DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FOR	M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	<u> 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	E SURVEY PLETED
		345140	B. WING			C / 26/2017
NAME OF PI	ROVIDER OR SUPPLIER	I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER	1		0 WEST FISHER STREET ALISBURY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	A complaint investiga from 1/24/17 through Jeopardy was identifi					
	(J) CFR 483.25 at tag F3 (J)	309 at a scope and severity 323 at a scope and severity 5490 and F520 at a scope				
F 309 SS=J	The tags F309 and F Quality of Care. Immediate Jeopardy removed on 1/26/17. conducted.	323 constituted Substandard began on 1/19/17 and was An extended survey was PROVIDE CARE/SERVICES L BEING	F 309			1/30/17
	applies to all care and residents. Each resid facility must provide t services to attain or r practicable physical, well-being, consisten	mental, and psychosocial				
	provided to residents consistent with profes	ure that pain management is who require such services, ssional standards of practice, erson-centered care plan,				
LABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E E	TITLE		(X6) DATE
	cally Signed					02/17/2017

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.

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/20 FORM APPROVI OMB NO. 0938-03	
TATEMENT OF DI ND PLAN OF COF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345140	B. WING		C 01/26/2017	
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·	
REIGHTMOOD	R NURSING CENTER			610 WEST FISHER STREET		
BRIGHTMOOI			1	SALISBURY, NC 28145		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIO		
(I)		e 1 ty must ensure that e dialysis receive such	F 309			
se of ca pre Th	rvices, consistent w practice, the compr re plan, and the res eferences. is REQUIREMENT	vith professional standards rehensive person-centered				
ph ca #1 tra the tha dre int the stu wa aff res ho In Re qu for tra PM cre rel lev tha jeo	ased on record revi ysician and staff inf Il for help for an act who fell from a wh insportation. The re- e floor during the fa at was stopped afte essing. Staff repos o the wheelchair ar e facility. Following ump, there was no e as monitored after the fected one (Resider sident who was tran- mediate jeopardy he esident #1 was mov alified person asse possible injuries a insport and was ren A when the facility pe edible allegation of main out of complia (rel of D (not actual an minimal harm that opardy) to ensure a	ew, observation and terview, the facility failed to ute assessment of Resident eelchair during van esident hit his left stump on Il resulting in active bleeding r staff applied a pressure itioned the resident back nd continued the transport to initial treatment to the evidence that the resident the fall. This problem nt #1) of one sampled nsported using the nursing began on 1/19/17 when red prior to having a ssed/examined the resident fter the fall in the van during noved on 1/26/17 at 2:20 provided an acceptable compliance. The facility will ince at a scope and severity harm with potential for more at is not immediate Il staff members were illity's policy and procedure		ADDRESS HOW CORRECTIVE A (S) WILL BE ACCOMPLISHED FO THOSE RESIDENTS FOUND TO BEEN AFFECTED BY THE DEFIC PRACTICE: The resident was evaluated by a registered nurse on January 19, 20 initiated first aid treatment to the s which included assessment to ensibleeding had stopped and a new of was applied. The resident who w and oriented denied any injuries. Nurse Practitioner evaluated the re on January 19, 2017 and no injurie the fall were noted. The resident w discharged on January 20, 2017 d un-related issues to the local hosp therefore no further evaluations of effected resident have been comp All nurses were in-serviced beginn January 26, 2017 and completed of January 27, 2017 by the Director of Nursing that included the following 1. Timely assessment of resident 2. Timely completion of incident.	DR HAVE CIENT D17 and tump ure Iressing as alert The esident e	

Facility ID: 923010

		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 02/27/20 FORM APPROV IB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		CONSTRUCTION	(X3	B) DATE SURVEY COMPLETED
		345140	B. WING				C 01/26/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				610 WEST FISHER STREET			
BRIGHTM	OOR NURSING CENTER	(S	ALISBURY, NC 28145		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 309	Continued From page	- 2					
1 309	Continued From page		F 3	09			_
		undated) was reviewed. The should you witness an			Nursing and Administrator concerning falls or events that occur.	ng any	
		essary to aid an accident					
		nder immediate assistance.			All CNA s were in-serviced beginni	ina	
	· · ·	m until he/she has been			January 26, 2017 and completed or		
		ered nurse for possible			January 27, 2017 by the Director of		
	injuries. "	·			Nursing that included the protocol for		
		nitted to the facility on			accident/incidents as relates to mov	ving a	
		e diagnoses including			resident prior to being assessed by	а	
	-	se stage 4, chronic anemia,			licensed nurse.		
	and bilateral above th	•			The Transmentation drives and Oardi		
		ge summary dated 12/19/16 nt #1 underwent left above			The Transportation driver and Certif Nursing Assistant were re-educated		
	the knee amputation				January 24, 2017 by the Administra		4
	The admission Minim				Vice President on the accident and		
	assessment dated 12	. ,			incident policy which states that a re	esident	t l
	Resident #1 had mod	lerate cognitive impairment			is not to be moved if there is an acc		
	and needed extensiv	e assistance with transfers.			while on the facility van, and that 91	1	
		indicated that the resident			should be called to make determina	tion if	
	had no falls since ad	mission or the last			medical attention is required and		
	assessment.				transportation to the hospital is nece	essary	-
	Resident #1's care pl				The Transportation Driver also has		
		care plan problems was the or falls and fall related injury			demonstrated competency to the Administrator on January 24, 2017	of the	
		endent on the staff for			physical restraint systems on the va		
	transfers due to bilate				according to the manufacturer		
		was the resident will follow			specifications.		
	safety guidelines by u				All staff was in-serviced on January	/ 30,	
		fers and toileting and will be			2017 by the Administrator and/or Di		
		should any fall occur			of Nursing on the following:		
	through the next revie				. .		
		will be provided with all			1. Transportation safety;		
		monitor for attempts to get			2. The accident and incident polic		
		nair unassisted, and therapy er transfers as needed.			3. Ensure anyone who assists wit transports is aware of the proper	11	
		s notes were reviewed. The			procedure for securing of the restrain	inte	
		at 3:02 PM indicated that on			system.	1113	
		y 12:30 noon Nurse #1 was			 Accidents and Incidents that oc 	cur	
		he building to assess			with any resident within or outside the		

Facility ID: 923010

						<u>10. 0938-03</u>		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
			A. BUILDING	i		C		
		345140	B. WING					
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1/26/2017		
				610 WEST FISHER STREET				
BRIGHTM	OOR NURSING CENTER	R		SALISBURY, NC 28145				
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF ((YE)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE		
F 309	Continued From page	e 3	F 30	9				
	Resident #1 due to a	fall that occurred in the van		facility to include assessme	nt of the			
		nent. The resident fell on the		resident by a licensed nurse				
		ling was noted from the left		healthcare professional (i.e.				
		e #1 observed Resident #1		Paramedic) prior to moving				
		l appeared " out of it and		a fall occurs.				
	had a flat affect. " T	he notes indicated that the						
		d when pressure was applied		ADDRESS HOW CORREC				
		and the treatment nurse		WILL BE ACCOMPLISHED				
		the left amputated leg.		RESIDENTS HAVING POT				
		s orders revealed that on		BE AFFECTED BY THE SA	ME			
		had an order to be sent to		DEFICIENT PRACTICE:				
		due to hemoglobin of 6.7		It is the policy of the facility				
	and hematocrit of 20.			residents be assessed in a				
		ted 1/22/17 at 6:37 AM nt #1 was discharged to the		and monitoring of each resi is indicated in the acute cha				
	hospital on 1/20/17.	int #1 was discharged to the		guidelines.	arting			
	The hospital records	dated 1/20/17 were		guidennes.				
	reviewed. The princip			All nurses were in-serviced	heainnina			
		nemorrhage and the active		January 26, 2017 and comp				
		nia of chronic renal disease		January 27, 2017 by the Di				
		The plan was to transfuse 2		Nursing to include the follow				
	units of packed red b				5			
		M, the Director of Nursing		1. Timely assessment of r	residents;			
		ed. The DON indicated that		2. Timely completion of in				
	she was made aware	e of the accident in the van		reports;				
	•	on 1/19/17. She stated that		3. Monitoring of residents				
	the resident's name v			Acute Episode charting guid				
	•	because Nurse #1 (assigned		4. Communication with th				
	-	not completed the incident		Nursing and Administrator of	concerning any			
		d that Nurse #1 was coming		falls or events that occur.				
		(17) to complete the incident		The Transportation driver a	nd Cortified			
	report and to provide	a written statement nt with Resident #1. She		The Transportation driver an Nursing Assistant were re-e				
		statements were obtained		January 24, 2017 by the Ad				
		ne nursing assistant (NA) #1		Vice President on the accid				
	who accompanied the			incident policy which states				
	-	was not able to provide a		is not to be moved if there is				
		lent #1. She added that the		while on the facility van, and				
		sting with the electronic		should be called to make de				

Facility ID: 923010

TATEMENT C									
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY IPLETED			
	CONTECTION	BENTI IGATION NUMBER.	A. BUILDING	<u> </u>					
			D MINO			С			
		345140	B. WING			/26/2017			
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE				
BRIGHTM	OOR NURSING CENTER	2		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE			
F 309	Continued From page	۵ ۵	F 30						
		was aware that Nurse #1	1 50		and				
		van accident involving		medical attention is required transportation to the hospita					
		rse's notes timely but the		The Transportation Driver al	-				
		ocument a late entry on		demonstrated competency t					
		so stated that Resident #1		Administrator of the physica					
		e nurses after the fall but the		systems on the van accordir					
		ment the monitoring in the		manufacturer specifications.					
		cords. The DON stated that		All staff was in-serviced on .	lanuary 30.				
	she and the Administr			2017 by the Administrator a					
	investigation time line			of Nursing on the following:					
	-	e line was reviewed. The							
	-	al the root cause of the		1. Transportation safety;					
	resident s fall. The tir	me line included:		2. The accident and incide	ent policy;				
	1/19/17 at 9:30 AM -	The Administrator was		3. Ensure anyone who as					
	called by the driver to	come outside the facility to		transports is aware of the pr					
	the van. She saw NA	#1 standing in front of		procedure for securing of the	e restraints				
	Resident #1 and was	holding the resident s		system.					
	stump that was bleed	ing. When she questioned		4. Accidents and Incidents	that occur				
	what happened, she	was told that the resident		with any resident within or o	utside the				
	had released his belt	and he fell out of his chair		facility to include assessmer	nt of the				
		dministrator immediately		resident by a licensed nurse					
	-	lurse #1 and NA #2. They		healthcare professional (i.e.					
		t cart and they cleaned him		Paramedic) prior to moving	he resident if				
		nside the facility. Nurse #1		a fall occurs.					
		dent was okay and for her to							
		report and to get statements		ADDRESS WHAT MEASUR	-				
		A #1 and to make sure that		PUT INTO PLACE OR SYS					
	the information were	-		CHANGES MADE TO ENSU					
		- The DON informed Nurse		THE DEFICIENT PRACTICI	= WILL NO I				
	•	ocumentation of the incident		OCCUR:					
	and when the stateme			Fach douths Administrat					
		report and to notify the		Each day the Administrator					
		k with her. The DON also		will review the 24 Hour Repo					
		urse Practitioner) to see		determine if any incidents/ac					
	Resident #1.	The DON informed the		occurred. If incidents/accide					
		The DON informed the		on the 24 Hour Report the A					
	resident's family of the			and/or DON will then comple	•				
	and inquired regardin	The DON called Nurse #1		Assurance review of the Acc reports and medical record t					

Facility ID: 923010

If continuation sheet Page 5 of 55

	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 02/27/20 ² MAPPROVE D. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		LETED
		345140	B. WING			C 26/2017
NAME OF P	ROVIDER OR SUPPLIER	·	- I	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
BRIGHTM	OOR NURSING CENTER	R		610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 309	1/20/17 at 5:00 PM - came and picked him 1/20/17 at 7:00 PM - to send the resident to units of Packed Red 10:30 PM, when the facility, EMS was call hospital. 1/23/17 at 12:45 PM to write her statemen provided his stateme forwarded it to the DO re-educated on the tr demonstrated comper restraint system acco the VP of Operation. 1/23/17 at 2:00 PM - the hospital to check She was informed that to orthopedic to see to 1/24/17 at 1:00 PM - and informed her that the incident report. 1/24/17 at 1:30 PM - to write a report on the wounds (stump). The conclusion writted action plan initiated 1 transports per the fact transport will be insper facility and upon retu Administrator or the D resident is properly stacch any issues are found the resident while be driver will not be allow	The family of Resident #1 a up to visit a family member. The NP called and ordered to the hospital to receive 2 Blood Cell (PRBC). Around resident returned to the ed to transfer him to the - The DON reminded NA#1 t of the incident. The driver int to the Administrator and DN. The driver was ansportation policy and tency of the physical ording to the manufacturer by The Nurse Manager called the status of the resident. at the resident was referred his stump. The DON called Nurse #1 t she needed to complete The DON requested NA #2 the status of the resident's an on the time line read " the /25/17 on the next 20	F 3(nt and ed. If i initiated, the vill instruct the tiate her incidents. rector of S/Care Plan care Plan to the incomplete DN will e Nurse within ering the on policy and he training will rvice internal QA hal process will e the facility rective actions, necessary nec, the Nurse will lical records to t; cks by the weekly for e months, and i s found I corrective	

