PRINTED: 08/18/2017 FORM APPROVED OMB NO. 0938-0391

AND DUAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION IG	1, ,	(X3) DATE SURVEY COMPLETED	
		345140	B. WING _			07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER	3	•	STREET ADDRESS, CITY, STATE, ZIP OF 610 WEST FISHER STREET SALISBURY, NC 28145	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 272 SS=D	(b) Comprehensive A (1) Resident Assess must make a compre resident's needs, stre preferences, using the instrument (RAI) speciassessment must incomplete the instrument (ii) Identification and (ii) Customary routin (iii) Cognitive pattern (iv) Communication. (v) Vision. (vi) Mood and behave (vii) Psychological work (viii) Physical fur problems. (ix) Continence.	ment Instrument. A facility shensive assessment of a engths, goals, life history and se resident assessment cified by CMS. The slude at least the following: d demographic information ne. ns.	F 2		CY)	8/10/17
	(xv) Special treatmer (xvi) Discharge p (xvii) Documentar regarding the addition on the care areas of the Minimum Data (xviii) Documentar assessment. The as include direct observation the resident, as well a licensed and	nts and procedures. blanning. tion of summary information nal assessment performed triggered by the completion		TITLE		(X6) DATE

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

08/01/2017

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

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.

Electronically Signed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIER	t		61	TREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	on all shifts. The assessment prodobservation and comas well as communic non-licensed direct cashifts. This REQUIREMENT by: Based on record reviacility failed to provide for behaviors which in risk factors, and factod developing individual for one of fifteen sam #27) with comprehent findings included: Resident #27 was ad and last readmitted of diagnoses included: anxiety and unspecification and the pressed 7-11 days days, feeling tired/litt rejection of care occuradministered during the period included 7 day antidepressant medic medication. A review of the Care behaviors dated 7/11 blank. There was no	cess must include direct munication with the resident, ation with licensed and are staff members on all is not met as evidenced iew and staff interview, the de a care area assessment included underlying cause, ors to be considered in ized care plan interventions pled residents (Resident sive assessments. The mitted to the facility 1/16/15 in 7/1/17. Cumulative insomnia, depression, ed mood disorder. Data Set (MDS) dated sident #27 was moderately Mood-feeling down, trouble with sleep 7-11 de energy 7-11 day and irred 1-3 days. Medications he seven day look back	F	272	F272- Comprehensive Assessments 1. Corrective action will be accomplisher for those residents found to have been affected by the deficient practice: a. The Care Area Assessment (CAA) behaviors on resident #27 was completed by the MDS nurse on 7/12/17 with behaviors being updated and addressed as outlined in the RAI manual b. The MDs for resident #27 was not due to be transmitted until 8/7/17 at whit time it was done by the MDS nurse. 2. Corrective action will be accomplis for those residents having potential to be affected by the same deficient practice. Any resident has the potential to be effected by the same practice. a. All previous comprehensive Minim Data Sets (MDSs) dated back to 7/1/17 were reviewed by the Director of Nursin (DON) on 7/17/17 to ensure CAAs were completed. b. The audit revealed no CAAs found be incomplete. c. All admission, annual, and significations comprehensive MDSs completed by the MDS nurse will be audited by the DON on a QA form to ensure CAAs are	for ted t d the december of	

Facility ID: 923010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345140	B. WING _			07/	13/2017	
			610	WEST FISHER STREET			
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	((X5) COMPLETION DATE	
considered in develop	ing individualized care plan	F 2	272	completed.			
planned. On 7/12/17 at 2:20 Pt conducted with the M the CAA for behaviors	M, an interview was DS nurse. She reviewed and said she was			that the deficient practice will not occur are: a. Admission, annual, and significant change MDSs will be documented on a QA form to ensure CAAs are completed	1		
behaviors. She said sompleted and her exfor behavior should hadid not know why it w	she thought it had been pectation was for the CAA ave been completed. She as blank.			weekly x I month, biweekly x 2 months monthly x 6 months by the DON. 4. The facility will monitor its performance to make sure solutions are sustained by:	е		
conducted with the Di the MDS nurse was re completion of the CA	rector of Nursing. She said esponsible for the A for behaviors and she			and DON audits will be reviewed in Monthly QA meeting b. The weekly reviews outlined above will be discussed monthly at the QA meeting. All QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance sho changes to the QAs need to be done p	ed ne s		
		F 2	280	to the quarterly meeting		8/10/17	
and implementation of plan of care, including (i) The right to participal including the right to its be included in the plan.	f his or her person-centered but not limited to: nate in the planning process, dentify individuals or roles to nning process, the right to						
	CORRECTION ROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From page considered in develop interventions or if beh planned. On 7/12/17 at 2:20 PM conducted with the Mi the CAA for behaviors responsible for the co behaviors. She said s completed and her ex for behavior should ha did not know why it wa On 7/12/17 at 3:45 PM conducted with the Di the MDS nurse was re completion of the CAA expected the CAA for 483.10(c)(2)(i-ii,iv,v)(3 PARTICIPATE PLANN 483.10 (c)(2) The right to part and implementation o plan of care, including (i) The right to particip including the right to ic be included in the plan	CORRECTION IDENTIFICATION NUMBER: 345140 ROVIDER OR SUPPLIER OOR NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 considered in developing individualized care plan interventions or if behaviors would be care planned. On 7/12/17 at 2:20 PM, an interview was conducted with the MDS nurse. She reviewed the CAA for behaviors and said she was responsible for the completion of the CAA for behaviors. She said she thought it had been completed and her expectation was for the CAA for behavior should have been completed. She did not know why it was blank. On 7/12/17 at 3:45 PM, an interview was conducted with the Director of Nursing. She said the MDS nurse was responsible for the completion of the CAA for behaviors and she expected the CAA for behaviors to be completed.	A BUILDIN 345140 B. WING_ ROVIDER OR SUPPLIER OOR NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 considered in developing individualized care plan interventions or if behaviors would be care planned. On 7/12/17 at 2:20 PM, an interview was conducted with the MDS nurse. 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She said the MDS nurse was responsible for the completion of the CAA for behaviors and she expected the CAA for behaviors to be completed. 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 considered in developing individualized care plan interventions or if behaviors would be care planned. On 7/12/17 at 2:20 PM, an interview was conducted with the MDS nurse. 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On 7/12/17 at 2:20 PM, an interview was conducted with the MDS nurse. She reviewed the CAA for behaviors and said she was responsible for the completed on of the CAA for behaviors should have been completed. She did not know why it was blank. 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She said the MDS nurse was responsible for the completed with the Director of Nursing. 15	

