STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115556	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightmoor Nursing Center, LLC	3235 Newnan Road Griffin, GA 30223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and review of the facility's policies titled Food Safety and Sanitation, the facility failed to ensure proper food labeling, dating, and storage, and failed to ensure food items were not available for resident consumption past their expiration date. These deficient practices had the potential to place the 118 residents who received an oral diet from the kitchen at risk of contracting a foodborne illness. Findings Include:Review of the facility's policy titled Food Safety and Sanitation, dated 2021, revealed the Food Storage section included, All time and temperature control for safety (TCS) foods (including leftovers) should be labeled, covered, and dated when stored.When a food package is opened, the food item should be marked to indicate the open date. This date is used to determine when to discard the food.Leftovers are used within 72 hours (or discarded). Note: 2017 Federal food code guidelines allow 7 days for food safety, with the day of preparation counted as day 1 of the 7 days, and then the food is discarded. Check local and state regulations and determine which regulation should be followed.Perishable foods with expiration dates should be used prior to the use-by date on the package.Canned and dry foods without expiration dates should be used within six months of delivery or according to the manufacturer's guidelines. During a kitchen tour on 12/19/2025 at 7:44 am, with the Assistant Dietary Director (ADD), the ADD stated that all personnel should check for expiration dates, past use, and/or expired foods, as well as for dented cans, and stated they should label food items being stored. Observation of the dry food storage revealed: One unlabeled and undated wrapped powder, which was confirmed by the ADD as cake mix. One five-pound (lb) container of cornmeal with no open or discard date, One gallon of Worcestershire sauce with no open or discard date, One 32 fluid oz of liquid smoke with no open or discard date, One 24-ounce (oz) container of gelatin with no open or discard date, One 36 oz container of baking soda with no open or discard date, One 128 oz of pomace oil with no open or discard date, One gallon of vegetable oil with no open or discard date, One 32 oz container of confectioners' powdered sugar with an expiration date of 11/19/2025 and no open date.Observation of the reach-in refrigerator revealed: nine unlabeled and undated containers of sliced oranges, 15 containers of yellow pudding. Observation of the walk-in freezer revealed: two half-sheet pans of dressing with an expiration date of 12/17/2025, one-half turkey with no use-by date on the label. Continued observation of the kitchen revealed a rack containing 91 assorted puddings intended for lunch, which were neither labeled nor dated. An interview with [NAME] MM, who confirmed that she had prepared the pudding-like food items at 7:00 am upon her arrival and planned to label them after placing the items in the cooler. In an interview on 12/20/2025, at 2:20 pm, [NAME] KK confirmed that she received training on storage, labeling, and dating. She emphasized the importance of labeling and dating everything that you handled.In an interview held on 12/20/2025 at 3:20 pm, the Registered Dietitian (RD), who also serves as a Dietary Manager (DM), stated that all items should be labeled and dated with the received date, open date, and expiration or use-by date. The RD/DM affirmed all observations and validated the visual inspections conducted during the tours.

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 correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, record review, and review of the facility policy titled Resident Rights, the facility failed to obtain consent from the resident or responsible party (RP) for the use of psychotropic medication treatment for two of five residents (R) (R16 and R21) sampled for the use of unnecessary medications. This deficient practice had the potential to place R16 and R21 at risk of medical complications. Findings include:Review of the facility policy titled Resident Rights, revised December 2016, revealed the Policy Interpretation and Implementation: section included, 1. Federal and state laws guaranteed certain basic rights to all residents of this facility. These rights include the Residents to . P. Be informed of, and participate in, his or her care planning and treatment. 1. Review of the admission Record for R16, located under the Profile tab of the electronic medical record (EMR), revealed R16 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, Alzheimer's disease, unspecified, undifferentiated schizophrenia unspecified psychosis not due to a substance or known physiological condition. delusional disorders, major depressive disorder, recurrent, unspecified, generalized anxiety disorder. Continued review revealed the resident's responsible party was documented as a daughter. Review of the Quarterly Minimum Data Set (MDS) assessment for R16, with an Assessment Reference Date (ARD) of 10/10/2025, revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating the resident was severely cognitively impaired. Review of the Order Summary Report for R16 revealed active orders for: Klonopin oral tablet 0.5 milligram (mg) (Clonazepam), one tablet by mouth every 12 hours as needed for anxiety, quetiapine fumarate oral tablet, give 12.5 mg by mouth at bedtime, related to unspecified psychosis, escitalopram oxalate oral tablet 10 mg, give one tablet by mouth one time a day, related to depression. Review of the EMR for R16 revealed no signed consent to administer the psychotropic medications. In a telephone interview on 12/21/2025 at 10:53 am, the RP for R16 stated that she was not familiar with a consent to administer the psychotropic medications to R16. She stated that she did not remember signing a consent to administer psychotropic medication to R16. 