Facility ID: 923010

If continuation sheet Page 6 of 55

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		. ,	MPLETED
						С
		345140	B. WING		- 0	1/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE	
BRIGHTM	OOR NURSING CENTER	3		610 WEST FISHER STREET		
BIGOTIN	CON NORCENTE			SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIATE IEFICIENCY)	(X5) COMPLETIO DATE
F 309	Continued From page	e 6	F 30	9		
	follow up and recomr	mendations to ensure the		Operations. After i	review the VP of	
	corrective actions is a	achieved and sustained. "		Operations will take	any necessary	
		M, NA #1 was interviewed.			mployee disciplinary	
	She indicated that sh			action up to termina	-	
		0/17 to accompany Resident		adhere to facilities		
		IV infusion. She was at the the resident. It was about 2		resident safety polic	ties is noted. TE FACILITY PLANS	
		facility when the driver had to			PERFORMANCE TO	
		rake and the resident slid out		MAKE SURE THAT		
		esident #1 ended kneeling		SUSTAINED. THE		
		he floor. The driver pulled		DEVELOP A PLAN		
	over, and she assess	sed the resident and noted		THAT CORRECTIC	N IS ACHIEVED AND	
		as bleeding through the		SUSTAINED. THE		
		d pressure on the dressing			ID THE CORRECTIVE	
		She and the driver lifted the				
		back in the wheelchair and to drive back to the facility.		EFFECTIVENESS.		
	· ·	ront of the facility and called		ASSURANCE SYS		
	· ·	came out and assessed the		FACILITY.		
		came out and changed the				
		ent's left stump. NA #1		Each day the Admir	nistrator and/or DON	
	further stated that sh	e was instructed not to move		will review the 24 H	our Report to	
		cident until assessed by a		-	idents/accidents have	
	-	t have any choice, they have			its/accidents are noted	
	-	neelchair in order to drive			ort the Administrator	
		NA #1 also stated that the one to call the facility and			n complete a Quality of the Accident/Incident	
	inform them about the	•		reports and medica		
		AM, the van driver was		timely assessment,		
		ed that he had been driving		interventions were of		
		ears. He was trained by the			not been initiated, the	
		on transportation safety			r DON will instruct the	
	· ·	roper procedure in securing		Interdisciplinary Tea		
		eelchair in the van before he		-	vent further incidents.	
	-	n. The van driver indicated		The Administrator a		
		Resident #1 to the hospital sion. It was about a mile		-	the MDS/Care Plan	
	away from the facility			Coordinator to upda reflect the intervent		

Facility ID: 923010

If continuation sheet Page 7 of 55

		MEDICAID SERVICES					0. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						С	
		345140	B. WING			01/	26/2017
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
BRIGHTM	OOR NURSING CENTER	ł			IO WEST FISHER STREET		
				S/	ALISBURY, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 309	Continued From page	e 7	F 3	309			
		he heard something on the			the Administrator and/or DON will		
		saw the resident on the floor.			complete re-training with the Nurse with	nin	
		sked the resident if he was			twenty-four hours of discovering the		
		hat he was fine. His buttock			violation of the documentation policy ar	nd	
		his left stump was bleeding.			procedure of the facility. The training w		
		1, they lifted the resident			be documented on an In-service		
		nis wheelchair. NA #1			Summary Sheet.		
	applied pressure on t				In addition to the facilities internal QA		
		iver stated that he can move			process the following external process	will	
	-	the resident was saying that			be implemented. To ensure the facility		
		o stated that he did not call			maintains implemented corrective actio	ns,	
	the facility because h			to achieve and sustain the necessary			
	facility.			program to ensure compliance, the			
	On 1/25/17 at 10:50 /	AM, the facility transport van			Regional Quality Assurance Nurse will		
	was observed with th				conduct an audit of the medical records	s to	
		an was equipped with a			include:		
	shoulder strap and a	•			1. Nurses notes;		
		v to apply the shoulder strap			2. Acute Condition Report;		
		esident and on how to			3. Incident Report;		
		r to the floor. He also			4. Care Plan;		
		sident and NA #1 were			5. Quality Assurance Checks by the		
		if the shoulder strap and the			Director of Nursing		
		to the resident he replied "I			This audit will be completed weekly for	nd	
		e shoulder strap " because nt would be fine with the NA			one month, monthly for three months, a quarterly thereafter if facility is found	ana	
	with him at the back of				compliant with implemented corrective		
		se #1 but she did not return			actions. The Regional Quality Assuran	~	
	the call.				Nurse will report the findings to the VP		
		AM, the Administrator was			Operations. After review the VP of		
		ted that she was called to go			Operations will take any necessary		
		building to see a resident			actions (including employee disciplinary	v	
		of the van. She thought			action up to termination) if failure to	,	
		the van was parked. She			adhere to facilities assessment and		
		t the resident fell on their			resident safety policies is noted.		
		ty. She immediately called			The findings of the Administrator and		
	-	he resident and to change			DON will be reported to the Regional		
		esident's left stump. She			Quality Assurance Nurse on a weekly		
	-	y for the staff to move the			basis for three (3) months. Weekly the		
	regident before a pur	se or any qualified person		- 1	plan will be evaluated to determine if th	<u> </u>	

Facility ID: 923010

If continuation sheet Page 8 of 55

						O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	E SURVEY IPLETED
						С
		345140	B. WING		01	/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
BRIGHTM	OOR NURSING CENTER	3		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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From page	e 8	F 30	09		
		sident as long as the resident		corrective actions are being	sustained, if	
	was alert and oriente	d and was able to tell that		not the plan will be evaluated	d and updated	
	he/she was okay. Th			to ensure facility is maintaini		
		I not expect the driver to call		compliance. The findings of		
		ney were a mile away from accident happened. She		Assurance checks internally externally and review by the		
		e driver and NA#1 were		Operations will be presented		
		portation safety (video of		Committee on a monthly bas		
r (-		perly securing the resident		up and recommendations to		
	on 1/23/17.			corrective action is achieved	and	
		an driver were reviewed. The		sustained.		
	-	facility's commercial auto driver's commitment on				
		ed " seat belt utilization is				
	required of all drivers					
	company owned vehi					
		y business. " The records				
		e driver was trained on				
		nsportation safety using the ction on how to secure the				
	wheelchair and the re					
	On 1/25/17 at 2:10 Pl	M, the attending physician of				
		rviewed. She stated that the				
	staff had informed he					
		l and the resident was se Practitioner the day of the				
		the next day the resident was				
		ergency room due to low				
		rit level which was not				
		e also indicated that she				
		move the resident from the				
	assess the resident.	body from the facility to				
		M, the Administrator was				
		he stated that she started as				
	administrator of the fa	acility in May 2016. She				
		follow the facility's policy and				
	procedure on accider					
	1 Un 1/25/17 at 2:35 Pl	M, the Administrator and the				1

Facility ID: 923010

If continuation sheet Page 9 of 55

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345140	B. WING			C 01/26/2017	
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
RDIGUTM	OOR NURSING CENTER			6	610 WEST FISHER STREET		
BRIGHTW	OOR NORSING CENTER			5	SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	jeopardy. The facility credible allegation of 2:20 PM. The credible allegation The resident was eva on January 19, 2017 at treatment to the stum assessment to ensure a new dressing was a was alert and oriented Nurse Practitioner eva January 19, 2017 and were noted. The resid hospital on January 2 unrelated to the fall. The Director of Nursin monitored for the fall. In the Director of Nursin monitored for the fall. In the Director of Nursing to not reflect the more should have document disciplinary action for or events that occur. in-serviced today, Jan Director of Nursing to 1. Timely assessme 2. Timely completion reports; 3. Monitoring of res Episode charting guid 4. Communication va and Administrator con- that occur. For any nurse not in-spice allowed to work un completed with the Director in the Director work un completed with the Director in the Director of Norsing to the Director of Nursing to allowed to work un completed with the Director in the Director of Norsing to the Director of Nursing to that occur.	informed of the immediate provided an acceptable compliance on 1/26/16 at n indicated: luated by a registered nurse and initiated first aid p which included e bleeding had stopped and upplied. The resident who d denied any injuries. The aluated the resident on a no injuries from the fall dent was discharged to the 0, 2017 for health issues The nursing staff stated to g that the resident was however the nurses notes intoring. The nurses who need have received a failing to document any falls All nurses will be nuary 26, 2017 by the include the following: ent of residents; n of incident/accident idents using the Acute lelines with the Director of Nursing incerning any falls or events serviced today they will not till the in-service is rector of Nursing.	F	309			
	incident reports were	reviewed on January 24,					

If continuation sheet Page 10 of 55

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY
		345140	B. WING	_		C 01/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	20/2017
				6	10 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER			s	SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	determine if there have accidents/incidents in residents and there we affected. The Transportation dr Assistant were re-edu the Administrator and accident and incident resident is not to be ne while on the facility va called to make determ is required and transp necessary. The Tran demonstrated compethe physical restraint according to the many All staff will be in-ser 2017 by the Administrator and incident policy to with transports is awa procedure which inclu the restraints system. 2. Accidents and In resident within the fac of the resident by a lid moving the resident if For any employee no be allowed to work ur	tiver and Certified Nursing ucated January 24, 2017 by Vice President of Nursing ucated January 24, 2017 by Vice President on the policy which states that a noved if there is an accident an, and that 911 should be nination if medical attention portation to the hospital is sportation Driver also has tency to the Administrator of systems on the van ufacturer specifications. viced on today January 26, rator on the following: on safety and the accident ensure anyone who assists are of the proper policy and udes proper securement of cidents that occur with any cility to include assessment censed nurse prior to a fall occurs. t in-serviced today, will not	F	309			
	The facility will ensure	e safe driving training					

Facility ID: 923010

If continuation sheet Page 11 of 55

					OMB NO. 0938-0
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDIN		С
		345140	B. WING		01/26/2017
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	
				610 WEST FISHER STREET	
	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETI THE APPROPRIATE DATE
F 309	Continued From page	s 11	F 3	00	
1 000		per use of cell phones ,	Г J	09	
	what to do in the ever				
	breakdown of vehicle, what to do in the event of				
	an accident and resid	ent safety during event.			
	The training will also include who to report an				
	incident to and how to report to the administrator. The Administrator will ensure annual reviews of				
	driver records for all a	authorized drivers by nce company for the facility			
	-	of the drivers check. This			
		aintained in a file in the			
	administrator 's office				
	The facility will visibly conduct quality assurance				
	checks to ensure that	•			
		ly and safely and document			
		lity assurance checks in the g. This will be done for the			
		ports per the facility van,			
	,	will be inspected prior to			
		d upon return to the facility			
		or Director of Nursing to			
	ensure the resident is	properly secured in the van			
		rly attached and locked in			
		are found with the proper			
		ent while being transported,			
		be allowed to transport any vill receive disciplinary			
	action up to and to inc				
	employment.				
	A Quality Assurance	review of all of the			
	•	orts will be completed daily			
	•	at which time if interventions			
		he Administrator will instruct			
		eam to initiate interventions			
	Nursing will instruct th	dents. The Director of			
		the Care Plan to reflect the			
	interventions.				

