Quality chair cleaning in July. Indicating the wheelchair was checked by the explained the nurse was to aides and the survey and was for interview. That nurse mg the survey and was for interview. The DON aiz's wheelchair and stated there was dried crumbs and pills on the frame of the as the control of the survey and was for interview. The DON aiz's wheelchair and stated there was dried crumbs and pills on the frame of the acceptable to 7/29/2016. The list had not been	F2	253	checked by the Administrative Staff and found to need cleaning was cleaned by the CNA's. The areas identified were checked by the Administrative Staff on August 5, 8, and 9, 2016 ADDRESS WHAT MEASURES WILL EPUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO OCCUR: The responsibility for cleaning the wheelchairs/geri-chairs on a weekly ba has been assigned to the CNA's on this shift. The chairs will be assigned to CN assigned to the resident on the scheducleaning day. The CNA's are responsite to complete a QA for wheelchairs/geri-chairs and turn it into DON on a weekly basis. The DON will review the QA checklist for accuracy of chairs being washed/cleaned for that week daily for one (1) month; bi-weekly two (2) months and monthly for six (6) months. On a daily basis Monday through Fridathe Administrative Staff are assigned to certain rooms as determined by a schedule made by the Administrator to check the resident rooms for the follow in addition to the other areas already being reviewed: 1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and not loose	sis of AA led ble the fall y for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/04/2010	
				610 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER			SALISBURY, NC 28145		
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F 253	Continued From page	÷2	F 25	4. Calls lights in place and in working order The Administrative staff bring their QA checks to the morning meeting at white time the Administrative Team will discounted any identified areas of concern and procorrective plan into place at that time. The Administrator will complete a Quantified Assurance Checklist weekly for one (month; Bi-weekly for two (2) months; Monthly for six (6) months; and report to the Quality Assurance Committee finine (9) months. INDICATE HOW THE FACILITY PLATO MONITOR IT'S PERFORMANCE MAKE SURE THAT SOLUTIONS AR SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED A SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The DON will be responsible to bring QA checklist of all chairs being washed/cleaned for that week for one month; bi-weekly for two (2) months a monthly for six (6) months. The Administrative staff bring their QA checks to the morning meeting at whitime the Administrative Team will discount in the place at that time corrective plan into place at that time.	A ch uss ut a ality 1) red for NS TO E AND TIVE the ch uss ut a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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		345140	B. WING			08/	04/2016
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F 274 SS=D	AFTER SIGNIFICAN A facility must conduct assessment of a reside facility determines, or that there has been a resident's physical or purpose of this section means a major declin resident's status that itself without further in implementing standar interventions, that has one area of the residentians.	PREHENSIVE ASSESS T CHANGE		2274	The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months to evaluate the system at ensure the facility is sustaining the corrective plan put into place. The resurf of the QA check by the VP of Operation will also be reported to the Quality Assurance Committee for six (6) month. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	d or and ults	8/12/16
	care plan, or both.)						

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	20,4252.02.0422.452	345140	B. WING _		•	8/04/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
BRIGHTM	OOR NURSING CENT	ER		610 WEST FISHER STREET			
				SALISBURY, NC 28145			
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F 274	Continued From pa	age 4	F 27	74			
	This REQUIREME	NT is not met as evidenced					
	by: Based on record r facility failed to cor	eview and staff interviews the nplete a significant change e of twenty residents (Resident		ADDRESS HOW CORRECT (S) WILL BE ACCOMPLISHING THOSE RESIDENTS FOUN BEEN AFFECTED BY THE INTERPRACTICE:	ED FOR D TO HAVE		
	The findings includ	ed:					
		tted to the facility on 4/11/16 Alzheimer's disease and sites.		The resident has been asses MDS Nurse and the Interdisc and the Care Plan reflects the changes and needs.	ciplinary Team		
	The Admission Minimum Data Set (MDS) assessment dated4/16/16 indicated Resident #24 had long and short term memory impairment, behaviors of rejection of care, required extensive assistance of two staff for bed mobility and transfers, supervision of one person to walk in the room and hallway, extensive assistance of one person for toileting, and personal hygiene. This MDS indicated the resident was always incontinent of bowel and frequently incontinent of bladder. Resident #24 had two falls since admission, one with injury. Review of the Care Area Assessment dated 4/16/16 for fall, indicated she had a history of falls, had 2 falls since admission. A personal body alarm (PBA) was in place when she was in bed. There were no referrals made, and a decision was made to proceed to care plan to monitor for fall related injuries. Review of a nurse 's note dated 5/8/16 at 6:00 PM revealed Resident #24 was in a wheelchair near the nurse 's station. She stood up, and the wheelchair moved due to not locking the brakes. Resident #24 twisted to the left, fell up against the			ADDRESS HOW CORRECT WILL BE ACCOMPLISHED IN RESIDENTS HAVING POTE BE AFFECTED BY THE SAID DEFICIENT PRACTICE: All residents were evaluated if a significant change was no other residents met the consignificant change. ADDRESS WHAT MEASUR PUT INTO PLACE OR SYSTEM CHANGES MADE TO ENSU	FOR THOSE ENTIAL TO ME to determine ecessary and riteria for a ES WILL BE FEMIC		
