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 06/09/2022

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 and complaint investigation survey was conducted on 06/07/22 through 06/09/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #LMOU11. 4 of the 4 complaint allegations were not substantiated. Intake NC00179851 was investigated.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 06/07/22 through 06/09/22. Event ID# LMOU1 4 of the 4 complaint allegations were not substantiated. Intake NC00179851 was investigated.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §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 request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		7/1/22

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

Electronically Signed | 06/22/2022

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on a family interview, staff interviews, and record review, the facility failed to invite the responsible party of a cognitively impaired resident to participate in the planning of the residents' care for 11 months. This occurred for 1 of 3 sampled residents reviewed for care plan meetings (Resident #9). The findings included: Resident #9 was re-admitted to the facility 11/11/19. Diagnoses included dementia with behaviors, psychosis, major depressive disorder, and anxiety, among others. Medical record review revealed the responsible party (RP) for Resident #9 was last invited and attended an interdisciplinary care plan conference on 06/02/21 to discuss the Resident's care. Medical record review revealed Resident #9's cognition was assessed as severely impaired on quarterly Minimum Data Set (MDS) assessments	F 553	Brightmoor Nursing Centers response to the survey does not denote agreement with citations received; nor does it constitute an admission that any stated deficiency is accurate. We are filing it simply because it is required to do so by law. All residents and designated family members have the right to participate in the care planning process. The facility is responsible for notifying the resident and designated family members of care conferences. All residents have the potential to be affected by this practice. The facility Minimum Data Set (MDS) Coordinator will timely provide the resident with a care conference meeting date and time as well as send care conference letters out to the designated family representatives. Resident #9 responsible party will be	

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F 553	Continued From page 2 dated 8/17/21, 11/8/21, 1/31/22 and on an annual MDS assessment dated 4/25/22. There was no record that the RP was invited to discuss the care for Resident #9 during these assessments. A family interview occurred on 06/07/22 at 1:46 PM and revealed the RP had not been invited to participate in a care plan meeting regarding Resident #9's care in several months. The RP stated he did not recall being invited to participate in a care plan meeting either in person or by phone and he wanted to discuss concerns he had regarding the Resident's recent weight gain. On 06/09/22 at 09:48 AM a phone interview with the MDS Nurse revealed she retired in July 2021, and then returned back to work on a part-time basis about 4 weeks ago. The MDS Nurse stated she was responsible to invite residents and their RP to care plan meetings which occurred in conjunction with the MDS assessment. She stated she mailed a letter to the RP and gave a copy of the invitation to the resident. The MDS Nurse further stated that before she retired in July 2021, she invited the RP for Resident #9 to attend care plan meetings, but he did not respond to the letter and he did not attend. The MDS Nurse could not recall the specific month when this occurred. She also stated that when the RP had questions about Resident #9, he called the facility to get his questions answered. An interview with the Regional Nurse Consultant/Director of Nursing (RNC/DON) on 06/09/22 at 10:00 AM revealed she had no further documentation to support that the RP for Resident #9 was invited to participate in care plan conferences in the last year. The RNC/DON stated that the last care plan meeting that the RP	F 553	invited to the next scheduled care plan meeting. The MDS Coordinator will record dates that notice was sent and/or given to residents and their family members on a Quality Assurance form. Quality Assurance audits will be conducted by the Administrator twice a week for four weeks then weekly for four weeks. The results of these Quality Assurance audits will be recorded on a Quality Assurance form and brought to the Quality Assurance Committee for review to ensure the practice does not recur. The Administrator is responsible for overseeing that the MDS Coordinator completes the Quality Assurance process. The facility will monitor its performance through the Quality Assurance Committee and the Quality Assurance Performance Improvement Committee review of the Quality Assurance audits to ensure the solution is sustained. Any changes to the solution will be determined at the aforementioned meetings and will be implemented immediately. The Plan of Correction completion date will be July 1st, 2022.	