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		345140	B. WING _		,	7/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 610 WEST FISHER STREET SALISBURY, NC 28145		
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F 280	(ii) The right to partici expected goals and of amount, frequency, a other factors related the plan of care. (iv) The right to receive included in the plan of care. (v) The right to see the right to sign after sign of care. (c)(3) The facility sharight to participate in light to participate	pate in establishing the utcomes of care, the type, and duration of care, and any of the effectiveness of the vertices and/or items of care. The care plan, including the difficant changes to the plan of the resident of the his or her treatment and dent in this right. The structure of the resident of the resident of the resident and/or vertices. The care plan must be- The days after completion of	F 2	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OOR NURSING CENTER	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			
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F 280	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practice the resident and the An explanation must medical record if the and their resident reprotection practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and reteam after each assessments. This REQUIREMENT by: Based on record revistaff interviews and called to update and retend the record revisitation.	price to- price with responsibility for the responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined be development of the e staff or professionals in since by the resident's needs are resident. vised by the interdisciplinary resident, including both the quarterly review or is not met as evidenced riews, resident interviews, observations, the facility revise the care plan	F 280	F280- Right to Participate Planning Care-Revise Care Plan		
	decreased vision, ca prevention (Resident	6 residents reviewed for re refusal, safety and fall # 1) and the care plan in the torative ambulation program		 1.1. Corrective action will be accomple for those residents found to have bee affected by the deficient practice: a. The MDS nurse updated the care on resident # 1 to include removal of light, Hospice safety plan agreement, 	n e plan	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345140	B. WING		07/13/2017
	ROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	·
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F 280	Continued From page The findings included 1.a. Resident #1 was 06/06/2017 with diage Congestive Heart Fat Obstructive Respirate Diabetes Mellitus Tyle depression and Post (PTSD) and insomning An admission Minim 06/18/2017, revealed cognitively intact, ab corrective lenses. Refer to 3 days and require transfers and toileting walking. Resident # and wore oxygen and 2 pressure ulcer. A review of the compassessment (CAA) of that Resident #1 worn newspaper, watch te while wearing eye gli	de 5 d: s admitted to the facility on gnoses that included fillure (CHF), Chronic ory Disease (COPD), pe 2 (DM2), anxiety, a Traumatic Stress Disorder a. um Data Set (MDS) dated do that Resident #1 was let to see large print and wore esident #1 rejected care for 1 ed limited staff assist for grand supervision for 1 had a fall prior to admission do was admitted with a stage orehensive Care Area dated 06/18/2017 revealed re glasses and could read the elevision and feed himself	F 28	DEFICIENCY)	e need care e e from oval of for tary ds cts n neading r nplished to be tice by:
	06/26/2017 revealed decreased vision and goal to continue to e reading through the intervention to leave A review of a physici 07/11/2017 revealed eye glasses in place An observation of Re	that Resident # 1 had d had to wear glasses with a njoy watching television and next review with an a night light on at night. an (MD) progress note dated in part that Resident # 1 had		effected by the same practice. a. Care plans were reviewed for a residents by the DON on 7/17/17 are found to be complete and accurate. b. All care plans will be audited by DON weekly x I month, biweekly x 2 months, monthly x 6 months on a C to ensure that correct coding and caplanning of assistive devices has be completed. a. All therapy discharges will be	all nd y the 2 QA form are

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		345140	B. WING		07/13/2017
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•
BRIGHTM	OOR NURSING CENTE	R		610 WEST FISHER STREET SALISBURY, NC 28145	
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F 280	Continued From pag	e 6	F 280		
F 280	no night light in use a room of Resident #1 On 07/13/2017 at 7:4 Resident #1 in the organises in place. On 07/13/2017 an M plastic utensils on trace. On 07/13/2017 an M plastic utensils on trace. An interview was contained to the modern of the modern	and no other lights on in the and no other lights on in the as AM an observation of lining room revealed eye. D note revealed to use ays. Inducted on 07/13/2017 at DS Nurse revealed that be as a vision ad wore eye as a never a nightlight in ould have left the bathroom aght. The MDS nurse revealed of a night light should have. 18 PM an interview was director of Nurses (DON) and expectation that all care plan atted and meet resident implete a clear picture of the action can be appropriate are plan interventions as needed to be appropriate are plan interventions that actific should be deleted. S admitted to the facility on anoses that included illure (CHF), Chronic ory Disease (COPD), pe 2 (DM2), anxiety, a Traumatic Stress Disorder as.	F 280	reviewed and initialed by the MDs not This will be recorded on a QA form a audited by the DON weekly x I month biweekly x 2 months, monthly x 6 mb. The DON will be responsible for overseeing each resident sets restoral program for appropriate approaches will initial all restorative referrals upour receipt and will ensure that restorating programs are updated accordingly. Will record these changes and update a QA form and this will be audited by Administrator for compliance weekly month, biweekly x 2 months, monthly months. 3. Measures put into place to ensure that the deficient practice will not occare: a. All therapy discharges will be reviewed and initialed by the MDs not and the DON. This will be recorded QA form and audited by the Administrator weekly x 1 month, biweekly x 2 monthmonthly x 6 months. b. The DON will be responsible for overseeing each resident setsoral program for appropriate approaches will initial all restorative referrals upour receipt and will ensure that restorating programs are updated accordingly. Will record these changes and update a QA form and this will be audited by Administrator for compliance weekly month, biweekly x 2 months, monthly months. 4. The facility will monitor its	and th, onths. r tive s. She on ve She tes on y the / x I ly x 6 ure cur urse on a strator ths, r tive s. She on ve She tes on y the / x I ly x 6
	06/18/2017, revealed	um Data Set (MDS) dated d that Resident #1 was le to see large print and wore		performance to make sure solutions sustained by: a. 100 % of all care plans will be	are

Facility ID: 923010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 280	to 3 days and require transfers and toileting walking. Resident # 1 and wore oxygen and 2 pressure ulcer. A review of the comp Assessment (CAA) d that Resident #1 refu and medications at till A review of Resident 06/30 /2017 revealed refused medications required a psychiatric causing self - harm; t 1 would verbalize fee in an acceptable mar place plastic utensils notice. An interview conduct at 7:14 AM revealed Resident # 1 needed nurse would have replastic utensils. On 07/13/2017 at 7:4 Resident # 1 in the di utensils in place, not the diet card for Resident # 1 net diated of the diet card for Resident # 1 in the di utensils in place, not the diet card for Resident # 1 in the di utensils in	sident # 1 rejected care for 1 and limited staff assist for g and supervision for 1 had a fall prior to admission d was admitted with a stage rehensive Care Area ated 06/18/2017 revealed sed nebulizer treatments mes. # 1's care plans initiated on 1 that Resident # 1 had and treatment at times and coreferral for thoughts of the goal was that Resident # 1 lings of anger and frustration on meal trays until further 1 that she was not aware that plastic utensils and that the ported to the NAs any use of 1.5 AM an observation of sining room revealed regular plastic utensils as noted on dent # 1.	F 28	reviewed weekly x 1 month; 7 biweekly x 2 months; 50 % months and 10 % each month ongoing. b. All QAs and audits will be the monthly QA meeting. c. The QA reviews outlined a discussed monthly at the QA now QA results will be discussed in the Medical Director at the Quimeetings unless changes are be made prior to that meeting. Medical Director will be contact advice and guidance should of the QAs need to be done prior quarterly meeting.	anthly x 6 after that reviewed in above will be meeting. All uarterly with arterly QA needed to The cted for hanges to	

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F 280	should be aware of the plan because each not plan through the elect the care plan book. On 07/13/2017 at 3:1 conducted with the Dexpectation that all caupdated and meet recomplete a clear pictic care. Care plan intervas needed to be approcare plan intervas needed to be approcare plan intervention specific should be dethat Resident #1 alway was not certain why pused the morning of definitely look into the had not been followed. 1.c. Resident #1 was 06/06/2017 with diaground Congestive Heart Fair Obstructive Respirate Diabetes Mellitus Type depression and Post (PTSD) and insomnia. An admission Minimum 06/18/2017, revealed cognitively intact, ablic corrective lenses. Reto 3 days and require transfers and toileting walking. Resident #1	blanned and that all staff are intervention on the care are had access to the care are had access to the care are plan interview was ON and revealed it was her are plan interventions be sident specific needs to are of the specific resident are that were not resident are that were not resident bleted. The DON revealed ays had plastic utensils and blastic utensils had not been or/13/2017, but she would are reason that the care plan d. admitted to the facility on moses that included lure (CHF), Chronic bry Disease (COPD), are 2 (DM2), anxiety, Traumatic Stress Disorder are are plan interview was are to see large print and wore are sident #1 was are to see large print and wore asident #1 rejected care for 1 d limited staff assist for	F 28	80		