				THE DEFICIENT PRACTICE OCCUR: When a resident is admitted re-admitted the facility will ha Admission Meeting seventy-after admission or readmissi Interdisciplinary Team to disciplines assessment to de there has been a decline or in the resident. The MDS Not the information gleaned from to assist them in the determine the control of t	or ave a Post two hours on with the cuss the each etermine if improvement urse will use in this meeting		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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				610 WEST FISHER STREET	Т		
BRIGHTM	OOR NURSING CENTER	R		SALISBURY, NC 28145			
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F 274	her left hand down to complained of pain in and upper thigh. She had sustained a fract the femoral neck of le replacement arthrople the left wrist. She was facility on 5/16/16. Review of the nurse revealed Resident #2 all ADL's, incontiner repositioning in bed, rest @ (at) present the and lift sheet for position after Resident #24 responsible. Interview with the Dir 8/4/16 at 12:50 PM in returned to the facility cast, and a surgical with she would expect the plan after her readming she did not know why had not been completed. Interview with the ME at 1:30 PM indicated.	er bottom. Resident #24 put catch herself. She her left wrist, left lower leg was sent out to hospital, ure of the wrist, fracture of eff hip with total hip easty. A cast was placed on as discharged back to the s notes dated 5/23/16 et a dependent on staff for the care, feeding, bathing/grooming. On bed me as ordered, using log roll	F 2	significant change MDS Nurse will init to reflect the discip document the area and what the decis justification for comcompleting a signification for completing a signification for completing a signification for completing a signification for completing a signification for computer the MDS Nurse with analysis Worksheet from our computer the current MDS computer the current MDS computer the current MDS computer the current MDS computer the management of the MDS Nurse with DON after the meet sign the form to incompute the IDC decision. The MDS Nurse with Significant Change (1) month; bi-week monthly for six (6) INDICATE HOW THE TO MONITOR IT'S MAKE SURE THAT SUSTAINED. THE DEVELOP A PLAN THAT CORRECTIC SUSTAINED. THE IMPLEMENTED ANACTION EVALUAT EFFECTIVENESS. INTEGRATED INTEGRATED INTEGRATED INTEGRATED INTEGRATED SYSTACILITY:	tiate a signature she lines present as well so discussed on a logion is and the appleting or not icant change ill also utilize the RU at that is generated system that reflects adding and the previous a second check to a significant change ill present this log to a significant change ill pre	G us of the iill the one of the state of the	
				The MDS Nurse wi	ill initiate a signature	;	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345140	B. WING _			08/	04/2016
	ROVIDER OR SUPPLIER OOR NURSING CENTER			61	TREET ADDRESS, CITY, STATE, ZIP CODE O WEST FISHER STREET ALISBURY, NC 28145		
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F 274	PERSONS/PER CAR The services provided must be provided by accordance with each care. This REQUIREMENT by: Resident #40 was ac	CICES BY QUALIFIED RE PLAN Id or arranged by the facility qualified persons in a resident's written plan of It is not met as evidenced Imitted on 6/8/2016 with a renal disease, diabetes,		274	sheet to reflect the disciplines present a well as document the areas discussed a log and what the decision is and the justification for completing or not completing a significant change assessment. The MDS Nurse will present this log to DON after the meeting and the DON wight the form to indicate agreement with the IDC decision. The MDS Nurse will complete the Significant Change QA Log weekly for (1) month; bi-weekly for two (2) months monthly for six (6) months. This log will be presented to the Quality Assurance Committee on a quarterly basis. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained. ADDRESS HOW CORRECTIVE ACTICS) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAV	on the ill h one ;; I	8/15/16
		um Data Set (MDS) nt revealed that Resident stood and had short term			BEEN AFFECTED BY THE DEFICIENT PRACTICE:	Γ	

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	10 113 211 011 001 1 21211				10 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER	t			ALISBURY, NC 28145		
24.0.15	CLIMMADY CT	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		0/5)
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F 282	and long term memor	ry problems. It also	F2	282	The resident's fingernails were cleaned August 4, 2016	on	
