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	345408	A. BUILDING _____ B. WING _____	C 11/20/2023

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SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

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F 000	INITIAL COMMENTS The survey team entered the facility on 11/16/23 to conduct a complaint survey and exited on 11/18/23. Additional information was obtained on 11/20/23. Therefore, the exit date was changed to 11/20/23. The following intakes were investigated NC00209155, NC00202343, NC00209776, NC208345, and NC00209460. Five of the seventeen complaint allegations resulted in deficiency. .	F 000		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and physician assistant interview the facility failed to assist with transportation for a resident to receive lymphedema treatment as ordered. This was for one (Resident # 4) of four residents reviewed for social service assistance. The findings included: Resident # 4 was admitted to the facility on 3/30/23 with diagnoses which in part included osteoarthritis and lymphedema. On 4/26/23 the Physician's Assistant (PA) noted Resident # 4 was seen for several questions which the resident had. Resident # 4 reported to the PA that the orthopedic physician was	F 745	Per the CMS-2567, the facility failed to assist with transportation for a resident to receive Lymphedema treatments as ordered by physician. This was for Resident #4. All residents have the potential to be affected by this deficient practice if requiring transportation to an outside appointment. A 100% audit was completed to ensure any resident with a scheduled outpatient appointment is properly scheduled and transportation is arranged. Resident #4 has all follow-up appointments made per the MD orders. She is scheduled twice per week for the	12/18/23

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

Electronically Signed | 12/06/2023

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F 745	Continued From page 1 recommending weight loss, and "lymphedema treatment (pumps, massage, etc.)." The PA further noted the facility had an OT (occupation therapist) trained in lymphedema management and she (the facility OT) would be consulted while the resident was in therapy at the facility. On 4/26/23 an order was written to refer for lymphedema therapy management. Also, on 4/26/23 there was an order for three pairs of compression stockings for lymphedema management for Resident # 4. On 5/9/23 Resident # 4 was seen by a facility PA, who noted the following. Resident # 4 was requesting to discuss her lymphedema treatment. The resident had been under the impression she would be seen by a specialist while at the facility and had been informed she would need to be seen as an outpatient. The PA noted at that time her treatment would be managed conservatively. On 7/3/23 Resident # 4 was seen by a facility PA, who noted Resident # 4 was currently utilizing TED (thromboembolic deterrent) hose for lymphedema, and she was wanting to go to the lymphedema clinic. Review of physician orders revealed an order, dated 7/3/23, for a referral to a lymphedema clinic. The specific clinic was referenced in the order. It was part of one of the local hospitals. There was no documentation that the resident went to the clinic after the referral was made. On 8/10/23 an order was written for Resident # 4 to have her lower legs wrapped with gauze and adherent wrap twice per week.	F 745	next 6 weeks and she has attended every appointment as scheduled. No adverse outcomes were noted with this audit. Education will be provided to all Nursing staff (including contract agency staff), Transportation staff, Social Service staff by the Director of Nursing and/or Designee regarding our facility appointment and transportation process with completion by 12/15/2023. This will include resident appointments and confirmation of scheduled transportation is arranged and verified to the appointment. To ensure ongoing compliance, the Director of Nursing and/or Designee will conduct compliance audits starting 11/20/2023, 3 times per week X 12 weeks to ensure the appointment scheduling and transportation process is working effectively. In-service will be provided with any areas of concern identified. The results of these weekly audits will be reported during the monthly QAPI meeting until such time that substantial compliance has been achieved X 3 months.	

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On 8/18/23 Resident # 4 was seen by the facility PA, who noted the following. Resident # 4 had been seen for pain management by an orthopedic physician that day. She did not qualify for hip surgery at that time due to comorbidities. To qualify for hip surgery, the resident would need to lose weight, show improvement of her lymphedema, get cardiac clearance, and be more active.

Resident # 4's quarterly MDS (Minimum Data Set) assessment, dated 9/7/23, coded Resident # 4 as cognitively intact.

On 10/2/23 Resident # 4 was seen by the facility PA who noted the following. Resident # 4 had started using her TED (thromboembolic deterrent hose) hose instead of UNNA boots (a compression wrap), but the swelling returned in her legs. She was concerned about the potential reason for this and whether the problem would become chronic. The PA noted she placed another referral for the lymphedema clinic.

On 10/2/23 there was a second physician order for a referral to a lymphedema clinic.

Review of consults revealed Resident # 4 went once to the lymphedema clinic. This was on 10/18/23. According to the consult, the lymphedema clinic was part of a hospital Department of Physical Therapy and Occupational Therapy. The therapist noted in the consult the orthopedic physician recommended she follow up with a lymphedema specialist to get the lower extremity edema under control prior to surgical consideration. The lymphedema clinic's recommended follow up was for Resident # 4 to

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be seen twice per week for three months for treatment at their clinic. One of the planned interventions was for aquatic therapy.

