STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BULDING       (X3) DATE SURV A. BULDING         NAME OF PROVIDER OR SUPPLIER       345408       STREET ADDRESS, CITY, STATE, 2IP CODE 6000 FAYETTEVILLE ROD DURHAM, NC 27713       (X4) DATE SURV COMELETE SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       STREET ADDRESS, CITY, STATE, 2IP CODE 6000 FAYETTEVILLE ROD DURHAM, NC 27713       (X4) OUTE COMELETE SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)       D REFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       D REFIX TAG       CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY       COM         E 000       Initial Comments       E 000       E 000       Initial Comments       E 000         A recertification and complaint investigation survey was conducted on 2/05/24 through 4/5/2024 through 3/21/24, and 4/1/2024						
AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETEI         345408       B. WING       C       04/05/21         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       6000 FAYETTEVILLE ROAD         SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       D       PROVIDER PLAN OF CORRECTION       00         PREFIX       TAG       REGULATORY OR USCIDENTIFYING INFORMATION)       TAG       PROVIDER PLAN OF CORRECTION SHOLD BE       Cold Content of the provide stream of the provid			MEDICAID SERVICES	S FOR MEDICARE & I	CENTER	
345408         B. WING		,				
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER     BOOD FAVETTEVILLE ROAD DURHAM, NC 27713       PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     OOD       E 000     Initial Comments     E 000       An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11.     F 000       F 000     A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC002021957, NC00203540, NC0021952, NC0020212747, NC0021381, NC00212124, NC00212747, NC0021389, NC00214683, NC00215867, NC00214689, NC00214683, NC00215867, NC00215186, and NC00215216 were investigated.     F 000	C 04/05/2024	3. WING	345408			
SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER         DURHAM, NC 27713           (M) ID PREFIX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         ID PREFIX TAG         PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         col           E 000         Initial Comments         E 000         E 000         FROUDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         col           F 000         Initial Comments         E 000         F000         F0000           An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11.         F 000         F 000           A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC002021955, NC00203540, NC0021952, NC002021957, NC00201688, NC002112124, NC00211247, NC002112181, NC00212124, NC00211247, NC00213089, NC00214864, NC00214890, NC00214864, NC00214890, NC00214864, NC00214890, NC00214863, NC00215067, NC00215186, and NC00215216 were investigated.         F000	TADDRESS, CITY, STATE, ZIP CODE	5		ROVIDER OR SUPPLIER	NAME OF PF	
Image: Construct of the second seco	AYETTEVILLE ROAD	e			SOUTHPO	
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       CON         E 000       Initial Comments       E 000       E 000       Initial Comments       E 000         An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11.       F 000         F 000       A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC0020185, NC00201952, NC00202185, NC00207068, NC0021952, NC002210946, NC00211281, NC00212124, NC00212747, NC00213089, NC00214683, NC00212747, NC00213089, NC00214683, NC00214827, NC00214689, NC00214683, NC00215067, NC00215186, and NC00215216 were investigated.       F 000	IAM, NC 27713	1	ND NEAEMOARE CENTER		300111-0	
An unannounced recertification and complaint investigation survey was conducted on 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11.F 000F 000INITIAL COMMENTSF 000A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC00201285, NC00203540, NC00204985, NC00201285, NC00203540, NC00219762, NC00211281, NC00212124, NC00212747, NC00213089, NC00213100, NC00214590, NC00214688, NC00214664, NC00214827, NC00215186, and NC00215216 were investigated.	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH C				
investigation survey was conducted on 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# MBNX11. F 000 A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC00201985, NC00201952, NC00201985, NC00201968, NC00210762, NC00201946, NC00211281, NC00211224, NC00212747, NC00213089, NC00213100, NC00214590, NC00214698, NC00214664, NC00214827, NC00215186, and NC00215216 were investigated.		E 000		Initial Comments	E 000	
A recertification and complaint investigation survey were conducted from 2/05/24 through 2/09/24, 3/20/24 through 3/21/24, and 4/1/2024 through 4/5/2024. Event ID# MBNX11. The following Intake Numbers: NC00201952, NC00202185, NC00203540, NC00204985, NC00205927, NC00207068, NC00210762, NC0021946, NC00211281, NC00212124, NC00212747, NC00213089, NC00213100, NC00214590, NC00214698, NC00214664, NC00214827, NC00214698, NC00214883, NC00215067, NC00215186, and NC00215216 were investigated.		E 000	vas conducted on 2/05/24 /24 through 3/21/24, and 2024. The facility was vith the requirement CFR Preparedness. Event ID#	investigation survey w through 2/09/24, 3/20 4/1/2024 through 4/5/ found in compliance w 483.73, Emergency P MBNX11.	E 000	
17 of the 70 complaint allegations resulted in deficiency.         Additional investigation was conducted from 4/1/2024 - 4/5/2024 resulting in a revised statement of deficiencies.         Immediate Jeopardy was identified at:         CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.25 at tag F684 at a scope and severity (J)		F 000	complaint investigation ad from 2/05/24 through ugh 3/21/24, and 4/1/2024 rent ID# MBNX11. The bers: NC00201952, 03540, NC00204985, 07068, NC00210762, 11281, NC00212124, 13089, NC00213100, 14698, NC00214664, 14889, NC00214883, 15186, and NC00215216 t allegations resulted in on was conducted from esulting in a revised cies. was identified at: 200 at a scope and severity	A recertification and o survey were conducte 2/09/24, 3/20/24 throu through 4/5/2024. Ev following Intake Numb NC00202185, NC002 NC00210946, NC002 NC00210946, NC002 NC00214590, NC002 NC00214590, NC002 NC00215067, NC002 NC00215067, NC002 were investigated. 17 of the 70 complain deficiency. Additional investigation 4/1/2024 - 4/5/2024 re statement of deficience Immediate Jeopardy w CFR 483.12 at tag F6 (J) CFR 483.25 at tag F6	F 000	
CFR 483.35 at tag F726 at a scope and severity       Image: CFR 483.35 at tag F726 at a scope and severity         LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE       TITLE       (X6) D.	TITLE (X6) DATE			_	LABORATORY	

**Electronically Signed** 

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.

03/01/2024

STATEMENT (	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	<u>D. 0938-039</u> E SURVEY PLETED
		345408	B. WING				C / <b>05/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04	100/2024
				60	000 FAYETTEVILLE ROAD		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		D	URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 000	Continued From page	e 1	F	000			
	(L)						
	The tags F600 and F Quality of Care.	684 constituted Substandard					
		began on 02/08/24 and was An extended survey was					
F 554 SS=D	Resident Self-Admin	Meds-Clinically Approp	F	554			4/30/24
	defined by §483.21(b this practice is clinica	erdisciplinary team, as )(2)(ii), has determined that					
	and staff interviews, t	iew, observations, resident, he facility failed to assess			F554 Self Administration		
	the ability of a resider	nt to self-administer			Corrective action for the residents four to be affected by the deficient practice		
		e bedside (Resident #97).			Resident #97 still resides in the facility An immediate sweep of resident rooms	<i>.</i>	
	Findings included:				was conducted to ensure there were n additional medications at bedside unle		
		mitted to the facility on			the self-administer medications	1	
		es that included bilateral of hip, muscle weakness,			policy/procedure had been implemente by Director of Nursing on 2/9/24.	eu	
	lymphedema, and ov	•			Immediately for resident #97 a self-administration assessment was		
		m Data Set (MDS) dated Resident #97 had intact			completed, a physician order for self-administration obtained and the ca plan was updated to reflect this change done by Director of Nursing on 2/9/24.		
	Review of Resident #	97's medical record					
	revealed no documer	ntation that Resident #97			Corrective action for other residents		
	was assessed for sel	f-administration of			having the potential to be affected by t	he	
	medications.				same deficient practice.		

Event ID: MBNX11

Facility ID: 922983

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		ND HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/26/202 RM APPROVE IO. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTIO		(X3) DAT	E SURVEY IPLETED
		345408	B. WING			04	C 4/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEN DURHAM, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 554			F 5	All resider	nts have the potential t		
	revealed no care plar medications. Review of physician's	sident #97's medical record n for self-administration of s orders for Resident #97 self-administration of		no other r negatively Systemic the deficie All Staff w Director o	by this alleged deficient residents were identifie y impacted. Changes made to ens ent practice will not rec vere educated by Assis of Nursing on the require ecifically, the licensed r	ed as being sure that cur. stant rements of	
	revealed an order for Nystatin Powder 100 topically every shift for days. Cleanse with r pat dry, apply nystati	d (MAR) for January 2024 : 000 UNIT/GM, apply to groin or fungal infection for 14 normal saline solution (NSS) n powder, and leave open to arted on 1/12/24 and was		staff/licen importance self-admir applicable self-admir leaving m residents On-going rooms by	ised agency staff on the ce of completing the nistration assessment e before any resident nisters medication, this nedications at bedside to take at a later time. monitoring of items in all staff to make sure i n resident locked cabir	e if s includes for resident items are	
	9:59 AM, Resident #9 of the bed, with nysta bedside table. Resid surveyor that she had	d an itchy rash near her rescribed nystatin topical on		applicable Plans to n sure that The DON admission assessme An enviro	e or in the medication of monitor its performance the solutions are susta l or designee will monit ns for self-administratic ent completion if appro onmental rounding tool nted, it includes checkir	cart. e to make ained. tor all new on priate. was	
	conducted on 2/6/24 the bedside table.	sident #97's room was at 4:29 PM. Nystatin was on		that shoul designee weekly x 4	□ rooms for any medic ld be secure. The DON will conduct this audit 4 weeks, then bi-week	l or at random ly x 2,	
	conducted on 2/7/24 the bedside table.	sident #97's room was at 8:24 AM. Nystatin was on		will be imi reported t Performai	thly x 1. All findings of mediately addressed a to the Quality Assurant nce Improvement (QAI	and ce PI)	
	with Nurse #12 who o Resident #97. Nurse	1 an interview was conducted occasionally medicated #12 explained that for a lication in their room they			ee by the DON for reviens or until substantial co ed.		

Facility ID: 922983

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		ND HUMAN SERVICES MEDICAID SERVICES				RINTED: 04/26/2024 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		345408	B. WING			C 04/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	04/00/2024
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 554	Continued From page	e 3	F 55	4		
F 334	would have to have a self-medicate and as have a resident that y self-medicate. Accor Resident #97's room bedside table. Resid	n order to be able to far as she knew she did not	F 55	Date of compliance: 4/30	//24	
	Nurse #12 revealed t have an order to self-	ed on 2/7/24 at 1:57 PM with hat Resident #97 did not medicate. Nurse #12 from Resident #97's room.				
	Director of Nursing (I resident to self-admir be assessed and car have a lock box to ke further revealed that intact and would be a DON found the order	ed on 2/7/24 at 2:18 PM with DON) revealed that for a hister medication they had to e planned for it, and must sep medication in. Interview Resident #97 is cognitively able to self-administer. The for Resident #97 for t #97 did not have an order				
F 578	Corporate Nurse Cor AM revealed that Res assessed for capabilit to self-administer me medication should no order and no lock box	ed with the Administrator and isultant on 2/8/24 at 11:58 sident #97 should have been ty and cognitive intactness dication. They indicated that of be at bedside if there is no k. ntnue Trmnt;FormIte Adv Dir	F 57	8		4/30/24
F 578 SS=D	CFR(s): 483.10(c)(6) §483.10(c)(6) The rig discontinue treatmen					4/30/24

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/2024 M APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	COM	E SURVEY PLETED
		345408	B. WING				C / <b>05/2024</b>
NAME OF PF	ROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	F 578 Continued From page 4			578			
	formulate an advance						
	construed as the righ the provision of medie	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or					
	requirements specifie subpart I (Advance D (i) These requirement inform and provide w residents concerning medical or surgical tra- resident's option, form (ii) This includes a wr facility's policies to im and applicable State (iii) Facilities are perm entities to furnish this legally responsible for requirements of this s (iv) If an adult individu time of admission and information or articula has executed an adva- may give advance dir individual's resident r with State law. (v) The facility is not r provide this information or she is able to rece Follow-up procedures the information to the appropriate time.	ts include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the uplement advance directives law. nitted to contract with other information but are still r ensuring that the section are met. ual is incapacitated at the d is unable to receive ate whether or not he or she ance directive, the facility rective information to the epresentative in accordance					
	•	iews and record review, the			F578 DNR		

Facility ID: 922983

If continuation sheet Page 5 of 116

		MEDICAID SERVICES				<u>VO. 0938-03</u>
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING	i		
		345408	B. WING			С
		545408		STREET ADDRESS, CITY, STATE, ZI		4/05/2024
NAME OF PR	ROVIDER OR SUPPLIER				PCODE	
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 578	Continued From page	9 5	F 57	8		
	facility failed to mainta			Corrective action for the	residents found	
		(code status) throughout		to be affected by the defi		
		edical record and paper		Resident #100 still reside	-	
		ents reviewed for advance		Code status was updated		
	directives (Resident #	4100 and Resident #73).		on 2/9/24 by the Director	of Nursing.	
				Resident # 73 still reside		
	The findings included	:		Code status was updated		
				on 2/9/24 by the Director	•	
		admitted to the facility on		Corrective action for othe		
	7/14/23.			having the potential to be	e affected by the	
	Posidont #100's Core	Plan included an area of		same deficient practice.	tantial to be	
		e resident/surrogate has		All residents have the po affected by the alleged d		
		self-determination. The		On 2/9/24 an audit was i		
		s decided after informed		Administrator to review a	-	
	-	e 'Do Not Resuscitate' (Date		charts for code status to		
	Initiated: 7/24/23)."	,		information is accurate th	nroughout the	
				residents□ electronic and	d paper medical	
	The resident's most re	ecent Minimum Data Set		record.		
	(MDS) was a quarterl			Systemic Changes made		
		the MDS assessment		the deficient practice will		
		00 had moderately impaired		On 2/9/24 the Administra		
	•	ent was receiving Hospice		Director of Nursing initiat		
	services.			all licensed nurses and a social workers and MDS		
	A review of Resident	#100's electronic medical		requirement of completin		
		nducted on 2/6/24. The		status in the medical rec	•	
	, ,	Resident #100's EMR page		and paper charts in a tim		
		had an advance directive		Education was complete		
	which read, "DNR" (D	o Not Resuscitate).		newly hired licensed nur		
		the resident's paper medical		workers or MDS staff will		
	-	ned form dated 7/14/23		the Assistant Director of	•	
		was a "Full Code." No		requirement of completin		
		ve form was placed in the		status in the medical rec		
	resident's paper char	t.		the state and approved (		
	An interviewers	ducted on 2/7/24 at 0.44 ARA		Administrator and/or the		
		ducted on 2/7/24 at 9:11 AM se #13 identified herself as		Nursing during new hire		
		nporary staff member) who		The Administrator, the D and Social Workers will r		

Facility ID: 922983

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	S FOR MEDICARE &			E CONSTRUCTION		<u>38-039</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345408	B. WING		С	
	ROVIDER OR SUPPLIER	575700		STREET ADDRESS, CITY, STATE, ZIP CODE	04/05/2	024
				6000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) MPLETIO DATE
F 578	Continued From page	e 6	F 57	8		
	was working as a hall #13 was asked where resident's advance di code status in the eve nurse reported she co from either the reside When asked, the nurs the paper chart shoul information related to directive. An interview was con with Nurse #14. Nurs an Agency Nurse who Resident #100's hall. information on a resid could be located, Nur either check the resid Administration Record look in the resident's would be the quickes the nurse reviewed R confirmed it indicated Nurse #14 then review chart and reported the information she saw i Code" status signed a #14 stated she would discrepancy further. An interview was con Coordinator and Assis (ADON) on 2/7/24 at interview, the Unit Co nursing staff could loo	I nurse. Upon inquiry, Nurse e she would locate a rective to identify his/her ent this was needed. The buld access this information ent's EMR or paper chart. se stated both the EMR and d contain the same of a resident's advance ducted on 2/7/24 at 9:15 AM se #14 identified herself as to was assigned to work on When asked where dent's advance directive rese #14 reported she could lent's Medication d (MAR) in his/her EMR or paper chart, whichever t to access. Upon request, tesident #100's EMR and the resident was "DNR". wed the resident's paper e only advance directive in the chart was for a "Full and dated 7/14/23. Nurse I need to look into this ducted with the Unit stant Director of Nursing 9:32 AM. During the pordinator was asked where cate a resident's advance oordinator reported this		admits and residents with signific changes 5 days a week for 4 we ensure code status is completed updated promptly. The licensed staff and agency nurses, social w and MDS nurses have been info the Administrator of their respons ensuring correct code status are completed in a timely manner sp the state and approved by CMS. Plans to monitor its performance sure that the solutions are sustai The Administrator, the Director of and Social Workers will review a admissions and residents with si changes for correct code status of daily standup meetings for 4 weet then weekly for 2 months and the monthly thereafter until 6 consect months of compliance is maintain Administrator will report any findi non-compliance to the Quality As and Performance Improvement Committee monthly for 3 months substantial compliance is achieve Date of compliance: 4/30/24	eks to and nursing vorkers rmed by sibility of ecified by to make ned. f Nursing Il new gnificant during eks and en utive ned. The ngs of esurance or until	

Facility ID: 922983

If continuation sheet Page 7 of 116

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/26/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>í</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345408	B. WING			-		C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 578	advance directives up both the EMR and pa "It's all of our respons An interview was con- with the facility's Adm interview, the Adminis informed there was a advance directive bet and paper chart. Wha agreed both sources of be consistent and acc 2. Resident #73 was a 1/6/24. Resident #73's electror revealed a physician's read "full code." Review of Resident # located at the nurse's #73 had two advance Do Not Resuscitate (I and a signed Full Coc Resident #73's Care I Resident #73's Care I Resident #73's care I Resident #73's care I Resident #73's admis (MDS) dated 1/13/24 moderately cognitively Resident #73's EMR s banner on the top of F	<ul> <li>b to date and accurate (in per chart), the ADON stated, sibility."</li> <li>ducted on 2/7/24 at 9:41 AM inistrator. During the strator stated she had been discrepancy related to the ween Resident #100's EMR en asked, the Administrator of this information needed to curate.</li> <li>admitted to the facility on</li> <li>onic medical record (EMR) sorder dated 1/6/24 that</li> <li>73's paper medical record estation revealed Resident 4/6/24 de form dated 1/6/24.</li> <li>Plan dated 1/12/24 revealed to be a Full Code and would hary Resuscitation (CPR) if</li> <li>ssion Minimum Data Set revealed Resident #73 was y impaired.</li> </ul>	F	578				
		Resident #73's opened EMR						

Facility ID: 922983

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		ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE 0. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345408	B. WING		04	C 4/05/2024
NAME OF PF	ROVIDER OR SUPPLIER	·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	INT REHABILITATION A	ND HEALTHCARE CENTER	6	000 FAYETTEVILLE ROAD		
300 m P 0			D	URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 578	Continued From page	o 8	F 578			
1 570			F 5/6			
		nducted with Nurse #4 on				
		Ouring the interview, Nurse d check the hard chart				
		d) and computer (EMR) for				
		sually checked the hard				
		record) first, as it was faster.				
		esident #73's advanced				
		the paper medical record.				
		DNR form and behind the				
		ten Full Code form. Nurse				
		n out of the binder and and threw it in the waste				
		ink you for noticing," and he				
	would check with his					
	An interview was cor	nducted with the Unit				
	Coordinator and Assi	stant Director of Nursing				
		9:32 AM. During the				
		pordinator was asked where				
	-	cate a resident's advance				
		coordinator reported this e both in the computer (the				
		paper medical record. When				
	, ,	onsible for keeping the				
		p to date and accurate (in				
		aper chart), the ADON stated,				
	-	sibility." ADON and Unit				
		ide aware of discrepancy				
	related to the advance					
	Resident #13's papel	r medical record and EMR.				
	An interview was cor	nducted on 2/7/24 at 9:41 AM				
	with the Administrato	r. During the interview, the				
		she had been informed there				
	was a discrepancy re					
		sident #73's paper medical				
		hen asked, the Administrator of this information needed to				

If continuation sheet Page 9 of 116

		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/26/2024 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION		ATE SURVEY MPLETED
		345408	B. WING				04/05/2024
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD		
					DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580 SS=D		jury/Decline/Room, etc.) ł)(i)-(iv)(15)	F	580	D		4/30/24
	consult with the resid consistent with his or representative(s) whe (A) An accident involve results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-the clinical complications (C) A need to alter treat a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provi- physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483. (B) A change in reside State law or regulatio (e)(10) of this section (iv) The facility must a	rediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring n; ge in the resident's physical, tial status (that is, a n, mental, or psychosocial reatening conditions or ); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and					

Facility ID: 922983

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 04/26/202 RM APPROVE O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONST		· · ·	E SURVEY IPLETED
		345408	B. WING			04	4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			YETTEVILLE ROAD M, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 580	Continued From page	e 10	F	580			
	that is a composite di §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on staff interv physician interview ar failed to notify the res physician of facility ac (Resident # 181), faci wound (Resident #5) the urinary catheter re reviewed for change of The findings included 1. Resident #181 was readmitted on 3/23/23 5/1/23. The diagnose dementia, hypertensio kidney failure, osteoa disease. The readmission Mini 3/23/23, revealed Res cognitively impaired a wounds or pressure u Review of the head-to 4/24/23 done by Nurs documented a new do and 3 open areas to t	admitted on 2/3/23, and discharged home on s included diabetes, on, dysphagia, chronic rthritis, and Alzheimer's mum Data Set (MDS) dated sident #181 was severely and was coded as not having alcers.		Corr to b Res facil Res facil Res facil Cor hav sam All r seri failu add the ider nce mar Sys the On sum	sident # 2 no longer resides in t lity. sident #5 no longer resides in th	tice. in the he ne ts by the suffer a of the ment appeara mely e that 24-hour e	

Event ID: MBNX11

Facility ID: 922983

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		O. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · ·	PLETED
						С
		345408	B. WING		04	/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	e 11	F 58	0		
	on the head-to-toe sk physician or RP were	in assessment that the notified.		ensure that timely notification condition occurs. The Assistant Director of	on of change of	
		023 Treatment d (TAR) dated 4/24/23 wound care to right heel.		Nursing/designee was notif by the Licensed Nursing Ho Administrator (LNHA) to ed	ome	
	Review of the weekly	pressure ulcer record		nursing staff on the notification of condition. This education	tion of change ı was also	
		#1(Wound Nurse) dated he onset of right heal wound /. The measurements		added to the general orient nursing staff upon hire. On 4/19/24 the Director of	auon ior	
	included 5.0 centimet centimeter, suspected	ers x 6.5 centimeters x 0.0 d deep tissue injury, wound		Nursing/designee will meet month to discuss and review	w the 24-hour	
		e. The form documented the and not the responsible		summary to ensure that tim of change of condition occu meet 5 days a week x 2 mc	irs and then	
	the Nurse #1 stated tl	ducted 2/5/24 at 3:25 PM, he process was for the aides him of any observations of		Plans to monitor its perform sure that the solutions are s A summary report of the no	sustained.	
	wound or skin change only informed about t	es. The nurse stated he was he breakdown on the		change of condition occurs to the Monthly Quality Assu	will be brought rance	
	mention of the open a buttocks. The nurse s			Performance Improvement Committee meeting by the Nursing (DON) for review a	Director of nd revision	
r ti		observation or the stated he was responsible		monthly x 3 months or until compliance is achieved. Date of compliance: 4/30/24		
		ble person and physician. was conducted on 2/5/24 at			+	
	2:15 PM, the family m had no pressure ulce	nember stated her mother rs when she was admitted.				
	the pressure ulcers of	tated she was unaware of n her mother's buttocks, mid				
	arrived home on 5/1/2	heel until the resident 23. She stated she saw a				
		ent's buttocks and when she e large wounds on both				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING		_	( 04/	) 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD DURHAM, NC 27713	ס		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	B PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	open area as well. Th when the pressure uld An interview was cond AM, the Director of Nu pressure ulcer record documented the perso and not the responsib Nursing stated the wor notified the responsib of the development of A telephone interview 12:34 PM, the Physic did not recall any disc Resident #181 having buttocks. The Physic process was the woun the physician about th and a discussion wou the treatment plan. 2. Resident #2 was are diagnoses included di kidney failure, urinary hyperplasia (increase gland. Symptoms may trouble starting to urin to urinate, or loss of b Alzheimer's disease. The admission Minim 3/7/24, revealed Resi cognitively impaired a urinary catheter.	ning. The right heel had an e facility did not inform her cer developed. ducted on 2/8/24 at 8:26 ursing, reviewed the weekly dated 5/1/23, the form on notified was the resident le person. The Director of bund nurse should have le person and the physician i the new wound. was conducted on 2/8/24 at ian Assistant #3 stated she cussion with nursing about any open areas on the an Assistant #3 stated the nd care nurse would notify ne changes in skin condition ld have been held regarding dmitted on 3/5/24. The tabetes, dementia, chronic retention, benign prostate in size of the prostate y include frequent urination, hate, weak stream, inability ladder control), and	F 580				

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		ID HUMAN SERVICES MEDICAID SERVICES					INTED: 04/26/2024 FORM APPROVED IB NO. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345408	B. WING _				C 04/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
				600	0 FAYETTEVILLE ROAD		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		DU	RHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	orders or changes wi Resident #2 was four room with his urinary floor. The nurses wer urinary catheter. The and stated if the resic next 8 hours, then to further instructions. Review of the nursing 24-hour report dated telephone log dated 3 information about cor person(s) and the resic catheter. A telephone interview at 11:25 AM. Nurse # returned from the hos catheter. She was cai whom she could not no She was told by the a to the sink and pulled arrived at the room the and she was unsucced catheter. She further physician who stated resident does not void then to call physician instructions. Nurse #8 directly to any family which family member	30 pm. There were no new th medications. At 7:00 PM nd standing at the sink in his catheter pulled out on the e unable to reinsert the on-call physician was called dent did not void within the call physician back to obtain g note dated 3/9/24, facility 3/9/24, and Nurse #8's 3/9/24, and Nurse #8's 3/9/24, did not have any ntacting the responsible sident pulling out the r was conducted on 3/21/24 8 stated Resident #2 spital on 3/9/24 with a lled to the room by an aide, recall the name of the aide. aide the resident was walking the catheter out. When she here was urine on the floor, essful in re-inserting the stated she called the on-call to monitor the resident, if d within the next 8 hours, back to obtain further 8 stated she did not speak member and could not recall to she called. She stated she	F	580			
	Resident #2 had an a self-care performance deconditioning secon hematuria with urinar catheter placement w	neld on 3/10/24, revealed activities of daily living					

