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 07/17/2019

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 7/15/19 to 7/17/19. The facility was found in compliance with the requirement CFR483.73, Emergency Preparedness. Event ID #YZQI11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey with complaint investigation was conducted from 7/15/19 through 7/19/19. One of the four complaint allegations was substantiated resulting in deficiency (F689) See event ID YZQI11.	F 000		
F 584 SS=C	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;	F 584		8/14/19

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

Electronically Signed | 08/09/2019

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F 584	Continued From page 1 §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain a clean and functional environment as evidenced by failure to maintain intact and easily cleanable resident bathroom floors for four of six rooms (Rooms 301, 305, 306, and 310) reviewed for environment. Findings included: Observations conducted during a round on 7/15/19, which started at 10:21 AM, revealed bathroom floors had cracked sheet flooring and gaps where the flooring failed to come into contact with the transition to the vinyl composite tile (VCT) in the resident rooms or the door molding which created a void where floor wax, dirt, and debris had accumulated in the bathrooms of the following rooms: 301, 305, 306, and 310.	F 584	Brightmoor Nursing Center's response to the survey does not denote agreement with citations received. We are filing it simply because it is required by law. The bathroom floors in rooms 301, 305, 306, 310 have been repaired so that there are no cracks or gaps that can collect wax and debris. Any resident has the potential to be affected by this practice. All remaining bathroom floors in the facility have been inspected and any floors found to be in need of repair have been repaired. The facility Maintenance Director will conduct Quality Assurance rounds on the bathroom floors to ensure that the floors remain in good repair. The Quality	

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F 584	Continued From page 2 Observations conducted during a round on 7/17/19, which started at 2:46 PM, revealed bathroom floors had cracked sheet flooring and gaps where the flooring failed to come into contact with the transition to the vinyl composite tile (VCT) in the resident rooms or the door molding which created a void where floor wax, dirt, and debris had accumulated in the bathrooms of the following rooms: 301, 305, 306, and 310. An observation conducted in conjunction with an interview with Housekeeper (HSK) #1 was conducted on 7/17/19 at 3:03 PM. The HSK stated that due to the gaps and cracks in the bathroom floor of room 301 there were some areas which she was unable to clean and the inability to clean these areas had resulted in a buildup of dirt and debris and was not clean. An observation conducted in conjunction with an interview with the Floor Technician (FT) was conducted on 7/17/19 at 3:10 PM. The FT stated that due to the gaps and cracks in the bathroom floor of room 301 he was unable to get down into the gap and remove the old wax, dirt, or debris completely. He said when he waxed the bathroom floors, he would try to clean out the debris, but what he was unable to remove would be covered with wax when he put down the new coats of wax on the bathroom floors. Observations were conducted in conjunction with an interview with the Maintenance Director (MD) during a round on 7/17/19, which started at 3:26 PM. The observation revealed bathroom floors had cracked sheet flooring and gaps where the flooring failed to come into contact with the transition to the vinyl composite tile (VCT) in the	F 584	Assurance rounds will be done weekly for three (3) months, and monthly for six (6) months. The result of these Quality Assurance rounds will be recorded on a Quality Assurance form and brought to the weekly Quality Assurance Committee Meeting for review to ensure the practice does not recur. The Administrator is responsible for overseeing that the Maintenance Director completes the Quality Assurance process. The facility will monitor its performance through the weekly Quality Assurance Committee and quarterly Quality Assurance Performance Improvement Committee review of the Maintenance Director's Quality Assurance rounds to ensure solutions are sustained. Any changes to the solution will be determined at these meetings and will be implemented immediately.	

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F 584	Continued From page 3 resident rooms or the door molding which created a void where floor wax, dirt, and debris had accumulated in the bathrooms of the following rooms: 301, 303, 305, 306, and 310. The MD stated the flooring in the bathrooms did not come all the way to the VCT in the resident rooms which created gaps and there were areas where the concrete slab under the building was visible. The MD stated there was also areas at the molding of the door frames where there were gaps and the bathroom flooring did not but up against the door frame and molding properly. The MD further pointed out areas where the bathroom floor had buckled or there were holes further exposing the concrete slab. The MD stated there was a buildup of dirt and debris in the gaps and buckled floor where the bathroom flooring was improperly installed and he stated the gaps, cracks, and buckles should be filled or repaired so the floor would be smooth and cleanable and there would not be an area for dirt, debris, and wax to build up. An interview was conducted with the administrator on 7/17/19 at 7:22 PM. The Administrator stated it was her expectation for flooring to be clean and if there were gaps or repairs needed to be made to the floor to allow ease of cleaning, those repairs would be made.	F 584		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and	F 679		8/14/19