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	ROVIDER OR SUPPLIER OOR NURSING CENTE	ER .	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	O BE COMPLETION	
F 280	Assessment (CAA) that Resident #1 wa weakness, shortness. Review of a care plus revealed that Reside and fall related injury guidelines and use and toileting throug interventions that in personal body alarmstaff of any attempt without assist, low be prevent injury, sensus sensor in chair related attempts to get up use rails for resident saft. An observation of Feron observed in place. An observation of Feron observed in place. An observation of Feron observed in place.	prehensive Care Area dated 06/18/2017 revealed as at risk for falls due to as of breath and incontinence. an initiated on 06/26/2017 ent # 1 was at risk for falls ry and would follow safety call bell for assist for transfers the the next review with included in part to maintain a rn (PBA) at all times to alert as to transfer or ambulate bed with mats as ordered to for mat beside bed and chair ted to frequent falls and unassisted and longer side fety. Resident # 1 on 07/12/2017 at resident # 1 sitting in his wheel the no chair alarm or bed alarm Resident # 1 on 07/13/2017 at resident # 1 asleep in bed with rowd, no alarm in the wheel ter length side rail elevated on a led and the right side of the	F 280			
	conducted with NA aware that Residen a chair alarm becaureported to her to u	:14 AM an interview #2 revealed that she was not t # 1 ever had a bed alarm or use the nurse had never				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345140	B. WING _		,	07/13/2017	
	ROVIDER OR SUPPLIER OOR NURSING CENTER	R		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 280	and if he did that the to the NAs that they was not certain why pused the morning of the vestigate why the capacitate who the morning of the vestigate why the capacitate who the push of the very manner.	r used a bed or chair alarm nurse would have reported were needed. ed with the MDS Nurse MDS 17 at 12:00PM revealed that ad a bed or chair alarm id not use PBAs and that the atomatically pulled to the difful risks automatically by all record system, but that should have been reviewed as the intervention for longer in the floor next to the bed. unable to explain why the ed on the care plan for she would delete those 8 PM an interview was ON and revealed it was her are plan interventions be sident specific needs to ure of the specific resident ventions should be changed ropriate for each resident. In that were not resident leted. The DON revealed ays had plastic utensils and plastic utensils had not been 107/13/2017, but she would are plans were incorrect and as soon as possible.	F 2	80			
	7/1/16. Cumulative of	vas admitted to the facility on liagnoses included dent (CVA) with left sided					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345140	B. WING		07/13/2017	
	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 280	An Admission Minimassessment dated 7/ #30 was cognitively in A care plan dated 4/s at risk for falls and fasided paresis related a walker/cane when times when he did not He also used a whee included, in part, ansided resident was not cognitively a sessment. An Annual Minimum 5/26/17 indicated Resident was not steasing without staff assessment period, for Resident #30 had two sustained from the fassessment. On 7/13/17 at 1:57 Pronducted with the Melt the intervention from the fassessment due to the periods of confusion to the facility. She sadoor closed and, who	and difficulty walking. January Data Set (MDS) Jay 16 indicated Resident intact. Jay 17 stated Resident #30 was ill related injury due to left to CVA. Resident #30 used ambulating but there were of use the walker or the cane. Elchair at times. Approaches wer any unusual noises as initively able to call for help. Data Set (MDS) dated sident #30 was cognitively was independent with ation in the room and hall. ady but he was able to a assistance. During the falls was documented that or or more falls with no injury alls since the last M, an interview was MDS nurse. She stated she or the approach that said to noises promptly as resident ble to call for help was e fact that Resident #30 had when he was first admitted aid Resident #30 kept his en she knocked, he ant anyone to come in. The	F 280			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345140	B. WING		07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER	t	1	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 280	she expected the car picture of the resident was cognitively intact on any unusual noise time. She stated the to call for help" was rown 2. b. Resident #30 to 7/1/16. Cumulative of cerebrovascular acciparesis (weakness) and Annual Minimum 5/26/17 indicated Reintact. Resident #30 transfers and ambula Balance was not steastabilize without staff assessment period, for Resident #30 had two sustained from the facts assessment. A care plan dated 6/17 received restorative a range of motion to bill	PM, an interview was irector of Nursing who stated e plan to reflect an accurate t. She stated resident #30 to and that staff would check es for any resident at any wording "not cognitively able not accurate. I was admitted to the facility on liagnoses included dent (CVA) with left sided and difficulty walking. Data Set (MDS) dated sident #30 was cognitively was independent with ution in the room and hall. The ady but he was able to assistance. During the alls was documented that to or more falls with no injury lls since the last 19/17 stated Resident #30 ambulation and assisted ateral lower extremities. I, in part, Use hand held	F 28	30	
	summary (undated) i to begin the restoration 6/19/17. There was	pational therapy discharge ndicated Resident #30 was we nursing program on no indication that hand held ulation was to be used.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345140	B. WING		07/13/2017	
	ROVIDER OR SUPPLIER OOR NURSING CENTE	₹		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 282 SS=D	Nursing Assistant (N of the restorative aid Resident #30 in the reviewed the care pland assisted range of stated Resident #30 walker on even surfaces restorative aide). Shand held assistance not been directed to On 7/13/17 at 2:38 F conducted with the Eshe expected the cargive an accurate pict reviewed the restorathe instructions from of hand held assistanticuluded in the care 483.21(b)(3)(ii) SER PERSONS/PER CAI (b)(3) Comprehensive The services provide as outlined by the comustanticulum of the care provided as outlined by the comustanticulum of the care provided as a care. This REQUIREMENT by: Based on record revand staff interviews,	M, an interview was held with A) #3. She said she was one es and had worked with restorative program. NA #3 an for restorative ambulation of motion dated 6/19/17 and was independent with a rices and contact guard assist (only to walk outside with le stated she did not use efor Resident #30 and had do so by therapy. M, an interview was Director of Nursing who stated re plan to be accurate and rure of the resident. She tive nursing plan of care and therapy and stated the use not should not have been blan. VICES BY QUALIFIED RE PLAN The Care Plans and or arranged by the facility, imprehensive care plan, utalified persons in the resident's written plan of the resident written plan of the resident written plan of the resident written p	F 28			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMR M	O. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	` ′	E SURVEY PLETED
		345140	B. WING			07	//13/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DDICUTM	OOR NURSING CENTER	•		61	10 WEST FISHER STREET		
BRIGHTIW	OOK NUKSING CENTER	•		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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page	e 14	F	282			
					for those residents found to have beer	l	
	Findings included:				affected by the deficient practice :		
					a. Care plans were updated to include		
		is admitted to the facility on			vision changes for residents #34 and 4		
		oses to include muscle			Resident # 34 was asked if she would	-	
		valking, and seizure disorder.			to an outside appointment to have her		
	2/22/2017 assessed	num Data Set (MDS) dated			eyes examined and she refused, statir that she preferred to wait for the facility	-	
		y impaired. The section			optometrist who is scheduled to come		
		ed her to have impaired			the facility in November. She has been		
		nt, but not regular print in			added to that list Resident # 43 had a		
		The Care Area Assessment			eye appointment scheduled for 8/7/17	and	
	(CAA) completed in the	he admission MDS noted			was transported to that appointment.		
		ered. The most recent			Corrective action will be accomplish		
	· ·	5/17/2017 assessed the			for those residents having potential to		
		ately cognitively impaired.			affected by the same deficient practice	by:	
		ision assessed her to have			Any resident has the potential to be		
	print in newspapers/b	large print, but not regular			effected by the same practice. a. Care plans have been audited to		
	print in newspapers/b	ooks).			identify any resident with changes in t	heir	
	A review of the care r	plans for Resident #34			vision		
		ns addressing impaired			b. No other residents have been		
		nad a care plan in place			identified as having changes in vision	or	
	"activities" with interv	entions to encourage word			that need vision appointments.		
	search, create cards	and read on her own.			Measures put into place to ensure		
					that the deficient practice will not occu	ſ	
		SW) was interviewed on			are:		
		M. She reported she was			a. The SW will notify the Clinical		
		sing residents for section B speech and vision). She			Services Coordinator (CSC)after each identified change in vision for residents		
		n, she would hand a resident			by documenting the need for follow-up		
	-	print and ask them to read.			appointments on the resident appoint		
	1	ifficulty, she scored them			request form.		
		lity. She reported that she			b. The Clinical Services Coordinator		
	was not certain why s	•			(CSC) will be responsible for ensuring	that	
	Resident #34 to an e	ye doctor.			appointments are made for residents vision changes	vith	
	Resident #34 was into	erviewed on 7/13/2017 at			c. Copies of the Resident appointme	ent	
		ed she was able to see the			request form will be brought to the		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		345140	B. WING _			07/	13/2017
NAME OF P	ROVIDER OR SUPPLIER		,	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
BRIGHTM	OOR NURSING CENTER	1	610 WEST FISHER STREET				
				SALIS	SBURY, 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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page 15		F 2	82			
	TV at the end of her bed without difficulty, but she was unable to see to read.			4.	orning meetings for review The facility will monitor its		
	4:44 PM. She reported was a change or declifrom the admission M. The Director of Nursing on 7/13/2017 at 5:07 expectation that SW on nursing staff to notify	wed again on 7/13/2017 at ed that she didn't feel there ine in Resident #34's vision IDS to the quarterly MDS. IDS (DON) was interviewed PM. She reported it was her communicate with the of resident changes and/or for outside services. The		su a. for mi biv the b. dis	erformance to make sure solutions and stained by: The resident appointment request rm will be reviewed daily in the morn eetings for 1 month; weekly x 1 montweekly x 1 month and monthly ereafter The QA reviews outlined above we scussed monthly at the QA meeting. A results Vill be discussed quarterly with the	ing th; ill be	
	DON concluded she fin communication bet	elt there was a breakdown ween the disciplines.		Me me be Me	edical Director at the Quarterly QA eetings unless changes are needed a made prior to that meeting. The edical Director will be contacted for		
	12/28/2016 and readr diagnoses to include pulmonary disease, in difficulty walking. The change MDS dated 6. Vision assessed their vision (sees large prinnewspapers/books. A Assessment (CAA) or change MDS noted vithe admission MDS or reviewed and the sechim to have adequate A review of the care prevealed no care planvision.	nuscle weakness and most recent significant /30/2017, Section B1000 resident to have impaired ont, but not regular print in a review of the Care Area completed in the significant ision care area triggered.		th	lvice and guidance should changes to the QAs need to be done prior to the parterly meeting	0	
		ading glasses were on his					