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 04/26/202 M APPROVEI D. 0938-039
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345408	B. WING			C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	I	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		00 FAYETTEVILLE ROAD JRHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	The resident had a hi infection and benign p urinary retention. The indwelling catheter of were unable to reinse resident's urinary trac without complications Resident #2 needs ex- incontinence care due Check at least every Resident #2's current activities of daily living with urology as order A telephone interview at 9:02AM. Family Me visit 3/10/24, she obs the catheter in place. Nurse #8 why the cat nurse stated Residen catheter and staff trie place but could not at 8 hours and call back Family Member #3 as been notified and if th nursing to notify the fa change of condition. I she informed the resp the situation and neittl aware of what happed A telephone interview at 2:41 PM with the R stated Resident #2 ha retention and atrophy times and when he ge more fluid resulting in He explained Resident	story of urinary tract prostate hyperplasia with a Resident pulled the at after admission and staff ert it. The goal indicated the at infection will resolve a. The approaches included detensive/total assistance with e to being legally blind. 2 hours for incontinence. I evel of function with g would improve. Follow up ed. was conducted on 3/20/24 ember #3 stated during her erved Resident #2 without She stated she asked heter was not in place, the t #2 had pulled out the d to put the catheter back in nd the doctor told her to wait if there was a problem. sked why had the family not here was a protocol for amily Member #3 stated ponsible parties via a chat of her responsible person was ned.	F 580			

		MEDICAID SERVICES				. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	SURVEY LETED	
	CONNECTION		A. BUILDING				
					C		
		345408	B. WING			05/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD			
				DURHAM, NC 27713			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIO DATE	
F 580	Continued From page	e 15	F 58	0			
		he catheter if he's not closely					
	monitored. He stated the resident wore mitts						
		nospital or was closely					
		him from pulling on the					
		e Person #1 stated he was					
		facility about Resident #2					
	pulling out the cathet						
		nily chat on 3/10/24, following					
	a visit from another fa						
	A telephone interview	v was conducted on 3/21/24					
	at 10:45 AM, Respon	sible Person #2 stated she					
	was at the hospital or	n 3/9/24 when Resident #2					
	was discharged with	a catheter. She reported a					
	care plan meeting wa	as held on 3/10/24. When					
	Family Member #3 vi	sited on 3/10/24 in the					
	evening, Resident #2	2 did not have the catheter in					
	place. Family Membe	er #3 spoke with nursing staff					
	about why Resident #	#2 did not have the catheter					
		he responsible person(s)					
	had not been contact	ted about Resident #2 pulling					
	the catheter out. She	stated after the family					
		d her and sent a family text					
	about her observation						
		to speak with the nurse and					
		to find out what happened.					
		son #2 stated she was upset					
		formed anyone in the family					
		h could have resulted in					
		ing an infection with the					
	catheter being out for	r an extended period.					
	An interview was con	nducted on 3/21/24 at 8:00					
	AM, with the Director	of Nursing revealed Nurse					
		ted that the responsible					
		d of Resident #2 pulling out					
		4 or the condition of the					

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	E SURVEY PLETED
		345408	B. WING				C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	An interview on 3/21/2 Administrator and Re- revealed Nurse #8 ha communication in the facility communicatior responsible person(s) resident pulling out th nursing staff were in-so of notification and door resident change of co- person(s) in the mont citation in this area. 3. Resident #5 was m significant change Min assessment, dated 3/ was severely cognitiv diagnoses included p mellitus, tube feeding Resident 5's plan of c the risk for skin break ulcers, with appropria Record review reveal dated 3/20/24, indicat documented" for Resi arm with blisters. Record review of the report, dated 3/20/24, with blisters" for Resid reviewed and signed (PA #1) on 3/20/24. Review of the wound management summa 3/20/24, revealed the of the right hand, 8.5 with 70 % (percent) g documented that the	24 at 12:00 PM, with the gional Nurse Consultant, d not documented any medical record or the n forms that Resident #2's ) had been informed of the e catheter. Both stated the serviced on the expectation cumentation process of indition to the responsible h of February for a past e-admitted on 2/6/24. The nimum Data Set 5/24, revealed Resident #5 ely impaired. The resident's ressure ulcers, diabetes and malnutrition. tare, dated 3/5/24, reflected d down and actual pressure te goals and interventions. ed the 24 hours report, ted that the "daytime nurse ident #5 the swollen right Communication to Physician , indicated "swollen left arm dent #5. The report was by the Physician Assistant evaluation and ry for Resident #5, dated new non - pressure wound x 2.0 x 0.1 cm (centimeters)	F	580			

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					PRINTED: 04/26/2 FORM APPRO OMB NO. 0938-0	VED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345408	B. WING			C 04/05/2024	
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
SOUTHPOINT REHABILITATIO	N AND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD URHAM, NC 27713			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT FICIENCY)	DATE	
Administration Re March 2024 revea resident received treatment medicat wound and cover week. On 3/21/24 at 9:00 interview, the fami 3/20/24, she visite informed by the W about the resident family member wa existing pressure facility did not info developed. On 3/21/24 at 10:2 PA #1 indicated th was notified via th book about new ri #5. Upon assess hand swollen, with referred it to the w 3/20/24, the PA #1 Resident 5's famil not know about th On 3/21/24 at 11: interview, the Woo indicated that on 3 Resident #5, in ad on the sacrum and presented the righ non-pressure wou bedside mentione	age 17 sician's order and Treatment cord (TAR) for Resident #5 for iled that beginning 3/20/24, the Xeroform Gauze (wound ion) to apply on the right hand with dressing three times per 3 AM, during the phone ily member indicated that on ed Resident #5 and was Yound Treatment Physician i's new right hand wound. The as aware of the resident's two ulcers and confirmed that the rm her when the new wound 20 AM, during an interview, the at on 3/20/24 at 8:30 AM, she e Communication to Physician ght-hand blister for Resident nent, the resident had her right of the skin opening. The PA #1 yound treatment team. On I had a conversation with y member, who stated she did e new right hand wound. 50 AM, during the phone und Treatment Physician, 3/20/24, upon assessment of Idition to current pressure ulcers d the left hip, the resident at the facility did not inform the resident's wound.	F 580				

If continuation sheet Page 18 of 116

TATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S	0938-039 URVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLE	ETED	
		245400	B. WING		С		
	ROVIDER OR SUPPLIER	345408		EET ADDRESS, CITY, STATE, ZIP CODE	04/0	5/2024	
		ND HEALTHCARE CENTER	6000	FAYETTEVILLE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 580 F 585 SS=D	On 3/21/24 at 1:50 PI Director of Nursing (E #5, who was assigned and completed the Co report about the new notify the family. The notify the responsible of the new wound. TI Nurse #5 was not ava Grievances CFR(s): 483.10(j)(1)-1 §483.10(j) Grievances §483.10(j)(1) The res grievances to the faci that hears grievances reprisal and without fe reprisal. Such grievan respect to care and tr furnished as well as th furnished, the behavior residents, and other of facility stay.	M, during an interview, the DON) indicated that Nurse d to Resident #5 on 3/19/24 ommunication to Physician right hand wound, did not DON expected the staff to person of the development he DON mentioned that ailable for interview.	F 580		4	/30/24	
	accordance with this §483.10(j)(3) The fac	e resident may have, in paragraph. ility must make information ance or complaint available					
	of all grievances rega contained in this para	ility must establish a nsure the prompt resolution rding the residents' rights graph. Upon request, the copy of the grievance policy					

Facility ID: 922983

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	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	· · ·	E SURVEY IPLETED
			A. BUILDING	·		
		345408	B. WING			С
		545406	B. WING			1/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
	1			DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 585	Continued From page	e 19	F 58	5		
	to the resident. The g			-		
	include:					
	(i) Notifying resident i	individually or through				
	postings in prominent	t locations throughout the				
	facility of the right to f					
	(meaning spoken) or	in writing; the right to file				
	grievances anonymo	usly; the contact information				
	of the grievance offici	ial with whom a grievance				
	can be filed, that is, h	is or her name, business				
	address (mailing and	email) and business phone				
		e expected time frame for				
	completing the reviev	v of the grievance; the right				
		cision regarding his or her				
	grievance; and the co	ontact information of				
	independent entities	with whom grievances may				
		ertinent State agency,				
		Organization, State Survey				
		ng-Term Care Ombudsman				
		n and advocacy system;				
	(ii) Identifying a Griev					
	-	eeing the grievance process,				
		g grievances through to their				
		any necessary investigations				
		ining the confidentiality of all				
		ed with grievances, for				
		of the resident for those				
	-	l anonymously, issuing				
		sisions to the resident; and				
		te and federal agencies as				
	necessary in light of s					
		king immediate action to tial violations of any resident				
		-				
	right while the alleged					
	investigated;	483.12(c)(1), immediately				
	reporting all alloged t	indations involving poglast				
		violations involving neglect, ies of unknown source,				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345408	B. WING		C 04/05/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	• • • • •
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD	
				URHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 585		e 20 rvices on behalf of the nistrator of the provider; and	F 585		
	as required by State (v) Ensuring that all v include the date the g summary statement of the steps taken to inv summary of the pertin regarding the resider as to whether the grid confirmed, any correct taken by the facility a and the date the writt (vi) Taking appropriat accordance with State of the residents' right or if an outside entity the State Survey Age Organization, or loca confirms a violation for rights within its area	law; vritten grievance decisions grievance was received, a of the resident's grievance, vestigate the grievance, a nent findings or conclusions at's concerns(s), a statement evance was confirmed or not ctive action taken or to be as a result of the grievance, ten decision was issued; te corrective action in the law if the alleged violation s is confirmed by the facility having jurisdiction, such as ency, Quality Improvement I law enforcement agency or any of these residents' of responsibility; and			
	result of all grievance 3 years from the issu decision. This REQUIREMENT by: Based on record rev facility failed to comp	ence demonstrating the es for a period of no less than ance of the grievance Γ is not met as evidenced iew and staff interviews, the lete and provide a written for 1 of 1 sampled resident		F585 Corrective action for the residents for to be affected by the deficient practic	
		iewed for grievances.		Resident #280 no longer resides in t facility. Corrective action for other residents having the potential to be affected by	he
	(revised March 2023) was the chief grievan indicated upon receip	nce /Complaint Filing policy ) revealed the Administrator ice officer. The policy ot of a grievance and /or nce officer would review and		same deficient practice. All residents could be affected by the alleged deficient practice. On 2/12/2 audit was initiated by the Administrate review all resident⊡s grievances for t	1 an or to

Facility ID: 922983

If continuation sheet Page 21 of 116

						FORM	D: 04/26/202 MAPPROVEI
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			D. 0938-039 SURVEY PLETED
		345408	B. WING				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	00/2024
					000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	AND HEALTHCARE CENTER			URHAM, NC 27713		
()(4) ID	SI IMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 585	Continued From pag	e 21	E E	585			
				505	last 60 dava (about 2 months) to anou		
	to the findings would	ation. A written report related			last 60 days (about 2 months) to ensu all grievances have been addressed,	C	
	Ū	five (5) working days of			resolved and written notice sent to the		
		ice and /or complaint. It also			Resident or the Responsible party.		
		sident and /or family member			Systemic Changes made to ensure the	at	
		and oral information about			the deficient practice will not recur.	al	
	the resolution.				The Administrator and/or Director of		
					Nursing will review all grievances 5 da	vsa	
	Resident #280 was a	admitted on 6/2/23 with			week for 4 weeks to ensure they have		
		ded congestive heart failure,			been resolved and written notice sent		
	-	ulmonary disease, and			the resident or the Responsible Party		
	diabetes mellitus typ	•			ensure satisfaction with resolution.		
		- <u>-</u>			Education for all staff on the grievance	•	
	Review of the reside	nt's admission Minimum			policy and procedure.		
		essment dated 6/8/23			Plans to monitor its performance to ma	ake	
		280 was assessed as			sure that the solutions are sustained.		
	cognitively intact.				The Administrator and/or Director of Nursing will review all grievances 5 da	vsa	
	Review of the concer	rn form dated 6/5/23			week for 4 weeks and then weekly for		
		t's family member had some			months and then monthly thereafter u		
		ance report was filled out			consecutive months of compliance is		
	-	erns. There were no details			maintained. The Administrator will rep	ort	
		rns were investigated. It just			any findings of non-compliance to the		
		on was completed and			Quality Assurance and Performance		
	addressed by the Dir	rector of Nursing (DON).			Improvement Committee monthly for 3	5	
		s as to how the concerns			months or until substantial compliance		
	were investigated an	d what the resolutions were.			achieved.		
	The grievance was ir	ncomplete and did not					
		n was reached, what the					
		individual who raised			Date of compliance: 4/30/24		
		ed with the resolution and					
		if needed. There was no					
		the staff completing the					
	investigation. The for Administrator on 6/5/	rm was signed by the /23.					
		#280's discharge-return not					
	anticipated MDS ass revealed the residen	essment dated 6/16/23 t was discharged to					
ORM CMS-256	67(02-99) Previous Versions Ob	solete Event ID: MB	NX11	Fac	ility ID: 922983 If continu	ation sheet	Page 22 of 1

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/26/2024 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		X3) DATE COMPI	SURVEY _ETED
		345408	B. WING			04/0	; )5/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, Z	IP CODE		
			6	000 FAYETTEVILLE ROAD			
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		OURHAM, NC 27713			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN			(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE			COMPLETION
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED		E	DATE
				DEFICI	ENCY)		
			[				
F 585	Continued From page	22	F 585				
	community.						
	, <b></b>						
	During an interview o	n 2/9/24 at 10:12 AM, the					
	-	ated when any resident was					
	-	facility, she would introduce					
	-	t and resident family and ask					
		concerns or questions. The					
		licated that she does not					
	0	but based on what she had					
	-	lent's family member had					
		cerns. These concerns were					
	-	ievance form dated 6/5/23.					
	-	I she had reported these					
	-	tor of Nursing (DON). The					
		licated a grievance form					
	-	esident or family expressed					
		form was given to the					
	-	It. She confirmed she had					
		N for further investigation.					
	J						
	During an interview o	n 2/9/24 at 9:07 AM, DON					
	-	rievance form would be					
	given to the appropria						
		olution and another copy					
	-	Administrator. When the					
	investigation was com						
		documented in the form and					
		Administrator. The DON					
	-	tor was the chief grievance					
		ator would replace the					
		the detailed form which					
		tion and the resolution					
		strator would then complete					
		s by contacting the resident					
		ig the resolution. The DON					
		ned about the family concern					
		ner service provided by the					
	-	grievance was investigated,					
		ninated. The DON indicated					

If continuation sheet Page 23 of 116

	S FOR MEDICARE &					O. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
			A. BUILDING			
		345408	B. WING			С
	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD		4/05/2024
				000 FAYETTEVILLE ROAD		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER	DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
				DEFICIENCE)		
F 585	Continued From page	e 23	F 585			
		grievance form was filed by				
	any staff member.	-				
	During an interview o	n 2/9/24 at 3:10 PM, the				
		rporate Nurse consultant.				
	The Administrator sta	ted she was hired on 2/5/24				
		grievance officer at that				
		Nurse consultant stated that				
		dministrator for the past 2 d she noticed that the				
		or was not following the				
	-	sure all grievances were				
	promptly resolved. T	-				
	consultant further ind					
		(PIP) was put in place on				
	12/27/23. All staff we	re in-serviced on the				
	Grievance process. V					
		she indicated it was an				
		did not have any completion				
	date. When the reque					
		s, she indicated there were				
	no audit tools, just the	morning meeting. Review of				
		realed that the SMART goal				
		00% written response to be				
		nilies. When asked if the				
	families were receivir	ig a written response, the				
		sultant stated she was not				
		response to residents or				
	-	who had concerns or filed a				
F 000	grievance.	NII4	F 000			4/00/04
F 600 SS=J		-	F 600			4/30/24
	8483 12 Freedom fro	m Abuse, Neglect, and				
	Exploitation					
		right to be free from obvioe				
		right to be free from abuse,				

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED		
		345408	B. WING		C 04/05/2024		
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE			
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 600	includes but is not lim corporal punishment, any physical or chem treat the resident's m §483.12(a) The facilit §483.12(a)(1) Not use physical abuse, corpo involuntary seclusion This REQUIREMENT by: Based on record rev recorded 911 call, the resident's right to be did not effectively res emergency. This occur reviewed for neglect. have a critical low blo unresponsive. Nurse nursing clinical asses emergency procedure and with 911. Nurse 911, demonstrated no and did not relay accu- situation to the rest or Emergency medical s called until 6:56 am. I 2/8/24. Immediate jeopardy to nursing staff failed to respond to a medical removed on 4/5/24 w an credible allegation removal. The facility compliance at a scop	efined in this subpart. This nited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced iew, staff interviews, and a e facility failed to protect a free from neglect when they pond to a medical urred for 1 of 1 resident Resident #232 was found to ood sugar of 28 and was #7 failed to complete a sment, failed to initiate es within the nursing home #7 also delayed in activating o urgency with the 911 call, urate information of the f the nursing staff. services (EMS) were not Resident #232 expired on	F 60	F 600 Neglect Corrective action for the residents to be affected by the deficient prace Resident #232 no longer resides in facility. Corrective action for other resident having the potential to be affected same deficient practice. All facility insulin dependent diabe residents that require insulin administration have the potential to affected by this deficient practice. immediate audit was completed by Clinical Regional Director/Designet verify all residents that are insulin dependent are following physician This audit monitors if a nurse was potentially neglectful for not follow physician orders for insulin dependent residents and for not following emer medical management policies and procedures. The audit reviews if r were not following emergent hypoglycemic policies and proced This audit was completed on 4/3/2 Clinical Regional Director/Designet	ctice. n the tts by the tic o be An y the se to o orders. ing dent ergency hurses ures. 24 by the		

Facility ID: 922983

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						0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL		
			A. BOILDING		с		
		345408	B. WING			5/2024	
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD			
				DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE	
F 600	Continued From page	25	F 60	00			
	that is not immediate			adverse outcomes were	e identified in this		
		ff have been in-serviced.		audit.			
				Systemic Changes mad			
	The findings included	:		the deficient practice wi			
				All licensed nurses, cer	-		
	This tag is cross refer	rred to:		assistants, agency/cont			
	E 684 Based on reco	ord review, staff interviews,		ancillary staff, and all ne employees will be educ	-		
		all, the facility failed to		Neglect Policy. The poli			
		y procedures including		Neglect as the failure of	-		
		11, when a resident who was		employees or service p	-		
		ic was discovered to have a		goods and services to a			
	blood sugar of 28 and			necessary to avoid phys			
		ound to have a critical low		mental anguish, or emo			
	-	urse #7 failed to complete a		education was complete	-		
		sment, failed to initiate		designee by 4/04/2024.			
		es within the nursing home		will include 1:1, and gro sessions. The admini			
		#7 also delayed in activating o urgency with the 911 call,		will be the person who			
		urate information of the		licensed nurses, certifie			
	-	232 expired on 2/8/24. This		assistants, agency/cont			
		sident reviewed for neglect.		ancillary staff, and all ne			
				employees will be educ	ated.		
		ord review, staff interviews,		Plans to monitor its per			
		all, the facility failed to		sure that the solutions a			
	-	vere trained and competent		To ensure ongoing com	-		
	with responding to me	procedures within the		Administrator and/or de conduct daily audits on	-		
		h emergency medical		dependent diabetic resi			
	-	sident (Resident #232)		insulin administration th	-		
		Nursing staff failed to		4/5/24 and will continue	-		
		ical assessments (including		then 5 x times a week f	•		
	vital signs), failed to i	-		A summary report of co	-		
		es within the nursing home		brought to the Monthly			
		nurse asked for a glucagon		Performance Improvem			
		aff also delayed in activating		Committee meeting by			
		o urgency with the 911 call, urate information of the		Nursing (DON) for revie monthly x 3 months or u			
	situation to the 911 of			compliance is achieved			

Facility ID: 922983

		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/26/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		TRUCTION		(X3) DATE COMF	SURVEY PLETED
		345408	B. WING			C 04/05/2024		
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER			YETTEVILLE ROAD M, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD E ED TO THE APPROPR FICIENCY)	BE	(X5) COMPLETION DATE
F 600	Continued From page	26	F 60	0				
	expired on 2/8/24.			Def	e of compliance:	4/20/24		
	The Administrator wa jeopardy on 4/2/24 at	s notified of immediate 6:27pm.			e of compliance.	4/30/24		
	The facility provided a immediate jeopardy r	a credible allegation of emoval dated 4/5/24.						
	are likely to suffer, a s a result of the noncor Resident #232 suffer practice. Nurse #7 an effectively respond to resident #232 blood s	nts who have suffered, or serious adverse outcome as npliance. ed related to this deficient nd Nurse #10 failed to a medical emergency when sugar was 28 and was vas not activated timely or						
	that require insulin ac potential to be affected An immediate audit w Regional Director/Dest that are insulin depen orders. Lastly, this ac was potentially negled physician orders for in and for not following of management policies audit reviewed if nurs emergent hypoglycen This audit was compl	ed by this deficient practice. vas completed by the Clinical signee to verify all resident's ident are following physician udit will monitor if a nurse ctful for not following nsulin dependent residents emergency medical and procedures. Lastly, the es were not following nic policies and procedures. eted on 4/3/24 by the ector/Designee. No adverse						
	4/2/24 by the Regiona reveals that the nurse	which was completed on al Clinical Director/designee #7 did not recognize the as a medical emergency in a						

Facility ID: 922983

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	2: 04/26/2024 1 APPROVED 2: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(3) DATE COMP	SURVEY LETED
		345408	B. WING				( 04/(	) 05/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD PURHAM, NC 27713			
0(0)15					PROVIDER'S PLAN OF CORRE			()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	E	(X5) COMPLETION DATE
F 600	Continued From page	27	F	600				
		neglected to assess and nanner. Conclusion via the						
	•	that she was not competent						
		naging emergency medical						
	situations or compete managing hypoglycer	ni in assessing and nia. Therefore, the nurse						
	was negligent in asse	ssing and intervening when						
	the resident was having	ng a medical emergency.						
	Specify the action the	entity will take to alter the						
	process or system fai	lure to prevent a serious						
		n occurring or recurring, and						
	when the action will b Nurse #7 has not wor	ked in the facility since the						
	date of this incident.	Her agency was notified of						
	-	Administrator, and she was						
	-	ministrator for her statement se to the medical emergency						
	All licensed nurses, co	ertified nursing assistants,						
	agency/contract staff,	all ancillary staff, and all						
		es will be educated on Abuse he policy describes Neglect						
	• •	icility, its employees or						
	service provider to pro	ovide goods and services to						
	a resident that are new harm, pain, mental an	cessary to avoid physical						
	distress. All educatio	<b>0</b>						
	DON/ADON designee	e by 4/04/2024. This						
		1:1, and group training						
		nistrator/designee will be nsure all licensed nurses,						
	certified nursing assis	tants, agency/contract staff,						
		all newly hired employees						
	will be educated. Immediate jeopardy w	vill be removed by 4/05/24.						
	The credible allegatio	n was validated onsite on						

If continuation sheet Page 28 of 116

TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		DNSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED
		345408	B. WING			C 04/05/2024	
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER		6000	EET ADDRESS, CITY, STATE, ZIP CODE <b>FAYETTEVILLE ROAD</b> RHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 609 SS=D	had received recent of Neglect Policy. Facili staff were educated of the facility, its employ provide goods and se were necessary to av mental anguish, or er reports and sign-in sh information. Audit too The tool identified res dependent, were reco orders, if signs and s were monitored by th medical managemen were followed, any si emergent hypoglycer negligent by not follor assess the resident to emergency. The revio Immediate jeopardy r validated. Reporting of Alleged CFR(s): 483.12(b)(5) §483.12(c) In respon neglect, exploitation, must: §483.12(c)(1) Ensure involving abuse, negli mistreatment, includii source and misappro are reported immedia hours after the allega that cause the allega serious bodily injury,	erviews revealed that they education on Abuse and ty documentation revealed on Neglect as the failure of yees or service providers to ervices to a resident that void physical harm, pain, motional distress. In-service heets were used to verify this of dated $4/4/24$ was reviewed. sidents who were insulin eiving insulin per physician ymptoms of hypoglycemia the nurses and emergency t policies and procedures gns and symptoms of mia and if the nurse was wing physician orders or to recognize a medical ew revealed no concerns. removal date of $4/5/24$ was Violations (i)(A)(B)(c)(1)(4) se to allegations of abuse, or mistreatment, the facility e that all alleged violations		500			4/30/24

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	LTH AND HUMAN SERVICES			PRINTED: 04/26/202 FORM APPROVE OMB NO. 0938-039
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	B. WING		C 04/05/2024
NAME OF PROVIDER OR SUPI	LIER		STREET ADDRESS, CITY, STATE, ZIP COD	)E
SOUTHPOINT REHABILIT	ATION AND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713	
PREFIX (EACH [	IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY FULL FORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
the administr officials (inclu adult protecti for jurisdiction accordance w procedures. §483.12(c)(4 investigations designated re accordance w Survey Agen- incident, and appropriate of This REQUIF by: Based on re- facility failed to the State A (APS), and th timeframe for reviewed for notified of ne immediate jee facility did no Agency within notification. Findings inclu Review of the 2/8/24, regar- information re Agency, no d and no record	ator of the facility and to other ding to the State Survey Agency an ve services where state law provide in long-term care facilities) in vith State law through established Report the results of all to the administrator or his or her presentative and to other officials in vith State law, including to the State cy, within 5 working days of the if the alleged violation is verified porrective action must be taken. EMENT is not met as evidenced cord review and staff interviews, the o submit an Initial Allegation Report gency, Adult Protective Services e police within the required 1 of 1 resident (Resident #232) neglect. The facility was officially glect on 4/2/24 at 6:27 pm when an opardy template was issued. The is submit an initial report to the State is the required timeframe following	n e t ed e,	F609 Reporting of Alleged V Corrective action for the resid to be affected by the deficien The facility failed to submit ar Allegation Report to the State Adult Protective Services (AF police withing the required tin of 1 resident (#232). The faci officially notified of neglect or 6:27pm when an immediate j issued. The facility submitted Allegation on 4/3/24 to the St Reporting Agency. The police notified on 2/8/24 around 6:5 911 call. APS was not notifie because the resident #232 w at that time. The Administrat facility did interviews with the involved with the incident reg Resident #232 and did not fir to label it as neglect, so an in was not done on 2/8/24 or 4/2	dents found t practice . and Initial e Agency, PS), and the meframe of 1 lity was an 4/2/24 at leopardy was d the Initial tate e were 6am during a ed on 4/3/24 ras deceased or stated the e staff arding and any reason uitial report

Facility ID: 922983

If continuation sheet Page 30 of 116

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 1 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345408	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	and an immediate ject to the administrator. template was signed administrator was ver- information regarding neglect. Review of the revealed the facility d to the State Agency w following the notificat During an interview w on 4/3/24 at 4:37 pm submit nor complete the State Agency reg- information provided had received on 4/2/2 interviews with the sta any reason to label it report was not done of also stated she wasn submit an initial repor point since the negled issued. The administ	pardy template was issued The immediate jeopardy by the administrator and the bally informed of the the situation involving e state agency records id not submit an initial report within the required timeframe ion of neglect. With the facility administrator she stated that she did not an initial allegation report to arding the neglect on the template which she 24. She stated the facility did aff involved and did not find as neglect, so an initial on 2/8/24 or 4/2/24. She 't aware she needed to t to the State Agency at that ct template had already been irrator further indicated she nor the police regarding the	F	609	Administrator also stated she wasn't aware she needed to submit an initial report to the State Agency at that point since the neglect template had already been issued on 4/2/24 by NC DHHS. T facility 5 day Investigation for Resident #232 concluded on 4/8/24 with a conclusion of being unsubstantiated. Corrective action for other residents having the potential to be affected by t same deficient practice. All residents have the potential to be affected by the deficient practice if ther an allegation of abuse reported that fits the criteria for the reporting circumstar and guidelines, and the facility fails to report timely to state reporting agency. APS, and police. The Administrator/Designee audited the pa months of reportable to the State Ager 4/19/24 to ensure timely reporting of at allegation of neglect/abuse was completed per the policy and procedur the Abuse/Neglect reporting guidelines. No adverse findings noted. Systemic Changes made to ensure that the deficient practice will not recur. 100% mandatory Education was provid to the whole staff, by the Administrator/designee, regarding the Resident Abuse and Neglect Reporting policy and procedures, with emphasis following the protocols of submitting ar initial report to the state agency within required timeframe following notification Regional Clinical Director provided 1:1 education to the Administrator on 4/3/2 regarding timely reporting time frames once and allegation is identified and	re is he ces st 3 icces st 3 iccy ny e of s. ded g on the n. 24	