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F 553	Continued From page 3 was invited to was 06/02/21. The RNC/DON stated that when the MDS Nurse retired about 1 year ago, the facility experienced a lot of staffing changes, the RNC/DON took on multiple responsibilities at the facility and although she was a prior MDS Nurse, her focus during this time was on the clinical needs of the residents. The RNC/DON stated she contacted the RP for Resident #9 to advise him of changes in the Resident's condition, but she could not explain why the RP was not invited to care plan meetings during each MDS assessment.	F 553		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 761		7/1/22

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F 761	Continued From page 4 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to store medications that required refrigeration in accordance with the manufacturer's instructions and to monitor refrigerator temperatures in 2 of 2 medication refrigerators (east hall and west hall). The facility also failed to date a multiple use medication vial when opened in 1 of 1 medication storage room (west hall). Findings included: The facility's temperature logs indicated the medication refrigerator temperature should be kept at 36-46 degrees (°) Fahrenheit (F). The facility's 'Administering Medication' policy dated May 2022 indicated a multi-dose medication should be dated and recorded on the container when opened. 1. On 06/08/22 at 9:15 AM the west hall medication refrigerator was checked with Nurse #1 in attendance. The medication room refrigerator temperature was checked and noted to be within normal range of 36-46 °F. Review of the May and June 2022 refrigerator temperature logs revealed no temperatures were documented for May 2, 3, 4, 5, 9, 10, 11, 12, 16, 17, 18, 19, 23, 24, 25, 26, 30, 31 and June 1 and 2. The instructions at the bottom of the Refrigerator temperature log read: 'drug room 36-46°F.' An interview was completed on 06/08/22 at 9:16 AM with Nurse #1 and she stated night shift was	F 761	Brightmoor Nursing Centers response to the survey does not denote agreement with citations received; nor does it constitute an admission that any stated deficiency is accurate. We are filing it simply because it is required to do so by law. The facilities refrigerator temperatures must be kept between 36 and 46 degrees Fahrenheit and recorded appropriately. Nursing staff has been in-serviced regarding refrigerator temperatures and appropriate logging practices. No individual residents were identified in the statement of deficiencies. However, the following will be the corrective action for this stated deficiency: Stored multi-dose medications must be dated and recorded on the container when opened. Nursing staff have been in-serviced on the policy of medication administration and the labeling of multi-dose medications. The Director of Nursing will audit refrigerator temperature logs twice a week for four weeks then once a week for four weeks. The results of these Quality Assurance audits will be recorded on a Quality Assurance form and brought to the Quality Assurance Committee for review to ensure the practice does not recur.	

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F 761	Continued From page 5 responsible for checking the temperatures in the medication refrigerator. She noted several dates in May 2022 and the two dates in June 2022 that temperatures were not recorded. Medications that were stored in the west hall refrigerator included in part: - Tuberculin (TB) purified protein tuberculin unit (tu)/0.1ml, 5 milliliters (ml) vial which was opened, dispensed on 9/7/21 and expired on 3/28/23. This was facility stock for tuberculin skin tests. Instructions indicated it was to be stored between 35-46°, dated when opened and discarded after 30 days. An interview was done on 06/08/22 at 9:18 AM with Nurse #1 regarding the opened and undated medication vial. She stated she was not aware when the TB test vial was opened, and she would have to check on how long the medication was good for once it had been opened. She acknowledged there was no date on the bottle, or the box and it was to be stored between 35-46 °F. The following additional medications were in the refrigerator on the west hall and required a storage temperature of 36-46 °F: - Procrit 20,000 ml-1 vial - Novalog prefilled pen-1 - Levemir insulin 100 units (u)/ml-1 On 06/08/22 a phone interview was attempted with Nurse #3 that worked nights 05/30/22, 05/31/22, 06/01/22 and 06/03/22, and had not recorded temperatures. She was unable to be contacted after two attempts on 06/09/22 at 9:32 AM and 4:36 PM.	F 761	The Director of Nursing will audit the multi-dose vials for appropriate labeling twice a week for four weeks then once a week for four weeks. The results of these Quality Assurance audits will be recorded on a Quality Assurance form and brought to the Quality Assurance Committee for review to ensure the practice does not recur. The Administrator is responsible for overseeing that the Director of Nursing completes the Quality Assurance process. The facility will monitor its performance through the Quality Assurance Committee and the Quality Assurance Performance Improvement Committee review of the Quality Assurance audits to ensure the solution is sustained. Any changes to the solution will be determined at the aforementioned meetings and will be implemented immediately. The Plan of Correction completion date will be July 1st, 2022.	

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An interview was conducted on 06/09/22 at 9:41 AM with the Nurse #4 that worked nights usually on the west hall. She noted she checked the medication refrigerator each night.

The Director of Nursing (DON) was interviewed on 06/08/22 at 4:58 PM regarding medication storage. She stated she would expect the medications to be stored within the manufacturer's recommended temperature range, medications that were opened were to be dated and that staff followed the manufacture guidelines for dating the vial or label the multi-dose vial. The DON added the temperature logs were to be completed each night and staff were to ensure that the temperatures were within range and signed. She noted maintenance should be notified with any temperature concerns.