Facility ID: 923010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345140	B. WING			07/13/2017	
	ROVIDER OR SUPPLIER OOR NURSING CENTER	2		STREET ADDRESS, CITY, STATE, ZIP COD 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)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 282	me." Nursing assistant (NA 7/12/2017 at 9:28 AN resident was able to problems. NA #7 was interviewed and she reported she aide for Resident #43 resident was not able count them by touchi The Social Worker (S 7/13/2017 at 11:21 A responsible for assess of the MDS (hearing, reported to test vision a piece of paper with If they resident had d according to their abit was not certain why s Resident #43 to an e she felt she did not rehe was a Hospice pa Hospice covered eye. The SW was interviewed at the same as a change or decivision. She reported difficulty seeing the pit took him a long time.	"They don't do much for A) #6 was interviewed on If and he reported the Isee food on his tray without and on 7/12/2017 at 9:44 AM Is was the certified medication If an every service on If an every service	F 24	32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345140	B. WING	 	07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER	t		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 282	the need for referrals DON concluded she	of resident changes and/or for outside services. The felt there was a breakdown	F 28	32	
F 313 SS=D		tween the disciplines. ATMENT/DEVICES TO G/VISION	F 3	13	8/10/17
	and assistive devices	g ints receive proper treatment is to maintain vision and facility must, if necessary,			
	(1) In making appoint	ments, and			
	office of a practitione treatment of vision or office of a profession provision of vision or	hearing impairment or the			
	Based on record rev and staff interviews, for a consultation for	ed on record review, observations, resident staff interviews, the facility failed to arrange consultation for vision care for 2 of 3 ents reviewed (Resident #34 and 43).		F313- Treatment/Devices to Main Hearing/Vision 1. 1. Corrective action will be accomplished for those residents have been affected by the deficier practice:	found to
	2/15/2017 with diagn weakness, difficulty of The admission Minim 2/22/2017 assessed moderately cognitive B1000 Vision assess vision (sees large pri	admitted to the facility on oses to include muscle valking, and seizure disorder. num Data Set (MDS) dated the resident to be ly impaired. The section ed her to have impaired nt, but not regular print in The Care Area Assessment		a. On 8/2/17 the Clinical Service Coordinator (CSC) went to speak resident # 34 about scheduling an appointment. The resident told her she did not want to go out of facilities eye doctor. She explained to her to would be a few months before the doctor would be on site and she sawas fine, she did not feel she was	to eye that y to an hat it eye aid that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345140	B. WING _			07	//13/2017
NAME OF PR	ROVIDER OR SUPPLIER		· I	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				61	0 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTE	₹		S	ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 313	Continued From pag		F3	313			
	(CAA) completed in the vision care area trigg quarterly MDS dated resident to be moder. The section B1000 Vimpaired vision (sees print in newspapers/IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	the admission MDS noted pered. The most recent 5/17/2017 assessed the ately cognitively impaired. Fision assessed her to have a large print, but not regular books). In plans for Resident #34 and addressing impaired SW) was interviewed on M. She reported she was assing residents for section B speech and vision). She and the print and ask them to read. It ifficulty, she scored them it ifficulty, she reported that she she had not referred by doctor. It is the was able to see the bed without difficulty, but she read. She denied seeing an an inssion to the facility. Interviewed on 7/13/2017 at the ded Resident #34 had not		313	any vision problems at this time. The edoctor will be in the facitly for his regul scheduled visit in November and he will be calling to confirm actual day as timingets closer and she has been placed of the list for that visit. b. An Eye appointment was made for resident #43 on 8/3/17 by the CSC and was scheduled for 8/7/17. 2. Corrective action will be accomplified for those residents having potential to affected by the same deficient practice. Any resident has the potential to be effected by the same practice. a. Every resident was reviewed on 7/26/17 for visual acuity by the Social Worker and Clinical Services Coordinate. b. Every resident who was cognitive able to be accurately assessed for vision was asked if they were able to see the headlines, subtitles, and fine print in the newspaper. c. Residents with cognitive issues at unable to be accurately assessed for vision will be seen yearly or as deemed more often by an Optometrist, or Ophthalmologist. d. Every resident sidentificant change assessment or as needed by the Social Worker as required of the MDS process. Residents identified as having changes in vision have been offered a choice of having an outside appointmental made for them now, or to be placed of the list to be seen by the eye doctor we the list to be seen by the eye doctor we have the social was a serious and the eye doctor we have the seen by the eye doctor we have the exper	arly ill e on or d shed be e by: ator. ly on e nd d	
	The Director of Nurs	ing (DON) was interviewed			is scheduled to come to the facility in November.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345140	B. WING		07	07/13/2017	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIGHTM	OOR NURSING CENTER			610 WEST FISHER STREET			
Dittorrin	OOK NOROMO GENTER	•		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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 313 Continued From page		e 19	F 313	3			
	on 7/13/2017 at 5:07 expectation that SW on nursing staff to notify the need for referrals DON concluded she in communication bet in communication bet 2. Resident #43 was 12/28/2016 and readdiagnoses to include pulmonary disease, ndifficulty walking. The change MDS dated 6 Vision assessed the rision (sees large prin newspapers/books. A Assessment (CAA) or change MDS noted vor The admission MDS reviewed and the second in the have adequated A review of the care prevealed no care plan vision. Resident #43 was interested and when asked Resident #43 stated, me." He denied seein admission to the facil	PM. She reported it was her communicate with the of resident changes and/or for outside services. The felt there was a breakdown ween the disciplines. admitted to the facility on mitted on 2/16/2017 with chronic obstructive muscle weakness and most recent significant /30/2017, Section B1000 resident to have impaired in the significant is in care area triggered. It is in care area triggered. It is in care area triggered. It is in a sees fine detail. In a review of the Care Area of the Care Are	F 31.	3. Measures put into place to ensure that the deficient practice will not occare: a. The Social Worker will notify the Clinical Services Coordinator after exidentified change in vision for resident by documenting the need for follow-responsible for ensuring that appointments on the resident appointments are made for residents with vision change. Copies of the Resident appointments are made for residents with vision change. Copies of the Resident appointments are made for mill be brought to the morning meetings for review 4. The facility will monitor its performance to make sure solutions sustained by: a. The resident appointment reques form will be reviewed daily in the momeeting b. The QA reviews outlined above discussed monthly at the QA meeting QA results will be discussed quarterly the Medical Director at the Quarterly meetings unless changes are needed be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes the QAs need to be done prior to the quarterly meeting	eur ach nts, up tment or will es. nent are st rning will be g. All y with QA d to		
	NA #7 was interviewe	ed on 7/12/2017 at 9:44 AM					