Event ID: MBNX11

Facility ID: 922983

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ATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
d plan of	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345408	B. WING		04/05/2024
IAME OF P	ROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, ZIP CODE	
OUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD URHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETIC
F 609	Continued From page	≥ 31	F 609	reported to the Grievance officer. staff education was completed on a Plans to monitor its performance to sure that the solutions are sustained To ensure ongoing compliance, the Administrator and/or designee will conduct compliance audits 3 x wee weeks to ensure if there is an Initia Allegation Report to the State Age APS, and police, that it is complete within the required timeframe follow notification. The facility will continue provide education on any areas of concern if necessary. The results of the audits will be rep at the monthly QAPI meeting until time that substantial compliance has achieved x 3 months.	4/5/24. b make ed. e ek x 12 al ncy, ed wing the le to ported such
F 657 SS=E	CFR(s): 483.21(b)(2)( §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an int includes but is not lim (A) The attending phy (B) A registered nurse resident. (C) A nurse aide with resident.	(i)-(iii) ensive Care Plans orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that hited to vsician. e with responsibility for the	F 657	Date of compliance: 4/30/24	4/30/24

Event ID: MBNX11

Facility ID: 922983

If continuation sheet Page 32 of 116

AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       CON         345408       B. WING       00         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       6000 FAYETTEVILLE ROAD         SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       6000 FAYETTEVILLE ROAD         (X4) ID PREFIX       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)         F 657       Continued From page 32 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.       F 657	ED: 04/26/2024 RM APPROVEI IO. 0938-0391	FOR			D HUMAN SERVICES MEDICAID SERVICES		
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER     5000 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)       F 657     Continued From page 32 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.     F 657	TE SURVEY MPLETED			. ,			
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       6000 FAYETTEVILLE ROAD         UX4) 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)         F 657       Continued From page 32 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.       F 657	C 4/05/2024	04		B. WING	345408		
SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER     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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       F 657     Continued From page 32 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.     F 657			IREET ADDRESS, CITY, STATE, ZIP CODE	S		ROVIDER OR SUPPLIER	NAME OF PF
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 657       Continued From page 32 the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.       F 657					ND HEALTHCARE CENTER	INT REHABILITATION AI	SOUTHPO
<ul> <li>the resident and the resident's representative(s).</li> <li>An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> </ul>	(X5) COMPLETION DATE	ON SHOULD BE HE APPROPRIATE	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	PREFIX	Y MUST BE PRECEDED BY FULL	(EACH DEFICIENCY	PRÉFIX
<ul> <li>team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:</li> <li>Based on record reviews, residents and staff interviews, the facility failed to review, revise, and include the participation of residents/resident representatives after the completion of Minimum Data Set (MDS) assessments for 5 of 5 residents reviewed for care plan participation (Resident # # 93), Resident # 97).</li> <li>Findings included:</li> <li>1. Resident #93 was readmitted to the facility on 11/14/23 with diagnoses that included urinary tract infection, neuromuscular dysfunction of bladder and panic disorder.</li> <li>A record review of the most recent quarterly Minimum Data Set (MDS) dated 1/19/24 revealed the resident was admitted on 11/18/22 and was assessed as cognitively intact. Assessment included uninary tract infection, neuromuscular dysfunction of bladder and panic disorder.</li> <li>A record review of the most recent quarterly Minimum Data Set (MDS) dated 1/19/24 revealed the resident was admitted on 11/18/22 and was assessed as cognitively intact. Assessment included uninary tract infection, neuromuscular dysfunction of bladder and panic disorder.</li> <li>A record review of the most recent quarterly Minimum Data Set (MDS) dated 1/19/24 revealed the resident was admitted on 11/18/22 and was assessed as cognitively intact. Assessment indicated the resident was dependent on staff for most of the Activities of Daily Living (ADL) care.</li> <li>Review of the modification annual assessment</li> <li>Review of the modification annual assessment</li> </ul>		nt practice. d to the facility inary team ing on 2/27/24 his current l to the facility on 11/12/23. DT) held a 24 with the nt l to the facility linary team ing on 2/27/24 his current ed to the facility nary team ing on 2/27/24	Corrective action for the reside to be affected by the deficient p Resident # 93 was admitted to on 8/22/23. The interdisciplina (IDT) held a care plan meeting with the resident to review his of comprehensive care plan. Resident # 37 was admitted to on 10/13/22 and readmitted on The interdisciplinary team (IDT care plan meeting on 2/27/24 w resident to review her current comprehensive care plan. Resident # 53 was admitted to on 10/19/23. The interdisciplina (IDT) held a care plan meeting with the resident to review his of comprehensive care plan. Resident # 104 was admitted to on 8/29/23. The interdisciplinar (IDT) held a care plan meeting	F 657	esident's representative(s). be included in a resident's participation of the resident resentative is determined a development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary asment, including both the uarterly review is not met as evidenced ews, residents and staff failed to review, revise, and on of residents/resident the completion of Minimum asments for 5 of 5 residents # sident # 53, Resident #104, readmitted to the facility on tes that included urinary nuscular dysfunction of order. e most recent quarterly IDS) dated 1/19/24 revealed itted on 11/18/22 and was ely intact. Assessment was dependent on staff for	the resident and the re An explanation must be medical record if the p and their resident repri- not practicable for the resident's care plan. (F) Other appropriate disciplines as determi- or as requested by the (iii)Reviewed and revi- team after each assess comprehensive and q assessments. This REQUIREMENT by: Based on record revi- interviews, the facility include the participation representatives after to Data Set (MDS) assess reviewed for care plan 93, Resident #37, Res and Resident #97). Findings included: 1. Resident #93 was in 11/14/23 with diagnoss tract infection, neuron bladder and panic disc A record review of the Minimum Data Set (M the resident was admi- assessed as cognitive indicated the resident	F 657

Facility ID: 922983

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		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
					С	
		345408	B. WING		04/05/20	24
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	ACTION SHOULD BE COM	(X5) PLETIC DATE
F 657	Continued From page	e 33	F 65	57		
	dated 11/21/23 revea			Resident # 97 was adn	nitted to the facility	
	assessed as cognitive			on 3/30/23. The interd	2	
				(IDT) held a care plan		
		93's care plan revealed it		with the resident to rev		
		vised on 11/21/23. There		comprehensive care pl		
		t resident participated in the		Corrective action for ot		
		in the development of the		having the potential to	-	
	care plan.			same deficient practice A new Social Worker b		
	During an interview o	n 2/5/24 at 1·29 PM		in February 2024. The		
	-	ed he was not invited to any		department initiated the		
		ne resident further indicated		process to include resid	-	
		ed in developing his care		Responsible Party (RP		
	plan goals. Resident	#93 stated that only therapy		As of 3/1/24, the Socia	Services	
		about his progress and if he		department reviewed a	Il residents for	
	had reached his thera	apy goal.		documentation of a cor	•	
				plan meeting with the r		
		n 2/7/24 at 11:46 AM, the		Responsible Party (RP	) and 72 of the 72	
		residents on short term a care plan meeting with		have been done. The Social Services de	partment have	
		esident's representatives		completed and mailed	•	
		conducted. The Social		letters to all residents a		
		ote was later documented in		Party (RP) notifying the		
		indicating when the care		care plan meeting date		
		nducted, who attended the		care plan already sche	-	
		s discussed. The Social		by 3/1/24 the facility ha		
	Worker stated for res			the resident/Responsib	,	
	-	are plan meetings were		Social Services depart	-	
		l and it was informal. The that each department		with a phone call to sch meeting with the reside	-	
		are plan goals related to the		Responsible Party (RP		
	resident after they co			Systemic Changes ma		
		le changes accordingly.		the deficient practice w		
		ignificant change and/or if a		The Administrator educ		
		as indicated by staff, then a		Workers on Comprehe	nsive Care plans	
		as scheduled. If not care plan		this was completed on		
	meetings were not so			Social Services depart		
		ent #93 was a long-term		the comprehensive car		
	care resident and his	last care plan meeting was		each resident as assig	ned quarterly,	

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		MEDICAID SERVICES				O. 0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		· · ·	E SURVEY	
			A. BUILDING	<u> </u>			
		245409	B. WING			С	
		345408	B. WING			4/05/2024	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD			
	1			DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 657	Continued From page	e 34	F 65	57			
		There were no care plan	1 00	annually and with a signific	cant change and		
	meetings after 3/7/23	•		distribute the care plan let			
		-		the resident and /or Respo			
	During an interview o	n 2/8/24 at 8:34 AM, the		(RP). The Social Worker w			
		OON) stated the Social		assigned care plans daily			
	Services were respor	sible for scheduling the care		Interdisciplinary Team (ID	T) meeting. The		
	plan meeting. DON i	ndicated the team discusses		Interdisciplinary Team (ID	T) will review		
		ng if any resident needs a		each care plan during care			
	care plan meeting du			with the resident and/or Re	esponsible Party		
	condition, or if it was			(RP).			
		up or if the resident or		The Social Worker (SW) w			
	-	tive had any concerns.		document via a log all sch			
	meeting with the resid	d then schedule a care plan		plan meetings weekly x4 v monthly x 3 months ensur			
	representative. Care			are conducted quarterly, a			
		es a week and the residents		a significant change with t	•		
		I their care plan meeting.		and/or Responsible Party			
		are plan meeting were		In-servicing was conducte			
		nours of admission, after		with Interdisciplinary Team			
		ion care plan and then		Licensed Nursing Home A			
	quarterly, or when the			the care plan meeting proc			
	changes, or if any res	sident or representative, or		mailing care plan invitation	ns letters		
	staff, requests for a c	are plan meeting. She		quarterly, annually and wit	th a significant		
		s not sure when the care		change and including the			
	plan for Resident #93	was reviewed/revised.		Responsible Party (RP) pa	•		
				the comprehensive care p			
	-	n 2/8/24 at 9:08 AM, the		Plans to monitor its perform			
		nen any resident was due for		sure that the solutions are			
	a MDS assessment, t			Results of the monitoring/l	-		
		m reviewed and completed		presented by Social Worke Quality Assurance Perforn			
		ons. The care plans were are plans were closed within		Improvement (QAPI) Com			
		n of MDS assessment. The		for review and revision x 3			
	MDS Nurse indicated			substantial compliance is a			
		luling a care plan meeting					
		d their representatives. She		Date of compliance: 4/3	0/24		
		Social Worker could run a					
		ssessments and care plans					
	-	could schedule the meetings					

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345408	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER	I		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)					(X5) COMPLETION DATE
F 657	<ul> <li>accordingly. The MDS #93's care plan review completion date was indicated the resident been reviewed by the 14 days from the star Nurse stated the resident been a care plan review 10/28/23.</li> <li>Resident #37 was 11/14/23 with diagnosheart failure, diabetes right shoulder. Review assessment dated 11 was admitted to the fa assessed as cognitive indicated the resident maximal assistance for Review of Resident # was reviewed and revi no indication that resi plan meeting or deve</li> <li>Review of the Social read in part "Care Pla resident, SW (Social indicated Resident #37 term care.</li> <li>During an interview of Review of Review of Review of Review of Resident #37 indicate care plan meetings. F recollect attending an During an interview of</li> </ul>	S Nurse stated Resident w start date was 6/28/23 and 1/19/24. The MDS Nurse I's care plan should have a IDT team and closed within t date i.e. 6/28/23. The MDS dent had a quarterly 9/23 and there should have ew or revision after readmitted to the facility on ses that included congestive s mellitus type 2 and pain in w of the quarterly MDS /18/23 revealed the resident acility on 10/13/22 and was ely intact. Assessment t needed substantial / or most of her ADL care. 37's care plan revealed it vised on 9/12/23. There was ident participated in the care lopment of the care plan. Worker note dated 1/26/23 an meeting held with Worker) and nursing." Note 87 was to remain in long n 2/5/24 at 11:43 AM, ed she was not invited to Resident stated she does not	F	657			

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		ID HUMAN SERVICES MEDICAID SERVICES				I	NTED: 04/26/2024 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345408	B. WING				C 04/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTUD		ND HEALTHCARE CENTER		600	0 FAYETTEVILLE ROAD		
300111-0		IND HEALTHCARE CENTER		DU	RHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	the resident and /or re and the meeting was Worker indicated a no the resident's record in plan meeting was cor- meeting and what wa Worker stated for res- long-term care, the ca- conducted as needed Social Worker stated reviewed their own ca- resident after they co- assessment and mad Unless there was a si- care plan meeting wa care plan meeting wa meetings were not so stated Resident #37 v resident and her last conducted on 1/26/23 meetings conducted In 1/26/23. During an interview of Director of Nursing (ID Services were respon- plan meeting. DON in in the morning meeting care plan meeting du condition, or if it was assessment coming u resident's representar Social Services would meeting with the resider representative. Care conducted 2 to 3 time	e a care plan meeting with esident's representatives conducted. The Social of was later documented in indicating when the care nducted, who attended the as discussed. The Social idents who were on are plan meetings were d and it was informal. The that each department are plan goals related to the mpleted the MDS de changes accordingly. ignificant change and/or if a as indicated by staff, then a as scheduled. If not care plan cheduled. The Social Worker was a long-term care care plan meeting was by the IDT team after an 2/8/24 at 8:34 AM, the DON) stated the Social nsible for scheduling the care ndicated the team discusses ag if any resident needs a e to some change in a quarterly or annual up or if the resident or tive had any concerns. d then schedule a care plan dent and/or their	F	657			

Facility ID: 922983

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	10. 0938-039 FE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	CON	MPLETED
		245409	B. WING			С
	ROVIDER OR SUPPLIER	345408	B. WING	STREET ADDRESS, CITY, STATE, ZIP COE		4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			6000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE
F 657	Continued From page	o 27	ГС	7		
1 007			F 65	57		
		hours of admission, after sion care plan and then				
	quarterly, or when the	-				
		sident or representative, or				
	-	are plan meeting. She				
		s not sure when the care				
	plan was reviewed/re	evised.				
	During an interview o	on 2/8/24 at 9:08 AM, the				
		hen any resident was due for				
	a MDS assessment,					
	-	m reviewed and completed				
	· ·	ons. The care plans were				
		IDT. The care plans were s of completion of MDS				
	-	S Nurse indicated Social				
		ble for scheduling a care				
	plan meeting with the					
		further indicated the Social				
	Worker could run a re	eport to see which re plans were completed and				
		neetings accordingly. The				
		esident # 37's care plan				
	review start date was					
		10/18/23. The care plan				
		d on 1/19/24. The MDS				
		esident's care plan should				
		by the IDT team and closed he start date i.e. 7/7/23. The				
		dicated that the resident had				
	an annual assessme	nt on 9/13/23 and quarterly				
		8/23. MDS nurse stated the				
		should have been reviewed				
	of these assessment	IDT team after completion s.				
	3. Resident #53 was	readmitted on 12/11/23 with				
		led diabetes mellitus type 2,				
	-	ase and dependent on renal				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/26/2024 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345408	B. WING			-		C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHPC	INT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD	•		
	-			D	OURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 657	Continued From page dialysis. Review of the assessment dated 1/2 was admitted on 6/13 the resident was mod and dependent on sta Review of Resident # was reviewed and rev no indication that the representatives partic meeting or in develop During an interview of #53 indicated he did r a care plan meeting. I him involved him with development. During an interview of Social Worker stated rehab, were schedule the resident and /or re and the meeting was Worker indicated a no the resident's record i plan meeting was con	e 38 e most recent quarterly MDS 2/24 revealed the resident //23. Assessment indicated lerately cognitively impaired aff with ADL care. 53's care plan revealed it <i>v</i> ised on 9/12/23. There was resident or resident's cipated in the care plan oment of the care plan. n 2/5/24 10:46 AM, Resident not recollect being invited to He stated nobody had asked his care plan goal n 2/7/24 at 11:46 AM, the residents on short term a care plan meeting with esident's representatives conducted. The Social of was later documented in indicating when the care nducted, who attended the s discussed. The Social		657			.ΤΕ	
	long-term care, the ca conducted as needed Social Worker stated reviewed their own ca resident after they con assessment and mad Unless there was a si care plan meeting wa care plan meeting wa meetings were not sc	are plan meetings were I and it was informal. The that each department are plan goals related to the mpleted the MDS le changes accordingly. ignificant change and/or if a is indicated by staff, then a is scheduled. If not care plan						

Facility ID: 922983

If continuation sheet Page 39 of 116

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2024 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345408	B. WING _				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			00 FAYETTEVILLE ROAD JRHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 657	the resident did not h since he transitioned long term care reside During an interview o Director of Nursing (D Services were respon- plan meeting. DON i in the morning meetin care plan meeting du condition, or if it was assessment coming of resident's representa Social Services would meeting with the resider representative. Care conducted 2 to 3 time were invited to attend DON indicated the car conducted within 48 h completion of admiss quarterly, or when the changes, or if any resistaff, requests for a c further stated she wa plan was reviewed. During an interview o MDS Nurse stated wi a MDS assessment, for opened. The IDT team their respective section also reviewed. The care 14 days of completion MDS Nurse indicated responsible for sched with the residents and	sed on the documentation ave any care plan meeting from short term rehab to nt. n 2/8/24 at 8:34 AM, the DON) stated the Social nsible for scheduling the care indicated the team discusses ing if any resident needs a e to some change in a quarterly or annual up or if the resident or tive had any concerns. d then schedule a care plan dent and/or their plan meetings were es a week and the residents their care plan meeting. If heir care plan meeting. The plan meeting were nours of admission, after ion care plan and then ere was a significant sident or representative, or are plan meeting. She s not sure when the care n 2/8/24 at 9:08 AM, the men any resident was due for the assessment was m reviewed and completed ons. The care plans were are plans were closed within in of MDS assessment. The	F	657			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		345408	B. WING			04	C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	I		:	STREET ADDRESS, CITY, STATE, ZIP CODE	1 -	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	report to see which as were completed and accordingly. The MDS 53's care plan review target completion dat Nurse indicated the re- have been reviewed I within 14 days from th MDS Nurse further in a significant change a quarterly assessment stated the last care pl The care plan needed revised by IDT after th assessment and quart 4. Resident #104 was diagnoses that includ with hypercapnia, cel contrition of the lungs MDS assessment dat resident was admitted was assessed as cog substantial / maximal ADL care. Review of Resident # was reviewed/revised indication Resident # plan meeting or deve During an interview o Social Worker stated	ssessments and care plans could schedule the meetings S Nurse stated Resident # start date was 1/2/23 and e was 1/16/24. The MDS esident's care plan should by the IDT team and closed he start date i.e. 1/2/23. The dicated that the resident had assessment on 8/14/23 and c on 10/2/23. MDS Nurse lan review was on 6/19/23. d to be reviewed and /or he significant change terly assessment. s readmitted on 2/5/24 with ed acute respiratory failure lulites of lower limb, and b. Review of the quarterly ted 10/9/23 indicated the d on 10/6/23. The resident initively intact and needed assistance with most of his 104's care plan revealed it I on 11/22/23. There was no 104 participated in the care lopment of the care plan. n 02/05/24 10:46 AM, ted he was not invited to any d had never participated in	F	657	7		

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		ID HUMAN SERVICES MEDICAID SERVICES			_	FORM A	04/26/2024 PPROVED )938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	IPLE CONSTRUCTION		X3) DATE SU COMPLE	RVEY
		345408	B. WING _			C 04/05	/2024
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
				6000 FAYETTEVILLE ROAD			
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORREC CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)		(X5) COMPLETION DATE
F 657	and the meeting was Worker indicated a not the resident's record plan meeting was cor meeting and what wa Worker stated for res long-term care, the ca conducted as needed Social Worker stated reviewed their own ca resident after they co assessment and mad Unless there was a s care plan meeting wa care plan meeting wa care plan meeting wa meetings were not so Worker stated Reside care resident and bas the resident did not h During an interview o Director of Nursing (D Services were respor plan meeting. DON i in the morning meetin care plan meeting du condition, or if it was assessment coming u resident's representa Social Services would meeting with the resider representative. Care conducted 2 to 3 time were invited to attend DON indicated the care	esident's representatives conducted. The Social betwas later documented in indicating when the care inducted, who attended the is discussed. The Social idents who were on are plan meetings were d and it was informal. The that each department are plan goals related to the impleted the MDS le changes accordingly. ignificant change and/or if a is indicated by staff, then a is scheduled. If not care plan theduled. The Social ent #104 was a long-term sed on the documentation ave any care plan meeting. In 2/8/24 at 8:34 AM, the DON) stated the Social isible for scheduling the care indicated the team discusses ing if any resident needs a e to some change in a quarterly or annual up or if the resident or tive had any concerns. d then schedule a care plan dent and/or their plan meetings were es a week and the residents l their care plan meeting.	F 6				
	completion of admiss quarterly, or when the	ion care plan and then ere was a significant					
L						1	

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 04/26/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING					C <b>05/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE,	ZIP CODE	-	
				6	000 FAYETTEVILLE ROAD			
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		D	URHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 657	Continued From page		F	657				
	staff, requests for a ca	ident or representative, or are plan meeting. She s not sure when the care						
	MDS Nurse stated wh a MDS assessment, to opened. The IDT tear their respective section also reviewed. The car 14 days of completion MDS Nurse indicated responsible for sched with the residents and further indicated the S report to see which as were completed and of accordingly. The MDS care plan was revised	n reviewed and completed ons. The care plans were are plans were closed within n of MDS assessment. The Social Worker was uling a care plan meeting t their representatives. She Social Worker could run a ssessments and care plans could schedule the meetings S Nurse stated the resident's t on 8/28/23.						
	Administrator stated t be done by interdiscip and/or resident's repr quarterly, as needed condition and annuall stated that the resider reviewed and closed completion of the MD Administrator indicate responsible for sched meetings. The resider representatives shoul meeting should be sc convenience of the re representative.	ed the Social services were uling the care plan nts and/or resident's d be invited to the care plan Ild be sent out and care plan						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345408	B. WING				/05/2024
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER		e	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	DURHAM, NC 27713 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	3/30/23 with diagnose primary osteoarthritis The quarterly Minimu 12/8/23 revealed the cognition. Review of Resident # was reviewed 12/8/23 that Resident #97 pai meeting or developm An interview on 2/6/2 #97 revealed she had invited to a care plan During an interview on MDS Coordinator rev responsible for sched The SW could run a r assessments and car schedule the meeting indicated the last care Resident #97 were 9/ further revealed MDS care plan notes for R An interview on 2/7/2 Social Worker (SW) r short-term rehab, she meeting with the families, in	es that included bilateral of hip. m Data Set (MDS) dated Resident #97 had intact 93's care plan revealed it 3. There was no indication rticipated in the care plan ent of the care plan. 4 at 9:46 AM with Resident d not attended or been meeting. n 2/8/24 at 11:29 AM, the ealed the SW was fuling care plan meetings. report to see which re plans were completed to 0. The MDS Coordinator e plan quarterly review for 7/23 and 12/8/23. Interview 5 Coordinator didn't see any	F	657			
	documented in the re when the care plan m attended the meeting The SW indicated for	sident's record indicating neeting was conducted, who and what was discussed. residents who were in neetings were conducted as					

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TATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		345408	B. WING		04/05/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD URHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLÉTIO
F 657	that each department plan goals related to the completed the MDS at accordingly. Unless the change and the staff resident or resident fat the condition and goat plan meetings conduct revealed Resident #9 resident and the SW last care plan meetings had not invited resided or invitations to attend Discharge Planning F CFR(s): 483.21(c)(1)( §483.21(c)(1) Dischart The facility must develop effective discharge pl on the resident's disc of residents to be active transition them to post reduction of factors lear readmissions. The fact process must be const rights set forth at 483 (i) Ensure that the dist resident are identified development of a disc resident. (ii) Include regular re- identify changes that discharge plan. The other that the discharge plan. The other that the discharge plan. The other that the discharge plan.	as formal. The SW indicated reviewed their own care the resident after they and made changes here was a very significant wanted to talk to the amily about the change in als there were no team care cted. Interview further 7 was a long-term care could not find the date of her g. The SW indicated she ents, mailed out notifications d care-plan meetings. Process (i)-(ix) rge Planning Process elop and implement an anning process that focuses harge goals, the preparation ive partners and effectively st-discharge care, and the eading to preventable cility's discharge planning sistent with the discharge .15(b) as applicable and- scharge needs of each I and result in the	F 657		4/30/24

Facility ID: 922983

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i	COMPLETED	
		345408	B. WING		04/05/202	24
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMP	(X5) PLETIO DATE
F 660	and the resident's or person(s) capacity ar required care, as part discharge needs. (v) Involve the reside representative in the discharge plan and in resident representative (vi) Address the reside treatment preference (vii) Document that a about their interest in regarding returning to (A) If the resident ind to the community, the referrals to local cont appropriate entities m (B) Facilities must up comprehensive care appropriate entities. (C) If discharge to the to not be feasible, the made the determinati (viii) For residents wh SNF or who are disch LTCH, assist resident representatives in se provider by using dat limited to SNF, HHA, patient assessment of measures, and data of	er/support person availability caregiver's/support of capability to perform t of the identification of ant and resident development of the aform the resident and ve of the final plan. dent's goals of care and s. resident has been asked receiving information the community. icates an interest in returning e facility must document any act agencies or other hade for this purpose. date a resident's plan and discharge plan, as nose to information received contact agencies or other has to information received contact agencies or other a community is determined e facility must document who ion and why. ho are transferred to another harged to a HHA, IRF, or ts and their resident lecting a post-acute care a that includes, but is not IRF, or LTCH standardized lata, data on quality on resource use to the extent The facility must ensure that	F 66	0		