	F 282 Continued From page 7 and long term memory problems. It also indicated that Resident #40 needed extensive assistance with activities of daily living, including bathing and hygiene. The care plan dated 6/27/2016 indicated that staff was to bathe, groom and dress Resident #40 and encourage resident to participate as she is able. The care plan also directed staff to provide nail care including keeping nails clean, trimmed and rough edges filed. On 8/2/2016 at 9:20 am Resident #40 was observed to have a black substance under her all her fingernails on both hands. On 8/3/2016 at 4:29 pm Resident #40 was observed again to have a black substance under her nails. On 8/4/2016 at 9:29 am Nurse Aide #2 was observed providing care for Resident #40. She provided the proper assistance with bathing, toileting and denture care. Nurse aide #2 did not provide nail care. On 8/4/2016 at 10:01 am Nurse Aide #2 was interviewed. She acknowledged that she didn 't complete nail care. She also indicated that she was aware that she was supposed to provide nail care daily. On 8/4/2016 at 11:10 am the Director of Nursing		F 282		August 4, 2016 ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOS RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's fingernails were checked the Administrative staff on August 5, 8 and 9, 2016 and documented on the da Quality Assurance Checklist and no oth unclean nails were identified. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO OCCUR: An In-service by the Administrator with the CNA's was conducted on August 18 2016 concerning resident's personal can needs being met according to their Individualized Care Plan. During this In-service emphasis was placed on the importance of personal grooming and a	DN SE by aily ner SE T	
	expected the nurse a nails daily.	ide to assess and clean her			a CNA the requirements to provide care basis on their training. CNA's will provide hand hygiene on a dobasis with the resident's ADL care and document the care or refusal of care by the resident on the Fingernail QA Shee which indicates the following: 1. Name of resident refusing nail care. 2. Name of resident receiving nail care. 3. Fingernails soaked in warm water prior to being trimmed;	laily t e;	

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 282	Continued From page	e 8	F 2	4. Fingernails trimmer 5. Interventions used resident to allow nail careident to allow nail careident to allow nail careident to allow nail careidents staff will provide Salon on a weekly basis requesting their nails be Activity Director will do on the Activity QA Recombreated the Providence of the residents daily Mensure that nail care is the Administrative staff checks to the morning retime the Administrative any identified areas of a corrective plan into place including re-education, or if required termination performing duties of the The DON will complete Assurance Checklist we month; Bi-weekly for twe Monthly for six (6) month to the Quality Assurance nine (9) months that residence in the Policy in the Policy in the Policy in the Policy in the Receiving appropriate national support of the Policy in	to encourage are. by the DON on a de Pretty Nail s for any residence done. The cument the request ord. If will conduct a Conday-Friday to being provided. If bring their QA meeting at which Team will discuss concern and put the at that time disciplinary action for not being provided. If bring their pob description is a Quality beekly for one (1) to (2) months; this; and reported the Committee for sidents are ail care. If ACILITY PLANS RECILITY MUST RENSURING SACHIEVED ANAN MUST BE	est DA Issa on n. Id	

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F 282	Continued From page	9	F2	EFF INTI ASS FAC CNA basi docu the i whice 1. 2. 3. prior 4. 5. resic The wee The requ The chec time any corr inclu or if perfi The Assi mon	FION EVALUATED FOR ITS FECTIVENESS. THE POC IS EGRATED INTO THE QUALITY SURANCE SYSTEM OF THE CILITY: A's will provide hand hygiene on a is with the resident's ADL care and ument the care or refusal of care be resident on the Fingernail QA She ch indicates the following: Name of resident refusing nail care in the provident of	QA O I. ch uss ut a tion on.		

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F 282	Continued From page		F 28	to the Quality Assurance Committee f nine (9) months that residents are receiving appropriate nail care. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved an sustained.	nd		
SS=D	daily living receives the maintain good nutrition and oral hygiene.		F 31	2	8/15/16		
	Resident #40 was act diagnoses of Anemia arthritis and a history. A review of the Minim admission assessment #40 was rarely undersand long term memor indicated that Resider assistance with activitial bathing and hygiene. The care plan dated was to bathe, groom a encourage resident to The care plan also direcare including keepin rough edges filed. On 8/2/2016 at 9:20	um Data Set (MDS) nt revealed that Resident stood and had short term		ADDRESS HOW CORRECTIVE ACTORS WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HABEEN AFFECTED BY THE DEFICIENT PRACTICE: The resident's fingernails were cleaned August 4, 2016. ADDRESS HOW CORRECTIVE ACTORS HOW CORRECTIVE ACTORS HOW POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's fingernails were checked the Administrative staff on August 5, and 9, 2016 and documented on the Quality Assurance Checklist and no of the Council	VE NT ed on TION DSE O d by 8 daily		

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F 312	Continued From page	e 11	F 3	12			
	her fingernails on bot On 8/3/2016 at 4:29			unclean nails were identified.			