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F 679	Continued From page 4 individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews the facility failed to provide an ongoing activity program for 1 of 1 resident reviewed for activities (Resident #2). Findings included: Resident #2 was admitted to the facility on 6/20/2016 and readmitted on 5/2/2017 with diagnoses to include diabetes and vascular dementia. The annual Minimum Data Set (MDS) dated 1/1/2019 specified Resident #2 enjoyed listening to music, religious activities and participating in groups activities. The most recent quarterly MDS assessment dated 7/2/2019 assessed Resident #2 to be severely cognitively impaired and he required extensive 2-person assistance with bed mobility, transfers and was non-ambulatory. A note dated 4/1/2019 written by the activity director (AD) noted Resident #2 had been up most days and sitting at the nurse ' s station or in the TV room. The note further documented Resident #2 participation in parties and worship services. Record review revealed no activity notes were written after 4/1/2019.	F 679	Brightmoor Nursing Center's response to survey does not denote agreement with citations received. we are filing it simply because it is required by law. Resident #2 is now off of contact isolation and is being taken to activities, the television/living room, and the nurse's station where he receives socialization. The Activities Director has updated the resident's medical record to include a current note on the resident's activity level and preferences. Any resident has the potential to be affected by this practice. All residents have been reviewed to ensure that they are receiving 1:1 activities of their choice if they do not attend group activities. A Quality Assurance check of all residents charts has been completed to ensure that all charts have up to date notes for activities. The Activities Director will record the names of all residents attending group activities or receiving 1:1 activities on an attendance form and the date of completion of Activity Notes on a Quality Assurance form. The attendance records will be done daily and the Note Quality Assurance will be done each time an	

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F 679	Continued From page 5 A physician order dated 6/10/2019 was written to initiate contact precautions for Resident #2 related to a gastrointestinal infection. A care plan dated 7/10/2019 for Resident #2 addressed activities with interventions to include to offer to turn on TV and keep the remote within Resident #2 ' s reach. Additional interventions included the AD to visit and provide social stimulation and conversation, and encouragement to attend activities. An observation of Resident #2 on 7/15/2019 at 11:02 AM revealed Resident #2 in bed sleeping and on his door was a notice of contact precautions and personal protective equipment. The TV was noted to be off in the resident ' s room and Resident #2 was alone. Resident #2 was observed on 7/15/2019 at 2:36 PM alone in his room and the TV was turned off in the resident ' s room. He turned his head when spoken to but did not respond to questions. An observation was conducted of Resident #2 on 7/16/2019 at 9:49 AM. The TV was turned off in the resident ' s room and Resident #2 was alone in bed. Resident #2 opened his eyes when addressed but did not respond to questions. Resident #2 was observed in bed with his eyes closed on 7/16/2019 at 3:09 PM. He was alone in his room and the TV was turned off in the resident ' s room. The AD was interviewed on 7/16/2019 at 3:26 PM and he reported he had no residents who required 1:1 in room visits.	F 679	Activity Note is completed. Both the attendance sheets and the Quality Assurance form will be presented to the Quality Assurance Committee at the weekly Quality Assurance Meeting for review to ensure that the practice does not recur. This process will have no end date and become common practice for the Activity Director. The Administrator is responsible for overseeing that the Activities Director completes the Quality Assurance process. The facility will monitor its performance through weekly review of the attendance sheets and Activity Note Quality Assurance form as well as quarterly review of each on at the quarterly Quality Assurance Performance Improvement Committee Meeting to ensure solutions are sustained.	

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F 679	Continued From page 6	F 679		

Nursing assistant (NA) #1 was interviewed on 7/16/2019 at 4:53 PM and she reported Resident #2 had very few visitors. NA #1 further explained Resident #2 stayed in his room and did not participate in activities due to the gastrointestinal infection. NA#1 further reported before Resident #2 had the infection, he would attend most of the activities and spent his day sitting in the living or at the nurse ' s station. NA #1 concluded by reporting Resident #2 did not actively participate in activities, but he seemed happy and would smile during activities.

Nurse #1 was interviewed on 7/17/2019 at 8:36 AM and she reported Resident #2 was on contact precautions and had stayed in his room since June. Nurse #2 reported Resident #2 had no visitors and only staff visited. Nurse #1 went on to explain Resident #2 was on contact precautions because of a gastrointestinal infection. Nurse #1 reported all staff had to wash their hands prior to going into the room, apply a protective gown over clothing, gloves and a mask. Nurse #1 reported Resident #2 was staying in his room until the contact precautions were lifted.

NA #2 was interviewed on 7/17/2019 at 11:42 AM and she reported Resident #2 had been in his room due to the contact precautions and she had not observed any visitors in the resident ' s room. NA #2 reported she had observed Resident #2 in the living room watching TV or sitting with other residents during the day before he was placed on contact precautions. NA #2 reported prior to be placed on contact precautions, staff took Resident #2 to worship services, singing and other group activities.