Facility ID: 922983

If continuation sheet Page 46 of 116

SUMMARY ST (EACH DEFICIENC REGULATORY OR I inued From page esident's goals o erences. Document, compl e resident's neer rd, the evaluatior is and discharge uation must be di ent's representa	f care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	· /	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) 50	HOULD BE COMPLETIC
EHABILITATION A SUMMARY ST (EACH DEFICIENC REGULATORY OR I inued From page esident's goals o erences. Document, compl e resident's need rd, the evaluation s and discharge uation must be di ent's representa	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 46 ff care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	ID PREFIX TAG	6000 FAYETTEVILLE ROAD DURHAM, NC 27713 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	04/05/2024 RECTION (X5) HOULD BE COMPLETIC
EHABILITATION A SUMMARY ST (EACH DEFICIENC REGULATORY OR I inued From page esident's goals o erences. Document, compl e resident's need rd, the evaluation s and discharge uation must be di ent's representa	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 46 of care and treatment lete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	PREFIX TAG	6000 FAYETTEVILLE ROAD DURHAM, NC 27713 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	RECTION (X5) HOULD BE COMPLETIO
SUMMARY ST (EACH DEFICIENC REGULATORY OR I inued From page esident's goals o erences. Document, compl e resident's neer rd, the evaluatior is and discharge uation must be di ent's representa	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 46 of care and treatment lete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	PREFIX TAG	DURHAM, NC 27713 PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
(EACH DEFICIENC REGULATORY OR I inued From page esident's goals o prences. Document, compl e resident's need rd, the evaluation s and discharge uation must be di ent's representa	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) e 46 of care and treatment lete on a timely basis based ds, and include in the clinical of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETIC
esident's goals o erences. Document, compl e resident's need rd, the evaluation s and discharge uation must be di ent's representa	f care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident	F 66	50	
esident's goals o erences. Document, compl e resident's need rd, the evaluation s and discharge uation must be di ent's representa	f care and treatment lete on a timely basis based ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident			
e resident's need d, the evaluation s and discharge uation must be di ent's representa	ds, and include in the clinical n of the resident's discharge plan. The results of the iscussed with the resident or tive. All relevant resident			
oid unnecessary harge or transfer. REQUIREMENT ed on record rev cy, physician, st to implement an hing process that ent's caregiver a informed of the rs, wounds, and red for the woun	ncorporated into the ilitate its implementation and delays in the resident's is not met as evidenced iew, family, home health aff interviews, the facility n effective discharge t included ensuring the und the home health agency resident's medication the treatment that was ids. This was for 1 of 3 or discharge (Resident #181).		F660 Corrective action for the residen to be affected by the deficient pr Resident #181 no longer resides facility. Corrective action for other reside having the potential to be affected same deficient practice.	ractice. s in the ents
mitted on 3/23/23 3 via stretcher tr ded diabetes, de hagia, chronic ki Alzheimer's disea	dmitted on 2/3/23, 3 and discharged home on ansport. The diagnoses mentia, hypertension, dney failure, osteoarthritis, ase. sion Minimum Data Set revealed Resident #181 rely impaired . She required		All facility residents that have a p discharge have the potential to b affected by this deficient practice Interdisciplinary team (IDT) fails implement an effective discharge facility in-house audit of all disch the last 30 days was conducted 2/26/24 by the Social Services T facility Administrator. Systemic Changes made to ens the deficient practice will not rec All IDT members involved with th discharge planning process were in-service and educated on by th	be e if the s to ge plan. A harges for on Team and sure that cur. the re he
mit 3 \ deo hag	ted on 3/23/23 via stretcher tr d diabetes, de gia, chronic ki heimer's disea of the admiss dated 3/23/23 verely cognitiv	ted on 3/23/23 and discharged home on via stretcher transport. The diagnoses d diabetes, dementia, hypertension, gia, chronic kidney failure, osteoarthritis, heimer's disease. of the admission Minimum Data Set dated 3/23/23 revealed Resident #181 verely cognitively impaired . She required ve assistance from staff with toileting, e, bathing, dressing and transfers. The	ted on 3/23/23 and discharged home on via stretcher transport. The diagnoses d diabetes, dementia, hypertension, gia, chronic kidney failure, osteoarthritis, heimer's disease. of the admission Minimum Data Set dated 3/23/23 revealed Resident #181 verely cognitively impaired . She required ve assistance from staff with toileting,	ted on 3/23/23 and discharged home on via stretcher transport. The diagnoses d diabetes, dementia, hypertension, gia, chronic kidney failure, osteoarthritis, heimer's disease.implement an effective discharge facility in-house audit of all disc the last 30 days was conducted 2/26/24 by the Social Services T facility Administrator. Systemic Changes made to ensi the deficient practice will not red dated 3/23/23 revealed Resident #181 verely cognitively impaired . She required ve assistance from staff with toileting,implement an effective discharge facility in-house audit of all disc the last 30 days was conducted 2/26/24 by the Social Services T facility Administrator. Systemic Changes made to ensi the deficient practice will not red discharge planning process wer in-service and educated on by the

Facility ID: 922983

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						0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL	
			A. BOILDING		с	
		345408	B. WING			5/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	-	
SOUTUD		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
30011110		IND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 660	Continued From page	e 47	F 66	30		
		e back to the community.	1 00	which is resident specific	for their	
		source the community.		appropriate discharge ne		
	Review of Resident #	181's care plan dated		in-service education was		
		sident #181's goal was to		2/26/24.	•	
	discharge home with	-		Plans to monitor its perfo	ormance to make	
				sure that the solutions ar		
	Review of the April 20			The Social Services Tea		
		d (TAR) for Resident #181		Administrator will audit a	•	
		received right heel wound		discharges 5x a week for		
		right heel which was to wipe		ensure a cohesive disch	÷ .	
		in prep 3 times a day, every for the whole month. The		includes ensuring that th		
		nted treatment for the sacral		specific needs are being discharge.	metion	
	wound.			Post discharge, a memb	er of the IDT will	
	wound.			follow-up with the reside		
	Review of physician of	discharge summary note		discharge to ensure all fo	-	
		led a physical exam was		home health, therapies,		
	completed on Reside			visits are in place and if		
	documented the skin	was warm, dry, and not		further assistance with th	neir transition	
		t #181 had right foot pain,		back into their home sett	tings. This audit	
		palpation. The discharge		will continue 5 x a week	-	
		t include a discussion, any		weekly for 2 months. Th		
		f the facility acquired deep		audit and any concerns i		
	tissue injury to the rig	ht heel or the sacral wound.		reported to our Quality A		
	Dovious of the interview	a ciplinan ( dia charge a		Committee monthly for th		
	Review of the interdis	/23 revealed Resident #181		until substantial compliar	ice is achieved.	
	-	harge home with family on		Date of compliance: 4/	/30/24	
		was made to a home health			00/24	
		for physical/occupational				
		to provide a medication				
		e summary did not include				
	-	of medications or wound care				
		ght heel or pressure wounds.				
	-	of the interdisciplinary				
	discharge summary s					
		ome health and hospice				
		aled the home health referral				
	did not include an ord	der for nursing to evaluate				

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		ND HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/26/2024 RM APPROVED IO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345408	B. WING		0	4/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 660	and treat Resident # wounds. A telephone interview 2:15 PM, the family n stated her mother ha she was readmitted. stated she was unaw her mother's buttocks heel until the residen She stated she saw a buttocks and when sl large wounds on both The right heel had an A telephone interview 1:39 PM, the Social V initiated the discharge 4/28/23 for Resident team was responsible designated section pr discharge date of 5/1 all interdisciplinary te form a packet would nurse. The nurse wou the resident and/or re would sign the docum the time of discharge prescriptions, appoin providers. The Social summary was prepar not know if a copy ha or responsible person did not state who follo of the packet since sl completing this form.	181's right heel and sacral was conducted on 2/5/24 at nember of Resident #181 d no pressure ulcers when The family member further are of the pressure ulcers on s, mid cheek area and right t arrived home on 5/1/23. a dressing on the resident's he removed it there were n cheeks that were draining. open area as well. was conducted on 2/7/24 at Nork Assistant stated she e plan and summary on #181. The interdisciplinary e for the completion of their rior to the Resident's /23. She further stated once am members complete the be prepared and given to the uld review the packet with esponsible person, they nent and be given a copy at with all medications, tments, and service I Work Assistant stated the red on 4/28/23 and she did to been given to the resident n. The Social Work Assistant owed up with the completion the left the facility after	F 66			
ORM CMS-256	AM, in conjunction w	iducted on 2/8/24 at 8:26 ith a record review with the				

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	S FOR MEDICARE &					10.0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	E CONSTRUCTION	· · ·	E SURVEY IPLETED
						С
		345408	B. WING		0.	4/05/2024
NAME OF PF	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
				6000 FAYETTEVILLE ROAD		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 660	Continued From page	e 19	F 660			
			F 000			
		evealed all interdisciplinary not completed the Resident				
		nmary. The discharge				
		tiated by the Social Worker				
	who would prepare th					
	medication list/presci	•				
		r support services and give				
	the packet to the disc					
	reviewed with the res	sident and/or responsible				
	-	discharge. The discharge				
		signature from the resident				
		erson and a copy would be				
	-	e second copy kept on file.				
		ng stated the facility did not				
	documentation that the	ket for Resident #181 or				
		the resident or responsible				
		discharge. The Director of				
	•	urrent discharge plan was not				
		nducted on 2/8/24 at 11:12				
		th a record review with Nurse				
		ed her nursing note dated				
		ented Resident #181 was				
	-	6 indicated she did not				
		of the resident at the time of				
	-	stated the discharge process e discharge paperwork from				
	-	hich included the discharge				
		lication and wound care				
	-	ald document in the record				
		nd wound care instructions				
	were reviewed with th	he resident and/or				
	responsible person.	A signed copy of the				
		would be sent home with				
	the resident and/or re	ananaihla nanan Numaa # C				
		esponsible person. Nurse # 6 call reviewing the paperwork				

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DA	10. 0938-039 TE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		345408	B. WING		0	C 4/05/2024
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP COD	Ε	
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 660	Continued From page	e 50	F 660			
		rk home with the resident.				
		v was conducted on 2/8/24 at cian Assistant #3 stated she				
	did not recall any dis	cussion with nursing about				
		g any open areas on the ian Assistant #3 stated the				
		ind care nurse would notify				
		he changes in skin condition				
	the treatment plan. T	uld have been held regarding				
	included in the discha					
	A telephone interview	v was conducted on 2/9/24 at				
		he health and hospice agency				
		eferral for Resident #181 was				
		for physical/occupational services, however, there				
	was no information c					
		ome health services began				
	on 5/2/23 and there v	vere no medication instructions for the wound				
		sent with the resident or to				
		on. The hospice nurse				
		ateral wounds on the sacral able wound to the right heel				
		ce nurse communicated with				
	the facility nurse the	following day to obtain the				
E 004	facility discharge sun	-	<b>F</b> 004			4/00/04
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)		F 661			4/30/24
	§483.21(c)(2) Discha					
		cipates discharge, a resident				
	must have a discharge but is not limited to, t	ge summary that includes, he following:				
		the resident's stay that				
	includes, but is not li	-				

Event ID: MBNX11

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED C
		345408	B. WING		04/05/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER	6	000 FAYETTEVILLE ROAD	
			C	OURHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 661	Continued From page	e 51	F 661		
		r therapy, and pertinent lab,	1 001		
	radiology, and consu				
		of the resident's status to			
	include items in para	graph (b)(1) of §483.20, at			
r t r		arge that is available for			
		l persons and agencies, with			
	the consent of the re-	sident or resident's			
	representative. (iii) Reconciliation of	all pre-discharge			
		resident's post-discharge			
	medications (both pre				
	over-the-counter).				
	(iv) A post-discharge				
		articipation of the resident			
		t's consent, the resident			
		ich will assist the resident to ew living environment. The			
	-	of care must indicate where			
		o reside, any arrangements			
		e for the resident's follow up			
	care and any post-dis				
	non-medical services				
		Γ is not met as evidenced			
	by: Based on record rev	iew, and staff interview, the		F661	
		lete a recapitulation of stay			
		ords reviewed for planned		Corrective action for the residents fou	nd
		munity(Resident #181).		to be affected by the deficient practice	
				Resident #181 no longer resides in th	e
	The findings included	1:		facility.	
	Resident #191 was r	eadmitted to the facility on		Corrective action for other residents	the
	3/23/23.	eadmitted to the facility on		having the potential to be affected by same deficient practice.	
				All residents have the potential to be	
	The admission Minim	num Data Set(MDS) dated		affected by the alleged deficient practi	ce.
		81 was coded severely		The Administrator initiated 100% audi	
	impaired with cognition	-		all residents within the facility on 2/26/	
				to ensure a discharge plan summary v	
	Resident #181 was d	lischarged to the community		in place. There were no other negative	e

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 04/26/2024 RM APPROVED IO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345408	B. WING		0,	C 4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 661	<ul> <li>1:39 PM, the Social M discharge plans were and responsible pers Resident #181 to retu initiated the discharge 4/28/23, a few days p The Social Worker as know if the other inte completed the recapi</li> <li>An interview was con AM, in conjunction w discharge summary w Director. The Social M was off at the time of however, the assistant discharge plan summ She confirmed the or system was the form all the interdisciplinar completed to recapitu which would have inco medication list/prescri- instructions. Each of members were responsections two days pri- discharge.</li> <li>An interview was con AM, in conjunction wi Director of Nursing (I discharge summary r the resident on 4/28/2</li> </ul>	of the closed record ailed to complete a esident's stay. A was conducted on 2/7/24 at Vorker Assistant stated the e discussed with the resident on on admission for urn to the community. She e plan and summary form on orior to discharge on 5/1/23. assistant stated she did not rdisciplinary team members tulation of stay. ducted on 2/8/24 at 9:15 with record review of the with the Social Work Nork Director stated she the resident's discharge; nt social worker prepared the nary form in her absence. Ny information in the facility completed on 4/28/23, and y sections were not ulate Resident #181's stay cluded the resident's iptions wound care the interdisciplinary team insible for completing their or to the scheduled ducted on 2/8/24 at 8:26 th a record review with the DON). Review of the evealed the physician saw 23 and completed a note recapitulation the	F 66	outcomes identified. Systemic Changes made to en the deficient practice will not re The Social Services departmer educated by the Administrator of on Discharge plan summaries if accordance with CMS guideling recapitulation of the residents required and must be complete IDT before the resident dischar the facility. Plans to monitor its performand sure that the solutions are sust The administrator or designee each discharge daily x 5 days a 4 weeks to ensure that a dischar summary has been completed. findings of concern will be imm addressed and reported to the committee monthly for 3 month further or until substantial comp achieved. Date of compliance: 4/30/24	ecur. Int was on 2/26/24 in es. A I stay is ed by the rges from ce to make cained. will review a week for arge . All ediately QAPI is for	

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/20 FORM APPROVE OMB NO. 0938-039
TATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345408	B. WING		C 04/05/2024
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SOUTUDO		AND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD	
30011120				DURHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLÉTIO
F 661	Continued From page	e 53	F 66 <sup>-</sup>		
		d not include any information	1 00		
		vounds on the heel or sacral			
		reatment or instructions			
	•	d. The Director of Nursing			
		I record and revealed the			
		as not completed by the n because they did complete			
		Resident #181's stay at the			
	•	e DON indicated the team			
		o days before the scheduled			
	discharge to ensure a				
	documentation was of paperwork was sent	-			
F 679		est/Needs Each Resident	F 679		4/30/24
SS=D	CFR(s): 483.24(c)(1)				
	§483.24(c) Activities.				
		cility must provide, based on ssessment and care plan			
		of each resident, an ongoing			
	-	esidents in their choice of			
		/-sponsored group and			
		nd independent activities,			
		e interests of and support the I psychosocial well-being of			
		raging both independence			
	and interaction in the				
	This REQUIREMEN	T is not met as evidenced			
	by:			5070	
		ons, staff interview and cility failed to provide an		F679 Corrective action for the residents for	ind
		gram that met the individual		to be affected by the deficient practic	
		or 1 of 2 cognitively impaired		Resident #74 still resides in house.	
		or activities (Residents #74).		Activity Care plan for resident #74 wa	as
	The findings included	1:		updated on 2/28/24.	
	Posidont #74 was ad	lmitted to the facility on		Corrective action for other residents having the potential to be affected by	, the
	I RESIDEN #14 Was ad		1	T DAVIDO DE DOLEDITALIO DE ALIECIEO DV	

Event ID: MBNX11

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 04/26/2024 APPROVED . 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G	(X3) DATE S COMPL	SURVEY LETED
		345408	B. WING		04/0	; )5/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	•	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETION DATE
F 679	Continued From page	e 54	F 67	79		
	Data Set(MDS) dated moderately impaired assistance with activi	ded on the annual Minimum l 6/23/23 as having cognition and he needed ties. The MDS also coded		All residents have the pot affected by the alleged de The Administrator initiated all residents within the fac to ensure cognitively impa are having their needs me	eficient practice. d 100% audit on cility on 2/26/24 aired residents et with activities.	
	to participate in favor and news and curren	y interest as very important ite activities to include music t events. The resident was ance with transfers and		There were no other nega- identified. Systemic Changes made the deficient practice will The Activity department w the Administrator on 2/26	to ensure that not recur. vas educated by	
	revealed Resident #7 in listening to music,	ssessment dated 6/22/23 '4's preference with interest news, and current events.		importance to ensure all of impaired residents□ need by the activity department with CMS guidelines, requ	ds are being met t in accordance	
	revealed Resident #7 involvement related t goal included Reside leisure activities. The	are plan dated 6/22/23 4 had little, or no activity o physical limitations. The nt #74 would choose his own intervention included staff d change the television		documentation and participation/attendance r kept up to date. The Administrator or design these areas 5x a week for then weekly for 4 weeks to thereafter.	gnee will monitor r 4 weeks and then monthly	
	notes available after	ed there were no activity the 6/22/23 assessment for were no documented notes ds for Resident #74.		Plans to monitor its performs sure that the solutions are The Administrator and/or monitor these areas 5x a weeks and then weekly for monthly thereafter. The A	e sustained. designee will week for 4 or 4 weeks then	
		d old school music,		present an analysis of this Quality Assurance Perfor Improvement Committee consecutive months of co sustained then quarterly.	s review to the mance monthly until 3 ompliance is	
	independent activities was done on 2/5/24 f	for 2/5/24 was reviewed for s. A continuous observation rom 10:00 AM to 2:30 PM of activities throughout the day		Date of compliance: 4/3	30/24	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING		_		C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 679	in bed during these tin alternate activities or available during the d Review of the activity the following activities name that song at 11 movies and manicure passing by the Reside stop to offer the reside in the scheduled activ Observation of the ac revealed the schedule visits.Resident #74 w in the room yelling ou with remote. The resid the remote. During th was observed in the a group of residents. Th done. The nurse aide providing care. Observation on 2/5/24 residents participated activity. Resident #74 There was no televisie An interview and obse 2/5/24 at 2:30 PM. R calling out for someor television was playing was across the room stated he had not see staff did not get him o	lar. Resident #74 remained me frames. There were no one-to-one activities ay. calendar on 2/5/24 offered a at 10:00 AM room visits, c00 AM, and 2:30 PM s. Staff were observed ent #74's room and did not ent assistance to participate rity. tivity on 2/5/24 at 10:00 AM ed activity was room as overheard and observed t for staff to come and assist dent had difficulty operating is time the Activity Director activity room with a small here were no room visits s were in other rooms 4 at 11:00 AM, revealed nine in the Name that Song 4 was in his room in silence.	F 679				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/26/2024 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·				LETED
		345408	B. WING		_		C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER	-	000 FAYETTEVILLE ROAD	)		
				OURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	• 56	F 679				
F 679	painting that song at resident council meet Staff were observed p room and did not stop assistance to participa An interview and obse 2/06/24 at 10:57 AM. enjoyed religious serv and food events. Res had limited physical n go to activities himsel was not provided with or assisted to an activ would go to activities remote control was ac out of reach of the res	11:00 AM, and 2:00 PM ing with black history facts. bassing by the resident's to offer the resident ate in the scheduled activity. ervation were conducted on Resident #74 stated he vices, sports, gospel music ident #74 further stated he nobility and was unable to f. Resident #74 reported he in in-room activities, offered, vity. The resident stated he if staff would take him.The cross the room on a counter	F 679				
	offer the resident the to the activities of the if the nurse aides wer unable to take resident the activities and may residents toward the e Nurse Aide #4 stated activity person workin An observation and in 2/8/24 at 2:16 PM. R bed with television on control was across the There were no other s room or within reach of #5 stated staff would with the use of the res	g with the resident. terview were conducted on esident #74 was observed in low volume and the remote e room on the counter. stimulatory items in the of the resident. Nurse Aide have to assist the resident mote control. Nurse Aide #5 d not seen Resident #74					

Facility ID: 922983

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	OF DEFICIENCIES	MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /			MPLETED
						С
		345408	B. WING		0	4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SOUTHDO		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
0001111 0				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 679	Continued From page	e 57	F 67	Q		
		by the activity staff. Nurse	1.07	5		
		d Resident #74 would yell out				
		ng or assistance. Nurse Aide				
		s try to assist with getting				
	residents to activities	, but if they were providing				
		ts, they were unable take				
	residents to activities					
	A i t					
		iducted on 2/7/24 at 3:00 I Resident #74 stayed in bed				
		she had not seen any direct				
		the resident. Nurse #12				
	•	recall if the activity person				
		esident. The nursing staff				
	had been very busy a	and had difficulty getting				
		when the workload was				
	heavy.					
	An interview was con	ducted on 2/8/24 at 12:00				
	PM, in conjunction wi	ith the record with the Activity				
	Director (AD). She st	ated she was aware				
		d music, news and games				
		done June 2023. She				
	-	ment and care plan at the				
		d not participated in any				
	group activities, and a	e-to-one activities activity				
		#74. The Activity Director				
	-	and acknowledged there had				
		l activity for Resident #74				
		ctivity Director stated she				
	was the only person					
		/ and the expectation was for				
		d bring residents to the				
	-	/ Director stated she had limited ability to transport				
		e to one room visits and				
	-	vities to the Director of				
	Person and dury dou		1			1

If continuation sheet Page 58 of 116

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04 FORM API OMB NO. 09	PROVE
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345408	B. WING		C 04/05/2	024
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER	6	TREET ADDRESS, CITY, STATE, ZIP CODE 000 FAYETTEVILLE ROAD 1URHAM, NC 27713	Ì	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COI	(X5) MPLETION DATE
F 679 F 684 SS=J	additional staff and gr assist with transport. An interview was com PM. The Director of N should be encouragin residents to preferred The facility staff shou activities as much as An interview was com AM. The Administrato plan and notes should preference and respondent residents who are no should be provided w activity. The facility w for the activities prog Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Base assessment of a reside that residents received accordance with profer practice, the comprete care plan, and the rest This REQUIREMENT by: Based on record rev recorded 911 call, the emergency procedure	ey were working on hiring etting the facility staff to ducted on 2/7/24 at 2:45 Aursing stated the staff ng/offering and assisting activities of interest daily. Id assist residents to possible. ducted on 2/9/24 at 7:30 or stated the resident's care d reflect resident's individual onse to the activity. The t involved in group activities vith one-to-one activities vas challenged with staffing ram. are indamental principle that int and care provided to ied on the comprehensive dent, the facility must ensure a treatment and care in essional standards of inensive person-centered	F 679	F684 Corrective action for the residents fou to be affected by the deficient practice Resident #232 no longer resides in the facility.	e.	)/24

Facility ID: 922983

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		ND HUMAN SERVICES			FOF	ED: 04/26/20 RM APPROVE
TATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DA1	IO. 0938-039 E SURVEY IPLETED
		345408	B. WING			C 4/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•	+/03/2024
				6000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	- FQ	<b>– – – – –</b>			
F 004			F 68		· · · ·	
	#7 failed to complete assessment, failed to			Corrective action for other		
		e nursing home and with 911.		having the potential to be a same deficient practice.	medieu by the	
	Nurse #7 also delaye			All facility insulin depender	nt diabetic	
		ency with the 911 call, and		residents have the potentia		
	-	e information of the situation.		by this deficient practice.		
		ed on 2/8/24. This occurred		completed by the Clinical F		
	for 1 of 1 resident rev	viewed for neglect (Resident		Director/Designee to verify	-	
	#232).			that are insulin dependent		
				insulin per the MD orders a	-	
		began on 2/8/24 when the		monitored for any signs of	• •	
	-	diately and effectively		acute emergent hypoglyce		
		emergency. The immediate ed on 4/5/24 when the facility		was completed on 4/3/24. events are noted in this au	•	
		eptable credible allegation of		corrected immediately by [		
	compliance. The fac			Systemic Changes made to		
		be and severity D (not actual		the deficient practice will no		
		or more than minimal harm		All licensed nurses, certifie		
	that is not immediate	jeopardy) to ensure		assistants, agency/contrac		
	monitoring and all sta	aff have been in-serviced.		newly hired licensed nurse		
				educated on the policies an		
	The findings included	1:		of responding to a medical		
	Resident #222 was a	dmitted to the facility on		and on how to manage Em	-	
	1/23/24 with diagnose	•		Hypoglycemic events. This include how to manage the		
	mellitus, long term us	-		medical code for initiation of		
	infarction (stroke), an			911 to report a medical em		
	recipient.			that EMS assistance is nee		
				emergently. This informati		
	-	Vinimum Data Set (MDS)		education is defined in the		
		/27/24, revealed he was		policy and the Medical Em		
		required limited assistance		Medical Emergency educa		
		v living. Resident #232		if calling a "code blue" is ne	•	
	received insulin injec	tions and tube feedings.		available staff report to res		
	A physician order det	ad 1/22/21 was nothing by		distress. Education will al		
		ted 1/23/24 was nothing by low ice chips after oral care.		specifics for managing eme Hypoglycemic events and	-	
	, ,	232's initial plan of care,		criteria for managing emer		
		ted he was a full code.		Hypoglycemia secondary t	•	

Event ID: MBNX11

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/2024 MAPPROVED O. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345408	B. WING			04	C //05/2024
NAME OF PF	ROVIDER OR SUPPLIER		- <b>I</b>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				60	00 FAYETTEVILLE ROAD		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		DI	URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 60	F 68	84			
	1.0				therapy. The education will have		
	A physician order dat	ed 1/26/24 was continuous			emphasis of blood glucose ranges th	at	
		.5 per PEG (percutaneous			would indicate a severe hypoglycemi		
		my) via Pump. Rate 70 ml			event and that may or may not prese		
		water flush 60ml every hour			with symptoms and how to assess ar		
	for 20 hours per day	from 2 PM to 10 AM			intervene quickly. Furthermore, for		
	(disconnect 10 AM - 2	2 PM).			further clarification, the policy will also	)	
					describe the need to follow Physician	s	
		ed 2/7/24 was insulin regular			orders, to determine when Hypoglyce		
	human injection solut				would result in a medical emergency		
		ect 28 units subcutaneously			each resident that is insulin dependent	•	
	-	or blood glucose less than			the physician's specific baseline bloo	a	
		standing or physician orders			glucose orders. The policy for Emergency medical management		
	for hypoglycemia.				indicates what pertinent information r	oods	
	A review of Resident	#232's Medication			to be given to 911 upon making an	eeus	
		d revealed that he received			emergency call. The education will be	e in	
		sulin at the following times:			person. All education will be initiated		
		h blood sugar of 202 and on			DON/ADON designee on 4/3/2024 ar		
		ith a blood sugar of 136.			continue daily prior to start of shift. A		
					new hires will receive this education i	n	
	An initial nurse's note	e dated 2/8/24 at 8:02 am			orientation prior to the start of their fir	st	
		ad written during the med			shift going forward from 4/4/2024. Th		
		dent #232's blood sugar			administrator/designee will be the per	son	
		e with the resident, and they			who will ensure all licensed nurses,		
	-	h. At 12:48 am she checked			certified nursing assistants,		
		d sugar and it was 136.			agency/contract staff, all ancillary sta		
		ed the insulin as ordered as it			and all newly hired employees will be		
		glucose less than 120. She over an hour to monitor			educated.		
	•	checked his blood sugar			Plans to monitor its performance to m	ake	
	•	it was 156. She wrote that			sure that the solutions are sustained.		
		and sat down to chart and			To ensure ongoing compliance, the		
		ompleted around 4:00 am.			Administrator and/or designee will		
		she took a lunch break from			conduct daily audits on all insulin		
		She began her last round at			dependent diabetic residents that req	uire	
		ne approached Resident			insulin administration this audit began		
	#232's room, she not	iced that he was not			4/5/24 and will continue for one mont	h,	
	responding so she ch	ecked his blood sugar level,			then 5 x times a week for 2 months.		