	observed again to hat her nails. On 8/4/2016 at 9:29 at observed providing coassisted her to the bat assistance. She then hands with a wash cluthe proper technique avoided washing her socks. Legs and feet with even the toes be brushed Resident #4 her hair. Nurse Aide #2 was in on 8/4/2016 at 9:48 at had been here two we care was to be done that she did not provided. She also indicate resident 's feet din her legs. She indicate on 8/4/2016 at 10:01 to the room to provided the Nurse Aide #?? Faide #2 stopped cleas he could trim and file and the nurse aide be nails. She explained that day to finish clead on 8/4/2016 at 11:10 was interviewed. She	am Nurse Aide #2 was are for Resident #40. She athroom, provided toileting in washed the resident 's oth. She bathed her using. She dressed her. She feet, but she did change her awere noted to have edemating swollen. The nurse aide 0 's dentures and brushed atterviewed after morning care are. She explained that she eeks. She indicated that nail every day. She admitted de nail care for Resident atted that she did not bathe use to the swelling and pain cated that the physician was sk her. am Nurse Aide #2 returned and nail care for Resident #40. It is and used an orange stick from on one hand, but the her hands and refused to let inish the nail care. Nurse ning the nails and asked if a them. The resident agreed agan trimming and filling the that she would return later ining them. am the Director of Nursing		ADDRESS WHAT MEASURE PUT INTO PLACE OR SYSTE CHANGES MADE TO ENSUR THE DEFICIENT PRACTICE OCCUR: An In-service with the CNA's a conducted the Administrator of 15, 2016 concerning resident' care needs being met according Individualized Care Plan. Dur In-service emphasis was place importance of personal groom a CNA the requirements to probasis on their training. CNA's will provide hand hygie basis with the resident's ADL document the care or refusal the resident on the Fingernail which indicates the following: Name of resident receiving: Name of resident receiving: Name of resident receiving: Interventions used to encresident to allow nail care. The form will reviewed by the weekly basis. Activities staff will provide President on a weekly basis for a requesting their nails be done Activity Director will document on the Activity QA Record.	EMIC RE THAT WILL NOT was on August s personal ng to their ring this ed on the hing and as ovide care ene on a daily care and of care by QA Sheet g nail care; rm water filed; courage DON on a tty Nail ny resident . The t the request		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345140	B. WING			С
	DOLUMED OF SURELIES	345140	B. WING _	077577 1070500 0177 07175	710 0005	08/04/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
BRIGHTM	OOR NURSING CENTER			610 WEST FISHER STREET		
		•		SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		DATE
F 312	Continued From page	e 12	F 3	12		
1 312	nails daily.			of the residents daily Mensure that nail care is The Administrative staff checks to the morning ratime the Administrative any identified areas of corrective plan into place including re-education, or if required termination performing duties of the The DON will complete Assurance Checklist we month; Bi-weekly for tw. Monthly for six (6) mont to the Quality Assurance nine (9) months that residentially appropriate national including	being provided. If bring their QA meeting at which Team will discus concern and put the at that time disciplinary action for not eir job description eir QA meeting at which the at that time disciplinary action for not eir job description eir job	n ss a on

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345140	B. WING			l	C
	201/1252 02 01/221/52	343140	D. WING_		TREET ADDRESS SITV STATE TID SORE	08/	04/2016
NAME OF PE	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER				10 WEST FISHER STREET		
2				S	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312				312	prior to being trimmed; 4. Fingernails trimmed and filed; 5. Interventions used to encourage resident to allow nail care. The form will reviewed by the DON on weekly basis The Activity Director will document the request on the Activity QA Record. The Administrative staff will conduct a confidence of the residents daily Monday-Friday to ensure that nail care is being provided. The Administrative staff bring their QA checks to the morning meeting at whice time the Administrative Team will discurance any identified areas of concern and put corrective plan into place at that time including re-education, disciplinary action if required termination for not performing duties of their job description. The DON will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months that residents are receiving appropriate nail care. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	QA h sss : a on on.	
F 323 SS=D	HAZARDS/SUPERVI	SION/DEVICES	F3	323			8/10/16
	The facility must ensu environment remains	as free of accident hazards					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345140	B. WING		08/04/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	1 00/04/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 323	as is possible; and e adequate supervision prevent accidents.	ach resident receives n and assistance devices to	F 3.	23	
	by: Based on observation record review the factorial to the bed frame (Resident #17). The findings included	ed to the facility on 8/20/2014		ADDRESS HOW CORRECTIVE A (S) WILL BE ACCOMPLISHED FO THOSE RESIDENTS FOUND TO BEEN AFFECTED BY THE DEFIC PRACTICE: The rail for the resident #17 was s to the bed frame on August 4, 201	DR HAVE CIENT ecured
	Review of the quarte dated 4/29/16 reveal moderate impairmen memory, required lin for bed mobility and a fall with no injury, s assessment	diabetes. rly Minimum Data Set (MDS) ed Resident #17 had t with long and short term nited assistance of one staff transfers and had sustained		ADDRESS HOW CORRECTIVE A WILL BE ACCOMPLISHED FOR T RESIDENTS HAVING POTENTIA BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All resident's side rails were check the Administrative staff on August and 10, 2016 and documented on daily Quality Assurance Checklist other loose rails were identified.	THOSE L TO sed by 8, 9 the