An interview was conducted with the AD on

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F 679	Continued From page 7 7/17/2019 at 2:09 PM. The AD reported Resident #2 had enjoyed going out for religious services, as well as observing group activities or sitting in the living room with other residents. The AD reported he had stopped by to speak to Resident #2 since he had been on contact precautions, but he had not considered that a 1:1 activity. The AD further reported he was not certain why there were no activity notes since 4/1/2019 and reported he thought it was an oversight. The AD concluded by reporting he was not aware that nursing staff were not turning on the TV for Resident #2 and he had not thought to ask Resident #2 if he wanted TV or the radio while he was on contact precautions. The AD went on to say Resident #2 had been a passive participant in most social activities, meaning, he did not actively participate in the activity, but appeared to enjoy the social aspect of the activities. The AD concluded by reporting he had not addressed Resident #2 ' s activity level during his contact isolation. The Administrator was interviewed on 7/17/2019 at 3:14 PM and she reported it was her expectation the Activities Department provided activities for all residents, including residents on contact precautions. The Director of Nursing was interviewed on 7/17/2019 at 3:30 PM and she reported resident who are on contact precautions were isolated and they required ongoing stimulation and attention and staff should be aware to the change in activity level and provide that stimulation and attention.	F 679		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		8/14/19

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F 688	Continued From page 8 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to provide care to address the resident's positioning needs and ordered Occupational Therapy treatments for 1 of 3 residents (Resident #21) reviewed for positioning. Findings included: Resident #21 admitted to the facility on 2/15/17 with diagnoses of stroke with flaccid hemiplegia affecting her left side. The most recent quarterly Minimum Data Set Assessment dated 5/29/19 revealed Resident #21 was severely cognitively impaired and required extensive assistance of two staff members for transfers.	F 688	Brightmoor Nursing Center's response to survey does not denote agreement with citations received. We are filing it simply because it is required by law. The failure to provide a positioning aide, larger chair, and ordered Occupational Therapy for resident #21 was due to the facility not being informed by the contract Occupational Therapist of the need for the equipment. However, the facility has now provided a larger geri-chair and splint for resident #21's left arm as outlined by the Therapist. Review of all resident records shows that no other resident is in need of equipment or services as determined/ordered by	

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F 688	Continued From page 9 An order written by Nurse #1 on 6/20/19 stated, "Needs support sling for left arm due to left sided hemiplegia/arm dangling." The Care Plan dated 6/22/19 revealed Resident #21 required a mechanical lift for transfers to her reclining wheel chair due to left side hemiplegia resulting from a stroke. An order for clarification written 6/26/19 by Occupational Therapy services stated, "skilled occupational services 3 times a week for 30 days to address therapeutic exercises, manual therapy, activity of daily living retraining, wheelchair position and upper extremity orthotic secondary to abnormal posture." A review of the Occupational Therapy Evaluation dated 6/26/19 revealed Resident #21's short term goals were to receive a wider chair to improve positioning and to receive a left upper extremity resting hand splint to wear up to three hours a day. The long-term goals listed for Resident #21 was to wear the left upper extremity hand splint for four to six hours daily. A therapy note written by Occupation Therapist #1 on 6/26/19 revealed Resident # 21 was currently in a wheelchair that was too small and she would benefit from a wider chair, but a wider chair was not available in the facility. Review of a therapy note written 7/1/19 by Occupational Therapist #2 revealed she had consulted nursing and attempted to locate a sling within the facility and had attempted to find alternative wheelchair seating system for possible attachment of positioning devices for Resident #21's left arm.	F 688	Therapy. The issue of the need not being communicated to the facility by the Therapist has been addressed with the Regional Director for the contract therapy company and a new system has been developed to ensure that lapses in communication do not recur. A new system has been put into place that requires all therapy disciplines to communicate via email with the facility Administrator, facility Director of Nursing, facility Minimum Data Sets Coordinator, and the Regional Director for the contract therapy company any equipment or services needs. Additionally, the Director of Nursing will conduct an audit of resident records within 48 hours of referral to therapy to ensure that equipment and service needs are met timely and not missed again. The Director of Nursing will record the results of the Quality Assurance on a Quality Assurance form and print outs of the Regional Director's emails to the Quality Assurance Committee for review at the weekly Quality Assurance Committee Meeting. The system will become common practice and will have no end date. The Administrator is responsible for overseeing the that the Director of Nursing, Minimum Data Sets Coordinator, and Regional Director for the contract therapy company completes the Quality Assurance process. The results of the Director of Nursing's Quality Assurance and print outs of the	

