STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 05/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/17/2021 through 05/20/2021. The facility was found in compliance with the requirement CFR 483.73. Emergency Preparedness. Event ID # 4LVE11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 05/17/2021 through 05/20/2021. One of the three complaint allegations was substantiated resulting in a deficiency. Event ID # 4LVE11.	F 000		
F 569 SS=D	Notice and Conveyance of Personal Funds CFR(s): 483.10(f)(10)(iv)(v) §483.10(f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. §483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.	F 569		6/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/31/2021

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F 569	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to convey funds within 30 days for 1 of 2 residents (Resident #123) and failed to send conveyed funds to the individual or probate jurisdiction administering the resident's estate for 2 of 2 residents (Resident #123 and Resident #23) reviewed for personal funds. Findings included: 1. Resident #123 was admitted to the facility 10/4/2005 and discharged to the hospital on 8/21/2020. Hospital records were reviewed and revealed a date of death of 8/27/2020. A review of the resident #123 ' s personal funds account managed by the facility revealed a facility check dated 1/8/2021 in the amount of $928.58 was paid to the order of Social Security. The regional Business Office Manager (BOM) was interviewed on 5/19/2021 at 2:33 PM. The BOM reported Resident #123 ' s funds were not conveyed until 1/8/2021 because she was out sick, and she was the only BOM for the facility. The BOM reported the facility had received a check from the Social Security Administration for Resident #123 after his death and the funds were sent back to the Social Security Administration. The BOM reported she was aware that personal funds needed to be conveyed within 30 days of a resident ' s death or discharge. A follow up interview was conducted with the BOM on 5/20/2021 at 11:27 AM. The BOM stated she was not aware the resident ' s personal funds should have been released to the individual or	F 569	BRIGHTMOOR NURSING CENTER□'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. " F-569: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The funds for residents #123 and #23 had already been conveyed prior to survey. The issue was the timing of the conveyance. Since the funds had already been conveyed, there is no further action that the facility can take to correct this deficient practice for residents #123 and #23. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident may have the potential to be	

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F 569	Continued From page 2 probate jurisdiction administering the resident's estate. The Administrator was interviewed on 5/20/2021 at 11:36 AM. The Administrator reported it was her expectation that resident funds were conveyed within 30 days of a resident death or discharge and that the funds were sent to the estate of the deceased or discharged resident to be distributed to the correct entities. 2. Resident #23 was admitted to the facility 7/30/2010 and died on 3/9/2021. A review of the resident #23 ' s personal funds account managed by the facility revealed a facility check dated 4/1/2021 was paid to the order of Social Security for $2574.10. An interview was conducted with the BOM on 5/20/2021 at 11:27 AM. The BOM reported that $770.10 was received by the facility from the Social Security Administration after Resident #23 ' s death. The BOM explained that $1804.10 was personal funds and should have been sent to the estate of Resident #23. The BOM stated she was not aware all residents personal funds should have been released to the individual or probate jurisdiction administering the resident's estate. The Administrator was interviewed on 5/20/2021 at 11:36 AM. The Administrator reported it was her expectation the resident personal funds were sent to the estate of the deceased or discharged resident to be distributed to the correct entities.	F 569	affected by this practice. All residents that discharge from the facility (return not anticipated) or that expire will have their funds and an accounting of those funds conveyed to them or to the proper individual or probate jurisdiction administering the resident□'s estate within 30 days of discharge or death. MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR: The Regional Business Office Manager and the Facility Business Office Manager have both been inserviced on 05/27/2021 by the Facility Administrator concerning the proper procedure for conveying funds upon a resident□'s discharge (return not anticipated) or death. Beginning 6/01/2021 and continuing for 6 months,for	

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F 569	Continued From page 3	F 569	all residents that leave the facility (return not anticipated) or expire, the Business Office Manager will record the resident□'s name, date of discharge/death, balance of funds in the Resident Trust Account, and disposition of funds including any documentation of said disposition on a QA form within 25 days of discharge and will present this form to the Facility Administrator for review once the funds have been distributed. The QA Form will then be brought to the Monthly QA Meeting by the Business Office Manager for review by the QA Committee. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS: Beginning 6/01/2021 and continuing for 6 months, the Facility Administrator will review the Business Office Manager'□s QA form each time funds are distributed to ensure that funds and final accounting of funds for all residents that have discharged or expired have been properly conveyed to the proper individual or probate jurisdiction within the required 30 day time period. The Business Office Manager will bring the QA form to the Monthly QA and Quarterly QAPI meetings for review to determine if the corrective action is achieved and sustained. The facility Administrator will be responsible for the Plan of Correction.	