2. Review of R21's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R21 was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Continued review revealed the resident's responsible party was documented as a daughter. Review of the Quarterly MDS for R21, with an ARD of 10/6/2025, revealed that Section C (Cognitive Patterns) documented a BIMS score of eight out of 15, indicating the resident was moderately cognitively impaired. Review of the Order Summary Report for R21 revealed active orders for: lorazepam oral tablet 1 mg, give one tablet by mouth every 24 hours as needed for anxiety, quetiapine fumarate oral tablet 25 mg, give one tablet by mouth at bedtime for sleep, escitalopram oxalate oral tablet 10 mg, give one tablet once a day for depression.Review of the EMR for R21 revealed no signed consent to administer the psychotropic medications. During an interview on 12/20/2025 at 10:00 am with the Director of Nursing (DON) regarding consent to treatment for R16 and R21 with psychotropic medication, she acknowledged that there were no consents for the use of psychotropic medications for R16 and R21. She stated that if a resident is on psychotropic medications, there should be a signed consent for the medication use by the resident and/or the RP.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, and review of the facility's policy titled Self-Administration of Medications, the facility failed to assess one of 48 sampled residents (R) (R8) for the ability ot safely self-administer medications before leaving medications at the bedside. This deficient practice had the potential to place R8 at risk of overmedicating and medical complications. Findings include: Review of the facility's policy titled Self-Administration of Medications, revised December 2012, documented Policy Statement: Residents in our facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. 1. Policy Interpretation and Implementation: As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: Ability to read and understand medication labels; Comprehension of the purpose and proper dosage and administration time for his or her medications; Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them; and Ability to recognize risks and major adverse consequences of his or her medications.Review of the facility's electronic medical records (EMR) revealed R8 was admitted to the facility on [DATE] with diagnoses including, but not limited to, Sjogren syndrome, muscle weakness, and symptoms and signs involving cognitive functions following cerebral infarction.Review of the Quarterly Minimum Data Set (MDS) assessment for R8, dated 12/16/2025, revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating R8 had intact cognition. Review of the Physician's Orders for R8 revealed an order dated 3/28/2023 for cyclosporine emulsion 0.05 % [percent], instill one drop in both eyes two times a day for dry eyes due to inflammation. Further review revealed no order for self-administration of medication. Review of the care plan for R8, dated 12/16/2025, revealed no care plan for self-administration of medication.Review of the clinical record for R8 revealed no assessment for self-administration of medication.Observation and interview on 12/20/2025 at 8:24 am during medication administration with Registered Nurse (RN) GG revealed there was a cup containing eight vials of cyclosporine ophthalmic solution 0.05 percent at R8's bedside. RN GG removed one container of eyedrops from the cup and stated that it was kept at R8's bedside and that she used the medication herself.In an interview on 12/20/2025 at 2:15 pm, in the presence of Licensed Practical Nurse (LPN)/ Unit Manager (UM) DD, R8 stated that she had taken the eye drops by herself when she needed them. She stated she usually took them around lunchtime each day for her dry eyes. She further stated that she had been self-administering the eyedrops at the facility for a long time.In an interview on 12/20/2025 at 2:16 pm, LPN/UM DD confirmed the cup with eight plastic vials of cyclosporin eyedrops on R8's bedside table. She stated she was not aware that R8 was using the eyedrops unattended. She stated that the nurses administer the eyedrops. LPN/UM DD confirmed there was no order for R8 to self-administer medications. LPN/UM DD stated that when the nurses administer the eye drops to R8, and she also self-administers them, she could have adverse effects. In an interview on 12/20/2025 at 5:55 pm, LPN HH stated that residents who self-administer medications must be alert and have an order for self-administration. She stated that a negative outcome would be that the residents may not know how to administer the medication effectively, and they could overdose. She stated it could be a harmful situation for R8 if there was no doctor's order for her to take the medication herself, in addition to the nurses administering it to her.In an interview on 12/21/2025 at 9:04 am, the Director of Nursing (DON) stated that an assessment was completed to determine whether the resident was appropriate to self-administer medications. The DON stated that R8 should not have medications at the bedside nor self-administer the eye drops. She further stated that the eyedrops R8 had were not prescribed by the facility, and she did not know they (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were at the bedside. She stated that R8 went to the eye doctor and received that prescription, and she was not aware that R8 was taking it on her own.