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F 688	Continued From page 10 Occupational Therapist #2's therapy note dated 7/2/19 revealed Occupational Therapist #2 consulted Occupational Therapist #1 regarding absence of Resident #21's sling. Occupational Therapist #1 told Occupational Therapist #2 Resident #21 had a sling at the time of the evaluation. Occupational Therapist #2 was unable to locate a sling within the facility and consulted a nearby facility regarding availability of sling to possibly use for patient due to lack of supplies. Occupational Therapist #2's therapy note dated 7/3/19 revealed she treated Resident #21 but did not mention positioning devices for her left flaccid extremity. A therapy note dated 7/5/19 by Occupational Therapy Assistant #1 revealed she had found a splint in the facility and manipulated it to fit Resident #21 left arm and applied the splint for 10 minutes. On 7/16/19 a therapy note written by Occupational Therapy Assistant #1 revealed splinting was withheld due to splint not being found. The note further stated Resident #21 would benefit from splint training to prevent risk of skin breakdown and further contracture. During an interview and observation of Resident #21 on 7/15/19 at 3:14 pm she was observed in her reclining wheelchair with her left arm hanging over the side of her chair. Resident #21 had no space between her body and the armrests of her chair. Resident #21 stated her wheelchair was too small and she had told a nurse and a therapist that it was too small and uncomfortable;	F 688	Regional Therapy Director's emails will be presented at the weekly Quality Assurance Committee Meeting and at the Quarterly Quality Assurance Performance Improvement Committee meeting for review to ensure that the solutions are sustained.	

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F 688	Continued From page 11	F 688		

and she was not able to keep her left arm from falling over the side of the chair. Resident #21 was not able to name the nurse or the therapist she spoke to.

An observation of Resident #21 on 7/16/19 at 9:30 am revealed she was in her reclining wheelchair in her room. Her left arm is hanging down at the side of the chair with no support. She attempted to pull her left arm onto her lap with her right hand and was not able to get it up on the armrest or her lap. There were no positioning devices or folded blankets on Resident #21's lap, chair or the floor around her chair.

During an interview with Nurse #1 on 7/16/19 at 2:41 pm she stated she had obtained an order for therapy to evaluate Resident #21. She stated she noticed Resident #21's arm dangling when she was in her wheelchair and the wheelchair was too small due to recent weight gain.
During an interview with Nurse Aide #1 on 7/16/19 at 2:53 pm she stated Resident #21 had gained weight and needed a larger chair. She stated she positioned Resident #21's arm with a blanket but her arm would fall off the wheelchair.

On 7/17/19 at 11:05 am an interview with Physical Therapy Assistant #1 indicated nursing had made the therapy department aware Resident #21's chair was too small and she needed positioning for her left arm. She stated the Occupational Therapist #1 had evaluated Resident #21 in June 2019 but she was not sure of the date.

During an interview on 7/17/19 at 11:10 am with Occupational Therapy Assistant #1 she stated she had treated Resident #21 two or three times.

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 07/17/2019

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
F 688	Continued From page 12	F 688		

She stated Occupational Therapist #1 had evaluated Resident #21 and ordered a brace and a larger chair. Occupational Therapy Assistant #1 stated Resident #21 would benefit from a larger chair because she would have more room to position her flaccid left arm. She stated she was waiting on Occupational Therapist #1 to decide the type of brace or sling that would be best for Resident #21's flaccid left arm. Occupational Therapy Assistant #1 stated she used blanket to support and position Resident #21's left arm.

A review of the Occupational Therapy Notes dated 7/5/19 revealed Occupational Therapy Assistant #1 had put a splint on Resident #21. Occupational Therapy Assistant #1 stated she had found a splint to use for Resident #21 but had not trained the staff to use the splint. She stated she did not return to the facility until 7/16/19 because she was filling in and did not normally work at the facility.

A second interview with Occupational Therapy Assistant #1 was conducted 7/17/19 at 11:18 am after a review of Occupational Therapy Notes dated 7/5/19 revealed she had placed a splint on Resident #21. Occupational Therapy Assistant #1 stated she found a splint for Resident #21 during her visit on 7/5/19 and manipulated the splint to fit. Occupational Therapy Assistant #1 stated when she treated Resident #21 on 7/16/19 she was not able to find the splint. Occupational Therapy Assistant #1 stated she had not trained the nursing staff on how to use the splint when she visited on 7/5/19.

An interview with Nurse #1 on 7/17/19 at 12:12 PM revealed she had told therapy and obtained

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 07/17/2019

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F 688	Continued From page 13	F 688		

an order for a therapy evaluation because Resident #21 was too big for her chair and her flaccid left arm was falling off her lap and hanging over the chair. She stated she could not recall which therapist she spoke with.

During an interview on 7/17/19 at 1:56 pm Occupational Therapist #1 stated she evaluated Resident #21 on 6/26/19 because nursing had asked for her to be evaluated due to her chair being too small and her flaccid left arm falling from her chair. She stated her goal had been for Resident #21 to have a splint to her left arm and a larger chair. Occupational Therapist #1 stated Resident #21 had agreed to be treated by Occupational Therapy for positioning and splinting. She also stated Resident #21 would benefit from a larger chair because the one she currently used was too small. Occupational Therapist #1 stated she had written an order for Resident #21 to be treated three times a week on 6/26/19 during her evaluation and she had not treated her since that evaluation.

