STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345408	A. BUILDING _____ B. WING _____	C 04/10/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 4/7/2025 through 4/10/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #B7GL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 4/7/2025 through 4/10/2025. Event ID #B7GL11. The following intakes were investigated: NC00219093, NC00219338, NC00219688, NC00220689, NC00221047, NC00221762, NC00222167, NC00222673, NC00223883, NC00223922, NC00225540, NC00225794, NC00225968, NC00228485, NC00228862, and NC00229263. 7 of the 44 complaint allegations resulted in deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff and Pharmacy Consultant interviews, the facility failed to protect the resident's right to be free from misappropriation of resident property for 1 of 3 residents reviewed for misappropriation (Resident	F 602	F602 Misappropriation/Exploitation Corrective action for the residents found to be affected by the deficient practice.	5/6/25

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

Electronically Signed | 05/05/2025

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F 602	Continued From page 1 #300). The findings included: Resident #300 was admitted to the facility on 9/27/24. She was discharged on 10/27/24. Review of the facility reported incident investigation dated 10/3/24 revealed the narcotic count for 100 hall was not correct the morning of 10/2/24. During the narcotic reconciliation completed by the off going Nurse #4 and the oncoming Nurse #5, the 100-hall cart was missing one card of oxycodone HCL (hydrochloride) 5 mg tablets (17 tablets) for Resident #300. All medication carts were audited, and the missing narcotic card was not found. The local police department was notified on 10/2/24. Review of the facility's 5-day Summary investigation report dated 10/7/24 revealed that all 11:00 PM to 7:00 AM staff who worked on 10/1/24 through 10/2/24 were interviewed. All facility narcotics were reconciled, and the pharmacy was notified. Staff education training was conducted, and the Drug Enforcement Administration (DEA) was contacted. Resident #300's individual controlled drug record was reviewed. The record revealed oxycodone HCL 5mg was prescribed for Resident #300 to take one tablet by mouth every 6 hours as needed for up to 5 days. The prescription was filled on 9/27/24 18 of 18 tablets were signed as received on 9/27/24. On 9/28/24 at 1:00am Resident #300's individual controlled drug record indicated 1 tablet was signed as administered, and the card contained 17 tablets. On the morning of 10/2/24 the entire narcotic card was	F 602	Resident #300 no longer resides in the facility. The Board of Nursing contacted to ensure that reporting of the misappropriation/exploitation had been reported. Complaint completed on 05/2/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice if there is an allegation of misappropriation/Exploitation reported fits the criteria for reporting circumstances and guidelines, and the facility fails to report timely to state reporting agency, APS, police and the board of nursing. The Regional Clinical Director audited the past 8 months of reportable to the State Agency 5/2/25 to ensure timely reporting of any allegation of misappropriation/exploitation was completed per the policy and procedure of the misappropriation/exploitation reporting guidelines. No adverse findings noted. Systemic Changes made to ensure that the deficient practice will not recur. 100% mandatory education was provided to the whole staff, by the Administrator/designee, regarding the Misappropriation/exploitation reporting policy and procedures, with emphasis on following the protocols of contacting all required agencies. The Regional Clinical	

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F 602	Continued From page 2 noted as missing during the narcotic count conducted by both the off going Nurse #4 and oncoming Nurse #5. A telephone interview was conducted on 4/9/25 at 6:06 PM with Nurse#4 who stated she shared a medication cart with another nurse during her shift on 10/1/24 to 10/2/24. She could not recall the nurse's name or a description. She stated during her shift she took two breaks, and she left the narcotic keys on top of the narcotic/medication cart while she was gone. During the narcotic count with the oncoming Nurse #5, it was discovered that one narcotic card for Resident #300 was missing from the cart. A follow up telephone interview was conducted on 4/10/25 at 11:11 AM with Nurse #4. She stated again she shared a medication cart with another nurse that shift, and they had only one set of keys to that medication cart. She stated she left the narcotic keys on the medication chart because she was sharing that cart with another nurse. She further stated that it was her practice to leave the narcotic keys on the medication cart because the narcotic keys cannot be kept while on break or when leaving the facility. An attempt was made to interview Nurse #6 who worked with Nurse #4 from 11:00 PM on 10/1/24 through 7:00 AM on 10/2/24 but was unsuccessful. Review of Nurse #5's witness statement dated 10/2/24 indicated he arrived at the facility at approximately 7:00 AM and conducted the narcotic count with Nurse #4. A discrepancy was noted for a missing narcotic card. This was reported to the Director of Nursing (DON).	F 602	Director provided 1:1 education to the Administrator on 5/2/25 regarding the protocols of contacting all required agencies, once the allegation is identified and reported to the Grievance officer. Entire staff educated was completed on 5/5/25. Any newly hired staff will be educated on the requirements of Misappropriation/exploitation reporting policy and procedures as specified by the state and approved by CMS by the Administrator and/or the Director of Nursing during orientation. Plans to monitor its performance to make sure that the solutions are sustained. To ensure ongoing compliance, the Regional Clinical Director will conduct compliance audits 3 x week x 12 weeks to ensure if there is an allegation of misappropriation/exploitation to report to the State Agency, APS, police, and board of nursing is completed within the required timeframe following the notification. The facility will continue to provide education in any areas of concern if necessary. The results of the audit will be reported at the monthly QAPI meeting until such time that substantial compliance has been achieved x 3 months. Date of compliance: 5/6/25	

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F 602	Continued From page 3	F 602		

An attempt was made to interview Nurse #5, however, was unsuccessful.