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	1, ,	E SURVEY PLETED
		345140	B. WING		07	/13/2017
	ROVIDER OR SUPPLIER	₹	•	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 313	and she reported she aide for Resident #4: resident was not able count them by touch. The Social Worker (\$7/13/2017 at 11:21 A responsible for asses of the MDS (hearing, reported to test vision a piece of paper with If they resident had according to their ab was not certain why Resident #43 to an eshe felt she did not rehe was a Hospice part Hospice covered eye. The MDS nurse was 1:57 PM. She reported been examined by an The SW was intervied 4:44 PM. She reported difficulty seeing the part took him a long time. The Director of Nursion 7/13/2017 at 5:07 expectation that SW	e was the certified medication 3. She further reported the e to see his pills, but would ing them. 6W) was interviewed on M. She reported she was asing residents for section B speech and vision). She in, she would hand a resident in print and ask them to read. Ilifficulty, she scored them ility. She reported that she she had not referred lye doctor. She reported that lefer Resident #43 because interviewed on 7/13/2017 at led Resident # 43 had not in eye doctor. Wed again on 7/13/2017 at led that she didn't feel there line in Resident #43 had laper she had him read, and le to read the paper. Ing (DON) was interviewed PM. She reported it was her communicate with the	F 3	13		
F 323	the need for referrals DON concluded she in communication be	of resident changes and/or for outside services. The felt there was a breakdown tween the disciplines. -(3) FREE OF ACCIDENT	F 3:	23		8/10/17

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		345140	B. WING _		07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 323 SS=E	(d) Accidents. The facility must ensigned from accident hazar (2) Each resident reand assistance devi (n) - Bed Rails. The appropriate alternation bed rail. If a bed or must ensure correct maintenance of bed to the following elent (1) Assess the resident or the residents and record maintain water temp degrees Fahrenheit (16) resident's bath 106/108, 107/109, 2	sure that - vironment remains as free ds as is possible; and ceives adequate supervision ces to prevent accidents. e facility must attempt to use ives prior to installing a side or side rail is used, the facility installation, use, and rails, including but not limited nents. Itent for risk of entrapment to installation. and benefits of bed rails with lent representative and obtain fior to installation. Deed's dimensions are resident's size and weight. It is not met as evidenced ion, interviews with staff and dreview, the facility failed to be ratures at or less than 116 (F) in fourteen (14) of sixteen rooms (101, 104, 103/105, 201/203, 202/204, 205,	F3	F323- Free of Accident Hazards/Supervision/Devices 1. 1. Corrective action will be accomplished for those residents for have been affected by the deficient	
	maintain water temp degrees Fahrenheit (16) resident's bathi 106/108, 107/109, 2 206,218, 301/303, 3	peratures at or less than 116 (F) in fourteen (14) of sixteen coms (101, 104, 103/105, 201/203, 202/204,205, 305/307 and e of two shower rooms (West).		Corrective action will be accomplished for those residents for	and

Facility ID: 923010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345140	B. WING _			07/	13/2017
NAME OF PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	_		61	10 WEST FISHER STREET		
BRIGHTMOOR NURSING CENTE	R		SALISBURY, NC 28145			
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
revealed "Temp Conmust be kept clean a any foreign matter b many water systems initial installation of determines that your deposits and foreign valve should be clean any observation on 7 stage 1 interview reversions from the faucet in the 103/105 was 120 degras obtained by using calibrated to 32 degras An observation on 7 stage 1 interview reversions from the faucet in the 102/104 was 120 degras he did not have any being too hot. An observation on 7 conducted with the faucet was 120 degras Bathroom shared by faucet was 12	ufacturer's instructions trol valve control mechanism and free from deposits and uild-up that will be present in b. Inspect within 30 days of operation. If inspection water system causes matter buildup monthly, then ned monthly." /10/17 at 3:00 PM during //ealed the hot water coming the bathroom shared by rooms grees F. The temperature ing a thermometer that was rees in ice water. /10/17 at 3:13 PM during //ealed the hot water coming the bathroom shared by rooms grees F. Resident # 2 stated complaints about the water /10/17 at 3:45 PM was collowing was noted: 103/105-water from the the see F. 201/203-water from the the see F. 206/208-water from the the see F. 206/208-water from the the see F. 102/104-water from the	F3	323	He noted that debris had collected in the mixing valve and was preventing it from working properly. He cleaned the valve and replaced it on the holding tank. On the tank was filled, he checked the temperature of the water to ensure that was within the allowable range and that the mixing valve was functioning proper. There were no further issues at this time. Corrective action will be accomplisted for those residents having potential to larger and that the mixing valve was functioning proper. There were no further issues at this time. Corrective action will be accomplisted for those residents having potential to larger that the same deficient practice. Any resident has the potential to be effected by the same practice. a. On July 12, the maintenance supervisor installed a manufacturer recommended thermometer on the holding tank that will allow him to check the temperature of the water in the tank. The Maintenance supervisor begandaily QA of temperatures in the resider rooms for allowable state approved temperatures. 3. Measures put into place to ensure that the deficient practice will not occur are: a. The water temperatures in the hold tank and all resident rooms will be checked daily by the maintenance supervisor to ensure it is within allowable range and will be documented on a preventive maintenance form that will be reviewed by the Administrator for compliance. b. The mixing valve will be checked monthly basis and documented on a Q form by the maintenance supervisor to ensure that no debris has collected in its ensure that the deficient process.	ce t it t rrly. e.e. shed be by: K K n a ats	