An interview with the Director of Nursing (DON) on 7/17/19 revealed Occupational Therapist #1 had visited the facility on 7/16/19 but had not seen Resident #21. She stated Occupational Therapist #1 reported to her this morning Resident #21 needed a bariatric reclining wheelchair and a resting splint to protect and maintain positioning of her left arm. She stated Resident #21 was not seen by therapy as ordered during the week of 7/6/19 to 7/15/19. The DON stated Occupational Therapist #1 could not give a reason for Resident #21 not being treated from 7/6/19 to 7/15/19. The DON stated the facility followed the recommendations of Therapy Department for any change in resident's chairs

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	345140	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 688	Continued From page 14 and any positioning devices. During an interview with the Administrator on 7/17/19 at 6:23 pm she stated she was not made aware Resident #21 had a recommendation by Occupational Therapist #1 for a larger chair and splinting to her left hand. The Administrator stated she expected the nursing and therapy staff to work together to ensure the orders are completed appropriately and timely.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the safe transfer via sling lift for one of four residents (Resident #131) reviewed for accidents. Resident #131 experienced and abrasion to his left outer leg while being transferred in a sling lift from a wheelchair to his bed. The findings included: Resident #131 was admitted to the facility on 10/15/18. The resident's cumulative diagnoses included: Traumatic Brain Injury (TBI), seizures, lack of coordination, generalized weakness, abnormal posture, contracture, and muscle	F 689	Brightmoor Nursing Center's response to survey does not denote agreement with citations received. We are filing it simply because it is required by law. Resident #131 was discharged from the facility on April 22, 2019. Therefore, no corrective action can be accomplished for this resident. Any resident may be affected by this practice. Review of incident reports for the past year shows that no other resident has received an injury while being transferred using the hoyer lift. However,	8/14/19

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 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 689	Continued From page 15 spasms. A review of Resident #131's Minimum Data Set (MDS) revealed the most recently completed comprehensive assessment was an admission assessment with an Assessment Reference Date (ARD) of 10/26/18. The MDS assessment indicated Resident #131 had severe cognitive impairment. The resident was coded as having required total assistance of two or more people to transfer such as from the bed to a wheelchair. Resident #131's care plan revealed a Problem/Need titled ADLs with a problem onset date of 1/21/19. The ADL care plan identified the resident as having had functional quadriplegia, flexion contractures, and muscle spasticity. The resident required total assistance with ADLs including transfers. The resident also had a Falls Problem/Need area, with an onset date 1/21/19, which had an approach identifying the resident needed two staff members during transfers. A review was completed of a Resident Incident Report for Resident #131 dated 3/4/19. The review revealed the resident had experienced and abrasion, reddened area to the left outer leg measuring 1.0 centimeters (cm) wide by 1.0 cm long and 0.1 cm deep. The report further documented, the wound was cleansed with normal saline (NS), triple antibiotic ointment (TAO) was applied, and the wound was left open to air. Resident #131's nursing notes revealed a note dated 3/4/19 and timed 9:21 AM. The note documented the resident was being transferred to bed via a sling lift and 2 staff members were assisting and the staff members had alerted the	F 689	all nursing staff have been in-serviced on the proper placement under a resident of the lift sling and how to properly transfer a resident using the hoyer lift so that abrasions do not occur. The facility Director of Nursing will conduct random Quality Assurance audits in which she observes staff placing the sling and transferring a resident with the hoyer lift. These audits will be conducted two (2) times a week for two (2) months, one (1) time a week for two (2) months, and then monthly for three (3) months. The results of the Quality Assurance audit will be recorded on a Quality Assurance form and will be presented to the Quality Assurance Committee at the weekly Quality Assurance Committee meeting for review to ensure the practice does not recur. The Administrator is responsible for overseeing the Director of Nursing completes the Quality Assurance process. The facility will monitor its performance through review of the Director of Nursing's Quality Assurance audits at the weekly Quality Assurance Committee meeting and the quarterly Quality Assurance Performance Improvement Committee meeting to ensure the solutions are sustained.	

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 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 689	Continued From page 16	F 689		

nurse to assess an area to the resident's left outer leg. The resident's leg was discovered to have had reddened area with an abrasion at the center. The wound was cleansed, and treatment was provided as documented in the incident report.

Resident #131's medical record revealed a Wound Evaluation and Management Summary dated 3/4/19. The resident was documented as having had a wound to the left lower extremity measuring 2.0 cm long by 1.2 cm wide and the depth was not measurable. The wound was documented as having had some drainage and treatment was provided as well as orders for daily dressing changes.

An interview was conducted with the Director of Nursing (DON) on 7/17/19 at 6:39 PM. The DON stated she had recently been appointed to the DON position and had not was not familiar with the incident detailed in the incident report dated 3/4/19 for Resident #131. The DON also stated upon further review of the incident report the nurse who had completed the incident report was no longer employed at the facility and the nurse had not documented in the incident report or the nurses' notes who the Nursing Assistants (NAs) were who were involved in the transfer of the resident.