	by the resident to as positioning when in the A fall risk assessmer Resident #17 was a recent fall occurred to Resident #17 had atthis wheelchair into the	n sides of the bed were used sist with independence in bed. at dated 4/29/16 indicated high risk for falls. The most on 7/20/16 at 12:00 PM. tempted to self- transfer from the bed. He indicated he had eelchair and was on the floor		ADDRESS WHAT MEASURES W PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE T THE DEFICIENT PRACTICE WILL OCCUR: On a daily basis Monday through I the Administrative Staff are assign certain rooms as determined by a schedule made by the Administrative	HAT L NOT Friday ed to

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 04/2016	
NAME OF PROVIDER OR	SUPPLIER	1 1 1	1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	04/2010	
					10 WEST FISHER STREET			
BRIGHTMOOR NURS	ING CENTER	₹			ALISBURY, NC 28145			
					·			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 323 Continue	d From page	e 15	F3	323				
in front of at that tin		hair. No injuries were noted			check the resident rooms for the follow in addition to the other areas already being reviewed:	ring		
resident ' bedframe side rail a pushing o Observat Maintena revealed Maintena side rails rail last w indicated request to notify him out a wor station. Interview revealed She had	s right side e. Resident # away from hi on the top of ions of the s nce Director the side rail nce Director every week eek and it w he had not of fix the side of mainten k order, whi with aide # she was aw made out a	16 at 2:29 PM revealed the rail was not secured to the #17 was able to push the is side about a foot, by the rail. Side rail with the ron 8/4/16 at 9:30 AM remained loose. The rexplained he checked the He had checked this side was not loose. He further received a maintenance erail. The system in place to ance issues included filling ch were kept at the nurse 's 1 on 8/4/16 at 9:31 AM rare the side rail was loose. Work order and thought the ose for a couple of weeks.			1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and not loose 4. Calls lights in place and in working order The Administrative staff bring their QA checks to the morning meeting at whice time the Administrative Team will discus any identified areas of concern and if stails are noted to be loose a Maintenan Request Form is completed at that time and given to the Maintenance Supervise who attends the meeting. Once he has completed the repair he returns the Maintenance Request Form to the Administrator who signs off that the are identified has been corrected. The Administrator will complete a Quality Assurance Checklist weekly for one (1 month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. INDICATE HOW THE FACILITY PLAN TO MONITOR IT'S PERFORMANCE of the Quality Assurance Committee for nine (9) months. INDICATE HOW THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED A SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECT	h ss ide nce e sor f sa		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345140	B. WING				04/2046
NAME OF PE	ROVIDER OR SUPPLIER	0.01.10		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	04/2016
	to the Little of the Little				10 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER				ALISBURY, NC 28145		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 329 SS=D	Continued From page 483.25(I) DRUG REG UNNECESSARY DR	IMEN IS FREE FROM		323	EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrative staff bring their QA checks to the morning meeting at which time the Administrative Team will discus any identified areas of concern and if si rails are noted to be loose a Maintenan Request Form is completed at that time and given to the Maintenance Supervis who attends the meeting. Once he has completed the repair he returns the Maintenance Request Form to the Administrator who signs off that the are identified has been corrected. The Administrator will complete a Quality Assurance Checklist weekly for one (1) month; Bi-weekly for two (2) months; Monthly for six (6) months; and reporter to the Quality Assurance Committee for nine (9) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	ss ide ce e or	8/31/16
	unnecessary drugs. A drug when used in ex duplicate therapy); or without adequate more	regimen must be free from An unnecessary drug is any cessive dose (including for excessive duration; or nitoring; or without adequate or in the presence of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345140	B. WING _		0:	C B/ 04/2016	
	ROVIDER OR SUPPLIER	3		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 329	should be reduced or combinations of the resident, the facility rown have not used a given these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention	es which indicate the dose r discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic all dose reductions, and	F 3	29			
	by: Based on record revinterviews the facility monitor interactions to of five sampled resid. The findings included Resident #24 was resolved femurand radius on disease, and history. A pharmacy consult recommendations to count (CBC). The ph. 7/21/16 and agreed to interviews.	d: -admitted to the facility on es including fracture hip, the left side, Alzheimer's of fallsreport dated 7/19/16 included obtain a complete blood hysician responded on o obtain the CBC		ADDRESS HOW CORRECTIVE (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BEEN AFFECTED BY THE DEF PRACTICE: The lab was obtained for Reside August 5, 2016. ADDRESS HOW CORRECTIVE WILL BE ACCOMPLISHED FOR RESIDENTS HAVING POTENTI BE AFFECTED BY THE SAME DEFICIENT PRACTICE: A review of all of the resident's olabs was completed on August 3	FOR O HAVE CICIENT Ant #24 on E ACTION R THOSE CAL TO Anders and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 56.125			,	С	
		345140	B. WING_				04/2016	
NAME OF PI	ROVIDER OR SUPPLIER	L		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0-1/2010	
					WEST FISHER STREET			
BRIGHTM	OOR NURSING CENT	ER			LISBURY, NC 28145			
(V4) ID	SLIMMADY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(YE)	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 329	Continued From pa	age 18	F3	329				
		ŭ			by the DON and Nurses Managers. If	anv		
	Interview with the [Director of Nursing on 8/3/16 at			orders or labs were not completed the	uny		
		a CBC was not done between			attending physician will be notified and	1		
	the dates of 7/19/1				facility will take corrective action based			
					the attending physician's			
	Interview with nurs	e #1on 8/3/16 at 3:43 PM			recommendations.			