Facility ID: 922983

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		ECONSTRUCTION	(X3) DATE S	
	CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
					С	
		345408	B. WING		04/0	5/2024
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		0000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 684	and it was 28. Nurse bring her a glucagon medicine used to treat The nurse aide broug she administered und When she rechecked Nurse #7 documenter glucagon shot on the to nursing station #2 at (Nurse #10) for a gluc that the charge nurse send a resident out for wrote that she was can the glucagon shot and Resident #232. She Operator to move the floor, a nonrebreather resident and chest co #7 also wrote that she assist her, and the ch couldn't help her beca back", so she proceet the floor alone. She co that more nurses carr (emergency medical so over care for an addit stopped compression through in the medical An amended nurse's am revealed Nurse #7 pass at 9:58 pm Resi was 68 and she spok agreed to hold insulin Resident #232's blood	#7 asked a nurse aide to shot (an emergency it severe low blood sugar). ht her glucagon gel, which ler Resident #232's tongue. his blood sugar, it was 45. d she was unable to locate a medication cart, so she ran and asked the charge nurse cagon shot. Nurse #7 wrote told her that she could not or low blood glucose. She alling 911 as she was getting d administering it to was instructed by the 911 resident from the bed to the r mask was placed on mpressions began. Nurse e asked the charge nurse to arge nurse stated he ause "it would break my ded to get the resident on oncluded her note by writing ne to assist, EMS services) arrived and took ional 5 minutes before EMS s. This note was struck	F 684	A summary report of compliance brought to the Monthly Quality A Performance Improvement (QA Committee meeting by the Direc Nursing (DON) for review and re monthly x 3 months or until sub- compliance is achieved. Date of compliance: 4/30/24	Assurance PI) ctor of evision	

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			FORM	): 04/26/2024 APPROVED ). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION		LETED
		345408	B. WING			C <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	she finished rounds a her last round was co Nurse #7 wrote that s 5:09 am to 5:40 am. 5:43 am and when sh #232's room, she not responding so she ch and it was 28. Nurse bring her a glucagon medicine used to trea The nurse aide broug she administered und When she rechecked Nurse #7 documenter glucagon shot on the to nursing station #2 (Nurse #10) for a gluc she was calling 911 a glucagon shot and ac #232. She was instru- move the resident fro nonrebreather mask chest compressions b note by writing that m EMS (emergency me took over care for an EMS stopped compre-	it was 156. She wrote that and sat down to chart and ompleted around 4:00 am. she took a lunch break from She began her last round at he approached Resident iced that he was not hecked his blood sugar level, #7 asked a nurse aide to shot (an emergency at severe low blood sugar). ght her glucagon gel, which der Resident #232's tongue. I his blood sugar, it was 45. d she was unable to locate a medication cart, so she ran and asked the charge nurse cagon shot. She wrote that as she was getting the dministering it to Resident ucted by the 911 Operator to im the bed to the floor, a was placed on resident and began. She concluded her nore nurses came to assist, dical services) arrived and additional 5 minutes before	F 68			
	occurred between the #7: The time stamps time elapsed in minut	e 911 Operator and Nurse entered below document the tes and seconds from the ated at 6:56 am. The phone				
	0-1:00-Nurse #7 was Operator the facility's	heard telling the 911 address and that she had a				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345408	B. WING				C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			5000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	keeping it up. She did emergency or ask the emergency services. was a full code. 1:10-1:16 -Nurse #7 w operator that she had glucagon shot. 1:17-1:30- Operator w several times if the re- he was conscious. Th pause before Nurse # was breathing but tha 1:31-1:40- The Opera seen a health care pro- hours and Nurse #7 s "I'm not getting any bl 1:43- Nurse #10 could room-unable to detern 1:47- Nurse #7 was h she was sending the 1:50-1:57-The Operator the resident was breat 2 to 3 seconds and st breathing". The Operator 1:58-2:10- Nurse #7 of #10 to bring her some heard asking Nurse #	sugar level that was he was having trouble d not state she had an e 911 Operator to send She stated that resident was heard telling the 911 just given a resident a vas heard asking Nurse #7 sident was breathing and if here was a 5 to 6 second 47 stated that the resident the "wasn't coming to". Ator asked if the resident had ofessional within the last 2 stated no. She also stated, lood". d be heard entering the mine what he asked. eard telling Nurse #10 that resident out now. tor asked Nurse #7 again if thing. Nurse #7 paused for lated "mm, yes he's "ator then asked if the g normally. can be heard asking Nurse ething. The Operator was 7 again if the resident was urse #7 is heard again	F	684			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING				C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STAT	TE, ZIP CODE		
SOUTHPC	INT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD OURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	9 64	F 684				
	saying "hello, hello". 7	is heard in the background The Operator said hello and eard telling the Operator that se.					
	she said go, she want number of times she s resident's chest. Nurs There was a 15 secon the Operator said "he stated she was there	tor told Nurse #7 that when ted Nurse #7 to count the saw rise and fall of the se #7 then stated, "hold on". and pause (2:36-2:51) and llo" again. Nurse #7 then and was trying to watch his tated it was "really faint".					
	said go, she wanted N number of times the r	tor stated again, when she Nurse #7 to count the esident's chest rose. She if she was ready before					
		old the Operator that she out it wasn't "a real rise and					
	•	tor told Nurse #7 that heir way. She also asked if <sup>,</sup> "him", and she stated yes.					
	flat on his back with n Nurse #7 responded t	tor told Nurse #7 to lay him othing under his head. hat she needed to unhook use she couldn't lay him flat					
		round noises heard until e 4:24 mark that the resident					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345408	B. WING _				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			00 FAYETTEVILLE ROAD JRHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	4:25-4:30- Nurse #7 i man to bring me som 4:31-5:11- The Opera #7 to listen carefully a how to do chest comp heard saying "so, we The Operator asked i floor and Nurse #7 sta stated that the reside Nurse #7 stated that i and the resident was 5:15- Nurse #7 told so was about to have to 5:26- Nurse #7 was h room to get her *inau 5:27-5:33- backgroun 5:34- Nurse #7 was h room that the 911 Op on the floor. 5:35-5:42- Nurse #7 v in the room "yes, but 5:43-6:06- backgroun 6:07- Nurse #7 was h they are about to get 6:10-6:48- The Opera #7 to stand close to th there is nothing unde	s heard saying, "I told this e oxygen". tor was heard telling Nurse and she was going to tell her pressions. Nurse #7 is are about to run a code". If the resident was on the ated, no. The Operator then int needed to be on the floor. there was no way to do that, lying on the bed. omeone in the room that she start a code. teard telling someone in the dible* and noises only teard telling someone in the erator wanted resident to be was heard telling someone it is very faint". and noises only teard telling the operator that	F 6	84			
	-	ing someone again the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 MAPPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		LETED
		345408	B. WING _				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD JURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	9 66	F6	684			
	help her get the resid #10's response was in telling the operator the help me". Nurse #7 is heard gru mark that the resident 7:28-8:02- The Opera Nurse #7 where she r do chest compression wanted her press dow chest and that they ne She then told her to c do them together. 8:03-8:21- The Opera chest compressions. saying anything. The Nurse #7 needed to c 8:22- Someone in the "full code." 8:22-8:41- Inaudible w background. Nurse # "I'm actively calling th heard trying to get Nut told her that she need was doing the chest c 8:42-8:57- backgroun "Hello, hello? I need f Nurse #7 is not heard 8:58- Nurse #7 stated had arrived; The Ope	tor was heard explaining to needed to put her hands to has. She told her that she what least 2 inches into his beded to be hard and fast. ount out loud so they could hor was heard counting Nurse #7 was not heard Operator again stated that bount out loud with her. background is heard yelling voices are heard in the f7 was heard yelling at 8:31, em. The 911 Operator is more #7's attention and again led to count out loud as she					

Facility ID: 922983

If continuation sheet Page 67 of 116

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345408	B. WING _				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page were there.	e 67	F	684			
		itor asked again if EMS was Nurse #7 stated "yes, yes".					
	9:15 - The call ended seconds from the star	abruptly 9 minutes and 15 rt.					
	that they arrived on s Resident #232 on the staff performing CPR that during initial airw was found to have "rij bilateral upper extrem resuscitation efforts w scene were unable to was last seen conscio states that patient wa glucose approximatel arrival but staff could breathing or alive at t stated that resident w 7:07 pm.	report dated 2/8/24 stated cene at 7:03 am and found floor with nursing home . The report further stated ay management, resident gor in jaw and confirmed in nities. All further vere discontinued. Staff on determine when patient ous and alert. Staff in room s administered buccal oral y one hour prior to EMS not confirm that patient was hat point." The report further ras pronounced expired at					
	on 4/2/24 and 4/3/24 were unsuccessful. During an interview w on 4/1/24 at 1:41 pm, assigned to the 100 h part of the 300 hall or worked both 2nd (3:0 (11:00 pm-7:00 pm) s that she began her la am and as she appro room around 6:30 am	who responded to the facility who responded to the facility she stated that she was all (nursing station #1) and a 2/8/24. Nurse #7 said she 0 pm-11:00 pm) and 3rd hifts that day. She stated st medication pass at 5:43 ached Resident #232's a, she noticed that he was when she tried to wake him					

Facility ID: 922983

If continuation sheet Page 68 of 116

				E CONSTRUCTION		
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY IPLETED
			A. BOILDING			С
		345408	B. WING		04	1/05/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē	
SOUTHDO		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
SOUTHFO		ND HEALINGARE GENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	e 68	F 684	4		
		she checked his blood	1 00-	T		
	•	vas 28. She stated that				
	stepped out of the roo	om and asked a nurse				
		ld not remember, to bring				
		on. Nurse #7 stated that a				
		room with glucose gel, and b, that she needed the				
		of the glucose gel which the				
		rom the nurse's station and				
	brought it to her. Nurs					
		agon gel to Resident #232				
		lockjaw and she had a hard				
		th enough to rub the gel on				
		k. The other nurse returned njection and Nurse #7 stated				
		I the injection to Resident				
	#232. She stated that					
		nt #232 onto the floor as				
		began performing chest				
	compressions. She st					
		uscitation efforts until EMS				
	Resident #232 the en	ted that she stayed with				
	A second interview w	as conducted with Nurse #7				
		n during which she stated a				
	-	er the glucose gel, not a				
		eviously stated. She also				
		ave the resident alone to go and retrieve a glucagon				
		d not know where to find it at				
	-	Nurse #10 (charge nurse)				
	-	n #2 and gave her the				
		urse #7 did not recall if she				
		all a code or not because				
	she was dialing 911 f	rom her cell phone while she				
	succession in the second se					
	-	he resident's room to give d she was pretty sure she				

Facility ID: 922983

If continuation sheet Page 69 of 116

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	
		345408	B. WING				05/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			0000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	<ul> <li>why. Nurse #7 stated checking to see if Res first because he was returned to the room a any vital signs becaus about getting his suga revealed after Nurse floor, she felt for his p and she couldn't see and she began chest</li> <li>During an interview w at 8:24 am, he stated #232 several hours e asked Nurse Aide #3 He stated he does no was and did not enter until he heard the over near shift change. He him to go to the nurse glucose gel. When as was certain Nurse #7 injection. He stated th gel, brought it back to attend to another resi he was unsure of the being closer to 6:00 a</li> <li>A fourth attempt to sp following Nurse Aide # unsuccessful.</li> <li>During an interview w 5:05 pm, he stated th code being called and stated he entered the was already on the flop performing chest com</li> </ul>	that she did not remember sident #232's had a pulse at still breathing when she and did not take time to do se she was more concerned ar up. The interview further #7 got Resident #232 on the pulse and could not feel one him breathing at that point compressions. with Nurse Aide #3 on 4/3/24 that he last saw Resident arlier in the shift when he to bring him some ice chips. t remember what time that the resident's room again erhead code being called e stated that Nurse #7 asked b's cart and bring her sked to clarify, he stated he asked for the gel and not an nat he retrieved the glucose o Nurse #7 and then left to dent. He stated again that time, but he remembered it im. eak to Nurse #7 on 4/3/23 #3's interview was	F	684			

Facility ID: 922983

If continuation sheet Page 70 of 116

		MEDICAID SERVICES		LE CONSTRUCTION		10. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		S	· · · ·	MPLETED
			A. BOILDING			С
		345408	B. WING		0	4/05/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				6000 FAYETTEVILLE ROAD		
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETION
F 684	Continued From page	e 70	F 68	4		
	and EMS entered the	e room and took over. He				
	stated he was unsure	e of the time, but it was				
	during shift change.					
	<u> </u>	··· • • • • • • • • • • • • • • • • • •				
	-	vith Nurse #24 on 4/2/24 at				
		hat she was speaking with arby when Nurse #7 came				
		asking for the glucagon				
		was on her cell phone but				
	did not know what sh	e was speaking to. She				
		not state who she needed the				
		rent blood sugar was, or ask				
	anyone to call a code	<b>.</b>				
	-	vith Nurse #10 (charge				
		:35 am, he stated that he				
		6:00 am at nursing station				
		her last round. He stated				
	nursing station #2 as	whone when she came up to				
		ve her. He stated he was				
		ut he remembered some first				
		) PM) workers had arrived.				
		rse #7 didn't ask him to call a				
		the shot was for or that				
		d sugar level was 28. Nurse				
		ne down the hall after a				
		s unsure of how much time the room Nurse #7 was in to				
	. ,	on. He stated he saw Nurse				
		telling someone that the				
	resident was breathir					
		10 indicated he did not				
		2 himself other than to do a				
		e would wake up and the				
		t was when Nurse #7 told whone with 911. He stated				
	-	was breathing and that she				
		was breaking and that she				1

Facility ID: 922983

If continuation sheet Page 71 of 116

	S FOR MEDICARE &					O. 0938-03
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		· · ·	E SURVEY IPLETED
						С
		345408	B. WING		04	4/05/2024
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP COI	DE	
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 71	F 68	4		
1 001		#232 was a large man and	FUO	4		
		ther staff member to help get				
	-	se #10 explained he told				
		dent #232 on some oxygen				
	because he had foun	d that oxygen helped a lot				
		ent with low blood sugar. He				
		I her ever telling him what				
		d sugar level was. Nurse				
	mask (non-rebreathe	room to get a nonrebreather				
		till able to breathe on their				
		ional oxygen) with oxygen,				
	-	e loudspeaker and to grab				
	someone else to help	put the resident on the				
		ed that they have a back				
	-	s tells them to put the				
		When he returned to the				
		the resident on the floor and e with 911. Nurse #10				
		by Nurse #7 resident was				
		e left the room, so he				
	-	ather mask with oxygen, and				
		the resident had "lockjaw"				
		to open his mouth very far.				
		call if Resident #232 felt limp				
		and he did not assess the				
		e if he was still breathing nonrebreather mask with				
		urse #7 began doing chest				
		e did not see Nurse #7				
	assess resident's pul					
		Nurse #8 came in to assist				
	with chest compressi immediately after that	ons and EMS arrived almost t.				
	Review of the death of	certificate dated for 2/12/24				
		#232's cause of death was				

Facility ID: 922983

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 1 APPROVED 0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	CONSTRUCTION			SURVEY LETED
		345408	B. WING		_		。 05/2024
NAME OF P	ROVIDER OR SUPPLIER	-	s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		000 FAYETTEVILLE ROAD URHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA REFICIENCY)		(X5) COMPLETION DATE
F 684	During an interview w Doctor on 4/1/24 at 12 felt like staff responde emergency. He state regarding the care the frame in which 911 w During an interview w Nursing on 4/2/24 at 7 resident found with a considered a critical le situation. She stated the nurse to yell or so assistance-anything t staff to let them know would have expected same. She stated that advised the charge m of the situation so he immediately. She also expected Nurse #7 to immediately, even if s still breathing. The D that low required a glu immediately. The DC that low required a glu immediately. During an interview w Nurse Consultant on Administrator stated to there several times by building since 2/8/24. that she was in the bu occurred, and she hat the code was conduc- not feel like the facility	with the facility Medical 2:47 pm, he stated that he ed appropriately to the d he had no concerns e staff provided or the time as called. With the interim Director of 12:10 pm she stated that a blood sugar of 28 was evel and was an emergency she would have expected tream for o get the attention of other she had an emergency and Nurse #7 to have done the at Nurse #7 should have urse (Nurse #10) the gravity could have called a code o stated she would have to check vital signs she felt like the resident was ON indicated a blood sugar ucagon injection DN indicated a blood sugar ucagon injection with the Administrator and 4/2/24 at 5:25 pm the hat Nurse #7 had worked ut has not worked in the The Administrator stated uilding when the event d no concerns about how ted at that time and she did y neglected Resident #232. revealed EMS was already	F 684				

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STATEMENT O		MEDICAID SERVICES					M APPROVED D. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345408	B. WING			04/05/2024	
NAME OF PR	OVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
SOUTHPO		ND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD		6000 FAYETTEVILLE ROAD		
				I	DURHAM, NC 27713		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	Continued From page	273	F	684	1		
	another resident back			00-	T		
		anom the hospital.					
	The Administrator was jeopardy on 4/2/24 at	s notified of immediate 6:27 PM.					
	The facility provided t allegation of immedia						
	are likely to suffer, a s a result of the noncon Resident #232 suffere practice. Nurse #7 ar complete an assessm implement emergency immediately calling 9 a known brittle diabet blood sugar of 28 and	d related to this deficient ad Nurse #10 failed to hent of the resident, failed to y procedures including 11. Resident #232, who was ic was discovered to have a t was unresponsive.					
	have the potential to b practice. An audit wil Clinical Regional Dire	ctor/Designee to verify all					
	insulin per the MD or	ns of symptoms of acute					
	completed on 4/3/24.	If any adverse events are vill be corrected immediately					
	by Regional Clinical E	which was conducted 4/2/24 Director/Designee reveals gnize the hypoglycemic					
		nergency in a timely manner EMS there was a Medical ion via the root cause					
	analysis is that she w	as not competent in her skill ergency medical situations					

Facility ID: 922983

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CENTER	S FOR MEDICARE &					IO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	· · ·	TE SURVEY MPLETED	
						С	
		345408	B. WING		04/05/2024		
NAME OF PI	ROVIDER OR SUPPLIER		- <b>I</b>	STREET ADDRESS, CITY, STATE, ZIP COL			
		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD			
500 m c			DURHAM, NC 27713				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 684	Continued From page	- 74	F 00				
Г 004	Continued From page		F 684	1			
		entity will take to alter the					
		ilure to prevent a serious					
		m occurring or recurring, and					
	when the action will b						
		ertified nursing assistants,					
		, and all newly hired licensed					
		ed on the policies and					
	procedures of respon	•					
		ow to manage Emergent					
		. This will also include how					
		on of a medical code for					
		ing 911 to report a medical					
		EMS assistance is needed					
		ormation for education is					
		ycemic policy and the					
		oolicy. Medical Emergency					
		if calling a "code blue" is					
		ailable staff report to resident					
		on will also include specifics					
		ent Hypoglycemic events and r managing emergent					
		dary to insulin therapy. The					
		mphasis of blood glucose licate a severe hypoglycemic					
	-	r may not present with					
		b assess and intervene					
		e, for further clarification, the					
	policy will also descri						
	Physicians orders, to						
	Hypoglycemia would						
		resident that is insulin					
		vsician's specific baseline					
		. The policy for Emergency					
		t indicates what pertinent					
	information needs to						
		y call. The education will be					
		ion will be initiated by					
	-	-					
	)( )[/][] ( ][] (]] (] [] (] [] (] [] (] [] [] [] [] (] [] [] [] [] [] [] [] [] [] [] [] [] []	e on 4/3/2024 and continue					

Event ID: MBNX11

Facility ID: 922983

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		MEDICAID SERVICES				IO. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	· · ·	E SURVEY	
	CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING	3			
						С	
		345408	B. WING		04/05/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
				6000 FAYETTEVILLE ROAD			
5001HPC		ND HEALTHCARE CENTER		DURHAM, NC 27713			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETIO DATE	
F 684	Continued From page		F 68	34			
		n in orientation prior to the					
	start of their first shift						
		istrator/designee will be the					
		re all licensed nurses,					
	-	stants, agency/contract staff,					
		l all newly hired employees					
	will be educated.						
	Immediate jeopardy v	will be removed by 4/05/24.					
	The gradible allogatic	on for romoval of immediate					
	-	on for removal of immediate					
		ed onsite on 4/5/24. Audit					
	tool dated 4/4/24 was						
		ho were insulin dependent,					
		n per physician orders, if					
		of hypoglycemia were					
		ses and emergency medical s and procedures were					
	<b>.</b> .	•					
		nd symptoms of emergent the nurse was negligent by					
		an orders or assess the					
		a medical emergency. The					
		oncerns. Nurse #7 was no					
		e facility as indicated.					
		records which included					
		terviews with staff confirmed					
	0	led on: Medical emergency					
		ard nursing practices,					
	diabetic managemen						
		gency Procedure - CPR					
		suscitation), Adult CPR and					
		n changes - clinical protocol,					
		to be provided to 911 upon					
		cy call. The education related					
		dures of responding to a					
		and on how to manage					
		mic events was added to					
		ires. The DON/ADON were					
		e all nurses and certified					
	nurse aides received		1				

Facility ID: 922983

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• • •	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 04/05/2024	
		345408	B. WING			
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		CEDED BY FULL PREFIX (EACH CORRECTIVE AC		CTION SHOULD BE COMPLE O THE APPROPRIATE DAT	
F 684	working on the floor.		F 6	84		
F 686 SS=D		event/Heal Pressure Ulcer (i)(ii)	F 6	86		4/30/24
	resident, the facility m (i) A resident receives professional standard pressure ulcers and c ulcers unless the indi- demonstrates that the (ii) A resident with pre- necessary treatment is with professional star promote healing, prev- new ulcers from deve This REQUIREMENT by: Based on record revi- physician interviews, document the pressur document the pressur document the treatme identified wound(s) or residents reviewed fo #181). The findings: Resident #181 was re 3/23/23. The diagnos dementia, hypertensio kidney failure, osteoa disease. The admission Minim	re ulcers. hensive assessment of a bust ensure that- a care, consistent with ls of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and assure ulcers receives and services, consistent dards of practice, to vent infection and prevent loping. is not met as evidenced ew and staff, family, and the facility failed to assess, re wound(s) identified and ent provided for the in the buttock for 1 of 3 r pressure ulcers (Resident eadmitted to the facility on es included diabetes, on, dysphagia, chronic rthritis, and Alzheimer's		F686 Corrective action for the reside to be affected by the deficient Resident #181 no longer resid facility. Corrective action for other resi having the potential to be affect same deficient practice. All residents have the potentia affected by the alleged deficient The Director of Nursing (DON) 100% body audits on all resides the facility on 2/18/24. There we skin integrity issues identified. The Director of Nursing (DON) Nurse Managers have reviewed wound audit conducted on 2/1	practice. des in the dents cted by the I to be nt practice. i initiated ents within vere no new and/or ed the	

Event ID: MBNX11

Facility ID: 922983

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			()(0)				NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		CONSTRUCTION		TE SURVEY
						С	
		345408	B. WING			04/05/2024	
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		60 Dl			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 686	Continued From page	e 77	F 68	36			
		ognitively impaired. She	1 00		2/20/24 and reviewed the documentati	on	
	required extensive tw				to ensure residents with skin impairme		
	•	nobility, transfers, and			had an order for treatment to areas. The		
	activities of daily living				Director of Nursing (DON) and Nurse	10	
	•	and bladder and was not			Managers reviewed residents with skir	ı	
	coded with wounds o				impairments identified on their 2/20/24		
					body audits to ensure the resident had		
	Resident #181 was d	ischarged to home on			treatment order in place, physician		
	5/1/23.				notification, RP Notification and docum	nent	
					of the condition/status/size/appearance		
	Review of the nutritio	nal care plan for Resident			the wound.		
		dentified a focus area as			The Director of Nursing (DON) and/or		
	Resident #181 was a	t nutritional risk related to			Nurse Managers began educating the		
	diagnoses of diabetes	s, dementia, and dysphagia.			Nurses/agency nurses on 2/29/24 on		
	Resident #181 noted	in 4/2023 an area of skin			weekly skin observations and		
	impairment on the rig	ht heel. One of the			documentation, physician notification,	RP	
	interventions included	the registered dietician was			notification, initiates treatment per		
	to evaluate nutritional	I needs and make diet			physician order for new / changes in s	kin	
	change recommenda	tions as needed.			integrity.		
					The Assistant Director of Nursing was		
	Review of the head-to	o-toe skin assessment for			notified on 2/26/24 by the Licensed		
	Resident #181 dated	4/24/23 done by Nurse #20,			Nursing Home Administrator (LNHA) to	С	
	identified and docume	ented a new deep tissue			add the skin observations and		
		l and 3 open areas to the			documentation education to the		
		81 wore protective boots to			Nurse/agency nurse general orientation		
	bilateral heels while in	n bed and the wound nurse			upon hire with emphasis that the nurse	e	
	was notified.				who identifies the skin integrity issue		
					completes the wound documentation,		
		was conducted on 2/8/24 at			physician notification, RP notification,		
		stated she completed the			initiates treatment per physician order	for	
		ent for Resident #181 on			new / changes in skin integrity.		
		ed she noticed that the			On 2/29/24 the Director of Nursing (DC	JN)	
		issue on the right heel and 3			and Nurse Managers educated the	nov.	
	-	ittocks. She said she did not			Certified Nursing Assistant (CNA)/ Age	-	
	recall documenting a				CNA on daily skin checks during perso	niai	
		was certain she informed the bservation of all of the			care. The Assistant Director of Nursing was		
	wounds.				The Assistant Director of Nursing was notified on 2/26/24 by the Licensed		
	woullus.				Nursing Home Administrator (LNHA), 1		

Event ID: MBNX11

Facility ID: 922983

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			IPLETED	
						С	
		345408	B. WING		04	4/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE		
SOUTHPO	DINT REHABILITATION	AND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE	
F 686	Continued From pag	e 78	F 686	6			
	Review of the April 2 Administration Reco revealed the residen right heel which was prep 3 times a day, e 4/24/23-4/30/23. The treatment for the sac Review of the weekly Wound Nurse update #181 dated 5/1/23 de 4/24/23 for the right facility. The measure 5.0-centimeter x 6.5- suspected deep tisse red purple. The form There was no docum of the 3 open areas i 4/24/23 by Nurse #2 A telephone interview 2:15 PM, the family is stated her mother has she was readmitted. she was aware that I health issues and was services. The family many wounds she has	2023 Treatment rd (TAR) for Resident #181 t received treatment to the to wipe the heel with skin every shift for wound care e TAR had no documented cral wounds. y pressure ulcer record the ed this record for Resident ocumented the onset date as heel wound acquired in the ements included centimeter x 0.0 centimeter, ue injury, wound edges dark was signed off as of 2/6/24. hentation of an assessment identified on the buttocks on		add the education to the gen orientation of the Certified Nu Assistant (CNA)/agency CNA Certified Nursing Assistant (C CNA will not be allowed to we 2/29/24 until they receive the Systemic Changes made to e the deficient practice will not On 2/26/24 the Director of Nu notified the Wound Nurse an Practitioner (NP) to meet we discuss and review all reside wounds. On 2/26/24 The Licensed Nu Administrator (LNHA) notified of Nursing (DON) and/or Nur Leadership to review the we observations, to validate all a identified have physician noti notification, treatments order wound is monitored for chang for four weeks then monthly the Plans to monitor its performation sure that the solutions are sur The facility wound manager of brought to the monthly Quality Performance Improvement (C	ursing A. Any CNA)/agency ork after e education. ensure that recur. ursing (DON) d the Nurse ekly to ents with ursing Home d the Director sing ekly skin areas ification, RP s are written, ges weekly thereafter. unce to make ustained. report will be ty Assurance QAPI)		
	the pressure ulcers of cheek area and right arrived home on 5/1/ dressing on the resid removed it there were cheeks that were dra	er stated she was unaware of on her mother's buttocks, mid : heel until the resident /23. She stated she saw a dent's buttocks and when she re large wounds on both aining. The right heel had an The facility did not inform her		Health Services (DHS) for re revision monthly x 3 months substantial compliance is ach Date of compliance: 4/30/2	or until nieved.		

