CENTERS F	OR MEDICARE & MEDICAID SERVICES	_		"A" FORM			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345534	B. WING	9/22/2016			
NAME OF PRO	OVIDER OR SUPPLIER		CITY, STATE, ZIP CODE				
SANFORD	ANFORD HEALTH & REHABILITATION CO SUMMARY STATEMENT OF DEFICIENCY Upon written authorization of a resident, t personal funds of the resident deposited w The facility must deposit any resident's personal funds to that account. (In poole share.) The facility must maintain a resident's per account, interest-bearing account, or petty The facility must establish and maintain a according to generally accepted accounting facility on the resident's behalf. The system must preclude any commingling person other than another resident.	2702 FARRELL F SANFORD, NC	ROAD				
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIENCE	CIES					
F 159	483.10(c)(2)-(5) FACILITY MANAGEN	MENT OF PERSONAL	FUNDS				
	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.						
	The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)						
	The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.						
	The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.						
	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.						
	The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.						
	The facility must notify each resident that receives Medicaid benefits 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 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.						
	This REQUIREMENT is not met as evid Based on record reviews and staff intervistatements for 1 of 3 sampled residents (I Findings included: Review of the facility policy for Resident revealed "Statement will be mailed with statement will be maintained in the RTF person mailing the statements".	ews the facility failed to Resident #39). t Trust Fund (RTF) pro- nin 30 days of the end o	vided by the facility Administrator on 9/2 f each calendar quarter. A copy of the				
	An interview on 9/21/16 at 3:23 pm with distributing the quarterly trust fund stater stated that they are sent to the resident 's was unable to find a copy of the trust fun	ments, revealed that she responsible party. She	e sends the RTF statements out quarterly. e reviewed all of her filed RTF statements	s and			

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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FOR SNFs AND NFs							
		345534	B. WING	9/22/2016			
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
		2702 FARRELL ROAD					
SANFORD HEALTH & REHABILITATION CO		SANFORD, NC					
ID							
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES						
F 159	Continued From Page 1 F39 did have a balance of \$67.35 in her trust fund.						
	An interview on 9/22/16 at 10:30 am with the facility administrator revealed the facility identified a systematic error in their computer software that had resulted in Resident # 39 not receiving their quarterly RTF statement.						
I	KIT statement.						