If continuation sheet Page 12 of 55

	-	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 02/27/201 M APPROVEI D. 0938-039	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345140	B. WING		C 01/26/2017		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
BRIGHTM	OOR NURSING CENTER	R	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 309 F 323 SS=J	on 1/26/17 at 2:30 PM including the van driv in-service on the facil and procedure. The in- reviewed and the in-service on the facil and procedure. The in- reviewed and the in-service 483.25(d)(1)(2)(n)(1)- HAZARDS/SUPERVI (d) Accidents. The facility must ensure (1) The resident envire from accident hazard (2) Each resident rectar and assistance device (n) - Bed Rails. The facility bed rail. If a bed or service must ensure correct in maintenance of bed rectar (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the be appropriate for the re This REQUIREMENT	on of compliance was verified M by interviewing the staff er that they have received ity's accident/incident policy in-service records were service on accident/incident was started on 1/26/17. -(3) FREE OF ACCIDENT SION/DEVICES ure that - ronment remains as free s as is possible; and eives adequate supervision es to prevent accidents. facility must attempt to use res prior to installing a side or ide rail is used, the facility nstallation, use, and rails, including but not limited ents. th for risk of entrapment o installation. and benefits of bed rails with not ro installation.	F 3(1/30/17	
	by: Based on record revi	iew, observation and		ADDRESS HOW CORRECTIVE	ACTION		

Facility ID: 923010

If continuation sheet Page 13 of 55

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	PLE CONSTRUCTION	(V2) DA	10. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	, <i>'</i>	G	· · ·	MPLETED	
			A DOILDIN	<u> </u>		C 01/26/2017	
		345140	B. WING		0		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
				610 WEST FISHER STREET			
	OOR NURSING CENTER			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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
F 323	Continued From page	e 13	F 3	23			
		terview, the facility failed to		(S) WILL BE ACCOMPLISHED	FOR		
		he van during transport		THOSE RESIDENTS FOUND T			
		cturer's recommendations		BEEN AFFECTED BY THE DEF	ICIENT		
	causing the resident	to fall for 1 (Resident #1) of		PRACTICE:			
	-	ho was transported using		The resident was evaluated by a			
		an. Resident #1 hit his left		registered nurse on January 19,			
	-	ring the fall resulting in		initiated first aid treatment to the			
		vas stopped after staff		which included assessment to e			
	applied a pressure dr	began on 1/19/17 when		bleeding had stopped and a new was applied. The resident who			
1		e van during transport and		and oriented denied any injuries			
		5/17 at 2:20 PM when the		Nurse Practitioner evaluated the			
		cceptable credible allegation		on January 19, 2017 and no inju			
		acility will remain out of		the fall were noted or injuries to			
	compliance at a scop	e and severity level of D (not		stump. The resident was discha	arged to		
	actual harm with pote	ential for more than minimal		the hospital on January 20, 201	7 for		
	staff members were i	ediate jeopardy) to ensure all n-serviced on the facility's		health issues unrelated to the fa	II.		
		on accidents/incidents and		ADDRESS HOW CORRECTIVE			
		ssessment, monitoring and		WILL BE ACCOMPLISHED FOR			
		lents/incidents. Findings		RESIDENTS HAVING POTENT	IAL TO		
	included:			BE AFFECTED BY THE SAME			
		nstructions for restraining the		DEFICIENT PRACTICE:			
	occupant in the van v instruction included h			There were no other residents a	ffected by		
	combination lap and			the alleged cited deficient practi	-		
		r caution " to always ensure		Incident reports were reviewed			
		is properly extended over		January 24, 2017 and again on			
		oss the upper torso of the		13, 2017 for the past three (3) m			
	occupant. "			the Administrator and Vice Pres			
		nitted to the facility on		Operations to determine if there			
	12/19/16 with multiple			been any other accidents/incide			
		se stage 4, chronic anemia,		involving the transportation of re			
	and bilateral above th			and there were no other residen	IS		
		e summary dated 12/19/16		affected.	otontial to		
	the knee amputation	nt #1 underwent left above		However, any resident has the p be affected therefore the following			
	The admission Minim			corrective actions have been pu	-		
			1		L II ILU	1	

Facility ID: 923010

If continuation sheet Page 14 of 55

		MEDICAID SERVICES				1	0. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE	SURVEY
	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDIN	NG _			
							С
		345140	B. WING			01/	26/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER	8			10 WEST FISHER STREET		
		•		S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI> TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIC DATE
F 323	Continued From page	- 14	Ea	323			
1 020			г с 	523	The Trenenertetion driver and Cartified		
		lerate cognitive impairment e assistance with transfers.			The Transportation driver and Certified	1	
	The assessment also			Nursing Assistant were re-educated January 24, 2017 by the Administrator	and		
	had no falls since adr				Vice President on the accident and	anu	
	assessment.				incident policy which states that a resid	lent	
	Resident #1's care pla	an dated 1/6/17 was			is not to be moved if there is an accide		
		care plan problems was the			while on the facility van, and that 911		
		or falls and fall related injury			should be called to make determination	n if	
		endent on the staff for			medical attention is required and		
	transfers due to bilate				transportation to the hospital is necess	ary.	
	amputation. The goal	was the resident will follow			The Transportation Driver also has		
	safety guidelines by ι			demonstrated competency to the			
	assistance with trans			Administrator and the Director of Facili	•		
		should any fall occur			Services of the physical restraint syste		
	through the next revie				on the van according to the manufactu	rer	
		vill be provided with all			specifications on January 24, 2017.		
		monitor for attempts to get			Any newly authorized drivers who		
		nair unassisted and therapy			transport residents are required to		
		r transfers as needed.			demonstrate comprehension and provi		
		t log for the last 3 months			documented evidence of proper use an	na	
	-	ember 2016 and January			competency of the physical restraint	-	
		Resident #1 was not listed			systems on the facility van according to		
	on the log as having a				manufacturer specifications (to be don when added to drivers list and annually		
		s notes dated 1/19/17 nt #1 had chronic anemia			thereafter) to the Regional Director of	y	
	and chronic kidney di				Facility Services and/or Vice President	tof	
		rologist and was awaiting a			Operations.		
		alysis and for iron infusion.			The Nursing staff to include Nurses an	d	
		s notes were reviewed. The			CNA s were in-serviced on January 2		
		at 3:02 PM indicated that on			27, 2017 and all staff were in-serviced		
	1/19/17 approximatel	y 12:30 PM Nurse #1			January 30, 2017 by the Director of		
		t #1) was called to the front			Nursing on transportation safety and th	ne	
		ess Resident #1 due to a fall			accident and incident policy to ensure		
	that occurred in the v	an following an appointment.			anyone who assists with transports is		
	The notes further indi	icated that Nurse #1 was			aware of the proper policy and procedu	ure	
	informed that the resi	-			which includes proper securing and		
	-	the front of the chair and			attachment of the restraints system.		
		driver to stay in his seat.					
	The resident was nor	- compliant and did not	1		The facility will continue to ensure safe		1

Facility ID: 923010

If continuation sheet Page 15 of 55

		MEDICAID SERVICES			OMB NO. 093		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION IG	(X3) DATE SURVE COMPLETED		
			5.11/11/0		С		
		345140	B. WING		01/26/20	17	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE		
BRIGHTM	OOR NURSING CENTER	1		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 ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE COM D THE APPROPRIATE	(X5) PLETIC DATE	
F 323	Continued From page	e 15	F 32	23			
		d when the van was parked		transport and driver train	ing provided		
		, the resident fell on the		includes:			
	-	ling was noted from the left		1. Proper procedure fo	r securing		
		e #1 observed Resident #1		resident in safety restrair			
		appeared " out of it and		transportation van;			
	had a flat affect. " Th	he notes indicated that the		2. Competency evaluat			
		I when pressure was applied		employment, annually ar	-		
		and the treatment nurse		3. What to do in the ev			
		I the left amputated leg.		mechanical breakdown o			
		ted 1/20/17 at 12:03 AM		4. What to do in the ev			
		nt #1 was referred and was		and resident safety durin	-		
		n provider group on 1/19/17 sputum and post fall from		5. Who to report an inc to report to the administra			
		van during transport. New		This training will be comp			
		or chest x-ray and complete		quarterly basis for one (1			
	blood count (CBC).			by the Regional Director			
		s a doctor's order to send		Services and/or Vice Pre	-		
	Resident #1 to the ho			Operations and documer	nted on the		
	hemoglobin/hematoci			In-service Summary Forr			
	The nurse's notes dat	ted 1/22/17 at 6:37 AM		will be conducted on an a	annual basis		
	indicated that Reside	nt #1 was discharged to the		and/or as new transporta	tion employees		
	hospital on 1/20/17.			are hired.			
		s notes at the hospital dated		The Administrator will en			
		ed. The principal diagnoses		reviews of driver records			
		GI) hemorrhage and the		drivers by contacting the			
		e anemia of chronic renal		company for the facility to results of the drivers che			
	transfuse 2 units of pa	orrhage. The plan was to		information will be mainta			
	(PRBC).			the administrator s office			
	. ,	M, the Director of Nursing		The facility will visibly co			
		ed. The DON indicated that		assurance checks to ens			
		of the accident in the van		are fastening restraints a			
	involving Resident #1	on 1/19/17. She stated that		safely and document the			
	the resident's name w			quality assurance checks			
	accident/incident log	because Nurse #1 has not		This will be done for the	next twenty (20)		
		nt report yet. She added that		transports per the facility	-		
	-	g early that night (1/24/17) to		transport will be inspecte			
		report and to provide a		the facility and upon retu			
	written statement reg	arding the accident with		by the Administrator or D	ON to ensure the		

Facility ID: 923010

		MEDICAID SERVICES				IO. 0938-03	
		(X1) PROVIDER/SUPPLIER/CLIA	· ,	LE CONSTRUCTION	· · ·		
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	IPLETED	
						С	
		345140	B. WING		0 [,]	1/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
PDICUTM	OOR NURSING CENTER			610 WEST FISHER STREET			
	OOR NORSING CENTER			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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE	
F 323	Continued From page	<u>- 16</u>	F 32	2			
1 020	10		F 52		in the yen		
		ON indicated that Resident al on 1/19/17 to have an		resident is properly secured and seat belt is properly atta			
	-	es for iron infusion. She		locked in place. If any issue			
		ident happened on the way		with the proper securing of t			
		d she had obtained written		while being transported, the			
	statements from the c			not be allowed to transport a			
		o accompanied the resident		residents and will receive di	•		
		The DON was not able to		action up to and to include to			
		rom Resident #1. She		employment			
	•	know the cause as to why		In addition to the facilities	internal OA		
		g transport but she and the		process the following extern			
		tten their investigation time		be implemented. To ensure			
	line after the accident	-		maintains implemented corr	-		
		 e line was reviewed. The		to achieve and sustain the n			
	-	al the root cause of the		program to ensure complian			
	resident's fall. The tir			Regional Director of Facility			
		The Administrator was		conduct an unannounced or			
		come outside the facility to		resident at the transportation			
		A #1 standing in front of		or origination (other than the			
		holding the resident's stump		visually ensure the van drive			
		/hen she questioned what		facility policies in proper app			
	-	old that the resident had		restraint system. The Regio			
		he fell out of his chair onto		Facility Services will conduc			
		istrator immediately went		visual audit once monthly fo			
	inside and got Nurse	#1 and NA #2. They		months, quarterly for an add			
		t cart and they cleaned him		months. The Regional Dire	ctor of Facility		
		nside the facility. Nurse #1		Services will report the finding	ngs to the VP		
	informed her the resid	dent was okay and for her to		of Operations. The VP of O			
		report and to get statements		take any necessary actions	· •		
		A #1 and to make sure that		employee disciplinary action			
	the information were	•		termination) if failure to adhe			
		- The DON informed Nurse		resident van transportation			
		ocumentation of the incident		resident safety is documente			
		ents were obtained to		unannounced onsite audits	•		
		report and to notify the		Regional Director of Facility			
		k with her. The DON also		ADDRESS WHAT MEASUR			
		urse Practitioner) to see		PUT INTO PLACE OR SYS			
	Resident #1.			CHANGES MADE TO ENSU	JRE THAT		
		The DON informed the		THE DEFICIENT PRACTIC			

Facility ID: 923010

If continuation sheet Page 17 of 55

		MEDICAID SERVICES					D. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE COMF	SURVEY
						С	
		345140	B. WING	B. WING		01/	26/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER			6	10 WEST FISHER STREET		
BINGIIIM	CON NORONO CENTER			S	SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIJ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 323	Continued From page	e 17	F	323			
	resident's family of the			020	OCCUR:		
		The DON called Nurse #1			The Transportation driver and Certified	4	
	and inquired regardin				Nursing Assistant were re-educated	А	
		The family of Resident #1			January 24, 2017 by the Administrator	and	
		up to visit a family member.			Vice President on the accident and	anu	
	-	The NP called and ordered			incident policy which states that a resid	dent	
		o the hospital to receive 2			is not to be moved if there is an accide		
		Blood Cell (PRBC). Around			while on the facility van, and that 911		
		resident returned to the			should be called to make determinatio	n if	
		ed to transfer him to the			medical attention is required and		
	hospital.				transportation to the hospital is necess	sarv.	
		- The DON reminded NA#1			The Transportation Driver also has	,) .	
		t of the incident. The driver			demonstrated competency to the		
		nt to the Administrator and			Administrator and the Director of Facil	itv	
	forwarded it to the DC	DN. The driver was			Services of the physical restraint syste	-	
	re-educated on the tra	ansportation policy and			on the van according to the manufactu		
	demonstrated compe				specifications on January 24, 2017.		
	restraint system acco	rding to the manufacturer by			Any newly authorized drivers who		
	the Vice President (V	P) of Operation.			transport residents are required to		
	1/23/17 at 2:00 PM -	The Nurse Manager called			demonstrate comprehension and prov	ide	
		the status of the resident.			documented evidence of proper use a	nd	
	· ·	at the resident was referred			competency of the physical restraint		
	to orthopedic to see h				systems on the facility van according t	0	
	1/24/17 at 1:00 PM - 1	The DON called Nurse #1			manufacturer specifications (to be don	e	
		she needed to complete			when added to drivers list and annuall	у	
	the incident report.				thereafter) to the Regional Director of		
		The DON requested NA #2			Facility Services and/or Vice Presiden	t of	
	-	e status of the resident's			Operations.		
	wounds (stump).				The Nursing staff to include Nurses an		
		n on the time line read " the			CNA s were in-serviced on January 2		
	action plan initiated 1				27, 2017 and all staff were in-serviced	on	
	transports per the fac				January 30, 2017 by the Director of		
		ected prior to leaving the			Nursing on transportation safety and the		
		rn to the facility by either the			accident and incident policy to ensure		
		OON to ensure that the			anyone who assists with transports is		
		ecured in the van and seat			aware of the proper policy and proced	ure	
		ed and locked in place. If			which includes proper securing and		
		with the proper securing of			attachment of the restraints system.		
	une resident while bei	ng transported, the van					1

