**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CLA. IDENTIFICATION NUMBER:** 345140

**(X2) MULTIPLE CONSTRUCTION**

**A. BUILDING**

**B. WING**

**(X3) DATE SURVEY COMPLETED**

C 08/05/2011

**NAME OF PROVIDER OR SUPPLIER**

BRIGHTMOOR NURSING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**

610 WEST FISHER STREET

SALISBURY, NC 28145

<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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| F 000  | INITIAL COMMENTS

There were no deficiencies cited as a result of the Complaint Investigation on 8/3/11 - 8/5/11. Event ID X27X11. Intake NC00074508, NC00074378, NC00073673, NC00071708. | F 000  |                                                                                                               |                 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(06) DATE

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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 patient. (See instructions.) Except for nursing homes, the findings stated above are disclosed 60 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 disclosed 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.