An interview with Administrator #1 was done on 06/08/22 at 5:17 PM in reference to the medication refrigerator on west hall. She was informed of concerns with the refrigerator log not being completed on several dates for May and June 2022, and the opened and undated multidose vial of Tubersol (TB) test solution. She stated she would expect temperatures in the medication refrigerator to be checked daily, monitored that they were in range and the TB vaccine solution would be dated when opened and discarded per manufacturer's guidelines or the facility policy.

2. The Temperature logs for May and June 2022 were reviewed for the east hall and revealed no temperatures were documented on 05/13/22 or 05/15/22. Temperatures were documented below the required range of 36-46 degrees Fahrenheit (°F) on all dates in May 2022 except 5/14/22,

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F 761	Continued From page 7	F 761		

5/19/22 and 5/22/22. These dates and temperatures were as follows:
- 5/1/22: 30°F
- 5/2/22: 32°F
- 5/3/22: 30°F
- 5/4/22: 30°F
- 5/5/22: 32°F
- 5/6/22: 30°F
- 5/7/22: 32°F
- 5/8/22: 30°F
- 5/9/22: 32°F
- 5/10/22: 30°F
- 5/11/22: 30°F
- 5/12/22: 30°F
- 5/13/22: no temperature documented
- 5/15/22: no temperature documented
- 5/16/22: 32°F
- 5/17/22: 32°F
- 5/18/22: 32°F
- 5/20/22: 34°F
- 5/21/22: 34°F
- 5/23/22: 31°F
- 5/24/22: 31°F
- 5/25/22: 32°F
- 5/26/22: 32°F
- 5/27/22: 32°F
- 5/28/22: 32°F
- 5/29/22: 32°F
- 5/30/22: 30°F
- 5/31/22: 30°F

East hall medication refrigerator temperature logs were reviewed for June 2022 temperatures and noted to be below the required range on 06/06/22 (32°F), 06/07/22 (32°F), and 06/08/22 (31°F). These 3 dates had been checked by Medication Aide #1. No comments were listed of actions taken for the temperatures that were out of range. The instructions at the bottom of the Refrigerator

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F 761	Continued From page 8	F 761		

log read: 'the drug room refrigerator temperature should be 36-46°F.

On 06/09/22 at 4:15 PM a review of the east side medication refrigerator was conducted with Medication Aide #3 in attendance from 4:15-4:30 PM, and Nurse #5 in attendance from 4:30-4:40 PM.

Medications that were stored in the east hall refrigerator that required a storage temperature of 36-46 °F per the medication packaging included in part:
- Levemir flextouch pen-1
- NovoLog injection flex pen -10
- Lantus solution injection pen -2
- Insulin glargine pens -2
- Latanoprost sol 0.005% eye drops
- Trulicity pens 4.5/0.5 milliliter (ml) solution-4
- Repatha injection 140 milligram (mg)/ml syringe -1

An interview was conducted with Nurse #5 on 06/09/22 at 4:15 PM regarding the medication refrigerator temperature logs. She stated the night shift checked the medication refrigerator temperatures and Nurse #5 verified several of the medications in the refrigerator required the storage temperature of 36-46°F.

Medication Aide (MA) #1 was interviewed via phone on 06/09/22 at 2:32 PM that worked nights and covered the east hall. The MA stated she checked the refrigerator in the morning when it had not been opened for a while, and thought the temperature range should be 33-46°F. She was asked when she recorded the temperature of 31°F on 06/08/22 night shift what actions were taken. The MA stated she meant to tell

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F 761	Continued From page 9	F 761		

maintenance before she left and forgot. She was asked if she had the option to have submitted a written request and she said "yes." She revealed she had not completed a written request. She was also asked about the 05/13/22 date when she had signed the log, but no temperature was logged and MA #1 stated she must have overlooked it. Medication Aide #1 was asked about the dates in May that she documented temperatures below range (May 2, 3, 4, 9,10, 11, 12, 16, 17, 18, 23, 24, 25, 30, and 31). She stated she should have had maintenance check them and completed a request, but she had not done so.

The Director of Nursing (DON) was interviewed on 06/09/22 at 3:20 PM. She stated she had just been made aware of the medication refrigerator temperature logs being out of range and too cold for the east hall. She noted the staff should have adjusted the temperature independently and rechecked the temperature. The DON also indicated staff should have notified maintenance immediately if it was not corrected.