Facility ID: 923010

If continuation sheet Page 18 of 55

			a				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	TE SURVEY MPLETED	
			A. BUILDING	3		C 01/26/2017	
		345140	B. WING				
		345140	B. WING				
NAME OF PH	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=		
BRIGHTM	OOR NURSING CENTER	2		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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE . DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 323	Continued From page	e 18	F 32	23			
		ved to transport future	1 02	The facility will continue to ens	sure safe		
		gs of the Administrator and		transport and driver training pr			
		rted to the QA Committee for		includes:			
		nendations to ensure the		1. Proper procedure for secu	urina		
		achieved and sustained. "		resident in safety restraints wh	•		
	The written statemen			transportation van;			
		nent from NA #1 was dated		2. Competency evaluations	upon		
	1/19/17 and read that	Resident #1 had been to		employment, annually and as			
		cedure and on the way back		3. What to do in the event of			
		messing with his seat/lap		mechanical breakdown of veh	-		
	• •	chair. When the driver had		4. What to do in the event of			
	to stop suddenly, he	slid himself out of his		and resident safety during eve	ent;		
	wheelchair and bump	ed his left stump while going		5. Who to report an incident	to and how		
		ne driver helped put him		to report to the administrator.			
	back into wheelchair.	Noticed the stump bleeding.		This training will be completed	l on a		
	Applied pressure to s	top the bleeding. Upon		quarterly basis for one (1) yea	r, conducted		
	returning to the buildi	ng, the wound care nurse		by the Regional Director of Fa	cility		
	came to the van. We	undressed the old		Services and/or Vice Presiden	nt of		
	bandage, cleaned an	d redressed the stump		Operations and documented of	on the		
	according to wound c	are direction. Assisted		In-service Summary Form. Th	ne training		
		nd back into the building. "		will be conducted on an annua			
		t of the van driver dated		and/or as new transportation e	employees		
		' on January 19, 2017 I		are hired.			
		1 from the hospital around		The Administrator will ensure a			
		him back to the facility.		reviews of driver records for a			
	Resident #1 was bein	•		drivers by contacting the insur			
		k of the van which was		company for the facility to rece			
	strapped down front a			results of the drivers check. T			
		aps and was wearing his lap		information will be maintained	in a file in		
		k to the facility, I pressed the		the administrator s office.			
	break slightly harder			The facility will visibly conduct			
	•	avoid another vehicle that		assurance checks to ensure th			
	had pulled out in from			are fastening restraints approp	-		
		noise in the back of the van		safely and document the result			
		he back with the resident		quality assurance checks in th	-		
		nd she stated that he had		This will be done for the next t transports per the facility van,	• • •		
	LAUGO OUT OT DIE W/DOO				LUCIN OTOOR	1	
		Ichair. Immediately, I pulled e road and got in the back of		transport will be inspected price			

Facility ID: 923010

If continuation sheet Page 19 of 55

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVE	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	T
			A. DOILDING		с	
		345140	B. WING		01/26/20	17
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				610 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER			SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL F REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMP	X5) PLETIC ATE
F 323	Continued From page	1 0	F 32	23		
1 020	· · · · · · · · · · · · · · · · ·	sked him if he was hurt	F 32		onsuro tho	
		ted " no " but I did notice		by the Administrator or DON to resident is properly secured in		
		ling at the amputation site		and seat belt is properly attach		
		After I noticed that his leg		locked in place. If any issues a		
		NA #1 some wipes and she		with the proper securing of the		
		sure to the area. I then		while being transported, the val		
		he facility and reported the		not be allowed to transport any		
		to my administrator. At this		residents and will receive discip		
		nurse and the nurse on the		action up to and to include term	•	
		ind they unwrapped the		employment		
		n his leg and treated the		In addition to the facilities inte	ernal QA	
	area that was bleedin	ig and by then the bleeding		process the following external p	process will	
	stopped. The wound	was treated and		be implemented. To ensure the	e facility	
	re-bandaged. He did	state several more times		maintains implemented correct	ve actions	
		or injured during this time.		to achieve and sustain the nece	-	
		y apparent signs of pain. "		program to ensure compliance,		
		t of Nurse #1 dated 1/24/16		Regional Director of Facility Se		
		uary 19, 2017 I was working		conduct an unannounced onsit		
		n the west unit of our facility		resident at the transportation de		
		or asked NA #2 (treatment		or origination (other than the fa		
		sist a resident in the front of		visually ensure the van driver a		
	-	the front of the building with		facility policies in proper applica		
		van parked in the front		restraint system. The Regional		
	#1 in his wheelchair s	e doors open and Resident		Facility Services will conduct th visual audit once monthly for th		
		butside of the van and NA #1		months, quarterly for an additio		
	· ·	ng pressure to the resident's		months. The Regional Directo		
		s noted on the van floor,		Services will report the findings		
		well as on the bandages that		of Operations. The VP of Oper		
		e time of this incident. NA		take any necessary actions (inc		
	•	nd began taking off the dirty		employee disciplinary action up	-	
	bandages and instruc	U U U		termination) if failure to adhere		
		down the hall and brought		resident van transportation poli		
		the front of the building		resident safety is documented t		
		A #2 immediately treated		unannounced onsite audits by t	-	
		was happening, the resident		Regional Director of Facility Se		
		no expression on his face.		INDICATE HOW THE FACILITY		
	He did not appear to	be in pain or in any sign of		TO MONITOR ITS PERFORM	ANCE TO	
	distropp Upon the tr	eatment being finished, all	1	MAKE SURE THAT SOLUTION		

Facility ID: 923010

If continuation sheet Page 20 of 55

		MEDICAID SERVICES			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDIN	NG	
		345440	B. WING		С
		345140	B. WING		01/26/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
BRIGHTM	OOR NURSING CENTER	1		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
E 222	Continued From none	- 20			
F 323	Continued From page		F 3		
	•	write statements. At this		SUSTAINED. THE FACIL	
	-	t was not immediately		DEVELOP A PLAN FOR E	
		vaiting on the completion of		THAT CORRECTION IS A	
		ements. I would like to add		SYSTAINED. THE PLAN	
	•	dent, Resident #1 was smoking with his daughter. I		IMPLEMENTED AND THE ACTION EVALUATED FO	
		n to light his cigarette as he		EFFECTIVENESS. THE F	
		At this time I had a long		INTEGRATED INTO THE	
		h of them regarding his		ASSURANCE SYSTEM O	
		dvised that he should go to		FACILITY.	
		here were any changes in		The facility will visibly conc	duct quality
	his health or condition			assurance checks to ensu	
		that he could go to the		are fastening restraints ap	
		he would inform the staff		safely and document the re	
		to assist them in doing so		quality assurance checks i	
	at any time as I was v	-		This will be done for the ne	-
		hour shifts all weekend.		transports per the facility v	
	Both of them stated th	nat he did not need to go to		transport will be inspected	-
	the hospital as it was	not necessary in their		the facility and upon return	to the facility
	opinion at this time. "			by the Administrator or DO	N to ensure the
	An attempt was made	e to call Nurse #1, but she		resident is properly secure	d in the van
	did not return the call.			and seat belt is properly at	tached and
		N, NA #1 was interviewed.		locked in place. If any issu	
	She indicated that she	-		with the proper securing of	
		/17 to accompany Resident		while being transported, th	
	•	IV infusion. She was at the		not be allowed to transport	-
		he resident. NA #1 reported		residents and will receive of	
		confused that day. It was		action up to and to include	termination of
		Iriver was driving the van		employment	
	· · · · · ·	ne observed Resident #1		In addition to the facilities	
		the edge of the wheelchair		process the following exter	-
		n his lap belt. She reminded stop messing with his lap		be implemented. To ensur maintains implemented co	-
		e resident's hands on the		to achieve and sustain the	
		not see if the resident had		program to ensure complia	-
		not but she kept telling him		Regional Director of Facilit	
		lone. It was about 2 miles		conduct an unannounced	-
	-	when the driver had to		resident transportation des	
	quickly step on the br			origination other than the f	

Facility ID: 923010

If continuation sheet Page 21 of 55

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		O. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· /	G		IPLETED	
			A. BOILDING			с	
		345140	B. WING		0	1/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
				610 WEST FISHER STREET			
BRIGHTM	OOR NURSING CENTER	ł		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From page	- 21	F 00				
F 525	Continued From page		F 32		veo to all facility		
		esident #1 ended up kneeling the floor. The driver pulled		ensure van drivers adherer	-		
	· ·	•		policies in proper application			
		ed the resident and noted s bleeding through the		system, once monthly for the quarterly for an additional n			
	· ·	d pressure on the dressing		Findings of quality assuran			
		She and the driver lifted the		be documented in the quali			
		back in the wheelchair and		log. The Regional Director			
		to drive back to the facility.		Services will report the find	•		
		ont of the facility and called		of Operations. The VP of C	U		
	-	came out and assessed the		take any necessary actions			
		came out and changed the		employee disciplinary actio			
		ent's left stump. NA #1		termination) if failure to adh			
	-	e was instructed not to move		resident van transportation			
		cident until assessed by a		resident safety.	•		
		t have any choice, they had		The findings of the Adminis	trator and/or		
		eelchair in order to drive		DON will be reported to the	VP of		
	back to the facility. N	IA #1 also stated that the		Operations on a weekly bas	sis until all		
	driver should be the o	one to call the facility and		transports have been comp	leted. At		
	inform them about the	e accident. At 11:05 AM, NA		which time if the corrective	actions are not		
	#1 was again intervie	wed and she stated that she		being sustained, the plan w	vill be evaluated		
	could not remember i	if the shoulder strap was		and updated to ensure facil	lity is		
		to Resident #1 during the		maintaining compliance. T			
	transport on 1/19/17.			the Quality Assurance chec	•		
		AM, the van driver was		and externally and review b	•		
		ed that he had been driving		Operations will be presente			
		ears. He was trained by the		Committee monthly for follo			
	-	on transportation safety		recommendations to ensure			
		oper procedure in securing		action is achieved and sust	ained.		
		eelchair in the van before he					
	-	n. The van driver indicated					
		Resident #1 to the hospital sion. The hospital had					
		staff member to sit with the					
	· ·	fusion and so NA #1 went					
	-	ack to the hospital to pick up					
		the hospital was not able to					
		-					
		the resident It was about					
		o the resident. It was about he resident, secured his					

Facility ID: 923010

If continuation sheet Page 22 of 55

		MEDICAID SERVICES				O. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	E SURVEY IPLETED	
	CONNECTION	BENTI IGATION NUMBER.	A. BUILDING	3			
					С		
		345140	B. WING		0	/26/2017	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				610 WEST FISHER STREET			
BRIGHIM	OOR NURSING CENTER	L		SALISBURY, NC 28145			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETIO	
F 323	Continued From page	s 22	F 32	23			
. 020			1 52				
		ack to the facility. It was					
	-	om the facility, when a car					
	· ·	nim. He applied the break					
		normal and then he heard					
	-	ck of the van and saw the the floor. He pulled over					
		nt if he was okay and he					
		ne. His buttock was on the					
	· ·	ip was bleeding. With the					
		fted the resident and put him					
		r. NA #1 applied pressure					
		the bleeding. The van driver					
	stated that he could move a resident as long as						
		ng that he was okay. He					
	-	d not call the facility because					
	he was a mile away fi	-					
		AM, the facility transport van					
	was observed with th						
		an was equipped with a					
	shoulder strap and a						
	-	apply the shoulder strap					
		esident and on how to					
		r to the floor. He also					
		sident and NA #1 were					
		if the shoulder strap and the					
	-	to the resident he replied "I					
		e shoulder strap " because					
		nt would be fine with the NA					
	with him at the back of						
		AM, the Administrator was					
		ted that she was called to go					
		building to see a resident					
		of the van. She thought					
		the van was parked. She					
		t the resident fell on their					
		ty. She immediately called					
		he resident and to change					
		esident's left stump. The					