Facility ID: 922983

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CONSTRUCTION		O. 0938-03	
	CORRECTION	IDENTIFICATION NUMBER:	· /		· · · ·	IPLETED	
						С	
		345408	B. WING		04/05/2024		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	ΡE		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD				
0001111 0				DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 686	Continued From page	e 79	F 686	3			
1 000		ducted on 2/5/24 at 3:25	1 000				
		ound Nurse) stated the					
		Jursing Assistants and					
		of any observations of					
		es. The nurse stated he was					
onl Res no but by doc #1	only informed about t						
	Resident #181's right	heel on 4/24/23, there was					
	no mention of the ope	en areas on the resident's					
	buttocks. He explaine	ed the skin assessment done					
	-	I/23, prior to his assessment,					
		areas on the buttocks. Nurse					
	#1 stated he had not						
	assessment and prob	-					
		the heel wound in passing the stated he observed the					
		ented more as a deep tissue					
		ther stated he measured the					
	area on the heel at 5.						
		imeter with no drainage and					
		n prep 3 times a day. The					
		ot communicate with the					
	physician or family re	garding the wound					
	observation or the tre	atment for the heel. The					
		he did not provide any					
	treatment to the resid	lent's buttocks.					
	An interview was con	ducted on 2/8/24 at 8:26 AM					
	in conjunction with a	record review with the					
	÷ ,	DON) reviewed the skin					
		dent #181 dated 4/24/23					
		#20. The DON stated Nurse					
		observation of a deep tissue					
		d 3 open areas on the					
		und Nurse was notified.					
		pressure ulcer form dated					
	heel 5.0-centimeter x	neasurements for the right					
	HEELO.O-CENTIMETELE						
	centimeter and there	was no evidence of					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345408	B. WING _			04/05/2024	
NAME OF PF	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG				×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 686	buttocks by Wound N Nursing stated the nur for completing the we documenting change development of new p injury and report char physician, family, and The Director of Nursin no documentation of to buttocks. The DON of wound treatment/meet acknowledged there w all of Resident #181's ulcer form dated 5/1/2 An interview was con AM, the Registered D became aware of the open areas on the but through her chart revit assessment dated 4/2 resident had 3 open a right heel wound. She to increase protein for A telephone interview 12:34 PM, Physician not recall any discuss Resident #181 having buttocks. The Physici process was the woul the physician about th and a discussion woul	urse. The Director of rsing staff was responsible ekly skin assessment and of skin condition, pressure ulcers/deep tissue age of skin condition to the obtain treatment orders. Ing acknowledged there was the identified areas on the lid not discuss the weekly eting process. She was no documentation about a wounds on the pressure 23. ducted on 2/8/24 at 11:53 vietician (RD) stated she right heel wound and 3 ttocks for Resident #181 ew. She stated the skin 24/23 documented the areas on her buttocks and a e made a recommendation	F	586			
F 726 SS=J			F	726			4/30/24
	§483.35 Nursing Serv	vices					

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/20 FORM APPROVE OMB NO. 0938-039	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/05/2024	
		345408	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
F 726	Continued From page	- 91	F 70			
F 720	1.0		F 72			
		e sufficient nursing staff with betencies and skills sets to				
		related services to assure				
		ttain or maintain the highest				
		mental, and psychosocial				
		sident, as determined by				
		s and individual plans of care				
	and considering the r					
		lity's resident population in				
	at §483.70(e).	facility assessment required				
		cility must ensure that				
		the specific competencies				
		ary to care for residents'				
	needs, as identified the	escribed in the plan of care.				
	§483.35(a)(4) Providi	ing care includes but is not				
	-	evaluating, planning and				
		nt care plans and responding				
	to resident's needs.					
	§483.35(c) Proficienc					
		ure that nurse aides are able				
	to demonstrate comp	•				
		y to care for residents'				
	needs, as identified the assessments and de	nrougn resident escribed in the plan of care.				
		is not met as evidenced				
	by:					
		iew, staff interviews, and a		F726		
		e facility failed to ensure		Corrective action for the residents for		
	•	ined and competent with		to be affected by the deficient practic		
		al emergencies, activating		Resident #232 no longer resides in th	ne	
		es within the nursing home		facility.		
		medical services for 1 of 1		Corrective action for other residents	, the	
		232) reviewed for neglect. complete nursing clinical		having the potential to be affected by same deficient practice.		

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IDENTIFICATION NUMBER: 345408 ND HEALTHCARE CENTER TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) 82	B. WING	S	LD BE COMPLÉTI
ND HEALTHCARE CENTER TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC 27713 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	O4/05/2024
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	6000 FAYETTEVILLE ROAD DURHAM, NC 27713 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLÉTI
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	DURHAM, NC 27713 PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLÉTI
Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	LD BE COMPLÉTI
82		Benoienory	
	F 72	6	
g vital signs), failed to nergency procedures within with 911 when a nurse injection. Nursing staff also 011, demonstrated no call, and did not relay of the situation to the 911 32 expired on 2/8/24. egan on 2/8/24 when mmediately and effectively emergency. The immediate d on 4/5/24 when the facility otable credible allegation of ity remains out of scope and severity of D botential for more than not immediate jeopardy) to nd ensure monitoring e for ensuring all staff are t before caring for residents dated 2/8/24 at 8:02 am d written during the med dent #232's blood sugar e with the resident, and they At 12:48 am she checked I sugar and it was 136. d the insulin as ordered as it plucose less than 120. She over an hour to monitor becked his blood sugar		All facility insulin dependent diabetic residents have the potential to be a by this deficient practice if the nurse not demonstrated or completed nur- competencies related to medical emergency management and signs symptoms of emergent hypoglycerr upon hire, annually, and as needed 100% audit completed by DON/ De- on 4/4/24 to ensure all licensed nur- employed at the facility have curren Nursing competencies in place for managing medical emergencies, to include management of emergent hypoglycemia in a medical emerger This audit was completed on 4/4/24 Regional Clinical Director/Designee adverse outcomes were identified in audit. All new licensed nurses and agency/contract nursing after 4/4/22 have confirmation of competencies completed prior to working their scheduled shift at the facility. Nur- managers/ designee will be respons for ensuring competencies are com prior to working a scheduled shift, o competencies were not completed by This will be ongoing starting 4/4/202 Nurse managers were notified by th Regional Clinical Director on 4/3/24 this directive to achieve substantial compliance for licensed nursing competencies. Systemic Changes made to ensure	ffected e has sing and hia signee ses it ncy. by the e. No n this d 4, will se sible pleted or if, yet. 24. ne with
	with 911 when a nurse njection. Nursing staff also 11, demonstrated no call, and did not relay f the situation to the 911 32 expired on 2/8/24. egan on 2/8/24 when mmediately and effectively emergency. The immediate d on 4/5/24 when the facility otable credible allegation of ity remains out of scope and severity of D otential for more than ot immediate jeopardy) to d ensure monitoring for ensuring all staff are t before caring for residents dated 2/8/24 at 8:02 am d written during the med lent #232's blood sugar e with the resident, and they At 12:48 am she checked sugar and it was 136. I the insulin as ordered as it lucose less than 120. She	with 911 when a nurse njection. Nursing staff also 11, demonstrated no call, and did not relay f the situation to the 911 32 expired on 2/8/24. egan on 2/8/24 when mmediately and effectively emergency. The immediate d on 4/5/24 when the facility otable credible allegation of ty remains out of scope and severity of D otential for more than ot immediate jeopardy) to nd ensure monitoring for ensuring all staff are t before caring for residents dated 2/8/24 at 8:02 am d written during the med lent #232's blood sugar e with the resident, and they At 12:48 am she checked sugar and it was 136. d the insulin as ordered as it lucose less than 120. She over an hour to monitor necked his blood sugar was 156. She wrote that nd sat down to chart and npleted around 4:00 am.	with 911 when a nurse njection. Nursing staff also indicated procession. Nursing all staff are to before caring for residentsby this deficient practice if the nurse not demonstrated or completed nur competencies related to medical emergency management and signs symptoms of emergent hypoglycem upon hire, annually, and as needed 100% audit completed by DON/ De on 4/4/24 to ensure all licensed nur emergency. The immediate is cope and severity of D otential for more than for ensuring all staff are to before caring for residentsby this deficient practice if the nurse management of emergent hypoglycem upon hire, annually, and as needed 100% audit completed on 4/4/24 to ensure and it was 136.dated 2/8/24 at 8:02 am d written during the med lent #232's blood sugar with the resident, and they At 12:48 am she checked sugar and it was 136.Nurse managers were not completed processing all staff are the deficient practice will not recur. All licensed nurses, nursing assistat ad sat down to chart and mpleted around 4:00 am.was 156. She wrote that d dat down to chart and mpleted around 4:00 am.Systemic Changes made to ensure the deficient practice will not recur. All licensed nurses will be ed

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CENTER	S FOR MEDICARE &				OMB N	0.0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION G	· · · ·	E SURVEY PLETED	
		245409	B. WING			С	
		345408	B. WING			/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	PCODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE	
F 726	Continued From page	\$ 83	E 70	26			
F 726	5:09 am to 5:40 am. 5:43 am and when sh #232's room, she not responding so she ch and it was 28. Nurse bring her a glucagon medicine used to trea The nurse aide broug she administered und When she rechecked Nurse #7 documenter glucagon shot on the to nursing station #2 (Nurse #10) for a glud that the charge nurse send a resident out for wrote that she was ca the glucagon shot and Resident #232. She Operator to move the floor, a nonrebreather resident and chest co #7 also wrote that she her, and the charge nurse services) arrived and additional 5 minutes b	She began her last round at he approached Resident iced that he was not ecked his blood sugar level, #7 asked a nurse aide to shot (an emergency it severe low blood sugar). th her glucagon gel, which ler Resident #232's tongue. his blood sugar, it was 45. d she was unable to locate a medication cart, so she ran and asked the charge nurse cagon shot. Nurse #7 wrote told her that she could not or low blood glucose. She alling 911 as she was getting d administering it to was instructed by the 911 resident from the bed to the r mask was placed on impressions began. Nurse e asked Nurse #10 to assist iurse stated he couldn't help I break my back", so she resident on the floor alone. ote by writing that more t, EMS (emergency medical took over care for an	F 72	emergency on how to ma Hypoglycemic events that a medical emergency by designee starting 4/3/24 start of initial shift. Going licensed nurses will have completed upon hire and of their shift. HR and DO notified on 4/2/24 of this their competencies need prior to them taking a me the Administrator. Educat managing emergent Hyp events, as well as activat immediately, will be com managers/designee start This will be done daily pr all licensed nurses, nursi agency/ contract staff an licensed nurses. This ea include the policy and pro- emergency medical man policy and procedure gui nursing staff to gather ac information/assessments be reported to 911 accura emergency call. 100% of Agency/contract staff Co completed by DON/Desig of their initial shift. DON/I notified by the scheduler, daily prior to any new age	at are considered nurse managers/ and daily before g forward all new e competencies d before the start N/Designee were requirement that to be completed edication cart by ation on oglycemic ting EMS pleted by nurse ting 4/3/2024. for to first shift for ing assistants, d all newly hired ducation will ocedures for agement. This des licensed courate medical s, in order for it to ately during the verification of mpetency will be gnee prior to start Designee will be / HR/ designee ency/ contract		
	am revealed Nurse # pass at 9:58 pm Resi was 68 and she spok	note dated 2/8/24 at 9:24 7 had written during the med dent #232's blood sugar e with the resident, and they . At 12:48 am she checked		staff working starting 04/ education will be in perso setting. 100% education completed DON/ADON c 4/04/2024. The administr will be the person who w	on, 1:1 or in group will be designee by rator/designee		

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TATEMENT (	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			PLETED
		345408	B. WING			C
	ROVIDER OR SUPPLIER	343400		STREET ADDRESS, CITY, STATE, ZIP CODE	04	/05/2024
				6000 FAYETTEVILLE ROAD		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 726	Continued From page	984	F 726			
F 720	Nurse #7 administered stated hold for blood stayed on the hall for patient. Nurse #7 rec around 2:00 am and is she finished rounds a her last round was co Nurse #7 wrote that s 5:09 am to 5:40 am. 5:43 am and when sh #232's room, she not responding so she ch and it was 28. Nurse bring her a glucagon medicine used to treat The nurse aide broug she administered und When she rechecked Nurse #7 documenter glucagon shot on the to nursing station #2 (Nurse #10) for a gluc she was calling 911 a glucagon shot and ad #232. She was instru- move the resident fro nonrebreather mask chest compressions to note by writing that m EMS (emergency me took over care for an EMS stopped compres During a recorded 91 2/8/24 at 6:56 am the	d the insulin as ordered as it glucose less than 120. She over an hour to monitor thecked his blood sugar t was 156. She wrote that nd sat down to chart and mpleted around 4:00 am. he took a lunch break from She began her last round at ie approached Resident iced that he was not ecked his blood sugar level, #7 asked a nurse aide to shot (an emergency it severe low blood sugar). ht her glucagon gel, which ler Resident #232's tongue. his blood sugar, it was 45. d she was unable to locate a medication cart, so she ran and asked the charge nurse cagon shot. She wrote that s she was getting the ministering it to Resident ucted by the 911 Operator to m the bed to the floor, a was placed on resident and began. She concluded her ore nurses came to assist, dical services) arrived and additional 5 minutes before essions.	F 726	<ul> <li>assistants, agency/contract staff, ancillary staff, and all newly hired employees will be educated.</li> <li>Plans to monitor its performance to sure that the solutions are sustain To ensure ongoing compliance, the Administrator and/or designee will conduct daily audits on staff compliance for one month, then 5 x to week for 2 months.</li> <li>A summary report of compliance will committee meeting by the Director Nursing (DON) for review and review monthly x 3 months or until substatic compliance is achieved.</li> <li>Date of compliance: 4/30/24</li> </ul>	o make ed. e petency imes a vill be surance ) or of ision	
	#7: The time stamps time elapsed in minut	911 Operator and Nurse entered below document the es and seconds from the ated at 6:56 am. The phone				

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		ND HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 / APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345408	B. WING _				05/2024
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
COUTURO				6	000 FAYETTEVILLE ROAD		
SOUTHPC		ND HEALTHCARE CENTER		D	URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 726	Continued From page	- 85	E 7	26			
	call lasted 9 minutes			20			
		and 15 seconds.					
		address and that she had a					
	resident with a blood 'trending down' and s	sugar level that was he was having trouble					
		d not state she had an					
		e 911 Operator to send					
		She stated that resident					
	was a full code.						
		was heard telling the 911					
	glucagon shot.	l just given a resident a					
		was heard asking Nurse #7					
		esident was breathing and if					
		here was a 5 to 6 second					
	pause before Nurse #	#7 stated that the resident					
	was breathing but that	at he "wasn't coming to".					
		ator asked if the resident had					
		ofessional within the last 2					
		stated no. She also stated,					
	"I'm not getting any b						
	room-unable to deter	d be heard entering the					
		neard telling Nurse #10 that					
	she was sending the	-					
		tor asked Nurse #7 again if					
		athing. Nurse #7 paused for					
	2 to 3 seconds and s	-					
	·	rator then asked if the					
	resident was breathin						
		can be heard asking Nurse					
		ething. The Operator was 7 again if the resident was					
		lurse #7 is heard again					
	saying, "mmmno, ł	-					
		is heard in the background					
		The Operator said hello and					
		eard telling the Operator that					
<u>.</u>	1	<b>č</b> i					l

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345408	B. WING				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
				6	0000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		C	DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 726	it was the charge nurs 2:28-3:01- The Opera she said go, she wan number of times she resident's chest. Nurs There was a 15 secon the Operator said "he stated she was there chest and see. She s 3:02-3:17- The Opera said go, she wanted N number of times the r asked Nurse #7 twice Nurse #7 stated yes. 3:18-3:33- Nurse #7 tv saw his chest go up, I fall". 3:34-3:49- The Opera paramedics were on f Nurse #7 was right by 3:50-4:02- The Opera flat on his back with n Nurse #7 responded his feeding tube beca with it connected. 4:03-4:24- only backg Nurse #7 stated at the was flat on his back. 4:25-4:30- Nurse #7 i man to bring me som 4:31-5:11- The Opera #7 to listen carefully a how to do chest comp heard saying "so, we The Operator asked i floor and Nurse #7 sta	se. thor told Nurse #7 that when ted Nurse #7 to count the saw rise and fall of the se #7 then stated, "hold on". Ind pause (2:36-2:51) and llo" again. Nurse #7 then and was trying to watch his stated it was "really faint". thor stated again, when she Nurse #7 to count the esident's chest rose. She e if she was ready before old the Operator that she but it wasn't "a real rise and ator told Nurse #7 that their way. She also asked if / "him", and she stated yes. tor told Nurse #7 to lay him tothing under his head. that she needed to unhook use she couldn't lay him flat pround noises heard until e 4:24 mark that the resident s heard saying, "I told this e oxygen". tor was heard telling Nurse and she was going to tell her pressions. Nurse #7 is are about to run a code". f the resident was on the ated, no. The Operator then nt needed to be on the floor. there was no way to do that,	F	726			

If continuation sheet Page 87 of 116

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/202 FORM APPROVE OMB NO. 0938-039
TATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		345408	B. WING		C 04/05/2024
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP COD	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		0 FAYETTEVILLE ROAD RHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLETIO
F 726	5:15- Nurse #7 told s was about to have to 5:26- Nurse #7 was h room to get her *inau 5:27-5:33- backgrour 5:34- Nurse #7 was h room that the 911 Op on the floor. 5:35-5:42- Nurse #7 with 5:43-6:06- backgrour 6:07- Nurse #7 was h they are about to get 6:10-6:48- The Opera #7 to stand close to t there is nothing unde sheet to pull him towa Nurse #7 is heard tell resident was a full co 6:49-7:27- Nurse #7 if help her get the resid #10's response was i telling the operator th help me". Nurse #7 i at the 7:27 mark that floor. 7:28-8:02- The Opera Nurse #7 where she do chest compression wanted her press dow chest and that they n She then told her to co do them together. 8:03-8:21- The Opera chest compressions. saying anything. The Nurse #7 needed to co	omeone in the room that she start a code. heard telling someone in the dible* ad noises only heard telling someone in the herator wanted resident to be was heard telling someone it is very faint". hd noises only heard telling the operator that a board. ator was heard telling Nurse he resident, making sure r their head, and to use the ard her and off the bed. ling someone again the	F 726		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345408	B. WING _				05/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 726	8:22-8:41- Inaudible v background. Nurse # 8:31 mark, "I'm active Operator is heard tryi attention and again to count out loud as she compressions. 8:42-8:57- backgroun stated, "Hello, hello? Ioud". Nurse #7 is not Operator. 8:58- Nurse #7 stated had arrived; The Oper the resident and the N were there. 9:04-9:09- The Opera with the resident and 9:15 - The call ended seconds from the stat A review of the EMS of that they arrived on so Resident #232 on the staff performing CPR that during initial airw was found to have "rig bilateral upper extrem resuscitation efforts w scene were unable to was last seen conscio states that patient wa glucose approximatel arrival but staff could breathing or alive at ti stated that resident w 7:07 pm.	voices are heard in the t7 was heard yelling at the t9 calling them." The 911 ng to get Nurse #7's old her that she needed to a was doing the chest of noises; the Operator I need for you to count out t heard responding to the t to the Operator that EMS rator asked if they were with Nurse #7 stated that they ator asked again if EMS was Nurse #7 stated "yes, yes". abruptly 9 minutes and 15 rt. report dated 2/8/24 stated cene at 7:03 am and found a floor with nursing home . The report further stated ay management, resident gor in jaw and confirmed in	F	726			

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:			· · · ·	IPLETED
						С
		345408	B. WING		04	4/05/2024
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
SOUTUD		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
0001111 0				DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 726 Continued From page 89		e 89	F 7	26		
		nall (nursing station #1) and				
		n 2/8/24. Nurse #7 said she				
	worked both 2nd (3:0	0 pm-11:00 pm) and 3rd				
		hifts that day. She stated				
	-	st medication pass at 5:43				
		ached Resident #232's n, she noticed that he was				
		when she tried to wake him				
		she checked his blood				
		vas 28. She stated that				
		om and asked a nurse,				
	whose name she could not remember, to bring her a glucagon injection. Nurse #7 stated that a					
		room with glucose gel, and b, that she needed the				
		ot the glucose gel Nurse #7				
		stered the glucagon gel to				
		e resident had lockjaw and				
		opening his mouth enough to				
	-	ide of his cheek. The other				
		room with the glucagon				
	injection and Nurse #	ction to Resident #232. She				
		ther staff members got				
		he floor as directed by 911				
		g chest compressions. She				
	stated she continued	· · ·				
		Intil EMS arrived. Nurse #7				
	entire time.	d with Resident #232 the				
		as conducted with Nurse #7				
		n during which she stated a				
		er the glucose gel, not a eviously stated. She also				
		ave the resident alone to go				
		and retrieve a glucagon				
	-	d not know where to find it at				
	her assigned station.		1			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/26/2024 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING			( 04/0	) 05/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
			6	000 FAYETTEVILLE ROAD			
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER	C	OURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
TAG F 726	Continued From page was at nursing station glucagon injection. Nu asked Nurse #10 to c she was dialing 911 fr was running back to t the injection. She said told the charge nurse why. Nurse #7 stated checking to see if Res first because he was returned to the room a any vital signs becaus about getting his suga revealed after Nurse # floor, she felt for his p and she couldn't see and she began chest A third interview was 4/2/24 at 10:23 am, d doesn't know why the through how to check for a pulse, and how to other than to say it was She stated that she w been in several codes assisted, and all those stated she was unawa injections were kept w Nurse #10 to get it for she had been a nurse had to complete onbo her agency, but she d those were. She stated	e 90 a #2 and gave her the urse #7 did not recall if she all a code or not because from her cell phone while she he resident's room to give d she was pretty sure she who the shot was for and that she did not remember sident #232's had a pulse at still breathing when she and did not take time to do se she was more concerned ar up. The interview further #7 got Resident #232 on the ulse and could not feel one him breathing at that point compressions. conducted with Nurse #7 on uring which she stated she 911 operator had to talk her for breathing, how to check to do chest compressions as all happening so fast. ras CPR trained and had is before, but she had only e patients survived. She	F 726			TE	DATE
	nursing stations, and orientation or individu	rooms, building layout, did not receive any further al competency training at d she did not receive training					

Facility ID: 922983

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		MEDICAID SERVICES		LE CONSTRUCTION		IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	· /			IPLETED
			A. BOILDING			С
		345408	B. WING			
	ROVIDER OR SUPPLIER	010100		STREET ADDRESS, CITY, STATE, ZIP CO		4/05/2024
	NOVIDEIN ON SOLT EIEN			6000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	AND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETIO DATE
F 726	Continued From page	e 91	F 72	6		
	on where to locate er	mergency drugs, so she was				
		te the glucagon injection.				
	During an interview v	vith Nurse #10 (charge				
		:35 am, he stated that he				
		d 6:00 am at nursing station				
		her last round. He stated				
		bhone when she came up to				
		king for the glucagon				
		ive her. He stated he was ut he remembered some first				
		) PM) workers had arrived.				
		rse #7 didn't ask him to call a				
	code or tell him who	the shot was for or that				
	Resident #232's bloc	od sugar level was 28. Nurse				
		me down the hall after a				
		is unsure of how much time				
	. ,	the room Nurse #7 was in to				
		on. He stated he saw Nurse				
	resident was breathir	telling someone that the				
		10 indicated he did not				
		2 himself other than to do a				
		e would wake up and the				
	resident did not. Tha	t was when Nurse #7 told				
		phone with 911. He stated				
		was breathing and that she				
		the floor. Nurse #10 stated				
		#232 was a large man and				
	-	ther staff member to help get				
		rse #10 explained he told dent #232 on some oxygen				
		id that oxygen helped a lot				
		ent with low blood sugar. He				
		l her ever telling him what				
	Resident #232's bloc	od sugar level was. Nurse				
		e room to get a nonrebreather				
		r masks are used for				
	individuale who are e	till able to breathe on their	1			1

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2024 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345408	B. WING				C 05/2024
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				60	000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		D	OURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	to call a code over the someone else to help floor. Nurse #10 state board, but 911 always resident on the floor. room, Nurse #7 had th was still on the phone indicated he was told still breathing when he applied the nonrebrea added that it felt like th because it was hard th Nurse #10 did not rec or stiff anywhere else resident himself to se before he applied the oxygen. He stated Nur compressions and he assess resident's puls compressions. Then h with chest compression immediately after that During an interview w Nursing on 4/2/24 at resident found with a considered a critical le situation. She stated the nurse to yell or sc assistance-anything to staff to let them know would have expected same. She stated the advised the charge nu of the situation so he	onal oxygen) with oxygen, a loudspeaker and to grab put the resident on the d that they have a back a tells them to put the When he returned to the ne resident on the floor and with 911. Nurse #10 by Nurse #7 resident was a left the room, so he ther mask with oxygen, and he resident had "lockjaw" o open his mouth very far. all if Resident #232 felt limp and he did not assess the e if he was still breathing nonrebreather mask with rse #7 began doing chest did not see Nurse #7 se prior to beginning Nurse #8 came in to assist ons and EMS arrived almost ith the interim Director of l2:10 pm she stated that a blood sugar of 28 was evel and was an emergency she would have expected ream for o get the attention of other she had an emergency and Nurse #7 to have done the tt Nurse #7 should have urse (Nurse #10) the gravity could have called a code	F	726	DEFICIENCY)		
	immediately. She also expected Nurse #7 to	stated she would have					