A second interview was conducted with the DON and the Administrator on 7/17/19 at 7:46 PM. The DON stated upon reviewing the incident report she stated it was her expectation for there to have been an investigation regarding the injury Resident #131 had experienced to ensure the action which had caused the injury would not occur again. The Administrator stated she was

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 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 17 not familiar with the incident, but her expectation as well was that the injury Resident #131 experienced should have been investigated. The DON stated it was her expectation when the sling lift was used properly, residents should not experience an injury. The DON further stated in the event a resident did experience an injury during a transfer, in addition to an investigation, the cause of the injury would be identified, and training would be provided to staff to ensure no more injuries occurred as a result of the identified cause.	F 689		
F 812 SS=E	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 observation and staff interviews, the facility failed to restrain facial hair of 2 of 2 male	F 812	Brightmoor Nursing Center's response to survey does not denote agreement with	8/14/19

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	345140	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 18 employees, failed to maintain clean food service equipment, and failed to maintain clean floor fans in the kitchen in 3 of 3 kitchen observations. Findings Included: 1. An observation of the kitchen conducted on 7/15/19 at 9:28 AM revealed the following: a. Two of two knobs on the 6-burner stove/oven combination unit were observed to have a buildup of debris on the knobs. b. Two of two knobs and two of two rocker switches on the convection oven were observed to have a buildup of debris on the knobs. c. One of three units of food service equipment in the cookline was observed to have had molten plastic, dust, and other debris build up on the outside back of the convection oven. d. Two of two operating floor fans were observed to have a buildup of debris on the front and rear grills which was sticky to the touch and had visible dust adhered to the sticky substance. One of the two fans were blowing in the direction of the prep sink/prep table area and the other fan was blowing toward the tray line/steam table area. 2. An observation of the kitchen conducted on 7/15/19 at 11:45 AM revealed the following: a. Two of two knobs on the 6-burner stove/oven combination unit were observed to have a buildup of debris on the knobs. b. Two of two knobs and two of two rocker switches on the convection oven were observed to have a buildup of debris on the knobs. c. One of three units of food service equipment in the cookline was observed to have had molten plastic, dust, and other debris build up on the outside back of the convection oven.	F 812	citations received. We are filing it simply because it is required by law. The facility kitchen has received a thorough deep clean to remove all buildup of debris, dust, and molten plastic from the following equipment: the 6 burner stove/oven combination unit, the knobs and rocker switch of the convection oven, the food service equipment on the cook line, and the floor fan. The two male dietary aides noted in the 2567 to have facial hair were wearing beard guards that covered their beards as required by regulation. A review of PP-832, Guidance to Surveyors. Of the most current version of the Long Term Care Survey Manual shows that the regulation speaks to beards only and does not include mustaches. Discussion with the Rowan County Health Department also reveals that mustaches are not required to be covered or restrained unless they exceed 1/4 inch in length. Both male dietary aides listed in the citation have mustaches that are shorter than 1/4 inch in length. However, in order to satisfy the citation, facility dietary personnel with mustaches will be required to cover/restrain the mustache with the appropriate guard/cover. Any resident has the potential to be affected by this practice. The facility kitchen and equipment has received a thorough deep cleaning and all male dietary employees with mustaches will be required to cover/restrain their mustaches in addition to their beards with the	

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	345140	A. BUILDING _____ B. WING _____	C 07/17/2019

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
F 812	Continued From page 19 d. Two of two operating floor fans were observed to have a buildup of debris on the front and rear grills which was sticky to the touch and had visible dust adhered to the sticky substance. One of the two fans were blowing in the direction of the prep sink/prep table area and the other fan was blowing toward the tray line/steam table where there was food being prepared to be trayed for lunch. e. Dietary Aide #1 was observed to have had unrestrained facial hair, a mustache, and was observed to have been taking the temperature of food which was to be placed into the steam table on the tray line. 3. An observation of the kitchen conducted on 7/17/19 at 11:40 AM revealed the following: a. Two of two knobs on the 6-burner stove/oven combination unit were observed to have a buildup of debris on the knobs. b. Two of two knobs and two of two rocker switches on the convection oven were observed to have a buildup of debris on the knobs. c. One of three units of food service equipment in the cookline was observed to have had molten plastic, dust, and other debris build up on the outside back of the convection oven. d. One of one operating floor fan was observed to have a buildup of debris on the front and rear grills which was sticky to the touch. The fan was blowing in the direction of the tray line/steam table area as the dietary staff were preparing food in the steam table and the tray line. e. Dietary Aide (DA) #1 was observed to have had unrestrained facial hair, a mustache, and was observed to have been assisting with the food preparation process for the lunch meal. Preparation processes included scooping ice out	F 812	appropriate guards. The Dietary Manager will develop a cleaning schedule and duty list for dietary staff to follow to ensure proper daily cleaning of the kitchen and equipment. The Dietary Manager will conduct random Quality Assurance audits weekly for six (6) weeks, bi-weekly for six (6)weeks, and monthly for six (6) months to ensure that the kitchen and equipment are clean and free of buildup, dust, and debris and that male employees are wearing the appropriate beard and mustache guards. The results of these Quality Assurance audits will be recorded on Quality Assurance forms and will be presented to the Quality Assurance Committee at the weekly Quality Assurance Committee meeting for review to ensure the practice does not recur. The Administrator is responsible for overseeing that the Dietary Manager completes the Quality Assurance process for the Plan of Correction. The facility will monitor its performance through the Dietary Manager's random Quality Assurance audits which will be presented at the weekly Quality Assurance Committee Meeting and the quarterly Quality Assurance Performance Improvement meeting for review to ensure the solutions are sustained.	