Facility ID: 923010

If continuation sheet Page 23 of 55

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I					FORM	D: 02/27/2017 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
	345140	B. WING				C / 26/2017
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTMOOR NURSING CENTER	1			310 WEST FISHER STREET SALISBURY, NC 28145		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
during the transport. written the driver up of the transportation safe resident during transp okay for the staff to m nurse or any qualified resident as long as th oriented and was able okay. The Administra did not expect the driv because they were a when the accident ha that the driver and NA transportation safety of properly securing the policy and procedure 1/23/17. She reveale monitoring tool to obs upon returning to faci ensure that the reside properly secured. Th the Administrator or th transport starting 1/25 The records of the va driver had signed the fleet policy and fleet of 1/13/15 which include required of all drivers company owned vehi operated on company also indicated that the transportation safety of instruction on how to the resident in the var On 1/25/17 at 2:10 Pt	oulder strap was not applied She indicated that she had on 1/25/17 for not following ety on properly securing the bort. She stated that it was nove the resident before a I person had assessed the eresident was alert and e to tell that he/she was ator also indicated that she ver to call the facility mile away from the facility ppened. She also indicated A#1 were reeducated on (video of manufacturer on resident) and the facility on accident and incident on et that she had created a serve the driver prior to and lity from appointments to ent and the wheelchair were e monitoring to be done by the DON on every other 5/17. In driver were reviewed. The facility's commercial auto driver's commitment on ed " seat belt utilization is and passengers in cles and in vehicles y business. " The records e driver was trained on using the manufacturer's secure the wheelchair and in on 3/21/16. M, the attending physician of rviewed. She stated that the r of the van accident	F	323			

Facility ID: 923010

If continuation sheet Page 24 of 55

							NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	· · ·	TE SURVEY MPLETED
			A. BUILDING				
		0.154.40			С		
		345140	B. WING -			0	1/26/2017
NAME OF PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
			610 \	WEST FISHER STREET			
			SAL	ISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	- <i>2</i> 4		323			
1 525				523			
		se Practitioner the day of the					
		the next day the resident was					
		ergency room due to low					
		rit level which was not					
		e also indicated that she					
		move the resident from the					
	assess the resident.	body from the facility to					
		M the Administrator and the					
		M, the Administrator and the					
		of Operation were informed					
		pardy. The facility provided					
	-	le allegation of compliance					
	indicated:	M. The credible allegation					
		lusted by a registered purse					
	on January 19, 2017	aluated by a registered nurse					
	treatment to the stum						
		e bleeding had stopped and					
		applied. The resident who					
		d denied any injuries. The					
		aluated the resident on					
		d no injuries from the fall					
	-	ident was discharged to the					
		20, 2017 for health issues					
		The nursing staff stated to					
		ig that the resident was					
		however the nurses notes					
		nitoring. The nurses who					
	should have docume						
		failing to document any falls					
	or events that occur.	. .					
		nuary 26, 2017 by the					
		include the following:					
	1. Timely assessme	-					
	-	on of incident/accident					
	reports;						
		idents using the Acute					
				1			
	Episode charting guid	delines					

Facility ID: 923010

If continuation sheet Page 25 of 55

		ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/27/2017 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345140	B. WING _				C 26/2017
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER	2		6	610 WEST FISHER STREET		
		-		5	SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 323	Continued From page	e 25	F:	323			
		ncerning any falls or events					
	For any nurse not in- be allowed to work un						
	completed with the D	2					
	2017 for the past thre Administrator and Vic determine if there has	e President of Operations to					
	residents and there w affected.	vere no other residents were					
	Assistant were re-edute the Administrator and	river and Certified Nursing ucated January 24, 2017 by I Vice President on the policy which states that a					
	resident is not to be r while on the facility va	noved if there is an accident an, and that 911 should be					
	is required and transpondent in the transpondent of transpondent of the transpondent of transpondent o	nination if medical attention portation to the hospital is Isportation Driver also has					
	the physical restraint	tency to the Administrator of systems on the van ufacturer specifications.					
	All staff will be in-served 2017 by the Administ	viced on today January 26, rator on transportation safety					
	anyone who assists w the proper policy and	incident policy to ensure with transports is aware of procedure which includes					
	any employee not in-	f the restraints system. For serviced today the employee work until the in-service is					
	completed with the A						
	All authorized employ transportation have b	yees who provide een trained; however, no					
	other employee will b	e allowed to drive the					

If continuation sheet Page 26 of 55

	F DEFICIENCIES	MEDICAID SERVICES	(X2) MI II TIP	LE CONSTRUCTION		IO. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	IPLETED
					С	
		345140	B. WING		0	1/26/2017
NAME OF PF	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE)E	
BRIGHTMOOR 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	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 323	Continued From page	e 26	F 32	3		
		til they have received the	1 52	5		
	in-service.					
	Any new authorized of	drivers who transport				
	residents are require					
	comprehension and p					
	· · ·	se and competency of the				
		tems on the facility van cturer specifications (to be				
	•	drivers list and annually				
		ninistrator or Director of				
	Nursing.					
	•	e safe driving training				
	provided includes pro	oper use of cell phones ,				
	what to do in the eve					
		e, what to do in the event of				
		dent safety during event.				
	-	include who to report an or report to the administrator.				
		e annual reviews of driver				
		ized drivers by contacting the				
		annually for driving record				
	review and negative	findings for authorized				
		negative findings will not be				
		pany vehicles or facility van.				
		be maintained in a file in the				
	administrator 's office	•••				
		r conduct quality assurance t drivers are fastening				
		ely and safely and document				
		lity assurance checks in the				
		done for the next twenty (20)				
	transports per the fac					
		ected prior to leaving the				
		rn to the facility by the				
		I to ensure the resident is				
		he van and seat belt is				
		d locked in place. If any the proper securing of the				

Facility ID: 923010

If continuation sheet Page 27 of 55

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTU	E CONSTRUCTION	(V2) DAT	O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	PLETED
					С	
		345140	B. WING		01	/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER			310 WEST FISHER STREET		
BIGOTTIM	CON NOROING 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 323	Continued From page	e 27	F 323			
	will not be allowed to					
	residents and will rec	eive disciplinary action up to				
	and to include termina	1 2				
		n of compliance was verified				
		A by interviewing the staff er that they have received				
		ity's accident/incident policy				
		in-service records were				
		ervice on accident/incident				
	policy and procedure	was started on 1/26/17.				
		s for the van driver was				
	reviewed and he was					
		and in properly securing the port on 1/23/17 by the VP of				
	Operation. He also w					
	•	ion on how to properly				
		The monitoring tool was also				
		ninistrator had observed the				
		on return from appointments				
	to ensure that the drive the the resident.	ver was properly securing				
F 356 SS=C		TED NURSE STAFFING	F 356			2/21/17
	483.35					
	(g) Nurse Staffing Info	ormation				
	(1) Data requirement the following informat	ts. The facility must post ion on a daily basis:				
	(i) Facility name.					
	(ii) The current date.					
	(iii) The total number by the following cates	and the actual hours worked				
		aff directly responsible for				
				1		1

Facility ID: 923010

If continuation sheet Page 28 of 55

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345140	B. WING			C 01/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIGHTM	OOR NURSING CENTER	1			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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 356	 (C) Certified nurse aid (iv) Resident census. (2) Posting requirement (i) The facility must post of specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readable (B) In a prominent plateresidents and visitors (3) Public access to perform the facility must, upor make nurse staffing data for a min required by State law This REQUIREMENT by: Based on observatio review, the facility fail Registered Nurse (LPN 	s. I nurses or licensed defined under State law) des. ents. ents. bs the nurse staffing data in (g)(1) of this section on a inning of each shift. ed as follows: le format. uce readily accessible to bosted nurse staffing data. n oral or written request, lata available to the public of to exceed the community tion requirements. The the posted daily nurse imum of 18 months, or as , whichever is greater. i is not met as evidenced n, staff interview and record ed to separate out the actual N) and the Licensed) hours on the daily staffing	F	356	ADDRESS HOW CORRECTIVE ACT (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAV BEEN AFFECTED BY THE DEFICIEN	Έ	
	Based on observatio review, the facility fail Registered Nurse (RN Practical Nurse (LPN	ed to separate out the actual N) and the Licensed			(S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAV	Έ	

Facility ID: 923010

If continuation sheet Page 29 of 55

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	3	COMPLETED	
					С	
	345140		B. WING		01/26/2017	
NAME OF P	IAME OF PROVIDER OR SUPPLIER BRIGHTMOOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM				610 WEST FISHER STREET		
	1			SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLE	
F 356	Continued From page	e 29	F 35	56		
	extended survey. Fir	ndings included:		The Nurse Staffing Information Re	eport is	
	In an observation on	1/26/17 at 9:20 AM, the daily		posted on a daily basis. The form	contains	
		osted indicated there were		the facility name, the current date		
		on each of the first shift,		total number and the actual hours		
	second and third shif			by the following categories of licer	ised and	
		ew on 1/26/17, staff hour d from 1/13/17 to 1/26/17		unlicensed nursing staff directly responsible for resident care per s	bift [.]	
		ated each day two licensed		Registered Nurses		
		e first, second and third shift.		Licensed Practical Nurses		
		ion on the daily staff hour		Certified Nurse Aides		
	sheet if the nurses w	orking were RN ' s or LPN '		Resident Census		
	S.					
		26/17 at 9:26 AM, the RN				
	-	is her responsibility to affing sheets. The RN		WILL BE ACCOMPLISHED FOR RESIDENTS HAVING POTENTIA		
		ector of Nursing stated they		BE AFFECTED BY THE SAME		
		he sheet had to differentiate		DEFICIENT PRACTICE:		
		or LPN 's because they had		The Nurse Staffing Information Re	eport is	
		e staff hour sheet for years.		posted on a daily basis. The form		
		27/17 at 9:50 AM, the		the facility name, the current date,		
		lent stated the RN Manager		total number and the actual hours		
	-	ect form and should have		by the following categories of licer	ised and	
	•	at differentiated between the s. She stated it was her		unlicensed nursing staff directly responsible for resident care per s	bift.	
		ect form be used to properly		Registered Nurses		
	reflect the staffing in			Licensed Practical Nurses		
		-		Certified Nurse Aides		
				Resident Census		
				The Nurse Manager scheduled M		
				Friday is responsible for posting the		
				Staffing Information form on the boord in the Administrative hallwa		
				morning. The Registered Nurse w	-	
				on the weekends is responsible for		
				posting the form on Saturday and		
				The Administrative Manager on D		
				the weekends is responsible to en		
				while they are in the facility the co		
			1	form is posted and in the proper p	ana	

Facility ID: 923010

If continuation sheet Page 30 of 55

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140		B. WING		C 01/26/2017
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE	· · · · · · · · · · · · · · · · · · ·
BRIGHTM	OOR NURSING CENTER	1		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 CORRECTIV CROSS-REFERENCE	AN OF CORRECTION (X5) E ACTION SHOULD BE COMPLETION D TO THE APPROPRIATE DATE CIENCY)
F 356	Continued From page	≥ 30	F 3	56 ADDRESS WHAT ME PUT INTO PLACE OF CHANGES MADE TO THE DEFICIENT PRA OCCUR: The approved Nursing which meets regulator implemented by the D and the Nurse Manage responsibility of the DO to ensure it is utilized. Nurse on duty on the of responsible for posting Saturday and Sunday. Manager on Duty for the ensure while they are correct form is posted place. INDICATE HOW THE TO MONITOR ITS PE MAKE SURE THAT SO SUSTAINED. THE F/ DEVELOP A PLAN FO THAT CORRECTION SYSTAINED. THE F/ DEVELOP A PLAN FO THAT CORRECTION SYSTAINED. THE PL IMPLEMENTED AND ACTION EVALUATED EFFECTIVENESS. TI INTEGRATED INTO T ASSURANCE SYSTE FACILITY. The Director of Nursin Administrator will verif form is posted in the p Friday by utilizing a O form to initial that they form for accuracy for t The Administrative Ma utilize their Quality Ass	R SYSTEMIC ENSURE THAT CTICE WILL NOT Information Form y compliance was irector of Nursing er. It is the DN/Nurse Manager The Registered weekends is g the form on The Administrative he weekends is to in the facility the and in the proper FACILITY PLANS RFORMANCE TO DLUTIONS ARE ACIITY MUST DR ENSURING IS ACHIEVED AND AN MUST BE THE CORRECTIVE FOR ITS HE POC IS 'HE QUALITY' M OF THE g and/or the y that the approved roper place Monday Quality Assurance have reviewed the hree (3) months. inager on Duty will