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to protect one of 49 sampled residents (R) (R75) rights to be free from verbal abuse by another resident (R49). This deficient practice had the potential to place R75 at risk of a diminished quality of life.Findings include:Review of the facility's policy titled Abuse, Neglect, and Exploitation, revised 6/14/2024, included It is the intent of this facility to actively preserve each resident's right to be free from mistreatment, neglect, abuse, or misappropriation of resident property. We believe that each resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusions. The Definitions section included, . 2. Verbal Abuse is defined as any use of oral, written, or gestured language that willfully includes sparing and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability. Examples of verbal abuse include (but are not limited to), threats of harm, saying things to frighten a resident, such as telling resident that she will never be able to see her family again. 1. Review of the clinical record for R75 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder, hypertension, and major depressive disorder.Review of the MDS for R75, dated 10/21/2025, revealed Section C (Cognitive Patterns) documented a BIMS score of 15 (indicating little to no cognitive impairment). Review of the Progress Notes for R75 revealed an entry dated 9/8/2025 documenting, (R75's name) expressed the desire to move to another room after his roommate had an unpleasant conversation between the two of them. He stated that his roommate kept repeating foul language to him over several times and that made him feel very uncomfortable. SSD made aware that resident is requesting a room change.2. Review of the clinical record for R49 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction, major depressive disorder, Alzheimer's disease, restlessness and agitation, unspecified psychosis not due to a substance or known diagnosis, rank insignificant physiological condition, and hypertension.Review of the Quarterly Minimum Data Set (MDS) for R49, dated 11/19/2025, revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of nine (indicating moderate cognitive impairment). Section E (Behaviors) documented that no behaviors were exhibited. Review of the care plan for R49 revealed a Focus, dated 7/3/2024 and revised 4/29/2025, that the resident was at risk for behaviors and had a history of yelling at staff and making inappropriate sexual comments. Interventions included, but were not limited to, intervening as needed to protect the rights and safety of others. Review of the Progress Notes for R49 revealed an entry dated 9/9/2025 documenting, Social Services (SS) spoke with R49 regarding his threatening statements toward another resident. R49 was observed rummaging through his roommates' belongings. The staff continued to redirect R49, and the redirection was unsuccessful. R49 and his roommate were separated, and R49 continued to yell out with aggression that he would kill his roommate. R49 admitted to making the statement of wanting to kill his roommate. SS initiated a 1013 (an involuntary mental health evaluation) for transport to (name of a mental health facility). SS called the representative, and she was appreciative of the information provided. She was also encouraged to call the facility for an update.In a telephone interview on 12/20/2025 at 10:30 am, the Social Service Director (SSD) disclosed that she had been made aware of the allegation of abuse by Certified Nurse Assistant (CNA) TT. The SSD stated that CNA TT visited her office to report that R49 had threatened to kill R75 and exhibited aggressive behavior in his pursuit. The SSD indicated that she took the threat seriously because R49 had the means but attempted to de-escalate the situation with R49; however, she was unable to redirect his aggression.In an interview on 12/20/2025 at 11:07 am, Licensed Practice Nurse (LPN) II indicated that she observed R49 rummaging through the items of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R75 while using inappropriate language. She stated that she attempted to intervene but was unsuccessful, prompting her to leave in order to seek assistance from the SSD. In an interview on 12/21/2025 at 10:43 am, CNA TT confirmed that he was assigned to R49 and R75 on the day of the alleged abuse. He stated that he recalled a verbal threat made by R49, which was derogatory words towards R75. CNA TT noted that R49 typically uses vulgar language and has previously exhibited aggressive behavior with different roommates. CNA TT explained that, after multiple attempts to redirect R49, he informed LPN II, who also attempted to redirect R49 but without success. CNA TT stated he reported the situation to the SSD.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility policy titled Abuse, Neglect, and Exploitation, the facility failed to ensure a thorough investigation was conducted in a timely manner following an allegation of resident-to-resident verbal abuse involving two residents (R) (R75 and R49) from a sample of 49. Findings include:A review of the facility's policy Abuse, Neglect, and Exploitation, revised 6/14/2024, revealed the Investigation section included, . 4. Interviews will be conducted all pertinent parties. Written signed statements from any involved parties will be obtained and notarized, if possible. Statements will be gathered from the suspect person making accusations resident involved, reliable resident who may have witness the incident and any other persons who may have some information identify any possible conflicts between witnesses. 