Facility ID: 923010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
				345140	0	B. WING			07/	13/2017
	ROVIDER OR SU						6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH	DEFICIENCY	TEMENT OF DE MUST BE PRE SC IDENTIFYIN	CEDED B	Y FULL	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued F An observary the bathrood Temperature thermometer faucet. The following wa Time water te 4:02 PM 4:05 PM 4:05 PM 4:09 PM 4:10 PM F 4:16 PM 120 dee 4:21 PM F. 4:23 PM F 4:23 PM F 4:28 PM F Con 7/10/17 conducted water temperature of the conducted wate	tion on 7/1 ms in the I es were ta er and were water fau as noted Room n emperatur 106/108 101 201/203 202/204 205 West wi grees F 301/303 305/307 306/308 302/304 at 4:55 PN with Nurse d with provite the same perature to d complain at 4:59 PN with Med A shift and I / resident	0/17 was consider the consider that the consider that the consideration of the consideration	ms. calibrate ms	water uch. The ion degrees F degrees F 120 degrees degrees F 124 degrees 122 degrees 120 degrees 120 degrees 120 degrees 120 degrees 120 degrees 120 degrees 150 d	F	323	by the Regional Facility Services Maintenance Supervisor monthly ongo c. Any area of concern will be report to the Regional Facility Services Maintenance Supervisor immediately. 4. The facility will monitor its performance to make sure solutions ar sustained by: a. Water temperatures will be monitor daily by the maintenance supervisor or preventive maintenance form and reported to the Administrator on a daily basis x 4 weeks; weekly x 1 month; biweekly x 1 month and weekly thereat or more often if need. b. The Regional Facility Services Maintenance Supervisor will audit the preventive maintenance form complet by the maintenance supervisor for recorded temperatures weekly x 4 we biweekly x 1 month and monthly thereat c. Water temperatures will be review by the Safety committee weekly x 4 weeks; biweekly x 1 month; monthly x months to the Monthly QA committee frompliance. d. The QA reviews outlined above with discussed monthly at the QA meeting. QA results will be discussed quarterly with the Medical Director at the Quarterly QA meetings unless changes are needed to be made prior to that meeting. The Medical Director will be contacted for advice and guidance should changes to the QAs need to be done prior to the quarterly meeting	e red n a riter ed eks; after ed for All	

	OF DEFICIENCIES CORRECTION	(X1)		R/SUPPLIER/CLIA ATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
				345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIE				•	6	STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEF	CIENCY MU	ST BE PRE	FICIENCIES CEDED BY FULL 3 INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From adjusted to their noticed it being On 7/10/17 at 5 conducted with assisted with bathad seen the wanot to the point noted any water bathrooms. On 7/10/17 at 5 temperatures in rooms was conducted in the point noted any water bathrooms.	ilking. Stoo hot. 16 PM, a Level II N ths and s ater hot in t was "ste too hot in 1:02 PM, a the resid ducted win ated he ch very Mono cked eve ad accura rector sta ged betw t wing of vater hear	in interviel A #2 who is howers. In the showers an observent room the the Manager of the informated the areen 107-the builditers. The	ew was o stated she She said she wer room but he had not dent's vation of water s and shower intenance e water ing. Most of because he ation. The verage water 108 degrees F. ng was farther e West wing	F	323			
	water temperate degrees F. The digital electronic calibrate the the calibrate below not routinely cal checking the water tempe calibrated therm the water flow s middle of the stream of the water Tempe S:10 PM 10	Maintena thermon rmomete 36.6 degribrate the ter temperature by cometer do that the em and tip ater. The	y ran beto ance Director. He res F. Ho thermone eratures. holding a irectly in water ac o of the p	ween 110-115 cotor had a e attempted to ould not le stated he did neter before He checked another the center of ctually fell on the robe was in the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION			/SUPPLIER/CLIA TION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER			1	6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST FISHER STREET SALISBURY, NC 28145	, ,,,,	
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I		EDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page 5:14 PM 102/104 5:16 PM 103/105 5:18 PM 101 5:20 PM 200 5:22 PM 201/203 5:24 PM 202/204 5:26 PM 205 5:28 PM 206/208 5:30 PM 209/207 5:32 PM 302/304 5:34 PM 301/303 5:36 PM 306/308 5:38 PM 307/308 5:36 PM 309 5:50 PM West w 112 degrees F. On 7/10/17 at 6:01 Pl temperature logs for July 2017 was condu were checked in twelraveraged 107-108 de Director stated he was temperature to 107-1 there. He said he did regulations stated about 107 Pl temperature to 107-1 there. He said he did regulations stated about 107 Pl temperature to 107-1 there. He said he did regulations stated about 107 Pl temperature to 107-1 there. He said he did regulations the did not routinely of mixing valve was conducted the knob highwater and it did not set indicated there was not a therm and no temperature of mixing valve. The Mathematical field in the mixing valve are for the form of the form	sink sink sink sink sink sink sink sink	f the water ne 2017 and nperatures athrooms and Maintenance et the water and leave it at the peratures. ation of the ne ne mixing valve ago. He said mixing valve ted on the rector stated ng valve and ne checked the gh. He ntenance done	F	323			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345140	B. WING		07/13/2017		
	ROVIDER OR SUPPLIER OOR NURSING CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPREDEFICIENCY)	JLD BE COMPLETION		
F 323	Maintenance Director March when he turn On 7/11/17 at 10:10 conducted with the I stated the water being should not be over 1 water coming straight and laundry was set there were not sepaland laundry areas. The routine maintenative. On 7/11/17 at 10:15 water tanks and mix the Maintenance Director Coordinator. There water was stored and kitchen areas. The mixing valve beful shower rooms and be separate lines for the temperature on the stanks indicated the water was no way of the water coming our resident bathrooms checking each one was tated he would try a check to see if it need immediately. He stamanufacturer's instrumaintenance was not the control of the c	apposed to be done. The or stated he last adjusted it in ed it back a little bit. AM, an interview was Maintenance Coordinator who ag used for resident care 16 degrees F. He stated the not off the boiler to the kitchen at 140-150 degrees F and trate lines going to the kitchen He was unsure if there should not done for the mixing AM, an observation of the ing valve was conducted with the ector and the Maintenance were two holding tanks where do before going to the laundry. The tanks also fed water to one it went to the resident wathrooms. There were no the kitchen/laundry. The gauge located on the holding water temperature was 145 antenance Coordinator stated is knowing the temperature of it of the mixing valve to the land showers without with a thermometer. He and adjust the mixing valve, and the state of the replaced in the state of the replaced in the land showers without with a thermometer. He and adjust the mixing valve, and the state of the replaced in the last of the last of the replaced in the last of the replaced	F 323				

PRINTED: 08/18/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIER			6	STREET ADDRESS, CITY, STATE, ZIP CODE 110 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	take care of the main have the Maintenance water temperatures. On 7/11/17 at 1:59 PI conducted with the Admintenance Coordin Coordinator stated he valve and the temper were within 104 degree Administrator stated to temperature checks were within normal lirelevated temperature aware there was a present the property of the property o	the maintenance people to tenance of the water and did tenance of the water and did to birector keep a log of the and the ator. The Maintenance that readjusted the mixing atures were rechecked and the sees F to 111 degrees F. The hey had been doing weekly and the temp checks inits. If there had been s, they would have been oblem with the mixing valve.	F	323			
F 356 SS=C	Maintenance Coordin Director stated he wa who told him the temp 101 degrees F -116 of temperature checks s monthly but he did wa weekly. 483.35(g)(1)-(4) POS INFORMATION 483.35 (g) Nurse Staffing Info	aintenance Director and the ator. The Maintenance is trained by the Coordinator perature should be between legrees F and water should be completed at least ater temperature checks TED NURSE STAFFING Dormation is. The facility must post	F	356			8/10/17

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER			6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 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 PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	e 28	F:	356			
	(ii) The current date.						
	by the following categ	aff directly responsible for					
	(A) Registered nurses	S.					
	(B) Licensed practical vocational nurses (as	I nurses or licensed defined under State law)					
	(C) Certified nurse aid	des.					
	(iv) Resident census.						
	(2) Posting requireme	ents.					
		ost the nurse staffing data h (g)(1) of this section on a inning of each shift.					
	(ii) Data must be post	ed as follows:					
	(A) Clear and readable	le format.					
	(B) In a prominent pla residents and visitors	ace readily accessible to .					
	The facility must, upo make nurse staffing d	posted nurse staffing data. In oral or written request, Italiata available to the public It to exceed the community					
		tion requirements. The the posted daily nurse					