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 31 of 55

	-	ID HUMAN SERVICES			FORM	D: 02/27/20 MAPPROVE D. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C	
	345140		B. WING			26/2017
NAME OF PROVIDER OR SUPPLIER		•	S	REET ADDRESS, CITY, STATE, ZIP CODE	• •	
BRIGHTM	OOR NURSING CENTER	R		10 WEST FISHER STREET ALISBURY, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 356	Continued From page	e 31	F 356	Form to indicate they have reviewed form for accuracy on the weekends (Saturday and Sunday). The QA for be reviewed by the Administrator or Mondays for compliance. Any occur of this form not being utilized or pos will result in re-training and possible disciplinary action. The Quality Asso forms will be presented by the administrator to the QAA Committee will review and make recommendat ensure compliance is achieved and been sustained.	ms will rrence ted urance e who ions to	
F 490 SS=J	483.70 Administration A facility must be adm enables it to use its re efficiently to attain or practicable physical, well-being of each re This REQUIREMENT by:	ninistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. T is not met as evidenced	F 490			1/30/17
	a resident in the trans fall with a bleed on the pressure dressing. T failed to enforce a po communication with I assessment from lice incidences within the the resident fell in the the resident back into	terview, the facility's to operationalize mmendations for transporting sportation van resulting in a le left leg stump needing a 'he facility administration licy that would address		ADDRESS HOW CORRECTIVE AG (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO H BEEN AFFECTED BY THE DEFICI PRACTICE: The Administrator will ensure the fa attaining and maintaining the highes practicable physical, mental, and psychosocial well being of each res The Vice President of Operations has conducted in-service education to th Administrator concerning requirement following and implementing facility policies. This also included adhered	R IAVE ENT cility is st ident. as ne ent of	

Facility ID: 923010

If continuation sheet Page 32 of 55

			()(0)			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		C	
		345140	B. WING		01/26/2017	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP C		
				610 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTER	R		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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLET THE APPROPRIATE DATE	
F 490	Continued From page	a 32	F 49			
1 430			F 490			
		ential injury. This was it #1) of 1 sampled resident		the operational manufactur recommendations for the fa		
		using the nursing home's		transportation van. This in-		
	van.			completed on January 24, 2		
		began on 1/19/17 when		result the Administrator has		
		e van during transport. The		the facility has adhered to a		
		back into the wheelchair and		manufacturer s recommer		
	-	e facility without assessment		transporting a resident in th		
		he immediate jeopardy was		transportation van by cond		
		at 2:20 PM when the facility		in-services and quality ass		
		ble credible allegation of		of the van driver when tran		
	compliance. The facil	lity will remain out of		resident.		
	compliance at a scop	e and severity level of D (not		The Transportation driver a	and Certified	
		ential for more than minimal		Nursing Assistant were re-		
		ediate jeopardy) to ensure all		January 24, 2017 by the Ad		
		n-serviced on the facility's		Vice President on the accid		
		on accidents/incidents and		incident policy which states		
		ssessment, monitoring and		is not to be moved if there		
		dents/incidents. Findings		while on the facility van, an		
	included:	- ·		should be called to make d		
	This example was a c			medical attention is require		
		ord review, observation and		transportation to the hospit		
		terview, the facility failed to		The Transportation Driver a		
		he van during transport cturer's recommendations		demonstrated competency Administrator and the Direct		
	-	to fall for 1 (Resident #1) of		Services of the physical res		
		ho was transported using		on the van according to the		
		an. Resident #1 hit his left		specifications on January 2		
	U U	ring the fall resulting in		The Nursing staff to include		
	-	vas stopped after staff		CNA s were in-serviced of		
	applied a pressure dr			27, 2017 and all staff were	-	
		AM, the Administrator was		January 30, 2017 by the Di		
		ted that she started working		Nursing on transportation s		
		nistrator in May 2016. The		accident and incident policy	-	
	-	that she was not informed by		anyone who assists with tra		
		e resident was not secured		aware of the proper policy	and procedure	
	with a shoulder strap	during the transport. She		which includes proper secu	Iring and	
		e van driver might have not		attachment of the restraints	-	
	used the shoulder str			The facility will visibly cond		

Facility ID: 923010

If continuation sheet Page 33 of 55

		MEDICAID SERVICES				<u>). 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· /	E SURVEY PLETED
					С	
	345140		B. WING		01	/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTMOOR NURSING CENTER			610 WEST FISHER STREET SALISBURY, NC 28145			
00015		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRE	CTION	(175)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 490	Continued From page	e 33	F 49	00		
	uncomfortable for the			assurance checks to ensure that	drivers	
		ord review, observation and		are fastening restraints appropria		
		terview, the facility failed to		safely and document the results	•	
		ute assessment of Resident		quality assurance checks in the 0		
	#1 who fell from a wh			This will be done for the next twe		
	transportation. The r	esident hit his left stump on		transports per the facility van, ev	ery other	
	the floor during the fa	Ill resulting in active		transport will be inspected prior t	o leaving	
	bleeding. Staff repos	sitioned the resident back		the facility and upon return to the	facility	
	into the wheelchair a	nd continued the transport to		by the Administrator or DON to e	nsure the	
	the facility. Following	initial treatment to the		resident is properly secured in th	e van	
		evidence that the resident		and seat belt is properly attached		
		he fall. This problem		locked in place. If any issues are		
	-	nt #1) of one sampled		with the proper securing of the re		
		nsported using the nursing		while being transported, the van		
	home's van.			not be allowed to transport any fu		
		M, the Director of Nursing		residents and will receive discipli	•	
		ed. She stated that the		action up to and to include termin	lation of	
		sting with the electronic added that Resident #1 was		employment ADDRESS HOW CORRECTIVE		
		ses after the fall but the		WILL BE ACCOMPLISHED FOR		
		ment the monitoring in the		RESIDENTS HAVING POTENTI		
	resident's medical re	0		BE AFFECTED BY THE SAME		
		AM, the Administrator was		DEFICIENT PRACTICE:		
		ted that she started working		The Administrator will ensure the	facility is	
		nistrator in May 2016. The		attaining and maintaining the hig	•	
	-	that she did not expect the		practicable physical, mental, and		
		facility to inform about the		psychosocial well being of each i		
	van accident because	e they were a mile away from		The Vice President of Operations		
	the facility. She also	indicated that it was okay for		conducted in-service education to		
	the staff to put the re-			Administrator concerning require	ment of	
		all because the resident was		following and implementing facilit		
		d he was able to tell that he		policies. This also included adhe	erence to	
	was okay.			the operational manufacturer s		
		M, the Administrator and the		recommendations for the facilitie		
		of Operation were informed		transportation van. This in-service		
		pardy. The facility provided		completed on January 24, 2017.		
		le allegation of compliance		result the Administrator has ensu		
	on 1/26/16 at 2:20 Pt indicated:	M. The credible allegation		the facility has adhered to operat manufacturer s recommendation		
	Lindiootod:		1	manutacturor le recommondation	ne tor	1

Facility ID: 923010

If continuation sheet Page 34 of 55

(X3) DATE SU COMPLE	
01/26	/2017
DN D BE (PRIATE	(X5) COMPLETIO DATE
ecks a ed or and sident dent 1 tion if essary. cility stems cturer and 26- ed on the re s edure	
log. (20)	
other	
	tems turer and 26- ed on the e s dure / rers and ne og. (20)

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 35 of 55

D HUMAN SERVICES /IEDICAID SERVICES			PRINTED: 02/27/20 FORM APPROV OMB NO. 0938-03
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
345140	B. WING		C 01/26/2017
		STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTMOOR NURSING CENTER		610 WEST FISHER STREET SALISBURY. NC 28145	
TEMENT OF DEFICIENCIES ' 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)	OULD BE COMPLETIC
35 mpleted on January 24, employee records for the to ensure training has been sportation and ites. ommittee minutes to ensure ng issues identified at the I of the Accident/Incident urteen (14) days, then 15% d then 5% for seven (7) here are no issues the rts will be reviewed on an the was initiated on January curs the Administrator or required to report to the rations and incident will be irrect protocol is being f Operations determines achieved and sustained it the Vice President of ate or arrange education for fter re-education is ance is not sustained then be taken. /or Director of Nursing and rations initiated the above ary 24, 2017 and will the interventions as they in was verified on 1/26/17 at ng the staff including the	F 45		Insure the le van d and le found e found e found esident driver will uture inary nation of WILL BE IC THAT LL NOT o to d provide use and aint ding to be done nnually tor of sident of e safe rided ng e in the on cessary;
	AEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345140 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 35 mpleted on January 24, mployee records for the to ensure training has been sportation and ies. ommittee minutes to ensure ing issues identified at the I of the Accident/Incident urteen (14) days, then 15% I then 5% for seven (7) here are no issues the rts will be reviewed on an th was initiated on January urs the Administrator or required to report to the rations and incident will be rrect protocol is being f Operations determines achieved and sustained it the Vice President of ate or arrange education for fer re-education is ance is not sustained then be taken. /or Director of Nursing and rations initiated the above ary 24, 2017 and will he interventions as they n was verified on 1/26/17 at	AEDICAID SERVICES (X2) MULTIR (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIR 345140 B. WING	AEDICAID SERVICES (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER: (P2) MULTIPLE CONSTRUCTION A BUILDING 345140 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145 TEMENT OF DEFICIENCIES (INUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH (CHANGES MADE TO DON TO BE (EACH CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH (CHANGES MADE TO ENSURE THE DEFICIENT PRACTICE WI (OCC UR: Any newly authorized drivers wh transport residents are required 1 demonstrate comprehension and documented evidence of proper competency of the physical restri systems on the facility van accor manufacturer specifications (to D when added to drivers list and ar thereafter) to the Regional Direct Facility Services and/or Vice Pre Operations. The facility will continue to ensurt transport and driver training prov includes: 1. Proper procedure for securi resident in safety restraints while transportation van; 2. Competency evaluations up employment, annually and as ne 3. What to do in the event of a (A What to do in the event of a (A Wha

Facility ID: 923010
	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	D: 02/27/2017 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED
		345140	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIGHTM	OOR NURSING CENTER	2		61	10 WEST FISHER STREET		
				S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	and the in-service on procedure was starter records for the van dr was re-educated on t in properly securing to on 1/23/17 by the VP driver also watched a instruction on how to The monitoring tool w administrator had obs	accident/incident policy and d on 1/26/17. The in-service river was reviewed and he he transportation safety and he resident during transport of Operation. The van video of the manufacturer's properly secure the resident. vas also reviewed and the served the driver prior to and ointments to ensure that the	F	490	5. Who to report an incident to and to report to the administrator. This training will be completed on a quarterly basis for one (1) year, conduby the Regional Director of Facility Services and/or Vice President of Operations and documented on the In-service Summary Form. The traini will be conducted on an annual basis and/or as new transportation employed are hired. In addition to the facilities internal Q process the following external process be implemented. To ensure the facilities be implemented. To ensure the facilities be implemented. To ensure the facilities conduct an unannounced onsite audit resident at the transportation destinat or origination (other than the facility) to visually ensure the van driver adheres all facility policies in proper application restraint system. The Regional Director of Facility Services will conduct this onsities will ensure the findings to the of Operations. The VP of Operations take any necessary actions (including employee disciplinary action up to termination) if failure to adhere to facility Services. If an incident/accident occurs the Administrator and/or Director of Nursi	ucted ng ees A s will ions will of a ion o s to n of tor of te licility VP will lities nd	

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 37 of 55

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345140	B. WING		01/26/2017
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 490	Continued From page	2.37	F 49		ality he VP of ality esponsible the facility are hs will be records for sure the dent minutes to i ssues ee. e Nurse n audit of by the ekly for e (3) r if facility ented al Quality
				the VP of Operations. After re VP of Operations will take any r actions (including employee dis	necessary

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 38 of 55

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02/27/2013 FORM APPROVED OMB NO. 0938-0391
-	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345140	B. WING		01/26/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTM	OOR NURSING CENTER			610 WEST FISHER STREET	
BRIGHTIN				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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 490	Continued From page	2.38	F 49	 action up to termination) if failu adhere to facilities assessme resident safety policies is noted if the Vice President of Operati determines that compliance is in achieved and sustained it is the responsibility of the Vice Presid Operations to re-educate or arr education for the Administrator Director of Nursing. After re-educed completed and compliance is in sustained then disciplinary acti- taken. INDICATE HOW THE FACILIT TO MONITOR ITS PERFORM, MAKE SURE THAT SOLUTION SUSTAINED. THE FACILIT M DEVELOP A PLAN FOR ENSU THAT CORRECTION IS ACHIE SYSTAINED. THE PLAN MUS IMPLEMENTED AND THE CO ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC INTEGRATED INTO THE QUA ASSURANCE SYSTEM OF TH FACILITY. The facility will visibly conduct of assurance checks to ensure th are fastening restraints approp safely and document the result quality assurance checks in the This will be done for the next tw transports per the facility van, of transport will be inspected prior the facility and upon return to th by the Administrator or DON to resident is properly secured in and seat belt is properly attach 	nt and d. ons not e dent of range and/or ducation is not on will be Y PLANS ANCE TO NS ARE MUST JRING EVED AND ST BE RRECTIVE S IS LLITY HE quality at drivers riately and s of the e QA log. venty (20) every other r to leaving he facility ensure the the van