		ss to ensure lab work was						
		the following: she gets			ADDRESS WHAT MEASURES WILL I	3E		
	' '	om the supervisor that have			PUT INTO PLACE OR SYSTEMIC	_		
		he computer. If the order is on			CHANGES MADE TO ENSURE THAT			
		endation, the unit manager			THE DEFICIENT PRACTICE WILL NO)		
		ole for those orders. It would			OCCUR:			
		process, the supervisor would e lab comes out to draw the lab			The Nurse Managers' will review the			
	work.	e lab comes out to draw the lab			Pharmacy Consultant Report and			
	Work				complete the follow-up recommendation	ons		
	Interview with the	unit manager on 8/3/16 at 3:47			as appropriate for each resident once			
		eviewed the pharmacy			Physician has written the order. Once			
		after the physician signed that			these are completed both Nurse			
	he/she reviewed th	em. She continued to explain			Managers or DON in absence of one of	of		
		pharmacy recommendation,			the nurse managers, will sign the form			
	i i	the contract lab would draw			indicating they have checked behind the			
		lab came to the facility three			other to ensure that all orders to include	-		
		" STAT " labs would be			labs have been initiated and complete			
		e floor nurse. The unit			The Nurse Managers are responsible complete a Lab QA Report monthly to	.0		
	_	I to explain she would process g a lab requisition in a number			indicate any lab recommendations and	4		
		folder was kept on east hall			the labs have been obtained.	1		
		checked the folder for labs to			The DON will review the Lab QA mont	hlv		
		n copy was kept by the unit			for six (6) months after the Nurse	,		
		uld check for results by the			Manager has completed the report and	lla t		
		the results came to the facility.			recommendations have been signed b			
		ept with the names of residents			the physician.			
		be obtained. The list was						
		lent #24 was not listed for a			INDICATE HOW THE FACILITY PLAN			
	CBC to be drawn.				TO MONITOR IT'S PERFORMANCE	_		
					MAKE SURE THAT SOLUTIONS ARE			
		with the unit manager on			SUSTAINED. THE FACILITY MUST			
	⊤ 8/3/16 at 4:00 PM i	revealed the pharmacy			DEVELOP A PLAN FOR ENSURING		1	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		345140	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	I	08/04/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 329	recommendations we and should be put in was put on the chart lab work was not dra Interview with the co 8/4/16 at 1:19 PM re due to possible intera	ere signed by the physician a basket for her to review. It , and not in her basket. The wn. Insultant pharmacist on wealed the CBC was ordered actions between Coumadin in NSAID (Mobic) the	F 32	THAT CORRECTION IS ACHIEVED SUSTAINED. THE PLAN MUST IMPLEMENTED AND THE CORE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUAL ASSURANCE SYSTEM OF THE FACILITY: The Nurse Managers' will review Pharmacy Consultant Report an complete the follow-up recomme as appropriate for each resident Physician has written the order. these are completed both Nurse Managers or DON in absence of the nurse managers, will sign the indicating they have checked be other to ensure that all orders to labs have been initiated and con The Nurse Managers are respor complete a Lab QA Report mont indicate any lab recommendation the labs have been obtained. The DON will review the Lab QA for six (6) months after the Nurse Manager has completed the reprecommendations have been sig the physician. The DON will tak QA to the Quality Assurance Commeting on a quarterly basis. The Assurance Committee will review nine (9) months. If no other issurdetermined during this time period will be reviewed as needed. The Quality Assurance Committee responsible to monitor the facilitic performance for effectiveness are referenced.	THE RECTIVE The dendations once the Once of the form hind the include	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345140	B. WING		08/04/2016	
	ROVIDER OR SUPPLIER OOR NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		1 00/04/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 329	Continued From page	e 20	F 329	ensure that solutions are achieved and sustained.	1	
F 463 SS=D	483.70(f) RESIDENT ROOMS/TOILET/BAT		F 463		8/4/16	
	resident calls through	nust be equipped to receive a a communication system and toilet and bathing				
	by: Based on observation facility failed to keep working order for Resident #5 was admidiagnoses including A Review of the quarter indicated Resident and was not interview Observations on 08/0 revealed the call light activate outside the design of the control of the contr	l: nitted to the facility on with Alzheimer 's dementia. rly Minimum Data Set dated #5 had cognitive impairment vable.		ADDRESS HOW CORRECTIVE ACT (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAN BEEN AFFECTED BY THE DEFICIEN PRACTICE: For Resident #5 the call light was repa on August 4, 2016 by the Maintenance Supervisor. ADDRESS HOW CORRECTIVE ACTI WILL BE ACCOMPLISHED FOR THO RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:	VE IT ired e	
	Observations on 08/0 rounds with the Maint the call light was not time revealed the ma aware the call light has further explained wor	12/2016 at 3:30 PM revealed in working order. 14/2016 at 9:12 AM on tenance Director revealed working. Interview at that intenance Director was not ad not been working. He k orders were at the nurse ' ot received a work order.		Each resident's call light was checked the Maintenance Supervisor on Augus 2016 to ensure that the call lights were working order. No other call lights were noted to not be in full operation. ADDRESS WHAT MEASURES WILL I PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT	st 4, e in re	

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 8/04/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/04/2016	
				610 WEST FISHER STREET			