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING			X3) DATE SURVEY COMPLETED		
		345140	B. WING		07/1	3/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PDICUTM	OOR NURSING CENTER	•	6	10 WEST FISHER STREET		
DICIGITIM	OOK 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 356	Continued From page	e 29	F 356			
	staffing data for a mir	nimum of 18 months, or as				
		, whichever is greater.				
	This REQUIREMENT by:	is not met as evidenced				
	Based on observatio	n, record review and staff		F356- Posted Nurse Staffing Informat	ion	
		failed to post an accurate				
		irsing staffing report of total		1.1. Corrective action will be accomplished.		
		nsed and unlicensed staff for		for those residents found to have been	1	
	· ·	iewed for the daily staffing		affected by the deficient practice : a. The daily staff hours report was		
	posting.			corrected immediately by the Director	of	
	Findings included:			Nursing on 7/14/17.	וכ	
	i mango moladea.			b. The facility scheduler was educate	ed	
	Upon entrance to the	facility on 7/10/2017 the		by the Director of Nursing on 7/14/17 of		
	-	d the current census of 41		how to record the hours for staffing ba		
	residents. The Admin			on separating the certified bed census		
	resident was at assist	ted living level. During the		numbers and assisted living census		
	initial tour of the facili	ty on 7/10/2017 at 11:00 AM,		number s on the posted daily staff hou	rs,	
		sting reported 41 residents.		and calculating actual nurse hours wor	ked	
		as 40 that date. The daily		every shift.		
		ut for all three shifts with		Corrective action will be accomplish		
		worked completed for first,		for those residents having potential to		
	second and third shift	ls.		affected by the same deficient practice	by:	
	A	an and daile a de adula		Any resident has the potential to be		
	A review of the staffin			effected by the same practice.		
		was incorrect by including sident with the skilled nursing		a. The DON or the Administrator will record on a QA form that she has		
	census on the following			reviewed the daily staff hours form and		
	6/29/2017, 7/1/2017,			that it is correct for the census and the		
	i i	7/6/2017, 7/7/2017, 7/8/2017,		actual hours worked by nurses M-F		
		7/11/2017, and 7/12/2017.		weekly x I month, biweekly x 2 months	· .	
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,		monthly x 6 months	,	
	A review of the staffin	g and daily schedule		The weekend supervisor is responsible	e for	
		nber of hours worked by		ensuring the correct staffing numbers		
	Registered Nurse (RI			on the report on the weekend and will		
	6/28/2017, 6/30/2017			record results on the QA form weekly	cI	
	7/6/2017, 7/7/2017, 7	/10/2017, and 7/12/2017.		month, biweekly x 2 months, monthly x months		
	A review of the staffin	g and daily schedule		b. The DON will report on the QA for	m in	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345140	B. WING			07/13/2017
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
DDICUTM	OOD NUDEING CENTER	n.		610 WEST FISHER STREET		
BRIGHTM	OOR NURSING CENTE	ĸ		SALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	
F 356	Continued From pag	e 30	F 3	56		
F 356	revealed the total nu Licensed Practical N 6/29/2017, 6/30/2017 7/11/2017. A review of the staffir revealed the total nu nursing assistants (N including the time wo resident on the follow 6/29/2017, 7/1/2017, 7/5/2017, 7/9/2017, 7/10/2017, 7/9/2017, 7/10/2017, 7/9/2017, 7/10/2017, 7/9/2017 at 8:54 AN responsible for filling staff report of total hounlicensed staff for explain she had been number of residents census. She then de RN nurse manager a coordinator as licens and second shift, but clinical services coor 5-6:00 PM when the reported she was no resident should not be census and was not adjust the total hours care. The Administrator an President (VP) were	mber of hours worked by Jurse (LPN) were incorrect on 7, 7/4/2017, 7/6/2017, and and daily schedule mber of hours worked by JA) was incorrect by orked with the assisted living wing dates: 6/28/2017, 7/2/2017, 7/3/2017, 7/6/2017, 7/7/2017, 7/1/2017, and 7/12/2017. Inducted with NA #3 on Jurse worked for licensed and each day. She went on to an instructed to list the total in the facility for the daily escribed the process to list the and the LPN clinical services are dependently of the nurse manager and redinator did not work past by were scheduled. She the aware the assisted living the included in the total aware she would have to soft the NA assigned to his and the Corporate Vice interviewed on 7/13/2017 at	F 3	the administrative morning mee accuracy of the census and act worked for nursing staff weekly biweekly x 2 months, monthly x 3. Measures put into place to that the deficient practice will not are: a. The DON or the Administrative record on a QA form that she has reviewed the daily staff hours for that it is correct for the census a actual hours worked by nurses. The weekend supervisor is respensuring the correct staffing nur on the report on the weekend a record results on the QA form b. The DON will report on the the administrative morning mee accuracy of the census and act worked for nursing staff includir form completed by the weekend supervisor 4. The facility will monitor its performance to make sure solur sustained by: a. QAs will be done weekly x biweekly x 2 months, monthly x b. The QA reviews outlined all discussed monthly at the QA m QA results will be discussed quarterly with Medical Director at the Quarterly meetings unless changes are n be made prior to that meeting. Medical Director will be contact	ual hours x I month 6 month ensure of occur ator will as orm and and the M-F consible mbers an nd will QA form eting for ual hours ng the QA d tions are I month, 6 month bove will eeting. A the ly QA eeded to The ed for	for re n in s A
	aware the assisted li be included in the to	nistrator and VP were not ving level resident was not to tal census for the building, or in the assisted living level		advice and guidance should characteristic the QAs need to be done prior to quarterly meeting	•	