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 39 of 55

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/27/2017 MAPPROVED D. 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/26/2017	
		345140	B. WING				
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	
PRICUTM				610 WEST FISHER STREET			
DRIGHTIM	OOR NURSING CENTER			S	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490	Continued From page	2.39	F	490	locked in place. If any issues are four with the proper securing of the reside while being transported, the van drive not be allowed to transport any future residents and will receive disciplinary action up to and to include termination employment In addition to the facilities internal Q process the following external process be implemented. To ensure the facilit maintains implemented corrective act to achieve and sustain the necessary program to ensure compliance, the Regional Director of Facility Services conduct an unannounced onsite audit resident at the transportation destinat or origination (other than the facility) t visually ensure the van driver adheres all facility policies in proper application restraint system. The Regional Direct Facility Services will conduct this onsi visual audit once monthly for three months, quarterly for an additional nin months. The Regional Director of Fa Services will report the findings to the of Operations. The VP of Operations take any necessary actions (including employee disciplinary action up to termination) if failure to adhere to faci resident van transportation policies ar resident safety is documented througi unannounced onsite audits by the Regional Director of Facility Services. The Vice President of Operations will responsible to: 3. Review all new employee record the next three (3) months to ensure training has been completed on the	nt r will n of A s will y ions will c of a ion o s to n of tor of te hcility VP will lities nd h	
					transportation and accident/incident		

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 40 of 55

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORI	D: 02/27/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	COM	E SURVEY PLETED
		345140	B. WIN	G			C / 26/2017
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1	
BRIGHTM	OOR NURSING CENTER	2			10 WEST FISHER STREET		
		-		S	ALISBURY, NC 28145		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 490 F 520 SS=J	483.75(g)(1)(i)-(iii)(2)	(i)(ii)(h)(i) QAA ERS/MEET		F 490	 policies. 4. Review the QA Committee minutensure the facility is addressing issue identified at the Safety Committee. The Regional Quality Assurance Nurse will be responsible to conduct an audithe medical records to include: 6. Nurses notes; 7. Acute Condition Report; 8. Incident Report; 9. Care Plan; 10. Quality Assurance Checks by the Director of Nursing This audit will be completed weekly for one (1) month, monthly for three (3) months, and quarterly for one (1) year facility is found compliant with implemented corrective actions. The Regional Quality Assurance Nurse wireport the findings to the VP of Operations. After review the VP of Operations will take any necessary actions (including employee disciplinat action up to termination) if failure to adhere to facilities□ assessment and resident safety policies is noted. The findings of the Quality Assurance checks internally and externally and review by the VP of Operations will be presented to the QAA Committee Mo for follow up and recommendations to ensure the corrective action is achiev and sustained. 	es se it of or r if II ary e nthly	1/30/17
	(g) Quality assessme	ent and assurance.					
ORM CMS-256	7(02-99) Previous Versions Ob	solete Event I	D: SM2X11	Fac	cility ID: 923010 If conti	nuation shee	t Page 41 o

If continuation sheet Page 41 of 55

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	
		345140	B. WING				C 26/2017
NAME OF P	ROVIDER OR SUPPLIER	1		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
BDICUTM				6	10 WEST FISHER STREET		
BRIGHTIW	OOR NORSING CENTER			S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 520	Continued From page	9 41	F	520			
	(i) The director of nur	sing services;					
	 (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the 	tor or his/her designee;					
	staff, at least one of wadministrator, owner,	vho must be the a board member or other					
			bers of the facility's st be the d member or other e; and nt and assurance d as needed to vities such as				
	coordinate and evalua identifying issues with assessment and assu	ate activities such as n respect to which quality					
	(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.						
	(i) Sanctions. Good fa committee to identify deficiencies will not b sanctions. This REQUIREMENT by:	and correct quality					

If continuation sheet Page 42 of 55

	OF DEFICIENCIES	MEDICAID SERVICES				MB NO. 0938- (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(.	COMPLETED
			A. BUILDING			С
		345140	B. WING			01/26/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS,	CITY, STATE, ZIP CODE	01/20/2011
				610 WEST FISHER	STREET	
BRIGHTM	OOR NURSING CENTER	2		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	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5 COMPLE E DAT
F 520	Continued From page	. 40	F F			
F 520	Continued From page		F 52			
	Based on record revi	-			HOW CORRECTIVE ACTIO	NN
		terview, the facility's Quality urance (QAA) committee			ACCOMPLISHED FOR SIDENTS FOUND TO HAVE	.
	failed to maintain imp			CTED BY THE DEFICIENT		
	failed to monitor the in		PRACTICE			
	following the 8/14/15			currently has and maintains a	a	
	surveys. The facility			ssment and assurance	-	
		he recertification surveys of			Added to the responsibilities	5
	8/4/15 and 8/14/16 ar	nd on a complaint		of the QA co	mmittee will be the following	g:
		of 1/26/17. The continued			n was re-educated on Janua	iry
		uring the three federal			the Administrator and Vice	
	surveys of record sho			Operations that any accider	nt,	
	facility's inability to su			ow minor, occurring while	h	
	program.	began on 1/19/17 when			sident in the van and properl d securing the vehicle restrai	-
	Resident #1 fell in the			ng actual transport and durin		
		6/17 at 2:20 PM when the		-	the restraint system and	
		cceptable credible allegation		-	g of the resident from the va	n
		acility will remain out of			ported immediately by phone	
		e and severity level of D (not			to the administrator. In the	
	actual harm with pote	ential for more than minimal		absence of t	he Administrator or inability	of
		ediate jeopardy) to ensure all			administrator, the van driver	r
		n-serviced on the facility 's			the incident verbally to the	
		on accidents/incidents and			lursing. If unable to reach th	ne
	-	ssessment, monitoring and			lursing the Van Driver must	
	reporting of any accid included:	lents/incidents. Findings			report the incident to the Vid Operations. He has also	ue
					cated on not moving the	
	This tag is cross refe	rred to:			I the resident has received	
					ssment and care.	
	F323 - Accidents - Ba	ased on record review,			w Van Driver or anyone else	
		sician and staff interview, the			a resident will be educated	
		e a resident in the van			efore being allowed to	
		rding to manufacturer's		transport a re		
		using the resident to fall for			ility administrator will review	
		ampled resident who was			cident/Incident reports daily	for
	transported using the	-			ventions for all incident and	
		ft stump on the floor during			nd will report to the QA any interventions not properl	
	the fall resulting in ac		1	I ammittae a	any interventions not properly	

Facility ID: 923010

If continuation sheet Page 43 of 55

						<u>IO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · · ·	TE SURVEY MPLETED
			A. BUILDING	<u> </u>		
		345140	B WING			C
		545140		STREET ADDRESS, CITY, STATE, ZIP COD		1/26/2017
NAME OF P	ROVIDER OR SUPPLIER				E	
BRIGHTM	OOR NURSING CENTER	2		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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 520	Continued From page	e 43	F 52	20		
		plied a pressure dressing.		taken by staff at time of the in	cident.	
		tion survey of 8/14/15 and		(4) Staff will be re-in serviced		
	-	s cited F323 for not securing		immediately by the Administra		
	the side rails to the b	ed frames.		of Nursing/Vice President of C		
	On 1/25/17 at 4:53 P	M, the Administrator was		on the interventions that shou	ld have	
		ted that she started as		been taken.		
		acility in May 2016 and she		(5) The Administrator and/or		
		acility's quality assurance		Nursing will inspect every oth		
	(QA) committee. The			for the next twenty (20) transp		
		edical Director, Pharmacist, and herself. The committee		the van leaving the facility car upon returning to the facility c	-	
	-	he stated that she was		proper attachment of all vehic		
		vas a repeat tag but there		systems properly attached in		
		cident involving the van		van. After the first ten have b		
	except on 1/19/17.	5		inspected, the Administrator a		
	On 1/25/17 at 2:35 P	M, the Administrator and the		Director of Nursing will inspec	t four (4) per	
	· ·	e informed of the immediate		month for the next three (3) m		
		provided an acceptable		(3) per month for the following	, ,	
		compliance on 1/26/16 at		months and then two (2) per r		
		le allegation indicated:		thereafter. The inspections w		
		has and maintains a quality		on an inspection form and will		
		urance committee. Added to the QA committee will be		submitted to the Safety and C Assurance Committees.	uanty	
	the following:			(6) The Safety Committee wi	ll review the	
	-	as been re-educated by the		Van Log information listed und		
		e President of Operations		point (5) above to ensure com		
		matter how minor, occurring		safety regulations as recomm		
	-	ent in the van and properly		the manufacture of the van.	-	
		g the vehicle restraint		(7) Any deviation from the		
	system, during actual			manufacturer⊡s procedures f		
	un-securing the restra			securing the chair and resider		
		esident from the van MUST		prior to transportation will resu	lit in	
	-	ely by phone or in person to		termination for the van driver.	o monsitte -	
	the administrator. In			(8) The Quality Assurance C		
	Administrator or inabi	n driver must report the		will be responsible to review t Committee Minutes to ensure		
		e Director of Nursing. If		interventions have been initiat		
	-	Director of Nursing the Van		ensure that solutions are achi		
		ely report the incident to the		sustained.	0.00 and	

Facility ID: 923010

		MEDICAID SERVICES			OMB NO. 093	<u>8-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		(X3) DATE SURVE COMPLETED	Y
					С	
		345140	B. WING		01/26/20	17
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
				610 WEST FISHER STREET		
BRIGHIM	OOR NURSING CENTER			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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMP THE APPROPRIATE D	(X5) PLETIO DATE
F 520	Continued From page	- 44	F 52	0		
1 020	-		F 52		l attand and	
		erations. He has also been oving the resident until the		(9) The Vice President wil participate in the Safety Co		
		l proper assessment and		weekly and Quality Assura		
	care.	Proper assessment dilu		meetings monthly to ensure		
	(2) Any new Van Dri	ver or anyone else		for the next twelve (12) mo		
		nt will be educated on the				
	above before being a					
	resident.	nowed to transport a		ADDRESS HOW CORREC		
		nistrator will review of all of		WILL BE ACCOMPLISHED		
		reports daily for proper		RESIDENTS HAVING POT		
		cident and accidents and		BE AFFECTED BY THE SA		
		Committee any interventions		DEFICIENT PRACTICE:		
		staff at time of the incident.		DEI IOIEINT TUXOTIOE.		
		serviced immediately by the		Any resident has the poten	tial to be	
		r of Nursing/Vice President		affected by the cited deficie		
		interventions that should			linoy.	
	have been taken.			(1) The facility Administrat	or is	
		or and/or Director of Nursing		responsible to educate the		
		er transport for the next		quarterly was re-educated		
		s prior to the van leaving the		2017 by the Administrator a	-	
		pon returning to the facility		President of Operations that		
		tachment of all vehicular		no matter how minor, occur	-	
		perly attached in the facility		placing a resident in the va	-	
		n have been inspected, the		applying and securing the		
		Director of Nursing will		system, during actual trans		
		onth for the next three (3)		un-securing the restraint sy		
		month for the following		disembarking of the resider		
		then two (2) per month		MUST be reported immedia		
		ections will be logged on an		or in person to the administ		
		vill be submitted to the		absence of the Administrate		
		ssurance Committees.		to reach the administrator,	-	
		mittee will review the Van		must report the incident ver		
		l under bullet point (5) above		Director of Nursing. If unat	-	
	-	with safety regulations as		Director of Nursing the Van		
		manufacture of the van.		immediately report the incid		
	(7) Any deviation fro			President of Operations. H		
		rly securing the chair and		been re-educated on not m		
		ior to transportation will		resident until the resident h	-	
	result in termination f	-		proper assessment and car		