Following 10/18/23, there was no record Resident # 4 returned to the lymphedema clinic.

Resident # 4's care plan, updated on 11/9/23, revealed the resident's goal was to one day return home. This had been added to the care plan on 4/12/23 and remained part of the active care plan. One of the interventions was to Identify, discuss, and address limitations, risks, benefits and needs for her maximum independence.

On 11/15/23 Resident # 4 was seen by a facility PA, who noted Resident # 4 was reporting the facility would not cover the cost of her transport to the lymphedema clinic.

The order initiated on 8/10/23 for lower legs to be wrapped with gauze and self-adherent wrap twice per week continued to be the active treatment for Resident # 4's lymphedema as of a review of the chart on 11/18/23.

Resident # 4 was interviewed on 11/16/23 at 10:30 AM and again on 11/19/23 at 5:00 PM. The resident reported the following during the interviews. She was in need of hip surgery due to degenerative arthritis of the hip, but in order to qualify as a candidate for hip surgery the orthopedic physician had informed her she needed to lose weight and also her lymphedema needed to be better managed. Her goal was to get better and eventually discharge from the facility. She wanted to do everything she could to manage her lymphedema as part of her goal. She had talked to two different PAs (physician

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assistants) about the issue. There had been orders written around July 2023 that she was to go to a special lymphedema clinic. Around that time there was also a facility therapist, who was accredited to treat lymphedema. The facility therapist was supposed to treat her lymphedema, but the therapist left employment at the facility. After the therapist left, she (the resident) was never referred to the lymphedema clinic. The facility "dropped the ball." She mentioned the problem again to a second PA, who was involved in her care. The second PA also wrote an order for her to go to a lymphedema clinic. Since the second order was written, she had gone once. The lymphedema clinic staff wanted her to return two times per week for five weeks for treatment. The lymphedema clinic staff informed her she would qualify for a lymphedema pump to help with the fluid in her legs if she came as recommended by them. The facility had one of their transportation vans wrecked recently and that had put a "cramp in their transportation." No one was taking her to the appointments. One of the lymphedema clinic staff members had brought the lymphedema pump to the facility to show her how it worked, but they could not leave it with her until she completed a course of treatment at their clinic. The facility wound nurse was wrapping her legs, but she felt the specialty care at the clinic would do more in managing the fluid in her legs. She very much wanted to complete the treatment at the clinic, and it was an order that she go. She had requested to talk to the social worker about the issue of trying to get to the appointments, but the social worker had not yet talked to her about the transportation problem.

The facility Assistant Rehab Director was

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interviewed on 11/22/23 at 1:08 PM and reported the following. A therapist had to be accredited in lymphedema management in order to treat lymphedema. Currently, the facility had no accredited therapist. There had been one earlier in the year, but she had left employment. This therapist, who had left, had seen Resident # 4 once for lymphedema management. This was in May 2023.

The facility Social Worker was interviewed on 11/20/23 at 3:00 PM and reported the following. She had spoken briefly to Resident # 4 about a month ago. They did not discuss any issues with transportation. She (the social worker) was to follow up with Resident # 4, and it was "on her radar to do so" but she had not yet had the time. As the facility Social Worker, she generally ensured appointments were made for the residents being discharged home, and the nursing staff worked on transportation arrangements for the other residents. She was not aware Resident # 4 had been having problems with going to the lymphedema clinic referrals as ordered.

Resident # 4's Unit Manager Nurse was interviewed on 11/20/23 at 4:40 PM and reported the following. She was aware the lymphedema clinic was going to bring a pump for Resident # 4 and that was all she knew. She was not aware of the missed appointments or trouble with transportation.

The DON (Director of Nursing) was interviewed on 11/18/23 at 9:45 AM and again on 11/20/23 at 2:00 PM and reported the following. She did not know why Resident # 4 had never gone to the lymphedema clinic when the first referral was

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made on 7/3/23. She was aware that about two weeks ago someone had brought Resident # 4 to her office. Resident # 4 had talked about the lymphedema clinic bringing a pump for her, and she told Resident # 4 to let her know how the pump was doing. She had not realized Resident # 4 never got the pump or was having problems with transportation for the lymphedema clinic. She did know that the facility usually had two vans and two van drivers for appointments. About four weeks ago, something happened to one of their vans and it needed repair. They were having trouble getting the van repaired, and they also had only one van driver. They were also using an outside company to help with transportation, but there were many residents in the facility who needed transportation assistance. They were going to hire a second van driver and get the second transportation van fixed, but that had not been accomplished yet.