Facility ID: 923010

(X1) PROVIDER/SUPPLIER/CLIA

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(X3) DATE SURVEY

OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBED:				(X3) DATE SURVEY COMPLETED	
	345140	B. WING _			07/13/2017	
ROVIDER OR SUPPLIER OOR NURSING CENTE	R		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	Ē		
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
resident could not be worked. The Administ their expectations we accurately posted, as licensed and unlicen accurate information	e included in the total hours strator and VP both stated ere the census was swell as the posting of sed staff was updated with at the end of the shift.				8/10/17	
COMMITTEE-MEME QUARTERLY/PLANS (g) Quality assessment (1) A facility must may and assurance comminimum of: (ii) The director of numbers (iii) The Medical Direction (iii) At least three oth staff, at least one of administrator, owner individual in a leader (g)(2) The quality assessment and evaluated identifying issues with assessment and assinecessary; and (ii) Develop and implication to correct identifer (g)	ent and assurance. eintain a quality assessment nittee consisting at a rsing services; ctor or his/her designee; er members of the facility's who must be the , a board member or other ship role; and sessment and assurance terly and as needed to late activities such as th respect to which quality urance activities are ement appropriate plans of ntified quality deficiencies;	F 5			8/10/1/	
(h) Disclosure of info	rmation. A State or the					
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From pags resident could not be worked. The Administ their expectations we accurately posted, as licensed and unlicen accurate information 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEME QUARTERLY/PLANS (g) Quality assessment (1) A facility must make and assurance comminimum of: (i) The director of nution (ii) The Medical Direction (iii) At least three oth staff, at least one of administrator, owner individual in a leader (g)(2) The quality assessment and assurance sommittee must: (i) Meet at least quark coordinate and evaluation in the correct identifying issues with assessment and assurancessary; and (ii) Develop and implication to correct identifying action to cor	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 resident could not be included in the total hours worked. The Administrator and VP both stated their expectations were the census was accurately posted, as well as the posting of licensed and unlicensed staff was updated with accurate information at the end of the shift. 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's 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	CORRECTION 345140 B. WING_ SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 resident could not be included in the total hours worked. The Administrator and VP both stated their expectations were the census was accurately posted, as well as the posting of licensed and unlicensed staff was updated with accurate information at the end of the shift. 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's 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;	A BUILDING 345140 B. WINS STREET ADDRESS, CITY, STATE, ZIP CODE (10 WEST FISHER STREET SALISBURY, NC 28145 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 31 resident could not be included in the total hours worked. The Administrator and VP both stated their expectations were the census was accurately posted, as well as the posting of licensed and unilcensed staff was updated with accurate information at the end of the shift. 483.75(g)(1)(l)-(iii)(2)(l)(ii)(l)(l)(QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The Medical Director or his/her designee; (iii) At least three other members of the facility's 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;	TOMOBER OR SUPPLIER 345140 3	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345140	B. WING	 	07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTE	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 520	records of such com such disclosure is re such committee with section. (i) Sanctions. Good committee to identifi deficiencies will not sanctions. This REQUIREMEN	ge 32 equire disclosure of the nmittee except in so far as elated to the compliance of the requirements of this faith attempts by the y and correct quality be used as a basis for	F 52		
	record reviews, the and Assurance Com implement, monitor action plans develop survey dated 08/04/survey dated 01/26/sustain compliance. deficiency to prever 323). The facility ha accurate daily stafficontinued failure of recertification surve shows a pattern of tan effective Quality findings included: 1. This F tag is crosside rail to the bed fresidents. 1.b. On 07/13/2017 water temperatures Fahrenheit (F) for 1-26/2017.	ions, staff interviews and facility's Quality Assessment mittee (QA and A) failed to and revise as needed the ped for the recertification (2016 and the extended (2017, in order to achieve and The facility had a repeat at accidents and hazards (F d a repeat deficiency to posting hour sheets (F356). The the facility during two ys and an extended survey he facility's inability to sustain Assurance Program. The s referenced to F 323. the facility failed to secure a frame for one of twenty the facility failed to maintain at or less than 116 degrees 4 of 16 resident bathroom (24,103/105, 106/108,		F520- QAA Committee- Members M Quarterly /Plans 1. Corrective action will be accomp for those residents found to have bee affected by the deficient practice: a. The facility had in place a Week monitoring system that was complete the Maintenance supervisor to record water temperature in resident rooms bathing areas. This QA had not ident any water temperature outside the allowable range. Due to the fact that there has now been an identified prothe QA process has been redefined to initiate a daily check of the water temperatures to ensure they are with the allowable range which is perform the maintenance supervisor. b. The facility scheduler has now beed deducated on how to record the hours staffing based on separating the cert bed census numbers and assisted living census numbers on the posted daily hours, and calculating actual nursing worked every shift. 2. Corrective action will be accomplete.	lished en y QA ed by d the and iffied blem, o hin ed by een for ified ring staff staff

		(X3) DATE COMP	SURVEY				
		345140	B. WING			07/	13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER	3	•	61	TREET ADDRESS, CITY, STATE, ZIP CODE 10 WEST FISHER STREET ALISBURY, NC 28145		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 520	301/303, 302/304, 30 (West Hall) of 2 resident An interview conduct with the Corporate Vithe facility had no act that the facility had no act that the facility monitor water temperature sto had already initiated the regulations for matemperatures through 2. This F tag is cross 2.a. On 01/26/2017, as eparate and actual LPN (Licensed Pract posted daily staffing freviewed. 2.b. On 07/13/2017, acertified bed census census numbers on the for 14 of 15 days revited did not calculate a every shift on the post 15 daily posted staff. An interview conduct with the Corporate Vithe facility had no act monitor that the facility and no act monitor that the facility had no act monito	22/204, 205, 206, 218, 25/307 and 306/308) and 1 lent shower rooms. ed on 07/1/32017 at 5:12 PM ice President revealed that tion plan in place to monitor ored water temperatures for ability and that the facility corrective actions to meet aintaining safe water mout the facility. referenced to F 356. the facility failed to post RN (Registered Nurse) and ical Nurse) hours on the hour sheets for 14 of 14 days the facility failed to separate numbers and assisted living the posted daily staff hours iewed and the facility failed ctual nurse hours worked sted daily staff hours for 8 of sheets reviewed. ed on 07/13/2017 at 5:12 PM ice President revealed that tion plan in place for to ty followed the regulations nation recorded on the	F	520	for those residents having potential to affected by the same deficient practice. Any resident has the potential to be effected by the same practice. a. The water temperatures in the hold tank and all resident some rooms will be checked daily by the maintenance supervisor to ensure it is within allowal range and will be documented on a preventive maintenance form that will reviewed by the Administrator for compliance. b. The mixing valve will be checked monthly basis and documented on a Gorm by the maintenance supervisor to ensure that no debris has collected in and be cleaned out. This will be audited by the Regional Facility Services Maintenance Supervisor monthly ongoid. Any area of concern will be report to the Regional Facility Services Maintenance Supervisor immediately. e. Resident rooms and bathing area have been added to the Quality Assurance Checklist that was already place for room condition and personal care of the residents, performed daily the administrative staff. If they find any resident room or bathing area that has water temperatures outside the allowar range they are to notify the Administrative and maintenance supervisor immediat. This will be ongoing. f. The DON or the Administrator will record on a QA form that she has reviewed the daily staff hours form and that it is correct for the census and the	by: ding ble be on a bA t d ing. ed s in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING (X3)			ATE SURVEY MPLETED			
		345140	B. WING _			07/13/2017
	ROVIDER OR SUPPLIER OOR NURSING CENTER	₹		STREET ADDRESS, CITY, STATE, 610 WEST FISHER STREET SALISBURY, NC 28145	ZIP CODE	
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F 520	Continued From page	e 34	F	monthly x 6 months The weekend supervis ensuring the correct st on the report on the we record results on the C month, biweekly x 2 me months g. The DON will report the administrative mont accuracy of the census worked for nursing state biweekly x 2 months, n 3. Measures put into that the deficient practicare:	affing numbers are eekend and will DA form weekly x 1 onths, monthly x 6 ort on the QA form in ning meeting for and actual hours of weekly x I month, monthly x 6 months. In place to ensure ice will not occur atures in the holding a rooms will be maintenance is within allowable imented on a ce form that will be distrator for will be checked on a numented on a QA ce supervisor to mas collected in it his will be audited by Services or monthly ongoing. For will be reported or Services or immediately, and bathing areas e Quality nat was already in on and personal performed daily by	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		345140	B. WING _			07/13/2017	
	ROVIDER OR SUPPLIER OOR NURSING CENTER	₹		STREET ADDRESS, CITY, STATE, Z 610 WEST FISHER STREET SALISBURY, NC 28145	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From pag	e 35	F 5.	resident room or bathing water temperatures outs range they are to notify and maintenance super. This will be ongoing. e. The DON or the Ad record on a QA form that reviewed the daily staff that it is correct for the cactual hours worked by weekly x 1 month, biwed monthly x 6 months. The weekend superviso ensuring the correct state on the report on the weekend record results on the QA month, biweekly x 2 momonths. f. The DON will report the administrative mornificaccuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for nursing staff biweekly x 2 months, may accuracy of the census worked for the morning meeting, of compliance is discussed and recorded on the 24 b. The Daily Water Te is discussed in the week X 4 weeks; bi-weekly x 2 x 6 months c. The DON will report hours form in the admin meeting for accuracy of actual hours worked for	side the allowable the Administrator visor immediately ministrator will at she has hours form and census and the nurses M-F ekly x 2 months, or is responsible for ffing numbers are ekend and will a form weekly x I noths, monthly x 6 ton the QA form ing meeting for and actual hours weekly x I month onthly x 6 months intor its ure solutions are Checklist for reviewed daily M-and any area out sed for follow-up hour report. Imperature Record ty Safety meeting 2 months, monthly ton the daily staff istrative morning the census and	n F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	3) DATE SURVEY COMPLETED
		345140	B. WING			07/13/2017
NAME OF PROVIDER OR SUPPLIER BRIGHTMOOR NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 610 WEST FISHER STREET SALISBURY, NC 28145		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLET DATE	
F 520			F 53	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		5