Facility ID: 923010

If continuation sheet Page 45 of 55

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		<u>O. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		. ,	PLETED
						С
		345140	B. WING		01	/26/2017
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	P 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	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 520	Continued From page	e 45	F 52	0		
		urance Committee will be		(2) Any new Van Driver	or anvone else	
		the Safety Committee		transporting a resident w		
	Minutes to ensure that	at interventions have been		the above before being a	allowed to	
		e that solutions are achieved		transport a resident.		
	and sustained.	ant will review the Ostate		(3) The facility administr		
		ent will review the Safety ty Assurance Committee		all of the Accident/Incider proper interventions for a		
	Minutes along with th	-		accidents and will report		
		ext twelve (12) months.		Committee any interventi		
		on was verified on 1/26/17 at		taken by staff at time of the		
	2:30 PM.			(4) Staff will be re-in ser		
		records revealed the van		immediately by the Admin		
		ed on transportation safety		of Nursing/Vice Presiden		
	and in properly secur transport on 1/23/17.			on the interventions that been taken.	Should have	
		urses, nursing assistants		(5) The Administrator ar	nd/or Director of	
	-	ed that they have received		Nursing will inspect ever		
	in-service on the facil	ity's accident/incident policy		for the next twenty (20) tr	ransports prior to	
	•	g on 1/26/17. Interview with		the van leaving the facilit		
	the Administrator reve			upon returning to the faci	• •	
		ng sure that incident and		proper attachment of all		
		the van monitoring log by the safety committee and		systems properly attache van. After the first ten ha		
	-	it in place. Interview with the		inspected, the Administra		
	VP of Operation reve			Director of Nursing will in		
	-	ving the QA minutes to		month for the next three	(3) months, three	
	ensure interventions			(3) per month for the follo		
		6/17 the van's monitoring log		months and then two (2)	-	
		erview with the Administrator served the van driver prior to		thereafter. The inspection on an inspection form an		
		y and upon his return from		submitted to the Safety a		
	-	6/17 to ensure that the driver		Assurance Committees.		
		g the resident in the van.		(6) The Safety Committe	ee will review the	
				Van Log information liste		
				point (5) above to ensure	-	
				safety regulations as reco	-	
				the manufacture of the value(7) Any deviation from the value		

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 46 of 55

CENTER		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MU		CONSTRUCTION	FORM	D: 02/27/2017 MAPPROVED D: 0938-0391
	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		345140	B. WING				26/2017
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER			61	0 WEST FISHER STREET		
				S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	2.46	F	520	 securing the chair and resident in the prior to transportation will result in termination for the van driver. (8) The Quality Assurance Committee be responsible to review the Safety Committee Minutes to ensure that interventions have been initiated and ensure that solutions are achieved an sustained. (9) The Vice President will attend an participate in the Safety Committee weekly and Quality Assurance Comm meetings monthly to ensure complian for the next twelve (12) months. ADDRESS WHAT MEASURES WILL PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NO OCCUR: In addition to the facilities internal Q process the following external process be implemented. To ensure the facilitit maintains implemented corrective act to achieve and sustain the necessary program to ensure compliance, the Regional Quality Assurance Nurse will conduct an audit of the medical record include: 1. Nurses notes; 2. Acute Condition Report; 3. Incident Report; 4. Care Plan; 5. Quality Assurance Checks by the Director of Nursing 	e will to d d ttee ce BE T DT A s will y ons, l ds to	
	7/02-90) Pravious Versions Obs	olate Event ID: SM2			 maintains implemented corrective active active achieve and sustain the necessary program to ensure compliance, the Regional Quality Assurance Nurse will conduct an audit of the medical recordinclude: 1. Nurses notes; 2. Acute Condition Report; 3. Incident Report; 4. Care Plan; 5. Quality Assurance Checks by the Director of Nursing This audit will be completed weekly for one month, monthly for three months, 	ons, I ds to r and	t Dogo 47 o

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 47 of 55

		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/27/20 FORM APPROV OMB NO. 0938-03	VED
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345140	B. WING			C 01/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER	I		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER	1			10 WEST FISHER STREET ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIC	ON
F 520	Continued From page	€ 47	F	520	quarterly for one year if facility is foun compliant with implemented corrective actions. The Regional Quality Assura Nurse will report the findings to the VI Operations. After review the VP of Operations will take any necessary actions (including employee disciplina action up to termination) if failure to adhere to facilities assessment and resident safety policies is noted. If an incident/accident occurs the Administrator and/or Director of Nursi required to report to the Vice Presider Operations and/or Regional Quality Assurance Nurse right away. The VF Operations and/or Regional Quality Assurance Nurse will then be respons to review the incident to ensure the policies and procedures of the facility being followed. The findings of the Administrator and DON will be reported to the Regional Quality Assurance Nurse on a weekly basis for three (3) months. Weekly th plan will be evaluated to determine if corrective actions are being sustained not the plan will be evaluated and upor to ensure facility is maintaining compliance. The findings of the Qual Assurance checks internally and externally and review by the VP of Operations will be presented to the Q Committee for follow up and recommendations to ensure the corre action is achieved and sustained In addition to the facilities internal Q process the following external proces	e of of of sible are determined of the sible are determine	
	7(02-99) Previous Versions Obs	solete Event ID: SM2	2V11		cility ID: 923010 If contin	nuation sheet Page 48 o	

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 48 of 55

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				PRINTED: 02/27/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	B. WING		C 01/26/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	-
BRIGHTMOOR NURSING CENT	BRIGHTMOOR NURSING CENTER			
			SALISBURY, NC 28145	
(X4) ID SUMMARY PREFIX (EACH DEFICIE TAG REGULATORY (N OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE JENCY)			
F 520 Continued From pa	age 48	F	520 be implemented. To en maintains implemented to achieve and sustain program to ensure com Regional Director of Fa conduct an unannounce resident at the transpor or origination (other that visually ensure the van facility policies in prope restraint system. The F Facility Services will co visual audit once month months, quarterly for an months. The Regional Services will report the of Operations. The VP take any necessary act employee disciplinary a termination) if failure to resident van transporta resident safety is docur unannounced onsite au Regional Director of Fa The findings of the Adm DON will be reported to Operations on a weekly transports have been co which time if the correct being sustained, the pla and updated to ensure maintaining compliance the Quality Assurance of and externally and revi Operations will be press Committee for follow up recommendations to en action is achieved and a	I corrective actions the necessary ppliance, the acility Services will ed onsite audit of a tation destination an the facility) to driver adhers to all er application of Regional Director of induct this onsite hy for three in additional nine I Director of Facility findings to the VP of Operations will cions (including action up to adhere to facilities tion policies and mented through udits by the the acility Services. inistrator and/or o the VP of y basis until all ompleted. At tive actions are not an will be evaluated facility is e. The findings of checks internally iew by the VP of ented to the QAA o and nsure the corrective

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 49 of 55

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 02/27/201 M APPROVE O. 0938-039	
· · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345140	B. WING				/26/2017	
NAME OF PI	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	1 01			
			61	10 WEST FISHER STREET				
BRIGHTMOOR NURSING CENTER				S	ALISBURY, NC 28145			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	TION SHOULD BE COMPLET THE APPROPRIATE DATE			
F 520	Continued From page	2 49	F	520	The Vice President of Operations will responsible to: 1. Review all new employee record the next three (3) months to ensure training has been completed on the transportation and accident/incident policies. 2. Review the QA Committee minute ensure the facility is addressing issue identified at the Safety Committee. The Regional Quality Assurance Nurse will be responsible to conduct an aud the medical records to include: 1. Nurses notes; 2. Acute Condition Report; 3. Incident Report; 4. Care Plan; 5. Quality Assurance Checks by the Director of Nursing This audit will be completed weekly for one (1) month, monthly for three (3) months, and quarterly for one (1) year facility is found compliant with implemented corrective actions. The Regional Quality Assurance Nurse with report the findings to the VP of Operations. After review the VP of Operations will take any necessary action up to termination) if failure to adhere to facilities assessment and resident safety policies is noted. If the Vice President of Operations determines that compliance is not achieved and sustained it is the responsibility of the Vice President of Operations to re-educate or arrange education for the Administrator and/or Director of Nursing. After re-education	ds for les to es se it of or r if ill ary		

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 50 of 55

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DA	NO. 0938-0391 ATE SURVEY DMPLETED
345140 B. WING	C 01/26/2017
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
BRIGHTMOOR NURSING CENTER 610 WEST FISHER STREET	
SALISBURY, NC 28145	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520 Continued From page 50 F 520 completed and compliance is not sustained then disciplinary action will be taken INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTIVE AND SYSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE POC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. In addition to the facilities:::::::::::::::::::::::::::::::::::	

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 51 of 55

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 02/27/2017 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		345140	B. WING			01/2	_ 26/2017
NAME OF PI	ROVIDER OR SUPPLIER		I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	
BRIGHTM	OOR NURSING CENTER			61	10 WEST FISHER STREET		
				S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From page	2 51	F	520	Operations. After review the VP of Operations will take any necessary actions (including employee disciplina action up to termination) if failure to adhere to facilities□ assessment and resident safety policies is noted. If an incident/accident occurs the Administrator and/or Director of Nursi required to report to the Vice Presider Operations and/or Regional Quality Assurance Nurse right away. The VF Operations and/or Regional Quality Assurance Nurse will then be respons to review the incident to ensure the policies and procedures of the facility being followed. The findings of the Administrator and DON will be reported to the Regional Quality Assurance Nurse on a weekly basis for three (3) months. Weekly th plan will be evaluated to determine if corrective actions are being sustained not the plan will be evaluated and up to ensure facility is maintaining compliance. The findings of the Qual Assurance checks internally and externally and review by the VP of Operations will be presented to the Q Committee for follow up and recommendations to ensure the corre action is achieved and sustained In addition to the facilities□ internal Q process the following external process be implemented. To ensure the faciliti maintains implemented corrective act to achieve and sustain the necessary	ng is nt of of sible are the the the the the the the the the th	
	7(02-99) Previous Versions Obs	olete Event ID: SM2			program to ensure compliance, the		

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 52 of 55

	-	D HUMAN SERVICES MEDICAID SERVICES				PRINTED: FORM A OMB NO. (PPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345140	B. WING			C 01/26	/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-
BRIGHTM	OOR NURSING CENTER				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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	-	(X5) COMPLETION DATE
F 520	Continued From page	2 52	F	520	Regional Director of Facility Services we conduct an unannounced onsite audit resident at the transportation destination or origination (other than the facility) to visually ensure the van driver adhers to facility policies in proper application of restraint system. The Regional Director Facility Services will conduct this onsite visual audit once monthly for three months, quarterly for an additional nine months. The Regional Director of Face Services will report the findings to the of Operations. The VP of Operations of take any necessary actions (including employee disciplinary action up to termination) if failure to adhere to facilit resident van transportation policies an resident safety is documented through unannounced onsite audits by the the Regional Director of Facility Services. The findings of the Administrator and/of DON will be reported to the VP of Operations on a weekly basis until all transports have been completed. At which time if the corrective actions are being sustained, the plan will be evalua and updated to ensure facility is maintaining compliance. The findings the Quality Assurance checks internall and externally and review by the VP of Operations will be presented to the QA Committee for follow up and recommendations to ensure the correct action is achieved and sustained The Vice President of Operations will be responsible to: 1. Review all new employee records the next three (3) months to ensure	of a on o all or of e cility VP will ties d or not ated of y of AA ctive	
	7(02-99) Previous Versions Obs	olete Event ID: SM2X				uation sheet P	

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 53 of 55

CENTERS FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES	_			FORM): 02/27/2017 / APPROVED). 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	345140	B. WING _				_ 26/2017
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTMOOR NURSING CENTER			61	0 WEST FISHER STREET		
			SA	ALISBURY, NC 28145		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 520 Continued From page	2 53	F	520	training has been completed on the transportation and accident/incident policies. 2. Review the QA Committee minute ensure the facility is addressing issues identified at the Safety Committee. The Regional Quality Assurance Nurse will be responsible to conduct an audit the medical records to include: 1. Nurses notes; 2. Acute Condition Report; 3. Incident Report; 4. Care Plan; 5. Quality Assurance Checks by the Director of Nursing This audit will be completed weekly fo one (1) month, monthly for three (3) months, and quarterly for one (1) year facility is found compliant with implemented corrective actions. The Regional Quality Assurance Nurse will report the findings to the VP of Operations. After review the VP of Operations will take any necessary actions (including employee disciplina action up to termination) if failure to adhere to facilities □ assessment and resident safety policies is noted. If the Vice President of Operations to re-educate or arrange education for the Administrator and/or Director of Nursing. After re-education completed and compliance is not sustained then disciplinary action will take not president of the disciplinary action will be taken The findings of the Quality Assurance for the findings of the Q	e of r if ry	

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 54 of 55

TATEMENT (OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /			O. 0938-039 E SURVEY IPLETED		
D I D II OI			A. BUILDING			C		
		345140	B. WING		01	/26/2017		
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		-		
BRIGHTM	OOR NURSING CENTER	R		310 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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE		
F 520 Continued From page 54		e 54	F 520	checks internally and externally review by the VP of Operations presented to the QAA Committe follow up and recommendations the corrective action is achiever sustained.	will be ee for s to ensure			

Event ID: SM2X11

Facility ID: 923010

If continuation sheet Page 55 of 55