Resident # 4's PA, who was routinely seeing Resident # 4, was interviewed on 11/20/23 at 1:10 PM and reported the following. The first referral to the lymphedema clinic was made by one of her fellow Physician Assistants who helps manage residents at the facility. She was not aware of why the resident had not gone to the lymphedema clinic in July 2023. She placed a second order for the lymphedema clinic in October 2023. Resident # 4 had finally gone for the initial consultation and the delay now seemed to be transportation assistance. Resident # 4's lymphedema treatment was not the only reason she could not have hip surgery at the current time. Other reasons included weight and diabetic control. The resident was working on those as well. The PA was interviewed regarding what the lymphedema pump would do, and responded that it was

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F 745	Continued From page 7 typically placed on for an hour at a time and helped circulate the arterial and venous flow to the legs to help with the lymphedema.	F 745		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, staff interview, and physician interview the facility failed to assure it administered significant medications on days when a resident had outside physician appointments. This was for one (Resident # 1) of two sampled residents reviewed for medications. The findings included: Resident # 1 resided at the facility from 10/16/23 to 10/21/23. According to hospital records, prior to Resident # 1's facility residency he had been hospitalized from 10/1/23 to 10/16/23 for a heart attack. According to Resident # 1's hospital discharge summary, dated 10/16/23, Resident # 1 had been identified to have 100 % occlusion of his right coronary artery. Resident # 1 underwent a percutaneous coronary intervention (a procedure where a stent is placed in the artery to open up the occluded blood vessel) to his right coronary artery and then a staged (at a later time) percutaneous coronary intervention to his obtuse marginal artery and his mid left anterior descending artery. Resident # 1 had additional diagnoses which in part included diastolic heart failure, chronic kidney disease, and diabetes. Resident # 1's admission Minimum Data Set	F 760	Per the CMS-2567, the facility failed to assure it administered significant medications on days when a resident had an outside physician appointment. Resident #1 was affected by this deficient practice. All residents have the potential to be affected by this deficient practice if they are due to have medications administered while out of the facility at a physician appointment. A 100% audit was completed to ensure that all residents with scheduled out of facility appointments which included prescribed medications were administered per physician order and if applicable, rescheduled administration times on those days of scheduled appointments. No adverse outcomes noted after this audit was completed. The Appointment Scheduler and/or Designee will be responsible each morning to provide a list to the nurse stations for all outpatient resident appointments scheduled for the day. The	12/18/23

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F 760	Continued From page 8 assessment, dated 10/21/23, coded Resident # 1 as cognitively intact. Upon facility admission on 10/16/23, Resident # 1 was ordered to take the following medications, and which were scheduled on the Medication Administration Record (MAR) at the following times: Aspirin 81 mg (milligrams) every day for coronary artery disease; scheduled at 9:00 AM Ticagrelor 90 mg every twelve hours for prevention of heart attack and stroke; scheduled at 9 AM and 9 PM Valsartan 80 mg every twelve hours for hypertension; scheduled at 9 AM and 9 PM Insulin Lispro 6 units three times per day; scheduled at 8:00 AM, 12:00 PM, and 5:00 PM Metoprolol succinate 25 mg XL (extended release) every day for hypertension; scheduled at 9 AM. Review of Resident # 1's October Medication Administration Record revealed the following notations. On 10/17/23 the following 8:00 and 9:00 AM medications were not documented as given. The medications were: Aspirin, Ticagrelor, Metoprolol, Valsartan, and Insulin. Nurse # 1 documented by the scheduled administration times that Resident # 1 was out of the facility. According to Resident # 1's medical record, he had been scheduled for an appointment on 10/17/23 at 10:00 AM. The facility's transportation van driver was interviewed on 11/17/23 at 12:36 PM and reviewed the transport logs for 10/17/23. The transportation van driver stated he picked	F 760	nurses are to review that list each morning. Education will be provided to all Nursing staff (including contract agency) by the Director of Nursing and/or Designee by 12/15/2023 regarding properly administering and documenting completion of a resident's physician ordered medication on days they have a scheduled physician appointment and what they are to do if there is an issue of providing medication in a timely manner. If nurses have a concern with how many residents have appointments and ability to provide MD prescribed medications in a timely manner, they are instructed to notify the Unit Coordinator and Director of Nursing immediately to prevent any adverse incidents and to ensure timely administration of medications to residents that have scheduled outpatient appointments, to avoid a delay in treatment. To ensure ongoing compliance, the Director of Nursing and/or Designee will conduct compliance audits starting 11/20/2023 for 5 times per week X 12 weeks to ensure that staff are administering and documenting medications as prescribed to residents who may have an appointment out of the facility. The facility will provide education on any areas of concern identified. The results of the audits will be reported at the monthly QAPI meeting until such time that the results of the audits have reached substantial compliance X 3 months.	