BRIGHTM	OOR NURSING CENTER			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 APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 463	on 08/04/2016 at 9:12 aware the resident ' s Interview with aide #1	nt #5 's nurse (nurse #2), 2 AM, revealed she was not call light was not working. on 08/04/2016 at 9:27 AM aware the call light did not	F 4	THE DEFICIENT PRACTICE WI OCCUR: On a daily basis Monday through the Administrative Staff are assig certain rooms as determined by schedule made by the Administrative check the resident rooms for the in addition to the other areas alrebeing reviewed: 1. Wheelchairs clean 2. Privacy curtains/walls 3. Side Rails being in place and loose 4. Calls lights in place and in worder The Administrative staff bring the checks to the morning meeting a time the Administrative Team will any identified areas of concern a lights are determined to not be will Maintenance Request Form is contact that time and given to the Maintenance Request Form is contact that time and given to the Maintenance Request the Administrator who signs off the Administrator who signs off the Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administrator will complete a Quanta identified has been corrected Administ	n Friday gned to a ator to following eady d not working eir QA at which I discuss and if call working a completed intenance eting. air he est Form to hat the ed. The ality cone (1) in this; reported ettee for PLANS INCE TO		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DDIGUTM	000 MUDOINO OFNITED			610 WEST FISHER STREET	
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(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 463	Continued From page 483.75(o)(1) QAA COMMITTEE-MEMB		F 4	SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED A SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECT ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrative staff bring their QA checks to the morning meeting at whice time the Administrative Team will discurance and identified areas of concern and put corrective plan into place at that time. The Administrator will complete a Qualified Assurance Checklist weekly for one (1 month; Bi-weekly for two (2) months; Monthly for six (6) months; and reported to the Quality Assurance Committee for nine (9) months. The VP of Operation will be responsible to conduct a Quality Assurance Round on a monthly basis six (6) months to evaluate the system ensure the facility is sustaining the corrective plan put into place. The responsible to the Quality Assurance Committee for six (6) month The Quality Assurance Committee for six (6) month The Quality Assurance Committee for six (6) month The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained.	ch uss at a lity) ed or us y for and sults ans hs.
5S=D	QUARTERLY/PLANS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345140	B. WING _			C 8/04/2016	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			00/04/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page	e 23	F 5	20			
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the					
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.						
		ords of such committee h disclosure is related to the ommittee with the					
		by the committee to identify efficiencies will not be used as					
	by: Based on record revinterviews the facilitie Assurance Committe implemented procedu interventions that the September of 2015. I deficiencies which we	ares and monitor these committee put into place in This was for two recited ere originally cited in August Il recertification survey and fication survey. The he areas of		ADDRESS HOW CORRECT (S) WILL BE ACCOMPLISHE THOSE RESIDENTS FOUND BEEN AFFECTED BY THE DE PRACTICE: For Resident #12 the wheeld was cleaned. The privacy curemoved and another clean of put back up on August 5, 201	ED FOR D TO HAVE DEFICIENT hair and wall urtain was curtain was		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С		
		345140	345140 B. WING		08	/04/2016		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>			
				610 WEST FISHER STREET				
BRIGHTMOOR NURSING CENTER				SALISBURY, NC 28145				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE API DEFICIENCY)					
F 520	Continued From page 24		F 5	220				
	accidents/hazards	. The continued failure of the		The rail for the resident #17 w	as secured			
	facility during two	federal surveys of record show		to the bed frame on August 4,	2016.			
	a pattern of the fac	cilities inability to sustain an						
	effective Quality A	ssurance Program.		ADDRESS HOW CORRECTIV				
				WILL BE ACCOMPLISHED FO				
	Findings included:			RESIDENTS HAVING POTEN				
				BE AFFECTED BY THE SAM	E			
	This tag is cross re	eferred to:		DEFICIENT PRACTICE:				
	4. 5.050			Each resident's room was che	•			
	1a. F 253: Housekeeping/Maintenance: Based on			Administrative Staff to ensure				
	observations, staff and residents interviews and			wall's were clean as well as th				
	record reviews the facility failed to keep a			curtains. There were no other noted. All resident wheelchair				
	wheelchair, privacy curtain and walls clean for one of twenty residents (Resident #12).			checked by the Administrative				
	One of twenty resid	dents (Nesident #12).		found to need cleaning was cl				
	During the annual	recertification survey August		the CNA's. The areas identified				
		ty was cited for F-253 for failing		checked by the Administrative				
		walls and baseboards, repair		August 5, 8, and 9, 2016				
		water faucet and replace						
		outlet covers in twelve of thirty		All resident's side rails were cl	hecked by			
	rooms. The facility	's plan in September of 2015		the Administrative staff on Au	gust 8, 9			
	indicated that the	Quality Assurance committee		and 10, 2016 and documented	d on the			
	would review the facility 's progress monthly and			daily Quality Assurance Check	klist and no			
	quarterly for effect	iveness and revise or develop		other loose rails were identifie	d.			