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label, and date opened food and drinks in 2 of 2 coolers observed. Findings included: The kitchen was observed on 5/17/2021 at 9:43 AM. The 2-door cooler was observed to have open and undated drinks: Thick and Easy Milk (expiration date 7/30/2021), Hydrolyte Thick water (expiration date 7/16/2021), nectar thick apple juice (expiration date 7/14/2021) and nectar thick ice tea (expiration date 7/15/2021). The 3-door cooler was observed to have open and undated food: 1/2-gallon size Hickory Smoke	F 812	" F-812: CORRECTIVE ACTION(S) THAT WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: As noted in the Statement of Deficiencies, the facility did have a system in place for checking that all opened food and drinks were dated and labeled in accordance with 483.60(i). The facility had already determined through the QA process that the stickers used for this purpose were not always adhering to the containers and had purchased new stickers that were	6/17/21

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F 812	Continued From page 5 BBQ sauce, 2 containers of pimento cheese (expiration date 8/21/2021); ½ gallon size of Ranch dressing (expiration 5/31/2021). The Dietary manager (DM) was interviewed on 5/17/2021 at 10:01 AM. The DM reported all food and drinks were to be dated when the items were opened and discarded after 5 days. The DM reported the kitchen used colored stickers to date all food items and sometimes those stickers fell off the food containers due to moisture in the coolers. The DM reported a dietary aide (DA) was responsible for checking the coolers daily to make certain all foods were had an open date sticker. The DM reported she did not know if the stickers fell off the drink and food containers or if the items were not dated when they were opened. DA #1 was interviewed on 5/20/2021 9:59 AM. DA #1 reported he was responsible for checking the coolers daily. DA #1 reported he looked for expired foods and drinks and checked to make certain all open foods or drinks were dated. DA #1 reported sometimes the colored tags fell off the food or drink containers and sometimes the kitchen staff forgot to label the food when they opened the containers. DA #1 reported he had not checked the coolers on 5/17/2021 for expired or undated food or drink items. The DM was interviewed on 5/20/2021 at 10:02 AM. The DM reported she felt that because the colored stickers were small and had a tendency to fall off, the cooking staff had a difficult time using that system and she had purchased larger stickers that had a different adhesive to prevent the stickers from falling off in the cooler. The DM reported she expected all food and drink items to be labeled with the date the item was opened.	F 812	larger and had a different adhesive to use on opened food and beverages. Those stickers had been ordered and had not come in before survey. All food and drinks that were noted on the day of survey to be opened and not dated were thrown away immediately upon the surveyor alerting the Dietary Manager of the issue. This corrected the deficient practice at that time. HOW OTHER RESIDENTS HAVE BEEN IDENTIFIED FOR HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND THE CORRECTIVE ACTION(S) THAT HAVE BEEN OR WILL BE TAKEN: Any resident has the potential to be affected by this practice. The facility had already determined through the QA process that the stickers used for this purpose were not always adhering to the containers and had purchased new stickers that were larger and had a different adhesive to use on opened food and beverages. Those stickers had been ordered and had not come in before survey. All food and drinks that were noted on the day of survey to be opened and not dated were thrown away immediately upon the surveyor alerting the Dietary Manager of the issue. All Dietary Staff have been inserviced by the Dietary Manager on 5/31/2021 and 6/1/2021 on the proper labeling and storage of opened food and beverages. The first and second shift dietary aide and cook will now be required to check the	

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F 812	Continued From page 6 An interview was conducted with the Administrator on 5/20/2021 at 11:36 AM. The Administrator reported it was her expectation that any opened containers of food or drink were labeled and dated appropriately.	F 812	cooler units at the start of their shift each day for any opened and unlabeled foods and will discard any foods that are opened and unlabeled. Beginning 6/1/2021 the dietary aides and cooks will record the results of these checks on a QA form that will be reviewed by the Dietary Manager twice a week for 1 month and then weekly for 6 months to ensure that the checks are done correctly and that all food is being labeled after being opened and before being stored in the cooler. MEASURES AND/OR SYSTEMIC CHANGES MADE OR TO BE MADE TO ENSURE THE DEFICIENT PRACTICE DOES NOT RECUR: The first and second shift dietary aide and cook will now be required to check the cooler units at the start of their shift for any opened and unlabeled foods and will discard any foods that are opened and unlabeled. The dietary aides and cooks will record the results of these checks on a QA form that will be reviewed twice a week for 1 month and then weekly for 6 months by the Dietary Manager to ensure that the checks are done correctly and that all food is being labeled after being opened and before being stored in the cooler. The Dietary Manager will bring the QA forms to the Monthly QA Committee	

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F 812	Continued From page 7	F 812	Meeting for review. HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THAT its SOLUTIONS ARE ACHIEVED AND SUSTAINED AND HOW THE PLAN WILL BE EVALUATED FOR IT□S EFFECTIVENESS: The Dietary Manager will review the QA forms twice a week for 1 month and then weekly for 6 months to ensure that the checks are done correctly and that all food is being labeled after being opened and before being stored in the cooler. The Dietary Manager will bring the QA forms to the Monthly QA Committee Meeting for review and to the Quarterly QAPI Meeting for review to ensure that the corrective action is achieved, effective, and sustained. The Facility Administrator will be responsible for the Plan.	