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Resident # 1 up between 8:40 AM and 9:00 AM on 10/17/23 for his appointment.

According to an interview with the Director of Nursing on 11/16/23 at 3:10 PM, Resident # 1 had not returned until the 3:00 PM to 11:00 PM shift on 10/17/23.

Nurse # 1 was interviewed on 11/16/23 at 4:22 PM and reported the following. She validated that if she had documented the resident was out of the facility on the MAR on 10/17/23, then she had not gotten to him in time to administer his morning medications prior to him leaving. She did not recall if the night shift nurse had told her in nursing report that Resident # 1 had an appointment on the morning of 10/17/23. She knew there were several residents going out that morning, but she felt she could have administered Resident # 1's morning medications by 8:45 AM if she had known he was leaving.

Nurse # 3 had cared for Resident # 1 on 10/17/23 on the 3:00 PM to 11:00 PM shift. Nurse # 3 was interviewed on 11/18/23 at 12:25 PM and reported the following. She did not recall what had been said in nursing report about Resident # 1 on 10/17/23. She did know she administered Resident # 1's evening medications that were due but did not know anything about his missed morning medications.

On 10/20/23 the following 8:00 and 9:00 AM medications were not documented as given. The medications were: Aspirin, Ticagrelor, Metoprolol, Valsartan, and Insulin. Nurse # 2 documented by the administration times that Resident # 1 was out of the facility.

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On 10/20/23 the MAR indicated Resident # 1 was back to the facility at a time to receive his 12:00 PM medication. There was no record that it was discussed with the physician/PA (physicians assistant) what action was to be taken about his missed morning medications.

According to Resident # 1's medical record, he had been scheduled for an appointment on 10/20/23 at 9:40 AM.

The facility's transportation van driver was interviewed on 11/17/23 at 12:36 PM and reviewed the transport logs for 10/20/23. The transportation van driver stated he picked Resident # 1 up at 8:45 AM on 10/20/23.

Nurse # 2 was interviewed on 11/18/23 at 11:50 AM and reported the following. She did not recall the specifics of what had occurred on 10/20/23 which led her not to administer Resident # 1's AM medications on that date. She did know there were dialysis residents who needed to go out also, and in general there were a lot of rehabilitation residents on her routine assignment who had appointments. She always arrived for work early or on time so she could get report from the off going nurse. If a regular nurse was there, then they were usually through with report by 7:30 AM. There was a list of residents who had appointments, so she would have known that Resident # 1 had an appointment. She also always tried to make sure the residents were ready to go to their appointments. At times unplanned things occurred and she would have to take care of those things as well as get her medications to the residents and make sure residents who were leaving were prepared. If she had administered any of Resident # 1's

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medications or discussed with the PA (physician's assistant) what to do when Resident #1 returned, she would have noted it in the record.

According to the record, Resident # 1 was transferred back to the hospital on 10/21/23 when he experienced chest pain. Review of Resident # 1's hospital discharge summary revealed he was admitted and hospitalized from 10/21/23 to 10/30/23. His admission diagnosis was a heart attack. Upon initial admission to the hospital, Resident # 1 was taken to the cardiac catheter lab and found to have a blockage of a stent that had been placed during his earlier October 2023 hospitalization.

Resident # 1 was interviewed via phone on 11/16/23 at 12:25 PM. Resident # 1 reported the staff had not administered his morning medications when he had appointments while residing at the facility.

The facility's medical director was interviewed on 11/17/23 at 4:36 PM and reported the following. When interventions (such as medications) were in place for a resident who had already suffered one heart attack, there was still a risk for another heart attack to occur. There should have been attempts to give Resident # 1 his morning medication before he left on his appointment dates. There were a lot of residents leaving for appointments from the rehabilitation section. If the morning medications had been missed, then it should have been reported to the PA that the medications were missed, and the PA should have been asked what to do regarding the missed medications. The PA was in the facility everyday and was accessible to the staff. He did not think the missed doses definitively caused the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 11/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713

(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 760	Continued From page 12 resident to have a second heart attack. The physician pointed out that he had received his medications as ordered on all other days on which he had not had appointments. The DON was interviewed on 11/20/23 regarding what the nurses were to do if they had unplanned events arise while trying to make sure all their residents were prepared for appointments and had their medications. The DON reported that she, the Wound Nurse, and the Unit Manager were always available to help the floor nurses, and the floor nurses should come to them for assistance if needed.	F 760		