5. Past performances and/or previous incident of involved parties will be evaluated. Review of schedules and assignments showing when and where suspect was working at the time of the alleged incident. 6. Describe actions taken by facility to protect the resident and to prevent a possible reoccurrence during the investigation. 7. All investigative information will be kept on file in a secured location. All information gathered is confidential in nature.1. Review of the clinical record for R75 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, anxiety disorder, hypertension, and major depressive disorder.Review of the MDS for R75, dated 10/21/2025, revealed Section C (Cognitive Patterns) documented a BIMS score of 15 (indicating little to no cognitive impairment). Review of the Progress Notes for R75 revealed an entry dated 9/8/2025 documenting, (R75's name) expressed the desire to move to another room after his roommate had an unpleasant conversation between the two of them. He stated that his roommate kept repeating foul language to him over several times and that made him feel very uncomfortable. SSD made aware that resident is requesting a room change.2. Review of the clinical record for R49 revealed the resident was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, cerebral infarction, major depressive disorder, Alzheimer's disease, restlessness and agitation, unspecified psychosis not due to a substance or known diagnosis, rank insignificant physiological condition, and hypertension.Review of the Quarterly Minimum Data Set (MDS) for R49, dated 11/19/2025, revealed that Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of nine (indicating moderate cognitive impairment). Review of the Progress Notes for R49 revealed an entry dated 9/9/2025 documenting, Social Services (SS) spoke with R49 regarding his threatening statements toward another resident. R49 was observed rummaging through his roommates' belongings. The staff continued to redirect R49, and the redirection was unsuccessful. R49 and his roommate were separated, and R49 continued to yell out with aggression that he would kill his roommate. R49 admitted to making the statement of wanting to kill his roommate. SS initiated a 1013 (an involuntary mental health evaluation) for transport to (name of a mental health facility). SS called the representative, and she was appreciative of the information provided. She was also encouraged to call the facility for an update.In a telephone interview on 12/20/2025 at 10:30 am, the Social Service Director (SSD) disclosed that she had been made aware of the allegation of abuse by Certified Nurse Assistant (CNA) TT. The SSD stated that CNA TT visited her office to report that R49 had threatened to kill R75 and exhibited aggressive behavior in his pursuit. The SSD indicated that she took the threat seriously and attempted to de-escalate the situation with R49; however, she was unable to redirect his aggression. The SSD confirmed that she did not contact law enforcement or the Ombudsman. She stated that she remembered conducting an interview with R75 but did not document it. The SSD further stated that she did not perform any other investigative tasks and was unable to provide additional information. In a concurrent interview on 12/20/2025 at 11:07 am, Licensed Practice Nurse (LPN) II indicated that she observed R49 rummaging through the items of R75 while using inappropriate language. She stated that she attempted to intervene but was unsuccessful, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prompting her to leave in order to seek assistance from the SSD. LPN II stated she had no further documentation of the incident. The Director of Nursing (DON) stated that allegations of abuse, neglect, or exploitation should be reported within two hours. The residents should be separated, interviews should be conducted, interventions implemented, and any necessary actions should be taken.In an interview on 12/20/2025, at 11:09 am, the Administrator stated that he expected staff to promptly inform him of any instances of abuse. He stated that he typically would call the police in such situations. The Administrator also acknowledged that he was aware of an incident that took place on 9/9/2025, although he was not the Administrator at that time. Further interview revealed that, to his knowledge, the investigation of the incident could not be located.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, staff interviews, record review, and review of the facility policy titled Care Plan-Comprehensive, the facility failed to develop a comprehensive person-centered care plan for two of 48 sampled residents (R) (R109 and R14). This deficient practice had the potential to place R109 and R14 at risk of unmet needs, medical complications, and a diminished quality of life. Findings include:Review of the facility policy titled Care Plan-Comprehensive, last revised October 2010, revealed that the facility's interdisciplinary and care plan teams would develop and maintain a comprehensive care plan for each resident, which would incorporate identified problems.1. Review of the admission Minimum Data Set (MDS) assessment for R109, dated 10/11/2025, revealed that Section H (Bowel and Bladder) documented that R109 had an indwelling urinary catheter.Review of the Order Summary Report for R109 revealed active orders for an indwelling urinary catheter and catheter care.Review of the care plan for R109 revealed no care plan for the indwelling urinary catheter. Observations on 12/19/2025 at 8:50 am, 12/20/2025 at 12:35 am, and 12/21/2025 at 8:30 am revealed R109 with an indwelling urinary catheter.2. Review