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	345140	A. BUILDING _____ B. WING _____	C 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 20	F 812		

of the ice machine and placing the ice in a cup and prepping the desert to be served with lunch.
f. DA #2 was observed to have been wearing a beard guard which covered the DA's beard on his chin but was not covering the DA's mustache and he had unrestrained facial hair. The DA was observed to have been assisting with the food preparation process for the lunch meal. Preparation process included placing food on trays for lunch.

An interview and observation that was conducted with the Dietary Manager (DM) on 7/17/19 at 11:45 AM revealed a floor fan in front of the tray line and steam table to have had a sticky feel to the frame, front, and real grills of the fan. The DM stated the fan had been cleaned and there was no more dust on the fan. The DM stated there still was a sticky surface on the fan and the fan needed to have been cleaned with a degreaser. The DM stated the knobs and rocker switches on the 6-burner stove/oven combination unit and the convection oven needed to be cleaned. The DM stated the back of the convection oven did have dust on it and there was molten plastic because the trash can was typically near the oven and it would get pushed up against the back of the oven. The DM continued to state when the garbage would make contact with the hot oven, it would melt the plastic of the garbage can and it would stick to the back of the oven. The DM stated it was not necessary for the DAs to wear a restraint on their mustaches because the hair on their mustaches were not long enough and if the DAs wore the facial hair restraint over their chins, mouths, and mustaches it would restrict their breathing and the facial hair restraint was not designed to have been worn in that manner.

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 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

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F 812	Continued From page 21 During an interview conducted on 7/17/19 at 4:41 PM the Administrator stated it was her expectation for knobs and the surfaces on food service equipment to be kept clean. In addition, the Administrator stated it was her expectation for the fans to have been kept clean in the kitchen, free of dust and grease build up. The Administrator stated they had beard guards in place for staff members with beards as facial hair and would be willing to adhere to an identified regulation regarding restraining the facial hair of a mustache.	F 812		
F 842 SS=C	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,	F 842		8/14/19

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 07/17/2019

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F 842	Continued From page 22	F 842		

regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed

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 07/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 23 professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to provide consistent information regarding a resident's code status for one of two residents (Resident #23) reviewed for advanced directives. Findings included: Resident #23 was admitted to the facility on 3/9/15 and was most recently readmitted on 6/5/19. The resident's cumulative diagnoses included, in part: Diabetes, stroke, dementia, hemiplegia (inability to move one side of the body), seizures, and dysphagia (difficulty swallowing). Review of Resident #23's most recent Minimum Data Set (MDS) revealed a quarterly assessment with an Assessment Reference Date (ARD) of 5/13/19. The resident was coded as having been unable to complete a cognitive assessment due to the resident having been rarely or never understood, which indicated severe cognitive loss. The resident was coded as having required total assistance, extensive assistance, rarely occurred or did not occur for all Activities of Daily Living (ADLs) including bed mobility, personal hygiene and toileting. While he required supervision or set up help for other ADLs such as transfer (such as from a bed to a wheelchair), walking in the room, walking in the corridor, dressing, and eating. A review was completed of Resident #23's	F 842	Brightmoor Nursing Center's response to survey does not denote agreement with citations received. We are filing it simply because it is required by law. The discrepancy between the face sheet and resident medical record for code status has been corrected to reflect the proper code status. Any resident has the potential to be affected by this practice. All face sheets and resident records have been reviewed and no other discrepancies have been found. The facility Social Worker will conduct weekly Quality Assurance audits of five (5) resident face sheets and medical records to ensure that there are no further discrepancies. The Social Worker will record the results of these audits on a Quality Assurance form and will conduct the audits for six (6) months. The Quality Assurance form will be presented to the Quality Assurance Committee at the weekly Quality Assurance Committee Meeting for review to ensure the practice does not recur. The Administrator is responsible for overseeing that the Social Worker completes the Quality Assurance process for the Plan of Correction.	