An interview with the Director of Maintenance was done on 06/09/22 at 3:15 PM regarding the medication refrigerator temperatures. He said there were no requests for the refrigerator temperatures being out of range in the medication rooms. He also noted that staff had a mailbox on each hall they could put the maintenance requests in, but they did not use it. The Maintenance Director stated he was at the facility before night shift left in the morning, made rounds each day and was not told of any issues.

An interview was done on 06/09/22 at 4:42 PM with Administrator #2 regarding the east side

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F 761	Continued From page 10 medication refrigerator temperatures. He stated the temperatures should have been reported to maintenance when temperatures were logging below the appropriate level. He noted some reeducation should be done to ensure staff know what the appropriate actions should be.	F 761		
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on an observation of the lunch meal tray	F 803	Brightmoor Nursing Centers response to	7/1/22

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F 803	Continued From page 11 line, interviews with staff and record review, the facility failed to serve a 4-ounce portion of fried rice and a 3-ounce portion of mechanical soft pineapple chicken per the menu. This failure had the potential to affect 21 of 23 residents. The findings included: An observation of the lunch meal tray line in progress occurred on 06/09/22 at 12:08 PM. The lunch menu included pineapple chicken and fried rice. Dietary Staff (DS) #1 (AM cook) was observed to plate both fried rice and mechanical soft pineapple chicken with a 2-ounce serving utensil for each item. Review of the menu, approved and signed by the Registered Dietitian (RD), revealed residents should receive a 4-ounce portion of fried rice and residents with a physician order for a mechanical soft diet should receive a 3-ounce portion of mechanical soft pineapple chicken. DS #1 was interviewed on 06/09/22 at 12:10 PM and stated that she worked at the facility for the past 19 years and currently worked 4 days one week and 3 days the next week. DS #1 stated she referred to the menu when serving food and that she knew that the menu recorded to serve a 4-ounce portion of fried rice and a 3-ounce portion of mechanical soft pineapple chicken, but that she chose to use a 2-ounce serving utensil for each because the portions on the menu was too much for the residents. DS #1 stated that she watched how much food came back uneaten by the residents and when she noticed that residents were not eating all of their food, she started cutting back on the portions. The Certified Dietary Manager (CDM) was	F 803	the survey does not denote agreement with citations received; nor does it constitute an admission that any stated deficiency is accurate. We are filing it simply because it is required to do so by law. All residents have the right to receive the appropriate portion sized meal that is approved by the Registered Dietician. All residents have the potential to be affected by this practice. No individual residents were identified in the statement of deficiencies. However, the following will be the corrective action for this stated deficiency: The Dietary Manager has conducted an in-service with the dietary staff to ensure the staff members are aware of the different sized scoops and understand which scoop to use with the meal. Education of new-hires will occur during their orientation process and will include how to reference the dietary menu spread sheets for adequate meal portions as well as visualizing the scoops and understanding where to see the scoop size. Quality Assurance audits will be conducted by the Dietary Manager twice a week for four weeks then weekly for four weeks to ensure this process is maintained. The results of these Quality Assurance audits will be recorded on a Quality Assurance form and brought to the Quality Assurance Committee for review to ensure the practice does not recur.	

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 06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 803	Continued From page 12 interviewed on 06/09/22 at 12:15 PM and stated that DS #1 had been a cook for 19 years, so the CDM stated she did not check behind her that often because DS #1 knew what to do and she knew to serve the portions as recorded on the menu. The CDM stated she was unaware that DS #1 served smaller portions because she was usually in the dining room during meals when DS #1 plated the foods. The CDM was observed to provide DS #1 with the correct size serving utensils and advised her that she was required to serve residents foods in the portions recorded on the menu. A telephone interview with the RD occurred on 06/09/22 at 1:20 PM and revealed she reviewed/approved each cycle menu and expected the menus to be followed. The RD stated that if a resident requested smaller/larger portions, the facility should obtain a physicians order for that and that plate waste was not an appropriate reason to serve smaller portions to residents. The RD stated that she expected dietary staff to let her know if they felt that residents did not eat the portions of foods provided for further discussion, otherwise, residents should receive the portions according to the menu. An interview with the Regional Nurse Consultant/Director of Nursing 06/09/22 at 4:00 PM revealed she expected residents to be served portions of food according to the menu that was reviewed/approved by the RD.	F 803	The Administrator is responsible for overseeing that the Dietary Manager completes the Quality Assurance process. The facility will monitor its performance through the Quality Assurance Committee and the Quality Assurance Performance Improvement Committee review of the Quality Assurance audits to ensure the solution is sustained. Any changes to the solution will be determined at the aforementioned meetings and will be implemented immediately. The Plan of Correction completion date will be July 1st, 2022.	