STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
		HAL034026	B. WING		05/2	1/2025
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
BRIGHT	ON GARDENS OF WI	NSTON SALEM	'NOLDA RO <i>A</i> I SALEM, NO			
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
		ensure Section conducted a n 05/20/25 and 05/21/25.				
D 375	10A NCAC 13F .10 Medications	005 (a) Self-Administration Of	D 375			
	10A NCAC 13F .1005 Self -Administration Of Medications  (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met:  (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and  (2) specific instructions for administration of prescription medications are printed on the medication label.					
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 sampled resident (#1) had a physician's order and assessment completed to self-administer medications related to a cough medicine, a stool softener, a medication used to treat temporary stomach discomfort, and a medication used to treat diarrhea.					
	The findings are:					
	revealed:	ty's Resident policy dated April 2023 hysician's order and a nursing				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

AND DIAN OF CORRECTION . IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING.			R	
	HAL034026		B. WING			21/2025
NAME OF PROVIDER OR SUP	PLIER	STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
BRIGHTON GARDENS C	F WINSTON SALEM		NOLDA ROA SALEM, NO			
PREFIX (EACH DEFI	Y STATEMENT OF DEFICIENCIE IENCY MUST BE PRECEDED BY OR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
safely administry. Nothing should unless they converted they converted the residents show self-administer. The resident self-administer. The resident self-administer should be self-administer. The self-administer self-admi	indicate that a resident of the his/her medications. It is a be at the resident's beguld self-administer. Sould not be on a combination of the ability to self-administer would be evaluated and with the wellness visit.  Ident #1's current FL-2 dialed diagnoses included and and cerebral infarction.  Ident #1's pre-admission of the ability of self-administration and the resident was signed by the residence of the ability of the ability of the alled Resident #1 was not of medications.  Ident #1's record revealed ministration assessment Resident #1.  Resident #1's signed physically of the stomach of the	dside ation of r safely validated lated anxiety, aled the istering her dent's ated t able to ed there isician's er for inporary 05/20/25 at cylate on	D 375			

Division of Health Service Regulation

AND DI AN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
	HAL034026			B. WING			R <b>21/2025</b>
NAME OF I	PROVIDER OR SUPPLIER	S	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
RPIGHT	ON GARDENS OF WIN	NSTON SALEM	2601 REY	NOLDA ROA	AD .		
БКІВПІ	ON GARDENS OF WII	VSTON SALEIVI V	VINSTON	SALEM, NO	27106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From pa	ge 2		D 375			
	secured.						
	Second observation 05/20/25 at 4:15pm -There was a bottle the resident's bedsi -The bottle was 65% -The top of the bish securely on the bottle was desired to be subsalicylate yester stomach was hurtin.	of bismuth subsalicylade table. % full. nuth subsalicylate was tle. dent #1 on 05/20/25 at one tablespoon of bismoday, 05/19/25 because	not 9:28am uth e her				
	Refer to the intervie on 05/20/25 at 4:23	ew with a medication ai pm.	de (MA)				
	Refer to the intervie (PCA) on 05/21/25	ew with a personal care at 9:26am.	e aide				
	Refer to the interview with a second MA on 05/21/25 at 9:28am.  Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am.		n				
	Refer to the telephorepresentative from 05/21/25 at 12:23pr	Resident #1's PCP's	office on				
	orders dated 03/18/	ent #1's signed physicia /25 revealed an order f sed to treat diarrhea) g s as needed (PRN).	or				

Division of Health Service Regulation

STATE FORM 6899 07L911 If continuation sheet 3 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
HAL034026			B. WING		<b>I</b>	R 2 <b>1/2025</b>	
	BRIGHTON GARDENS OF WINSTON SALEM 2601 REY				STATE, ZIP CODE AD 5: 27106		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Observation of Res 9:28am revealed: -There was a bottle resident's bedside the state of bottle.  Interview with Resident revealed she took of yesterday, 05/19/25 loose.  Observation of Res 9:27am revealed the was not on the resident was not on the resident revealed she did not loperamide liquid we with a MA revealed: -Resident #1 asked day" and then the nestool softener.	ident #1's room on 05/of loperamide liquid of able. the liquid remaining in the liquid remaining remaining in the liquid remaining remaining remaining remaining remaining rem	n the the 9:28am ramide vere /21/25 at liquid 9:27am le of m t every	D 375			
		ne interview with Resid 05/21/25 at 9:42am wa					
	Refer to the intervie on 05/20/25 at 4:23	ew with a medication a pm.	ide (MA)				
	Refer to the intervie 9:26am.	ew with a PCA on 05/2	1/25 at				
	Refer to the interview with a second MA on						

Division of Health Service Regulation

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND FLAIN	PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED		
						F	₹
		HAL034026		B. WING		1	1/2025
NAME OF	PROVIDER OR SUPPLIER		STRFFT AD	DRESS CITY S	STATE, ZIP CODE		
7.0.00E OF 1	TIDER OR OUT FILE			NOLDA ROA			
BRIGHT	ON GARDENS OF WI	NSTON SALEM		I SALEM, NO			
040.15	CUMMADY CTA	TEMENT OF DEFICIENCE				ON	0.5
(X4) ID PREFIX		ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B		ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
D 375	Continued From pa	ige 4		D 375			
	05/21/25 at 9:28am	`					
	03/21/23 at 9.20am	l.					
	Refer to the intervie	ew with the facility's	Registered				
		Administrator on 05					
	10:07am.						
	_ ,						
	Refer to the telepho						
	representative from		's office on				
	05/21/25 at 12:23pr	m.					
	c. Review of Reside	ent #1's signed nhys	sician's				
	orders dated 03/18/						
	sennosides and do						
	constipation) 8.5-50						
	hours PRN.	0.0	,				
		sident #1's room on	05/20/25 at				
	9:28am revealed:	of documents andium	a (ataal				
	softener) on the res	of docusate sodiun					
	-There was an unde						
	the bottle.	ctermined namber c	n tabloto in				
	-						
		dent #1 on 05/20/25					
	revealed she took 3						
	on Saturday, 05/17/		ad not				
	gone to the bathroo	om in a long time.					
	Observation of Resident #1's room on 05/21/25 at						
	9:27am revealed the bottle of docusate sodium						
	was not on the resident's bedside table.						
	Interview with Resid		-				
	revealed she did not know where the bottle of						
	docusate sodium w	/as.					
	Interview with a MA	on 05/21/25 at 0:29	Rom				
	revealed Resident						
	today, 05/21/25.	# 1 a3NGU 101 a 31001	301101101				