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2024 MAPPROVED D: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345408	B. WING				C 105/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 726	that low required a glu immediately. She state orientation to the build they do not do an ind list like they do for the She stated they rely of with competent staff of done initial competent assessments, emerge abuse/neglect training During an interview w Nurse Consultant on stated that the facility files or do individual of staff. The Administration confirms that the nurse license and a current Administrator provide Nurse #7's current CF She stated they rely of individual competence to assigning them to the Administrator stated the there several times be building since 2/8/24. The Administrator wa jeopardy on 4/2/24 at The facility provided the allegation of immediat Identify those recipier are sult of the noncor Resident #232 suffered	ON indicated a blood sugar ucagon injection the that the facility provided ding for all agency staff, but ividual competency check eir direct hire employees. on agencies to provide them whom they have already cy testing on such as initial ency preparedness, g. with the Administrator and 4/2/24 at 5:25 pm, they does not keep employee competencies for agency tor stated that the facility se has an active nursing CPR card only. The d the surveyor a copy of PR card during the interview. on agencies to complete ies on their employees prior their buildings. The hat Nurse #7 had worked ut has not worked in the s notified of immediate 6:27 PM. the following credible te jeopardy removal.	F	726			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(V2)	IO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,		· · · ·	APLETED
			A. BUILDING			0
		245400				С
		345408	B. WING			4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHDO		ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
0001111 0				DURHAM, NC 27713		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COF	RECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE / DEFICIENCY)	APPROPRIATE	DATE
F 726	Continued From page	e 94	F 726			
		urse #10 were competent in	1720			
		nent skills, to properly				
		a medical emergent event.				
		by Nurse #7 and Nurse #10;				
		ately assess and implement				
		cy rapid response for a				
		nge in condition. When				
		e unresponsive and had a				
	-	of 28, Nurse #7 failed to				
	•	Code Blue within the facility				
		ritical medical information				
		232 to the 911 operator.				
		pendent diabetic residents				
		be affected by this deficient				
	•	nas not demonstrated or				
		ompetencies related to				
		nanagement and signs and				
		nt hypoglycemia upon hire,				
		ded. 100% audit completed				
		n 4/4/24 to ensure all				
		loyed at the facility have				
	current Nursing com	-				
		mergencies, to include				
		rgent hypoglycemia in a				
		This audit was completed				
	on 4/4/24 by the Reg					
	<b>-</b>	No adverse outcomes were				
		t. All new licensed nurses				
		nursing after 4/4/24, will				
		competencies completed				
		scheduled shift at the				
		agers/ designee will be				
		ing competencies are				
		orking a scheduled shift, or if,				
		not completed yet. This will				
		/4/2024. Nurse managers				
	-	Regional Clinical Director on				
	4/0/04 10 01 1		1			1
		tive to achieve substantial ed nursing competencies.				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	· · ·	E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	IPLETED
		345408	B. WING		04	C 1/05/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-	105/2024
SOUTHPC	DINT REHABILITATION A	ND HEALTHCARE CENTER	6000 FAYETTEVILLE ROAD DURHAM, NC 27713			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 726	Continued From page	95	F 726			
	reveals that the nurse hypoglycemic event a timely manner. On 4, called to interview the #7 was employed with Agency was able to v nursing competencies The Agency stated to that Nurse #7 had no completed in her file. verify that the competencies Nurse #7 working her Conclusion is that Nut documented competencies hiring Nursing Agency Nursing home failed to to Nurse #7 working her Specify the action the process or system fail adverse outcome from when the action will b All licensed nurses, m agency/contract staff nurses will be educat responding to a media manage Hypoglycem considered a medical	rse #7 did not have encies completed by her y employment, and the o ensure competency prior her shift. e entity will take to alter the lure to prevent a serious n occurring or recurring, and e complete. ursing assistants, and all newly hired licensed ed on the process of cal emergency on how to ic events that are				
	licensed nurses will h completed upon hire shift. HR and DON/D 4/2/24 of this requirer need to be completed	hift. Going forward all new ave competencies and before the start of their esignee were notified on nent that their competencies I prior to them taking a e Administrator. Education				

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-03
		IDENTIFICATION NUMBER:	· /	G	· · ·	IPLETED
					С	
		345408	B. WING			4/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD		
				DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 726	Continued From page	e 96	F 72	26		
		nanagers/designee starting	1 1 2			
		e done daily prior to first shift				
	for all licensed nurses					
	agency/ contract staf	f and all newly hired licensed				
		ion will include the policy				
	and procedures for e					
		olicy and procedure guides				
	0	f to gather accurate medical ents, in order for it to be				
		rately during the emergency				
	-	on of Agency/contract staff				
		completed by DON/Designee				
		nitial shift. DON/Designee				
		scheduler/ HR/ designee				
		/ agency/ contract staff				
	<b>u</b>	4/2024. The education will				
	-	n group setting. 100%				
	education will be com designee by 4/04/202	•				
		ee will be the person who will				
	-	urses, certified nursing				
		ontract staff, all ancillary				
		red employees will be				
	educated.					
	Immediate jeopardy v	will be removed by 4/05/24.				
		on for removal of immediate				
		ed onsite on 4/5/24. Audit				
	tool dated 4/4/24 was					
		ho were insulin dependent,				
		n per physician orders, if				
		of hypoglycemia were ses and emergency medical				
		and procedures were				
		nd symptoms of emergent				
		the nurse was negligent by				
		an orders or assess the				
	resident to recognize	a madical amarganay. The				
	review revealed no c	a medical emergency. The				

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TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		TE SURVEY MPLETED
		345408	B. WING		0	C 4/05/2024
	ROVIDER OR SUPPLIER	ND HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 5000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 726 F 761 SS=E	records which include interviews with nurses assistants confirmed Medical emergency n nursing practices, dia Management of hypo Procedure - CPR (cal resuscitation), Adult (C condition changes - c information to be prove emergency call. The fi- checklists completed Diabetes skills checkl Change of conditions Adult CPR and AED as Review revealed no c jeopardy removal dat Label/Store Drugs an CFR(s): 483.45(g)(h) §483.45(g) Labeling of Drugs and biologicals labeled in accordance professional principle appropriate accessor instructions, and the of applicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the faci biologicals in locked of	a. In-service education ed sign-in sheets and s and certified nurse education was provided on: nanagement, Standard betic management, glycemia, Emergency rdiopulmonary CPR and AED, Acute linical protocol, pertinent <i>v</i> ided to 911 upon making an following nurse competency by nurses were reviewed: 1) list - glucose monitoring; 2) competency checklist, 3) skill Testing checklist. concerns. The immediate e of 4/5/25 was validated. d Biologicals (1)(2) of Drugs and Biologicals a used in the facility must be e with currently accepted s, and include the y and cautionary expiration date when f Drugs and Biologicals ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.	F 726			4/30/24

Facility ID: 922983

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 04/26/202 M APPROVE <u>D. 0938-039</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COM	E SURVEY PLETED
		345408	B. WING			C / <b>05/2024</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 761	storage of controlled the Comprehensive I Control Act of 1976 a abuse, except when the package drug distribu- quantity stored is min- be readily detected. This REQUIREMENT by: Based on observation facility failed to remov- injectors of insulin an medication cart draw administration carts ( remove the expired n formula supplements medication storage ro- rooms #1 and #2). Findings included: 1.a. On 2/5/24 at 1:10 PM medication administra #17 revealed one ope dated as opened on Pen (insulin) dated as manufacturer's instru- days, which would be On 2/5/24 at 1:15 PM #17 indicated that the medication carts, were expired medications. training, every nurse opening on multi-dos	Affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can T is not met as evidenced ans and staff interviews, the ve expired multi-dose pen d expired tablets from the er for 2 of 7 medication 100 and 300 halls), failed to nedications, enteral feeding and supply kit from the booms (medication storge A, an observation of the ation 300 hall cart with Nurse ened insulin Lispro Kwik pen 1/4/24 and one Novolin Flex is opened on 1/4/24. The ctions were discard after 28	F 76		ractice. o be cation edication y the Managers. removed ber policy. lents to be practice. ts, 2 on rooms irector of Any vved and olicy. sure that cur. ing and the on	

Facility ID: 922983

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		ND HUMAN SERVICES				FOF	ED: 04/26/2024 RM APPROVED
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
		345408	B. WING	_			C
	ROVIDER OR SUPPLIER	010100			TREET ADDRESS, CITY, STATE, ZIP CODE	0	4/05/2024
					000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 761	The nurse stated she expired medication the 1.b. On 2/5/24 at 1:25 PM medication administra (split) hall with Nurse insulin Lispro Kwik pe 12/27/23. The manur discard after 28 days and one opened box (mg), containing 66 ta January 2024. On 2/5/24 at 1:30 PM #18 indicated that the medication carts were expired medications. training, every nurse date on medications. had not checked the medications in her me at the beginning of he had not administered shift. 2.a. On 2/5/24 at 2:40 PM medication storage ro Nurse #6 revealed th multi-dose containers Suspension, 2 mg (me 100 ml, expired on 1/ Additionally, there were (percent) Sodium Chi 1/14/24 and six sealer Perative 1.3 Cal (enter	the beginning of her shift. a had not administered his shift. 1, an observation of the ation cart on the 100-300 #18 revealed one opened en dated as opened on facturer's instructions were , which would be on 1/24/24 of Famotidine, 10 milligram ablets that expired in 1, during an interview, Nurse e nurses who worked on the e responsible for discarding She mentioned that per should check the expiration The nurse stated that she expiration date on edication administration cart er shift. The nurse stated she expired medication this 1, observation of the born #1 on 100/300 halls with ere were two sealed a of Omeprazole Oral hilligram) in mL (milliliter), 24/24 in the refrigerator. ere two plastic bags of 0.9% loride, 1000 ml, expired on ed plastic containers of	F	761	educated by 2/12/24. The licensed nurses/agency nurses will review the assigned medications rooms and medication carts for expired medicati for 5 days a week for 4 weeks and th weekly for 4 weeks then monthly thereafter. The licensed nurse/ agence nurses review will be given to the Dir of Nursing to validate the removal of expired medications. The Consultant Pharmacist will review the medication carts and medication rooms for any expired medications. This audit will o monthly. Plans to monitor its performance to m sure that the solutions are sustained. The Director of Nursing and/or Nurse Managers will validate the License Nurse/agency nurses review of the Medication rooms and the Medication carts daily for 5 days a week for 4 we and then weekly for 4 weeks then mot thereafter. The Consultant Pharmacis review the medication rooms and medication carts for expired medicati monthly. The Director of Nursing will present an analysis of their review to Quality Assurance Performance Improvement committee monthly unti consecutive months of compliance is sustained then quarterly. Date of compliance: 4/30/24	ons en cy ector all ccur nake nake st will ons the	

Facility ID: 922983

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	S FOR MEDICARE &		()(0)			O. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		E SURVEY IPLETED
			A. DOILDING		с	
		345408	B. WING		0,	4/05/2024
NAME OF P	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
		ND HEALTHCARE CENTER	e	000 FAYETTEVILLE ROAD		
50011170			C	DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 761	Continued From page cabinet.	e 100	F 761			
	with Nurse #19 revea multi-dose container Suspension, 2 mg in 11/30/23 in the refrige plastic bag of 0.9% S expired on 1/19/24, o Sodium Chloride, 100 2023, one plastic bag 250 ml, expired in Au	oom #2 on 200/400/500 halls led there was one sealed				
	Director of Nursing (E nurses were respons medications in medic and medication stora and remove expired r every shift. She expe	I, during an interview, the DON) indicated that all the ible to check all the ation administration carts ge rooms for expiration date medications and supplies cted that no expired items ion carts or medication				
	Administrator indicate facility on 2/5/24. Her expired items be left medication storage ro					
F 809 SS=E			F 809			4/30/24
		/ of Meals sident must receive and the at least three meals daily, at				

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/26/2024 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345408	B. WING		C 04/05/2024
NAME OF P	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	· ·
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		5000 FAYETTEVILLE ROAD DURHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 809	regular times compar the community or in a needs, preferences, r §483.60(f)(2)There m hours between a sub breakfast the followin nourishing snack is s hours may elapse be meal and breakfast th group agrees to this r §483.60(f)(3) Suitable meals and snacks mu who want to eat at no of scheduled meal set the resident plan of c This REQUIREMENT by: Based on observation of Dietary Operations (RD) interviews, and failed to have no great between the provision meal and breakfast th served their meals or Cart-1; 400 Hall Cart- Hall Cart) utilized for The findings included A schedule of the Me 8/12/21) was provide review of this schedu delivery times allowe 30 minutes to lapse b day and first meal of	<ul> <li>able to normal mealtimes in accordance with resident requests, and plan of care.</li> <li>aust be no more than 14 stantial evening meal and g day, except when a erved at bedtime, up to 16 tween a substantial evening ne following day if a resident meal span.</li> <li>a, nourishing alternative ust be provided to residents on-traditional times or outside ervice times, consistent with are.</li> <li>T is not met as evidenced</li> <li>and Registered Dietitian record review, the facility ater than a 14-hour lapse n of a substantial evening ne following day for residents of 8 meal carts (400 Hall Cart-3 and 500 meal service.</li> <li>al Delivery Times (Revised d by the facility on 2/5/24. A le indicated the meal cart d as much as 15 hours and between the last meal of the</li> </ul>	F 809	F809 Corrective action for the residents for to be affected by the deficient practi On February 6, 2024, the schedule Meals was changed to meet the mir standard to be no greater than 14 ho between dinner and breakfast. Corrective action for other residents having the potential to be affected b same deficient practice. All residents have the potential to be affected by the same deficient pract On February 12, 2024, the Dietary Regional manager in-serviced all die staff that it is their responsibility to m the schedule of meals to ensure compliance. This in-service will be p the orientation process for all newly dietary employees.	ce. for nimum ours y the e ice. etary nonitor

Facility ID: 922983

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G	COMPLETED
					С
		345408	B. WING		04/05/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	E
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETIO
F 809		istered Dietitian (RD).	F 80	Systemic Changes made to en	
	with the facility's Registered Dietitian (RD). During the interview, the RD was shown the facility's meal delivery schedule provided and asked what her thoughts were with regards to the			the deficient practice will not n On February 12, 2024, the Dia Regional manager educated a	etary III dietary
tim bre "TI ad wc ev be rep me	"That's not okay." Th	ig day. The RD stated, ie RD acknowledged that in		staff that it is their responsibilit the schedule of meals to ensu compliance. This in-service wi	re Il be part of
	would also need to of everyone if greater th	-		the orientation process for all dietary employees. The Dieta will monitor this schedule 5x a	ry Manager week for 4
	reported that to her k meet these requireme	Breakfast the next day. She nowledge, the facility did not ents. The RD questioned ivery schedule provided for		weeks and then weekly for 4 weekly for 4 weekly for 4 weekly thereafter. The Dietar will give these audits to the Action of the the second sec	y Manager
	telephoned the Region Operations and reque	y's current schedule. She onal Director of Dietary ested a current meal delivery		Plans to monitor its performan sure that the solutions are sus The Administrator will review a	stained. all the daily
		l, the Regional Director of		audits 5x a week completed b manager for 4 weeks and ther 4 weeks and then monthly the	n weekly for reafter until
		rovided a copy of the schedule and joined the with the RD. The facility's		6 consecutive months of comp maintained. The Administrator any findings of non-complianc	will report
	current meal delivery schedule was different from the original schedule provided. A review of the facility's current Meal Schedule (not dated) indicated the meal cart delivery times were scheduled as follows:			Quality Assurance and Perform Improvement Committee months and then quarterly to a compliance is maintained.	thly for 3
	delivered at 5:30 PM for Breakfast (indicati minute time span bet	was scheduled to be for Dinner and at 8:15 AM ive of a 14-hour and 45 ween the two meals).		Date of compliance: 4/30/24	
	delivered at 5:40 PM for Breakfast (indicati minute time span bet	for Dinner and at 8:25 AM ive of a 14-hour and 45 ween the two meals).			
	scheduled as follows: The 400 Hall Cart-1 delivered at 5:30 PM for Breakfast (indicati minute time span bet The 400 Hall Cart-2 delivered at 5:40 PM for Breakfast (indicati minute time span bet The 400 Hall Cart-3 delivered at 5:50 PM	was scheduled to be for Dinner and at 8:15 AM ive of a 14-hour and 45 ween the two meals). was scheduled to be for Dinner and at 8:25 AM ive of a 14-hour and 45 ween the two meals).			l

Facility ID: 922983

If continuation sheet Page 103 of 116

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVE COMPLETED C         NAME OF PROVIDER OR SUPPLIER       345408       B. WING       C         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       04/05/20         SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       STREET ADDRESS, CITY, STATE, ZIP CODE       6000 FAYETTEVILLE ROAD DURHAM, NC 27713         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       COMING		RTMENT OF HEALTH AN ERS FOR MEDICARE &					FORM	): 04/26/2024 APPROVED 0. 0938-0391
345408     B. WING       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER     STREET ADDRESS, CITY, STATE, ZIP CODE       SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER     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)     COM TAG       F 809     Continued From page 103 minute time span between the two meals). The meal cart for the 500 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 8:05 AM for Breakfast (indicative of a 14-hour and 5 minute time span between the two meals). The 200 Hall Cart-1 was scheduled to be delivered at 6:10 PM for Dinner and at 7:50 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals). The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).    The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).    The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).    The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40	STATEMENT	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,			(X3) DATE COMP	SURVEY LETED
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)       COM COM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS			345408	B. WING				
SOUTHPOINT REHABILITATION AND HEALTHCARE CENTER       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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Com Com (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         F 809       Continued From page 103 minute time span between the two meals). The meal cart for the 500 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 8:05 AM for Breakfast (indicative of a 14-hour and 5 minute time span between the two meals). The 200 Hall Cart-1 was scheduled to be delivered at 6:10 PM for Dinner and at 7:50 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals). The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).	NAME OF P	F PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PREFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COM         F 809       Continued From page 103 minute time span between the two meals). The meal cart for the 500 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 8:05 AM for Breakfast (indicative of a 14-hour and 5 minute time span between the two meals). The 200 Hall Cart-1 was scheduled to be delivered at 6:10 PM for Dinner and at 7:50 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals). The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).       F 809	SOUTHPO	IPOINT REHABILITATION A	ND HEALTHCARE CENTER			D		
<ul> <li>minute time span between the two meals).</li> <li>The meal cart for the 500 Hall was scheduled to be delivered at 6:00 PM for Dinner and at 8:05</li> <li>AM for Breakfast (indicative of a 14-hour and 5 minute time span between the two meals).</li> <li>The 200 Hall Cart-1 was scheduled to be delivered at 6:10 PM for Dinner and at 7:50 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).</li> <li>The 200 Hall Cart-2 was scheduled to be delivered at 6:15 PM for Dinner and at 7:55 AM for Breakfast (indicative of a 13-hour and 40 minute time span between the two meals).</li> </ul>	PREFIX	X (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE
<ul> <li>be delivered at 6:25 PM for Dinner and at 7:30</li> <li>AM for Breakfast (indicative of a 13-hour and 5 minute time span between the two meals).</li> <li>The meal cart for the 300 Hall was scheduled to be delivered at 6:30 PM for Dinner and at 7:40</li> <li>AM for Breakfast (indicative of a 13-hour and 10 minute time span between the two meals).</li> <li>A follow-up interview was conducted on 2/8/24 at 4:25 PM with the Regional Director of Dietary Operations. At that time, a review of the facility's current meal delivery schedule was discussed.</li> <li>Concerns regarding the time lapse of greater than 14-hours between Dinner and Breakfast the next day for 4 of the 8 meal carts was shared with the Director. Upon review, the Director stated he was not sure why the 400 Hall carts were served first for the Dinner meal when the same 400 Hall carts were served last for Breakfast the following day. The Regional Director of Dietary Operations reported the order of the meal carts being sent to the halls would need to be changed to ensure no more than 14 hours elapsed between the two meals.</li> </ul>	F 809	<ul> <li>minute time span betwin-The meal cart for the be delivered at 6:00 FAM for Breakfast (individual minute time span betwin-The 200 Hall Cart-1 delivered at 6:10 PM for Breakfast (individual minute time span betwin-The 200 Hall Cart-2 delivered at 6:15 PM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:25 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the be delivered at 6:30 FAM for Breakfast (individual minute time span betwin-The meal cart for the Diner mexist day for 4 of the Aetwin-The meal carts were served las day. The Regional D reported the order of the halls would need more than 14 hours experiments of the betwin-The meal cart for the betwin-First for the Diner mexist for the Diner mexist day. The Regional D reported the order of the halls would need more than 14 hours experiments for the Diner mexist for the Diner mexist for the Diner mexist for the Diner mexist day. The Regional D reported the order of the halls would need more than 14 hours experiments for the Diner mexist for the Diner mexist for the Diner mexist for the Diner mexist day. The Regional</li></ul>	ween the two meals). e 500 Hall was scheduled to PM for Dinner and at 8:05 icative of a 14-hour and 5 ween the two meals). was scheduled to be for Dinner and at 7:50 AM ve of a 13-hour and 40 ween the two meals). was scheduled to be for Dinner and at 7:55 AM ve of a 13-hour and 40 ween the two meals). e 100 Hall was scheduled to PM for Dinner and at 7:30 icative of a 13-hour and 5 ween the two meals). e 300 Hall was scheduled to PM for Dinner and at 7:40 icative of a 13-hour and 10 ween the two meals). e 300 Hall was scheduled to PM for Dinner and at 7:40 icative of a 13-hour and 10 ween the two meals). was conducted on 2/8/24 at gional Director of Dietary me, a review of the facility's schedule was discussed. he time lapse of greater en Dinner and Breakfast the 8 meal carts was shared with eview, the Director stated he 400 Hall carts were served eal when the same 400 Hall there is the following irector of Dietary Operations the meal carts being sent to to be changed to ensure no	F 809				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					M APPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345408	B. WING				C / <b>05/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page	e 104	F	812			
F 812 SS=E	Food Procurement,S	tore/Prepare/Serve-Sanitary		812			4/30/24
	§483.60(i) Food safe The facility must -	ty requirements.					
	<ul> <li>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</li> <li>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</li> <li>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility</li> </ul>						
	safe growing and foo (iii) This provision do	ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.					
	serve food in accorda standards for food se	prepare, distribute and ance with professional rvice safety. 「 is not met as evidenced					
	Based on observation Director of Dietary Op record reviews, the fa date, and discard exp refrigerator in 1 of 2 M Hall Nourishment Ro	ns, staff and the Regional perations interviews, and acility failed to: 1) Label, bired food items stored in the Nourishment Rooms (300 om) observed; and 2)			F812 Corrective action for the residents four to be affected by the deficient practice On February 5, 2024, the following iter were discarded by the Dietary Regiona Manager from the nourishment room	ns al	
	without chipped edge	able for use as the meal			refrigerator a sandwich, fried chicken a a brown bag containing an unidentifiab food item. On February 5, 2024, six pellets were identified as being broken and thrown		
	The findings included 1. Accompanied by t	l: he facility's Dietary Manager,			away. Corrective action for other residents having the potential to be affected by t	he	
	an observation was n	nade of the 300 Hall			same deficient practice.		

Event ID: MBNX11

Facility ID: 922983

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	S FOR MEDICARE &					VO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
		345408	B. WING		C 04/05/2024	
AME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP (	CODE	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 812	Continued From page	e 105	F 81	2		
F 012	Nourishment Room of Observations made of Room identified the for the refrigerator: Two separate plastic containing one meat sist be labeled with a resinumber. Both contain days prior to the obser- One plastic take-out resident's name and it to contain 4 pieces of was labeled with a dat the observation). One unlabeled brow the refrigerator. A foot inside the brown pape paper (also not labeled food item, the Dietary item as a bacon, lettur sandwich (a sandwich bread). Upon inquiry confirmed the sandwit touch and needed to At the time of the 300 observation, the Dietar as she removed the erefrigerator. The Dietane needed to find out whe expired and unlabeled who was responsible the refrigerator were to if they were expired, to she was not sure.	n 2/5/24 at 9:32 AM. f the 300 Hall Nourishment ollowing items were stored in c containers, each sandwich, were observed to dent's name and room hers were dated 1/19/24 (17 ervation). c container labeled with a room number was observed c chicken. The container the of 1/29/24 (7 days prior to m paper bag was stored in bod item was observed to be er bag and wrapped in white ed). Upon unwrapping the Manager identified this food ce, and tomato (BLT) panini in typically made with Italian , the Dietary Manager ch was very hard to the be discarded. Hall Nourishment Room ary Manager reported she hat she should do with the d food items. When asked for making sure all items in within date and/or discarded the Dietary Manager stated		All residents have the pote affected by the same defic On February 5, 2024, the I manager in-serviced all die is their responsibility to mo nourishment rooms and ch be discarded to ensure con in-service will be part of the process for all newly hired employees. Systemic Changes made to the deficient practice will n On February 12, 2024, the Regional manager educate staff that it is their respons the nourishment rooms an pellets to ensure complian in-service will be part of the process for all newly hired employees. The Dietary N monitor these areas daily § weeks and then weekly for monthly thereafter. The Die will give these audits to the Plans to monitor its perforr sure that the solutions are The Administrator will revie audits completed by the Di for 5x times a week for 4 v weekly for 4 weeks and the thereafter until 6 consecuti compliance is maintained. Administrator will report ar non-compliance to the Qua and Performance Improver Committee monthly for 3 n quarterly to ensure complian maintained.	ient practice. Dietary Regional etary staff that it onitor the hipped pellets to mpliance. The e orientation dietary to ensure that ot recur. e Dietary ed all dietary ibility to monitor d chipped ce. This e orientation dietary Manager will 5x a week for 4 r 4 weeks then etary Manager e Administrator. mance to make sustained. ew all the daily ietary manager weeks and then en monthly ive months of The ny findings of ality Assurance ment nonths and then	

Facility ID: 922983

If continuation sheet Page 106 of 116

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 04/26/2024 MAPPROVED O. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345408	B. WING			04	C 1/05/2024
NAME OF PF	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				60	000 FAYETTEVILLE ROAD		
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		D	URHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 812	food brought in from a and stored in the nou- labeled, kept within d expired. He stated it Department's) respon- long perishable food could be kept before Director reported that show when the item of could hold it in the re- food item included a would use that date to food was expired. He monitored the Nouris temperatures daily to acceptable temperatu 400 Fahrenheit (F) ar ensure no unlabeled Upon request, the Dir facility' entitled, "Food (Original date 5/2014 The Policy Statement procured from source satisfactory by federa authorities." The Pro 4]: Food may be bro family, visitors, or oth facility staff will assist and handling, as app 2. An observation wa tray line on 2/7/24 at	responsible to be sure the the outside for a resident rishment refrigerator was ate, and discarded when it was "our" (the Dietary hsibility. When asked how brought from the outside becoming expired, the t if a receipt was provided to was purchased, the facility frigerator for 7 days. If the "use by date," the facility o determine whether the e reported the Dietary staff hment Room refrigerator ensure they maintained an ure of less than or equal to not were responsible to or expired food was kept. rector provided a copy of the d From Approved Source" , Revised 9/2017, 10/2022). t read, "All food will be es approved or considered al, state and local cedures read, in part: "4 [of ught into the facility by er outside sources. The t with proper food storage	F	812	Date of compliance: 4/30/24		
	facility utilized a therr maintain the tempera pellet (made of a high	observation revealed the nal pellet system to help tures of hot food. A thermal n density plastic material) an insulated base. Each					