of the physician's orders for R14 revealed that the resident has an active order of an electronic alert system device in place related to exit-seeking behavior.Review of the care plan for R14revealed no care plan for the electronic alert system device. During an interview with the Minimum Data Set Coordinator (MDS EE) on 12/19/2025 at 6:05 pm, she explained that the admission assessment typically identifies care areas for residents based on their needs and clinical status. She also mentioned that the MDS uses the physician's orders to help determine which care areas need to be developed for each resident. MDS FF acknowledged that R109 did not have a care plan created for the indwelling urinary catheter, attributing this to an oversight.During an interview with the Minimum Data Set Coordinator (MDS FF) on 12/20/2025 at 3:46 pm, she explained that daily clinical meetings were held with multiple disciplines and MDS staff. During these meetings, any new or existing resident issues are discussed, and MDS staff update interventions and care plans based on residents' clinical status. MDS FF noted that resident R14 should have been care planned for the use of an electronic alert system device. During an interview with the Administrator on 12/20/2025 at 3:53 pm, he stated that he expects all residents with an indwelling urinary catheter or electronic alert system device to have those specific needs addressed in their care plans.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interview, observation, and review of the facility's policy titled Hazard Communication Program, the facility failed to ensure that one of 49 sampled residents (R) (R135) rooms was free from accident hazards. This deficient practice had the potential to place R135 at risk of avoidable accidents and to diminish its quality of life. Findings include:Review of the facility's policy titled Hazard Communication Program revealed the Policy Statement section included, The purpose of the hazard communication program is to ensure that the hazards of all chemicals used in this facility have been classified and that the information concerning the hazard is communicated to employees. Review of the electronic medical record (EMR) revealed R135 was admitted on [DATE] with diagnoses including unspecified anxiety disorder and unspecified rheumatoid arthritis.Review of the Quarterly Minimum Data Set (MDS) for R135, dated 11/24/2025, revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15, indicating the R135 was cognitively intact. Section GG (Functional Abilities and Goals) documented that the resident used a walker or wheelchair and required partial to moderate assistance, with the helper performing less than half the effort. Review of the physician's orders for R135 revealed no orders for rubbing alcohol, hydrogen peroxide, or Benadryl.Observations on 12/19/2025 at 10:18 am and 3:30 pm and on 12/20/2025 at 8:17 am revealed a container of rubbing alcohol, a container of hydrogen peroxide, and a four-ounce container of liquid Benadryl stored on the back of the resident's room door. In an interview on 12/20/2025 at 10:35 am, Certified Nursing Assistant (CNA) SS confirmed the rubbing alcohol, hydrogen peroxide, and Benadryl in R135's room. She stated that such items should not be in the resident's room.In an interview on 12/20/2025 at 11:03 am, Licensed Practical Nurse (LPN) II confirmed the rubbing alcohol, hydrogen peroxide, and Benadryl were present in R135's room and stated she had not previously seen them. She acknowledged that the items should not have been in the room. The resident gave the LPN permission to remove the items.In an interview on 12/22/2025 at 8:29 am, the Director of Nursing (DON) confirmed that the items identified should not be in the resident's room. She further stated that the facility provides education to the family regarding these expectations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115556	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightmoor Nursing Center, LLC	3235 Newnan Road Griffin, GA 30223

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, record review and review of the facility's policies titled Security of Medication Cart, Administering Medications and Storage of Medications, the facility failed to lock one of six medication carts, remove expired medication from one of two medication rooms and failed to place open dates on blood glucose strips in one of six medication carts. This deficient practice had the potential to place residents at increased risk of medical complications. Findings include: Review of the facility's policy titled Security of Medication Cart, revised April 2007, documented Policy Interpretation and Implementation: When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.Review of the facility's policy titled Administering Medications, undated, documented Policy Interpretation and Implementation: 12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.Review of the facility's policy titled Storage of Medications, revised April 2007, documented The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation: The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.1. Observation and interview on 12/20/2025 at 11:45 am revealed one medication cart unlocked and unattended on the 500 Hall. Registered Nurse (RN) BB was observed walking from the end of the 500 Hallway and came to lock the medication cart. RN BB confirmed the medication cart was left unlocked and unattended. She stated that residents may open the cart and take medications from the cart. She further stated that the medications may not be the medications they should take, and the residents could get hurt.Observation and interview on 12/20/2025 