6899

Division of Health Service Regulation STATE FORM

07L911 If continuation sheet 5 of 9

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL034026	B. WING			R <b>21/2025</b>
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
BRIGHT	ON GARDENS OF WIN	NETON SALEM	YNOLDA ROA			
	T	WINSTO	N SALEM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From pa	ge 5	D 375			
		ne interview with Resident #1's 05/21/25 at 9:42am was				
	Refer to the intervie on 05/20/25 at 4:23	ew with a medication aide (MA pm.				
	Refer to the intervie 9:26am.	ew with a PC) on 05/21/25 at				
	Refer to the interview with a second MA on 05/21/25 at 9:28am.  Refer to the interview with the facility's Registered Nurse (RN)/Interim Administrator on 05/21/25 at 10:07am.					
			I			
	Refer to the telephorepresentative from 05/21/25 at 12:23pr	Resident #1's PCP's office or	1			
	d. Review of Resident #1's signed physician's orders dated 03/18/25 revealed an order for guaifenesin 100mg/5ML give 10ml every 6 hours as needed (PRN) for cough.					
	9:28am revealed: -There was a bottle congestion liquid m bedside table.	ident #1's room on 05/20/25 a of severe cough and edication on the resident's the liquid remaining in the	t			
	revealed: -She had the cough needed an expecto did not have any the	dent #1 on 05/20/25 at 9:28am n medicine because she rant, and the MA told her they ey could administer. when she last took the cough				

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
HAL034026				B. WING 05			R <b>21/2025</b>
BRIGHTON GARDENS OF WINSTON SALEM 2601 REY				DRESS, CITY, S NOLDA ROA I SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED B' SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Attempted telephor family member on cunsuccessful.  Refer to the interview 4:23pm.  Refer to the interview 9:26am.  Refer to the interview 05/21/25 at 9:28am.  Refer to the interview Nurse (RN)/Interimm 10:07am.  Refer to the telephore representative from 05/21/25 at 12:23pm.  Interview with a MA revealed: -Resident #1 had "of far as her memoryShe would administ and at 8:00pm the indication at 8:00pm medicationShe did not think Far medications said interview with a PC revealed: -If staff saw medication and at 8:00pm medicationShe did not think Far medications said interview with a PC revealed: -If staff saw medication and at 8:00pm medicationShe MA would mail order for the medication and mail order for the medication.	s "when the pollen was a line interview with Respondent and Market with a second Market with a second Market with the facility's Administrator on 05 and interview with a Resident #1's PCP m.  Ton 05/20/25 at 4:23 good days and bad of the second market would not resident would not rebeing administered Resident #1 could act fely.  A on 05/21/25 at 9:2 ations in a resident's	sident #1's was  5 at  6 at  7 on  Registered 6/21/25 at  8 office on  8 pm  days" as  at 3:00pm  ecall the  dminister  26 am  room,  had an  bom, and if	D 375			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
					R		
		HAL034026		B. WING		05/2	21/2025
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
BRIGHT	ON GARDENS OF WII	NSTON SALEM		NOLDA ROA I SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From parthe resident whyShe had been in R 5/21/25, but she did the resident's beds  Interview with a sec 9:28am revealed: -Resident #1 did not self-administer her -She had seen eye before and told the the eye drops in he -She was concerne something she had the MAShe did not see the resident's bedside to  Interview with the far (RN)/Interim Admin 10:07am revealed: -The PCAs should nurse if medication resident's roomThe MA should let there was an order medication at the b -Resident #1 could wanted medications -Resident #1 was n in her roomShe had not comp Resident #1 for the medications becaus want her to self-adm  Telephone interview Resident #1's PCP	Resident #1's room and not see the medical de table.  Cond MA on 05/21/2 of have an order to medications.  drops in Resident are resident she could a room.  In the defendant was a medication on the table today, 05/21/2 of the medication on 05/21/2 of the medication of the resident to lead the nurse know and for the resident to lead the medication of the resident to lead the medication of the medication of the medication of the resident to self-adication of the medication of the resident to self-adication of the resident to self-adication of the medication of the medication of the resident to self-adication of the resident to self-adication of the medication of t	#1's room not keep d take inistered by ne 25.  Nurse 5 at he facility's a d see if have the e she medications nt on minister her per did not ations.	D 375			
	12:23pm revealed l self-administer her		g as the				

Division of Health Service Regulation

STATE FORM 6899 07L911 If continuation sheet 8 of 9

AND DUAN OF CODDECTION DENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
HAL034026		B. WING			R 21/2025	
NAME OF F	PROVIDER OR SUPPLIER	•	DDRESS, CITY,	STATE, ZIP CODE	1 00/1	172020
BRIGHT	ON GARDENS OF WI	NSTON SALEM	YNOLDA ROA N SALEM, NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 375	Continued From pa	ge 8	D 375			
	facility staff was in a	agreement.				

6899

Division of Health Service Regulation STATE FORM