		necessary to ensure the						
	system is sustaine	ed.		ADDRESS WHAT MEASURE				
				PUT INTO PLACE OR SYSTE				
		/Hazards: Based on		CHANGES MADE TO ENSUF				
	observations, staff interviews and record reviews			THE DEFICIENT PRACTICE	WILL NO I			
	the facility failed to secure a side rail to the bed frame for one of twenty residents (Resident #17).			OCCUR:	sli4.			
	name for one of tv	verity residents (Resident #17).		The overall process of the qua	-			
	During the annual	recertification survey August		assurance plans for the facility reviewed to determine where				
	During the annual recertification survey August 14, 2015 the facility was cited for F-323 for failing			failed that contributed to the d	•			
		s for three of three sampled		being recited. After review by				
		nt #4, #41 and #66) whose bed		Committee it was determined				
		ured firmly to the bed. The		QA's were completed howeve				
		September of 2015 indicated		not consistently reviewed or d	-			
	that the maintenance supervisor was responsible			after the time frame identified				

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BRIGHTMOOR NURSING CENTER			SALISBURY, NC 28145				
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PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIA	HOULD BE COMPLETION		
F 520 Continued From page	25	F 5	520				
to do facility quality as weekly basis to identificancern, the plan also would conduct QA rou 3 months to ensure the made and the facility rand comfortable envirous the necessary correction the administrator will consist. During an interview with 8/4/16 at 11:45 AM residentified, the department titled, "Quality Assurate department managers rooms to check daily, concern area is identified that department which and maintenance. The are to be filled out and	Continued From page 25 to do facility quality assurance rounds on a weekly basis to identify and repair any areas of concern, the plan also indicated the administrator would conduct QA rounds on a monthly basis for 3 months to ensure that all facility repairs are made and the facility maintain a sanitary, orderly and comfortable environment. If after 3 months the necessary corrections are being made then the administrator will do QA rounds on a quarterly basis. During an interview with the administrator on 8/4/16 at 11:45 AM revealed that a plan has been identified, the department managers have a form titled, " Quality Assurance Checklist " and the department managers are assigned a set of rooms to check daily, she explained that if a concern area is identified then it is reported to that department which is usually housekeeping and maintenance. The maintenance request form are to be filled out and maintenance checks the identified concern immediately.		of Correction. The facility he the way the Quality Assurant completed and reviewed. The procedure to prevent the fasystems is as follows: 1. The Administrative statichecks to the morning mee 2. At which time the Administrative according place at that time. 3. If it is a Maintenance is Maintenance Request form in the meeting and given to Maintenance Supervisor where the Maintenance Supervisor where the Administrator/Designee where form after the Administrator visually looked at whatever as being complete. 5. If it is another Department the issue will be discussed into place at that time. The Manager is responsible to results of the initiated plan. 6. The Administrator will of Quality Assurance Checklist one (1) month; Bi-weekly formonths; Monthly for six (6) reported to the Quality Assurance Committee for nine (9) mor QAA Committee recomment the QA checks because of	for two (2) months; and curance at weekly for months; and curance other ends at weekly for months; and curance other ends at weeks complete other complet	ed he er ne nas ed er put to e e d d the		

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(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 520 Continued From page 26 F 520 responsible to determine the time frame necessary to achieve compliance. 7. The VP of Operations will be responsible to conduct a Quality Assurance Round on a monthly basis for six (6) months to evaluate the system and ensure the facility is sustaining the corrective plan put into place. 8. The VP of Operations conducted a training for the Administrative Staff and completed a walking QA Round with each of the Administrative Staff member to train them on how to identify any area of concern and the process once it is identified on August 29, 2016. The results of the QA check by the VP of Operations will also be reported to the Quality Assurance Committee for six (6) months. The Quality Assurance Committee is responsible to monitor the facilities performance for effectiveness and to ensure that solutions are achieved and sustained INDICATE HOW THE FACILITY PLANS TO MONITOR IT'S PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE FLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The Administrator will complete a Quality Assurance Checklist weekly for one (1)			

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F 520	Continued From page	27	F 5	month; Bi-weekly for two (2) m Monthly for six (6) months; and to the Quality Assurance Cominine (9) months unless the QA Committee recommends continually the QAA Committee will be redetermine the time frame necessachieve compliance. The VP of Operations will be not to conduct a Quality Assurance a monthly basis for six (6) mor an extended period of time is it evaluate the system and ensufacility is sustaining the correctinto place. The Quality Assurance Comming responsible to monitor the facing performance for effectiveness ensure that solutions are achieved.	d reported mittee for AA nuing the uing issue esponsible essary to responsible Round on the unless identified re the titve plan iittee is and to	es. es to			