Facility ID: 922983

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/26/2024 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345408	B. WING		-	( 04/	05/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
SOUTHER		ND HEALTHCARE CENTER	6	000 FAYETTEVILLE ROAD	1		
300111-0	NIT REHABILITATION A	ND HEALINGARE CENTER	C	OURHAM, NC 27713			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 812	Continued From page		F 812				
	thermal pellet before on an individual's mea- to the resident's hall. thermal pellets (each approximately 2-3 inc deep on the pellet's e been placed among the tray line and ready for the thermal pellets we and sharp to the touch pellet was partially ex- when the pellet was p base and dinner plate harm to a resident. A thermal pellets observe	food was set on top of the being covered and placed al tray and a cart for delivery During the observation, 6 with a large chip measuring hes long and 3/4 inches dge) were observed to have he pellets stacked near the r use. The chipped edges of ere observed to be jagged h; the edge of the thermal posed and could be touched blaced between the insulated e, posing a potential risk of Il six (6) of the chipped ved were rejected and pulled either the facility's cook or when the cook was					
	food was plated. On	d the chipped pellet after the 2/7/24 at 11:53 AM, the re were "a lot" of chipped to indicate 'yes.'					
	PM with the Regional Operations. At that ti to observe two remain within the stack of the on the tray line. Whe related to the outside exposed to touch and for residents, the Dire would be pulled from interview conducted of Regional Director of D estimated there were out of approximately of lunch tray line observ	me, the Director was asked ning chipped pellets visible rmal pellets ready for use n concern was expressed edge of the pellet being posing a potential hazard ctor stated these pellets use. During a follow-up on 2/7/24 at 3:32 PM with the Dietary Operations, it was 6 chipped pellets identified 50 pellets used during the					

Facility ID: 922983

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345408	B. WING _				05/2024
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1	
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867 SS=E	QAPI/QAA Improvem CFR(s): 483.75(c)(d)( §483.75(c) Program f monitoring. A facility must establis policies and procedur collections systems, a adverse event monitor procedures must inclu following: §483.75(c)(1) Facility systems to obtain and from direct care staff, resident representativ information will be us are high risk, high vol opportunities for impr §483.75(c)(2) Facility systems to identify, co information from all d not limited to the facil §483.75(c)(3) Facility and evaluation of per including the methodo development, monitor	ent Activities (e)(g)(2)(i)(ii) feedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the maintenance of effective d use of feedback and input other staff, residents, and ves, including how such ed to identify problems that ume, or problem-prone, and ovement. maintenance of effective ollect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance development, monitoring, formance indicators, ology and frequency for such	F 8	367		ATE	4/30/24
	including the methods systematically identify analyze and use data adverse events in the	s by which the facility will , report, track, investigate, and information relating to facility, including how the ta to develop activities to					

If continuation sheet Page 109 of 116

					FORM	APPROVED 0. 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	
	345408	B. WING				05/2024
ROVIDER OR SUPPLIER		- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
DINT REHABILITATION A	ND HEALTHCARE CENTER					
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	K			(X5) COMPLETION DATE
Continued From page	9 109	F٤	367			
§483.75(d) Program systematic analysis and systemic action.						
aimed at performance implementing those a and track performanc	e improvement and, after ctions, measure its success, e to ensure that					
implement policies ac (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility w of its performance im	Idressing: a systematic approach to causes of problems ems; elop corrective actions that fect change at the systems y of care, quality of life, or ill monitor the effectiveness provement activities to					
§483.75(e) Program a	activities.					
performance improve high-risk, high-volume consider the incidenc of problems in those a outcomes, resident sa resident choice, and o §483.75(e)(2) Perform activities must track n resident events, analy	ment activities that focus on e, or problem-prone areas; e, prevalence, and severity areas; and affect health afety, resident autonomy, quality of care. nance improvement nedical errors and adverse /ze their causes, and					
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER DINT REHABILITATION A SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I Continued From page §483.75(d) Program s systemic action. §483.75(d)(1) The fac aimed at performance implementing those a and track performance implements are rea §483.75(d)(2) The fac implement policies ac (i) How they will use a determine underlying impacting larger syste (ii) How they will deve will be designed to eff level to prevent qualit safety problems; and (iii) How the facility wi of its performance improver §483.75(e)(1) The fac performance improver §483.75(e)(2) Perform activities must track n resident choice, and o §483.75(e)(2) Perform activities must track n resident events, analy implement preventive	CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:         345408         ROVIDER OR SUPPLIER         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 109         §483.75(d) Program systematic analysis and systemic action.         §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.         §483.75(d)(2) The facility will develop and implement policies addressing:         (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;         (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULT A. BUILDIN 345408         ROVIDER OR SUPPLIER       345408       B. WING_         ROVIDER OR SUPPLIER       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 109       F 6         §483.75(d) Program systematic analysis and systemic action.       F 6         §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.       §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.         §483.75(e) Program activities.       §483.75(e) Program activities.         §483.75(e) Program activities. </td <td>S FOR MEDICARE &amp; MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLUA IDENTIFICATION NUMBER:       (X2) MULTIPLE A BUILDING</td> <td>S FOR MEDICARE &amp; MEDICAID SERVICES         preperiorized construction       (x1) PROVIDERSUPPLIERCLIA       (x2) MULTIPLE CONSTRUCTION         A BUILDING      </td> <td>MENT OF HEALTH AND HUMAN SERVICES COMB NC SFOR MEDICARE &amp; MEDICALD SERVICES OMB NC prediction in the service of the service</td>	S FOR MEDICARE & MEDICAID SERVICES         OF DEFICIENCIES CORRECTION       (X1) PROVIDER/SUPPLIER/CLUA IDENTIFICATION NUMBER:       (X2) MULTIPLE A BUILDING	S FOR MEDICARE & MEDICAID SERVICES         preperiorized construction       (x1) PROVIDERSUPPLIERCLIA       (x2) MULTIPLE CONSTRUCTION         A BUILDING	MENT OF HEALTH AND HUMAN SERVICES COMB NC SFOR MEDICARE & MEDICALD SERVICES OMB NC prediction in the service of the service

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	-	ID HUMAN SERVICES				FORM	APPROVED
STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345408	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
SOUTUDO		ND HEALTHCARE CENTER		6	0000 FAYETTEVILLE ROAD		
300160		ND HEALTHCARE CENTER		0	DURHAM, NC 27713		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI		COMPLETION DATE
		,			DEFICIENCY)		
F 867	Continued From page	e 110	F	867			
	facility.						
	6400 75(-)(0) A						
	§483.75(e)(3) As part	s, the facility must conduct					
		improvement projects. The					
	-	y of improvement projects					
		lity must reflect the scope					
		facility's services and					
		as reflected in the facility					
	assessment required	,					
		s must include at least t focuses on high risk or					
		identified through the data					
		is described in paragraphs					
	(c) and (d) of this sec	tion.					
	§483.75(g) Quality as	sessment and assurance.					
	§483.75(g)(2) The qu	ality assessment and					
		reports to the facility's					
	governing body, or de						
		rning body regarding its					
		ler paragraphs (a) through					
	(e) of this section. Th						
	(ii) Develop and imple	ement appropriate plans of					
		tified quality deficiencies;					
		and analyze data, including					
		the QAPI program and data					
	available data to mak	gimen reviews, and act on					
		is not met as evidenced					
	by:						
	Based on observatio	ns, record review, resident,			F867 QAPI		
	and staff interviews, t						
		ess failed to implement,			Corrective action for the residents four		
		s needed the action plan ertification and complaint			to be affected by the deficient practice 1. Resident # 2 no longer resides in		
		crancation and complaint			1. Resident # 2 no longer resides in	110	

Facility ID: 922983

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04 FORM AP OMB NO. 09	PROVE
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	(X3) DATE SUR COMPLETE	
		345408	B. WING _		C 04/05/2	2024
NAME OF PR	OVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP COD	•	
SOUTHPO	INT REHABILITATION A	ND HEALTHCARE CENTER		6000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE CC APPROPRIATE	(X5) DMPLETIO DATE
	complaint investigation and 8/2/21 to achieve These were for recite recertification and con- dated 2/9/24. The de- following areas: repor- discharge planning pri- prevent /heal pressur and biologicals, food store/prepare/serve - records - identifiable if failure during federal pattern of the facility's effective quality assur The findings included This tag is cross-refer 1. F609-Based on reco- interviews, the facility Allegation Report to t Protective Services (/ the required timefram (Resident #232) revie- was officially notified pm when an immedia issued. The facility d to the State Agency w following notification. During a complaint in the facility failed to re drugs to the State ag- report and the 5-day i	3, and 8/26/21 and for on dated 8/18/23, 12/22/21, e and sustain compliance. d deficiencies on the recent mplaint investigation survey ficiencies were in the ting of alleged violations, rocess, treatment/services to e ulcers, label/ store drugs procurement, sanitary and resident information. The continued surveys of record showed a sinability to sustain an rance program. : renced to: cord review and staff failed to submit an Initial he State Agency, Adult APS), and the police within e for 1 of 1 resident ewed for neglect. The facility of neglect on 4/2/24 at 6:27 te jeopardy template was id not submit an initial report vithin the required timeframe	F 8		esides in the resides in resides in ential to be dication Medication by the e Managers. e removed y per policy. e following Dietary nourishment fried ataining an ets were d thrown r resides in resides in resides in sidents ected by the al to be ent practice. rector of ers of QAPI surance and oblicy/process	

Facility ID: 922983

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						10.0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · ·	E SURVEY IPLETED
		345408	B. WING			С
	ROVIDER OR SUPPLIER	575700		STREET ADDRESS, CITY, STATE, ZIP CODE	0,	4/05/2024
				6000 FAYETTEVILLE ROAD		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER		DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	h		1			
F 867	Continued From page	e 112	F 86	7		
		ecord review, family, home		completed on 2/29/24 and 4/19		
		cian, staff interviews, the		Administrator will lead Quality A		
		ment an effective discharge		and Performance Improvement		
		t included ensuring the		with emphasis and focus on en	-	
		and the home health agency		any areas on non-compliance a		
		resident's medication		addressed to prevent further de		
		the treatment that was		practices related to the followin		
		nds. This was for 1 of 3		580, Tag 609, Tag F660, Tag F		
	residents reviewed to	or discharge (Resident #181).		F761, Tag F812, and Tag F842		
	<b>.</b>			one member of the regional tea		
		vestigation survey dated		includes senior nurse consultar	•	
	8/18/23, the facility fa	-		vice president will attend QAPI	meetings	
		an that included ensuring a		for 3 quarters.	ouro that	
		d home health services was d for services and that DME		Systemic Changes made to en		
	-	angements coordinated for		the deficient practice will not re The Quality Assurance and Per		
		of 1 resident reviewed for		Improvement committee will co		
	discharge planning.			monitor implemented procedure monitor the plan of correction (	es and	
	3. F 686 - Based on s	staff interviews, family		in place for Tag 580, Tag 609,		
		nterview and record review,		Tag F686, Tag F761, Tag F812	, and Tag	
	the facility failed to as	ssess and document the		F842 monthly until 3 consecutiv	ve months	
	pressure wound(s) id	entified on the buttock for 1		of compliance is maintained the	en quarterly	
	of 3 (Resident #181)	residents reviewed for		thereafter. The Quality Assurar		
	pressure ulcers.			Performance Improvement con		
				meet monthly to review the trac	-	
		vestigation survey dated		trending analysis of areas that		
		e sampled residents with		repeat tag/deficiencies. The fac		
	-	acility failed to thoroughly		develop a retrospective plan to		
		ear treatment orders when a		facility standards and ensure ne	o repeat	
		d to have a pressure sore so		citations.		
		follow through with an				
	approved plan of care	e for the pressure sore.				
				Plans to monitor its performance		
		observations and staff		sure that the solutions are sust		
		failed to remove an expired		The administrator will lead the	Quality	
		ors of insulin and expired		Assurance and Performance		
		cation cart drawer for 2 of 7		Improvement meetings monthly		
	medication administra	ation carts (100 and 300		emphasis and focus on areas t	nat have	

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TATEMENT	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP			(X3)	3 NO. 0938-039 DATE SURVEY COMPLETED
			A. BUILDING	i			C
		345408	B. WING			04/05/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET AL	DDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			ETTEVILLE ROAD /I, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 867	Continued From page	e 113	F 86	7			
	<ul> <li>B67 Continued From page 113 halls), failed to remove the expired medications, enteral feeding formula supplements and supply kit from the medication storage rooms (medication storge rooms #1 and #2).</li> <li>During a previous recertification and complaint investigation survey dated 1/10/23, the facility failed to: 1) Discard expired medications, loose capsules from an opened stock bottle of medication and one unidentified tablet lying on the bottom of a medication (med) cart drawer; and 2) Store medications in accordance with the manufacturer's storage instructions. This was occurred observed for 2 of 3 medication carts observed (Station 2 A/B Med Cart and Station 1 Med Cart).</li> <li>During the recertification and complaint investigation survey dated 8/26/21, the facility failed to date opened medications in 2 of 6 medication administration carts (400 and 500 halls.) and failed to remove expired medications stored in 1 of 6 medication administration carts (500 hall.)</li> <li>5. F812 - Based on observations, staff and the</li> </ul>			609, F812 facilit non-c need pract that i or ard quart effec the C Impro non-c then quart comp	b repeat deficiencies Tag 580, Tag F660, Tag F686, Tag F76 2, and Tag F842. This will ensu ty is identifying areas on compliance and addressing the led to prevent further deficient tice. A member of the regional ncludes the senior nurse cons ea vice president will attend Q tings for the next 3 months and terly to ensure the QAPI proce tive. The administrator will rep Quality Assurance and Perform ovement Committee any areas compliance monthly for 3 mon quarterly and/or needed for 3 ters for further recommendatio bliance is sustained. of compliance: 4/30/24	1, Tag re the em as team ultant API d then ss is ort to ance s of ths and	
	Regional Director of I interviews, and recor to: 1) Label, date, and stored in the refrigera Rooms (300 Hall Nou and 2) Maintain therm and without chipped observed to be availa service tray line was	Dietary Operations d reviews, the facility failed d discard expired food items ator in 1 of 2 Nourishment urishment Room) observed; nal pellets in good condition edges for 6 of 60 pellets able for use as the meal conducted.					
	investigation survey of	certification and complaint dated 1/10/23, the facility reparation areas, food					

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345408	B. WING				C 05/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD DURHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 867	free from debris, great spills from the dry ing kitchen observations. the floor and ceiling v prep and food service potential to affect food 6. F842 - Based on re- physician interviews, an accurate Medicatio (MAR) for pain medic 1 resident (Resident 4 management. During a complaint in 8/2/21, the facility failure records were complet changes for two of the dressing changes. During an interview of Administrator stated to committee 1) identifie a root cause analysis and monitors that plan outcome. The Admini- the team would use the whys) to identify caus- improvement plan wo tools and monitoring so System changes and put in place as needed Regarding the repeat Administrator stated so 2/5/24. The Administrator analyzed to see wher	but service equipment clean, ase buildup, and/or dried redient bins during two The facility failed to clean ents located over the food a area. This practice had the d served to all residents. ecord review, staff and the facility failed to maintain on Administration Record ation administration for 1 of #280) reviewed for pain vestigation survey dated ed to assure the medical te related to dressing ree sampled residents with n 2/9/24 at 2:28 PM, the the Quality Assurance (QA) as areas of concern, 2) does , 3) develops a plan, audits, n and 4) discusses the strator stated if applicable he fish bone analysis (5 as and performance ould be developed. Audit system would be used. additional tasks would be d to resolve the issue. ed deficiencies the she was recently hired on ator indicated that the old uld be revisited and	F	867			

Facility ID: 922983

If continuation sheet Page 115 of 116

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 04/26/2024 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345408	B. WING				C 05/2024
NAME OF PI	ROVIDER OR SUPPLIER			SI	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-17	00/2024
SOUTHPO	DINT REHABILITATION A	ND HEALTHCARE CENTER			000 FAYETTEVILLE ROAD		
				D	URHAM, NC 27713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 867	Continued From page	• 115	É F	867			
	the cause of repeat d	eficiency. The Administrator					
		an was put in place, audits nase would be completed.					
	The repeated concern	ns would also be discussed					
		e QA committee would see n be changed if needed.					
		r be changed in needed.					

Facility ID: 922983

If continuation sheet Page 116 of 116

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	VI OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			AF "A" FORI					
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM WIT	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AND	NFs	345408	B. WING	4/5/2024					
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE						
		6000 FAYETTE	6000 FAYETTEVILLE ROAD						
SOUTHPOI	NT REHABILITATION AND HEALTHCARE CEN	DURHAM, NC							
ID		•							
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES								
F 655	Baseline Care Plan								
F 033	CFR(s): 483.21(a)(1)-(3)								
	§483.21 Comprehensive Person-Centered Care Planning								
	§483.21(a) Baseline Care Plans								
		§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes							
	the instructions needed to provide effective a		d care of the resident that meet professional						
	standards of quality care. The baseline care plan must-								
	(i) Be developed within 48 hours of a resident's admission.								
	(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-								
	(A) Initial goals based on admission orders.								
	(B) Physician orders.								
	(C) Dietary orders.								
	(D) Therapy services.								
	(E) Social services.								
	(F) PASARR recommendation, if applicable.								
	§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the								
		comprehensive care plan- (i) Is developed within 48 hours of the resident's admission.							
	(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this								
	section).								
	§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline								
	care plan that includes but is not limited to:								
	0	(i) The initial goals of the resident.							
	(ii) A summary of the resident's medications								
	(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.								
	(iv) Any updated information based on the d	etails of the compr	ehensive care plan as necessary						
	This REQUIREMENT is not met as evidence	-							
	Based on staff interviews and record reviews	-	to develop a baseline care plan within 48						
			sidents reviewed (Resident #100 and Resident						
	#381).								
	The findings included:								
	-		cumulative diagnoses included cancer, asthma	,					
	cachexia (a wasting syndrome that leads to loss of skeletal muscle and fat), and dysphagia (difficulty swallowing).								

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

The above isolated deficiencies pose no actual harm to the residents

	ENT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES	_		AH "A" FORM					
STATEMENT (	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:					
FOR SNFs AN	D NFs	345408	B. WING	4/5/2024					
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE	1					
		6000 FAYETTEV	6000 FAYETTEVILLE ROAD						
SOUTHPO	INT REHABILITATION AND HEALTHCARE CH	DURHAM, NC							
ID									
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE	S							
F 655	Continued From Page 1								
	Nurse #16 (Dated 7/24/23) and reviewed/si	A review of Resident #100's electronic medical record (EMR) revealed a baseline care plan was completed by Nurse #16 (Dated 7/24/23) and reviewed/signed by the facility's Director of Nursing (DON) on 7/25/23 (11 days after the resident's admission to the facility).							
	asked who was responsible to complete a n	An interview was conducted on 2/8/24 at 2:50 PM with Nurse #11. During the interview, this hall nurse was asked who was responsible to complete a newly admitted resident's baseline care plan. The nurse reported there was an "admitting nurse" who typically completed the baseline care plan.							
	An interview was conducted on 2/8/24 at 3:05 PM with the facility's Director of Nursing (DON). During the interview, she identified Nurse #16 as the nurse who assumed responsibility for completing baseline care plans for newly admitted residents. The DON stated that since Nurse #16 was a Licensed Practical Nurse (LPN), each baseline care plan needed to be reviewed and signed off on by a Registered Nurse (RN). She reported that either she (the DON) or another RN would sign off on the baseline care plans.								
	An interview was conducted on 2/8/24 at 3:30 PM with Nurse #16. During the interview, Nurse #16 reported it was her responsibility to complete the baseline care plans for newly admitted residents. However, the nurse reported that since she was an LPN, an RN needed to review and sign off on each baseline care plan. The nurse reported she would usually text the DON or ask another RN working in the facility to review and sign off on a baseline care plan after it was completed. The nurse reported that to her knowledge, she was the only staff member who completed baseline care plans. Nurse #16 added there was no other coverage for this task to be completed when she took time off, as she did during July of 2023 (when Resident #100's baseline care plan was due). Nurse #16 confirmed the baseline care plan was required to be completed within 48 hours of a resident's admission.								
	On 2/8/24 at 3:20 PM, the facility's Administrator was informed of the identified concern related to the facility's failure to complete baseline care plans within 48 hours of a resident's admission. The Administrator reported she had been made aware of this concern.								
	2. Resident #381 was initially admitted to t seizure disorder and malnutrition.	he facility on 11/3/2	3. His cumulative diagnoses included a						
		A review of Resident #381's electronic medical record (EMR) revealed a baseline care plan was completed by Nurse #16 (Dated 11/7/23) and reviewed/signed by a Registered Nurse (RN) on 11/7/23 (4 days after the resident's admission to the facility).							
	An interview was conducted on 2/8/24 at 2 asked who was responsible to complete a n there was an "admitting nurse" who typical	ewly admitted reside							
	An interview was conducted on 2/8/24 at 3	An interview was conducted on 2/8/24 at 3:05 PM with the facility's Director of Nursing (DON). During the							
031099									

	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			AF AF "A" FOR!		
STATEMENT (	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY		
	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:		
FOR SNFs ANI	J INFS	345408	B. WING	4/5/2024		
	WIDER OR SUPPLIER	6000 FAYETTEV	STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC			
ID PREFIX FAG	SUMMARY STATEMENT OF DEFICIENCE	ES				
F 655	Continued From Page 2 interview, she identified Nurse #16 as the plans for newly admitted residents. The D (LPN), each baseline care plan needed to b reported that either she (the DON) or anot An interview was conducted on 2/8/24 at 3 it was her responsibility to complete the bar reported that since she was an LPN, an RN nurse reported she would usually text the 1 off on a baseline care plan after it was con staff member who completed baseline care to be completed when she took time off. I completed within 48 hours of a resident's a On 2/8/24 at 3:20 PM, the facility's Admin facility's failure to complete baseline care reported she had been made aware of this					
F 842	<ul> <li>Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)</li> <li>§483.20(f)(5) Resident-identifiable information in the facility may not release information in the facility may release information in the contract under which the agent agrees not itself is permitted to do so.</li> <li>§483.70(i) Medical records.</li> <li>§483.70(i)(1) In accordance with accepted medical records on each resident that are-(i) Complete;</li> <li>(ii) Accurately documented;</li> <li>(iii) Readily accessible; and</li> <li>(iv) Systematically organized</li> <li>§483.70(i)(2) The facility must keep confirregardless of the form or storage method of (i) To the individual, or their resident reprint the formation of the</li></ul>	nation. that is resident-identifi nat is resident-identifi to use or disclose the l professional standard dential all information of the records, except v	able to an agent only in accordance with a information except to the extent the facility is and practices, the facility must maintain a contained in the resident's records, when release is-			
	<ul><li>(ii) Required by Law;</li><li>(iii) For treatment, payment, or health card</li></ul>	-				
31099	P	vont ID: MDNV11		If continuation she		

CENTERS FO	OR MEDICARE & MEDICAID SERVICES	-		"A" FC				
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY				
	H ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:				
FOR SNFs AND	INFS	345408	B. WING	4/5/2024				
NAME OF PRO	VIDER OR SUPPLIER	STREET ADDRESS,	CITY, STATE, ZIP CODE					
COUTUDOI	NT DEHADH ITATION AND HEATTHCADE CEN	6000 FAYETTEVILLE ROAD						
SUUTHPUT	NT REHABILITATION AND HEALTHCARE CEN	DURHAM, NC						
ID PREFIX								
TAG	SUMMARY STATEMENT OF DEFICIENCIES							
F 842	Continued From Page 3							
-	164.506;							
	(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities,							
	judicial and administrative proceedings, law							
	1 1	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 me	\$483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or						
	unauthorized use.							
	\$492 70(i)(4) Madical records must be retained for							
	<ul><li>§483.70(i)(4) Medical records must be retained for-</li><li>(i) The period of time required by State law; or</li></ul>							
	(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;							
	(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 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 record review, staff and physician interviews, the facility failed to maintain an accurate Medication Administration Record (MAR) for pain medication administration for 1 of 1 resident (Resident #280)							
	Administration Record (MAR) for pain medication administration for 1 of 1 resident (Resident #280) reviewed for pain management.							
	Findings included:							
	Review of the physician orders 6/6/23 revealed	ed, 5 / 325 milligra	ms (mg) hydrocodone / acetaminophen -1					
	tablet to be given twice a day by mouth for pa	-						
	medication which is a controlled substance).							
	Review of the Medication Administration Rev	cord (MAR) for Ju	ine 2023 revealed 5 / 325 mg hydrocodone /					
		Review of the Medication Administration Record (MAR) for June 2023 revealed 5 / 325 mg hydrocodone / acetaminophen 1 tablet to be given twice a day by mouth for pain was marked as administered on 6/10/23 at 9						
	AM and 9 PM by Nurse #23.							
	Review of the Control Substance Sheet (a dec	Paview of the Control Substance Sheet (a declining inventory of a controlled substance mediantics discovered						
		Review of the Control Substance Sheet (a declining inventory of a controlled substance medication dispensed for a resident) revealed the resident received the medication on 6/10/23 at 9 AM and did not receive it at 9						
	PM. The medication count for controlled sub-							
	discrepancy in the amount of controlled substance remaining when the resident was discharged.							
031099								

	NT OF HEALTH AND HUMAN SERVICES OR MEDICARE & MEDICAID SERVICES			AH "A" FORM
STATEMENT O	F ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:
FOR SNFs AND	NFs	345408	B. WING	4/5/2024
NAME OF PROVIDER OR SUPPLIER SOUTHPOINT REHABILITATION AND HEALTHCARE CEN		STREET ADDRESS, CITY, STATE, ZIP CODE 6000 FAYETTEVILLE ROAD DURHAM, NC		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES	<u> </u>		
F 842	Continued From Page 4			
	Review of the Treatment Administration Record (TAR) for June 2023 revealed the pain scale was marked as zero on 6/10/24 at 9 AM and 9 PM.			
	Review of the vital signs for June 2023 revealed the pain scale was marked as zero on 6/10/24.			
	During a telephone interview on 2/8/24 at 9:48 AM, Nurse #23 indicated she was an agency nurse and had not been working at the facility for more than 6 months. The nurse was unable to provide any information.			
	changed it to scheduled. DON stated the Med order "5 / 325 mg hydrocodone / acetaminopl administered at 9 AM and 9 PM on 6/10/23. I the medication was pulled from the inventory	trolled substance) ication administration nen- Give 1 tablet However, the Com- for administration nece sheet was accu- v documented as an the TAR for 6/10/23 tated the physician ocumented. 6 AM, Physician	as needed (PRN) and later discontinued it and tion record (MAR) indicates the physician twice a day by mouth for pain" was marked as trol substance sheet did not indicate a tablet of a to Resident #280 on 6/10/23 at 9 PM. The trate all the way through. The DON indicated dministered when the medication was not 3 revealed a zero pain scale for 9 AM and 9 and 6/11/23 was an agency nurse who no a orders should be followed and medication Assistant (PA) #4 stated it was very essential	
		he Corporate Nur	se consultant stated Physician orders should be	
031099	I Evan	t ID: MBNX11		If continuation sheet