at 3:21 pm revealed one medication cart unlocked and unattended on the 500 Hall. RN BB was at the nurses' station and stated she had left it unlocked and unattended.2. Observation and interview on 12/20/2025 at 11:55 am, during review of the medication room at the 500 Hall with Licensed Practical Nurse (LPN) AA, revealed one bag containing 30 Heparin Lock Flush solution 50 units/5 milliliters (ml), 5 ml single-use, sterile solution syringes, which were located in the bottom cupboard beside the refrigerator, had expired on 9/30/2025. LPN AA confirmed that all the syringes had an expiration date of 9/30/2025. She further stated that the heparin solution in the syringes was used to keep intravenous (IV) ports free of blood clots, and that if the solution had expired, it could be ineffective.3. Observation and interview on 12/20/2025 at 4:38 pm during review of the medication cart on the 600 Hall with LPN AA revealed one bottle of blood glucose strips with no open date. LPN AA stated that there should be an open date on the blood glucose strips because 30 days after they were opened, they could lose their effectiveness, which could result in inaccurate blood glucose test results. Review of the blood glucose strips bottle instructions revealed that it documented Indicate the first opening date on the bottle.In an interview on 12/20/25 at 5:55 pm, LPN HH stated that expired medications should not be in the medication room. She stated that expired medications could have altered effectiveness past the expiration date and could cause adverse effects for the residents. LPN HH stated that blood glucose strips should have open dates because the strips had a life span of up to 30 days after they are opened, and could then lose their effectiveness. She stated that if there were no open dates and the strips were used for residents, there could be inaccurate glucose readings. In an interview on 12/21/2025 at 9:04 am, the Director of Nursing (DON) stated that expired medication should not be in the medication rooms. She stated her expectations were for the nurses to remove expired medications and dispose of them per protocol. The DON further stated that if residents received expired medications, the medications may not be as potent after expiration dates and would not be beneficial for the residents. She stated that blood glucose strips should have open dates and should be discarded 30 days after opening. She (continued on next page)

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	115556	A. Building B. Wing	12/21/2025

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Brightmoor Nursing Center, LLC	3235 Newnan Road Griffin, GA 30223

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that if the container did not have an open or discard date, the resident could have inaccurate blood sugar readings and be treated for the inaccurate readings if there were no open dates.

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	115556	A. Building B. Wing	12/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brightmoor Nursing Center, LLC	3235 Newnan Road Griffin, GA 30223

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policies titled Infection Control and Handwashing/Hand Hygiene, the facility failed to implement infection control protocol by not practicing hand hygiene between glove changes. This deficient practice had the potential to place residents at risk of infections due to cross-contamination. The facility census was 119. Findings include:Review of the facility's policy titled Infection Control, revised December 2012, documented Purposes of Infection Control Programs: The major purposes of Infection Control Programs in the nursing facility are to minimize the effects of infections on residents and employees, and to educate the staff. A successful Infection Control Program requires an underlying commitment and facility-wide participation. It should not just be seen as a way to meet paperwork requirements but as a way to analyze and use information effectively to improve care and prevent problems.Review of the facility's policy titled Handwashing/Hand Hygiene, revised April 2012, documented This facility considers hand hygiene the primary means to prevent the spread of infections. Policy Interpretation and Implementation: .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors.Observation on 12/20/2025 at 9:20 am revealed Licensed Practical Nurse (LPN) CC removed and disposed of gloves when exiting resident room [ROOM NUMBER]. She then donned (put on) a new pair of gloves without sanitizing her hands, and cleaned the blood pressure cuff attached to the blood pressure machine beside the medication cart. LPN CC then removed the second pair of gloves, disposed of them in the bin, and went to the medication storage room to get medications for the medication cart. Observation revealed LPN CC did not sanitize her hands after removing the second pair of gloves. During an interview on 12/20/2025 at 9:20 am, LPN CC confirmed that she did not sanitize her hands between glove changes. She stated that she should have sanitized her hands to prevent the spread of infection and cross-contamination. In an interview on 12/21/2025 at 9:04 am, the Director of Nursing (DON) stated her expectations were for the staff to wash their hands or use hand sanitizer between glove changes and after removing gloves. She stated that if staff did not hand-sanitize between glove changes, residents could contract infections. In an interview on 12/21/2025 at 10:35 am, Infection Preventionist (IP) OO stated hand hygiene should be performed between glove changes and after removing gloves to prevent cross-contamination and the spread of infection to the residents.