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	345140	A. BUILDING _____ B. WING _____	C 07/17/2019

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F 842	Continued From page 24 Medical Record (EMR) revealed a face sheet (a written summary of resident information) which had the resident's advanced directive as a full code, meaning all measures of life saving or life extending measures were to be attempted, including but not limited to: Cardio Pulmonary Resuscitation (CPR), use of artificial breathing, and/or supplemental feeding. Further review of the resident's medical record revealed a golden rod colored Do Not Resuscitate (DNR) sheet, dated 10/11/18. The DNR sheet directed lifesaving or life extending efforts such as resuscitation should not be attempted. Review of the physician's orders in the resident's medical record revealed an order documenting the resident was a DNR. During an interview conducted in conjunction with a review of the medical record on 7/17/19 at 10:25 PM with Nurse #2 she stated Resident #23 was a DNR which is what the golden rod DNR sheet in the chart was. The nurse stated the resident's actual golden rod DNR sheet had been sent out to the hospital with the resident and they kept a copy of the golden rod sheet in the resident's chart for when the resident was out of the facility. The nurse reviewed the copy of the golden rod DNR sheet and stated the DNR was dated 10/11/18. The nurse reviewed the resident's face sheet and stated the face sheet documented the resident was a full-code which provided conflicting information and did not match the code status of the golden rod DNR form. The nurse stated the code status on the face sheet was incorrect. The nurse further stated the face sheet which documented the resident was a full code would be one of the documents which would be copied and sent out to the hospital with the resident when he was discharged.	F 842	The facility will monitor its performance by reviewing the Social Worker's Quality Assurance audit at the weekly Quality Assurance Committee Meeting and at the quarterly Quality Assurance Performance Improvement Committee Meeting to ensure the solutions are sustained.	

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F 842	Continued From page 25 During an interview conducted on 7/17/19 at 10:52 AM with the Director of Nursing (DON) she stated the face sheet for Resident #23 was filled out prior to the resident becoming a DNR. The DON stated the resident had an order to be a DNR, the face sheet was incorrect, and the face sheet needed to be updated with the correct code status of DNR. The DON stated it was her expectation for all residents' code status to be correct and consistent throughout the medical record. An interview was conducted with the Administrator on 7/17/19 at 7:46 PM and she reported it was her expectation for a resident's code status to be accurate and consistent throughout the medical record.	F 842		
F 947 SS=C	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		8/14/19

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F 947	Continued From page 26 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide required annual dementia management training for the facility ' s nurse aides. Findings included: A review of the facility nursing in-service logs for 2018 revealed dementia management training was provided for the nurse aides on 3/28/2018. A review of the facility nursing in-service logs for 2019 revealed dementia management training had not been provided for the nurse aides . The Director of Nursing (DON) was interviewed on 7/17/2019 at 5:04 PM and she reported the dementia training for the facility had not been completed in 2019, but the facility was approved to receive a grant for the Virtual Dementia Tour later this year. The DON went on to explain the previous DON had left the facility in March 2018 and the dementia training had not been completed since the prior DON left. The Administrator was interviewed on 7/17/2019 at 6:37 PM and she reported it was her expectation that annual training was completed, including dementia training. The Administrator went on to explain the prior DON left her position when the dementia training was due and the in-services for dementia were not completed for the staff. The Administrator confirmed the staff would participate in the Virtual Dementia Tour, but	F 947	Brightmoor Nursing Center's response to survey does not denote agreement with citations received. We are filing it simply because it is required by law. All facility staff will receive Dementia Specific training through in-service training with post training written testing. The facility has also been awarded a grant for the Virtual Dementia Training Tour and is awaiting the materials to conduct that training later in 2019. Any resident has the potential to be affected by this practice. All facility staff will receive Dementia Specific training through in-service training with post training written testing. The facility has also been awarded a grant for the Virtual Dementia Training Tour and is awaiting the materials to conduct that training later in 2019. An in-service that was mandatory for all staff was conducted July 22-July 26 with dementia specific training with a post training written test. This in-service was conducted by the facility Director of Nursing. An annual in-service with dementia specific training will occur and it will become standard practice with no end date. The facility will now be including Dementia	

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F 947	Continued From page 27 the date was unknown.	F 947	Specific Training as part of the General Orientation for all new hires and will ensure that all staff repeat Dementia Specific Training yearly as required. The facility Staffing Coordinator will conduct monthly Quality Assurance audits on all employee files to ensure that all employees have received Dementia Specific Training. The results of the Quality Assurance audits will be recorded on a Quality Assurance form and will present the results to the Quality Assurance Committee for review at the weekly Quality Assurance Committee meeting. The Administrator is responsible for overseeing the Director of Nursing and Staffing Coordinator completes the Quality Assurance and appropriate training for the Plan of Correction. The facility will monitor its performance by reviewing the Staffing Coordinator's Quality Assurance audits at the weekly Quality Assurance Committee meetings and at the quarterly Quality Assurance Performance Improvement Committee meeting to ensure the solution is sustained.	