On 4/10/25 at 7:57 AM an interview was conducted with Nurse #8 regarding the narcotic reconciliation process at the change of shift. Nurse #8 stated the oncoming nurse gets the narcotic key and opens the narcotic box. The off going nurse reads the count from the narcotics binder including the name of the medication, the dose, and the resident's name. The oncoming nurse verifies this information with the actual narcotic cards/bottles and reads back the same information. This procedure is completed for both the medication cart and the medication refrigerator in the medication room. Once completed, both the off going and oncoming nurses sign the narcotics book verifying the count was correct.

An interview was conducted on 4/10/25 at 3:35 PM with Nurse #7 who worked the evening shift (3PM-11PM) on 10/1/24 on Station 1/Hall 100. She stated she did not recall the staff members she worked with that day or whether she had her own medication cart or split/shared it with another nurse.

An interview was conducted on 4/10/25 at 4:01 PM with Nurse #2. She stated on days and evening shifts each nurse has their own medication cart, however on the night shift (11PM-7AM) 2 nurses may share a medication cart. She further stated there was only one set of keys per medication cart and the keys must always be with a nurse. When going on a break or leaving the facility, the narcotic keys are given to another nurse and never left on a medication

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F 602	Continued From page 4	F 602		

cart.

An attempt to contact the investigating officer on 4/10/25 at 10:45 AM was unsuccessful.

On 4/10/25 at 11:05 AM an interview was conducted with the Pharmacy Consultant. She stated she was notified of the missing narcotic card by the DON, and she helped the facility report the diversion to the DEA. She stated she reconciled all the medication carts on 10/2/24 after the incident. She further stated she regularly performed monthly random narcotic audits of the medication carts and medication rooms. She stated she had no issues or concerns both before and after this incident.

On 4/9/25 at 12:17 PM an interview with the Director of Nursing (DON) was conducted. She stated the discrepancy with the narcotic count for the 100-hall cart was reported to her on the morning of 10/2/24 by Nurse #4 and Nurse #5 upon discovery and an investigation was immediately started. The Administrator and Nurse #4's staffing agency was also notified. All medication carts were audited, and no additional missing narcotics were found. Nursing staff conducted pain assessments, and no residents reported issues with pain that shift. The DON further stated that the narcotic keys should never be placed/kept on a medication cart and are to be kept with a nurse on their person. Two nurses are responsible for completion of the narcotic count at the change of shifts: one outgoing and one oncoming nurse. She further stated any discrepancy found must be reported immediately and an investigation would be started.

On 4/10/25 at 4:38 PM a review of the county

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F 602	Continued From page 5 courts website revealed Nurse #4 had been charged with felony larceny by an employee and a court date scheduled for 4/15/25. In an interview with the Administrator on 4/10/25 at 8:19 AM she stated that the facility did not report Nurse #4 to the North Carolina State Board of Nursing because she was not the facility's employee and was employed by a staffing agency. A follow up interview was conducted with the Administrator on 4/10/25 at 5:06 PM. She stated her expectation was for the nursing staff to keep the narcotic drawer and medication cart locked at all times when not in use, medication cart keys on nurses at all times, for nursing staff to count narcotics on the cart each shift, and both ongoing and oncoming staff sign off the narcotic count was completed and was correct. The facility presented a draft plan of correction for past noncompliance. Past noncompliance could not be substantiated due to the facility's failure to report Nurse #4 to the North Carolina State Board of Nursing.	F 602		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 1 of 31 residents whose MDS	F 641	F641 Accuracy of Assessments Corrective action for the residents found to be affected by the deficient practice.	5/6/25

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F 641	Continued From page 6 assessment were reviewed (Resident #75). Findings included: Resident #75 was admitted to the facility on 9/17/2024 and diagnoses included hypertension and heart failure. Resident #75's care plan dated 10/11/2024 included a focus for diuretic therapy related to heart failure. Interventions included administering diuretics, medications used to reduce enema (extra fluid in the body), as ordered by the physician. Physician orders dated 1/23/2025 included an order for Bumetanide, a diuretic medication, 2 milligrams (mg) every day for edema. Resident #75's March 2025 Medication Administration Record (MAR) recorded Bumetanide 2 mg was administered daily from 3/1/2025 through 3/31/2025. The quarterly MDS assessment dated 3/27/2025 was not coded for Resident #75 receiving diuretics. In a phone interview with MDS Coordinator on 4/10/2025, she stated Resident #75 had received Bumetanide during the seven day look-back period from 3/21/2025 to 3/27/2025 and the quarterly MDS assessment dated 3/27/2025 should have been coded that Resident #75 was receiving diuretics. In a follow-up phone interview on 4/10/2025 at 3:20 pm, MDS Nurse #1 stated it was an oversite as the reason Resident #75's MDS assessment was not coded for diuretics.	F 641	Resident #75 remains in the facility. MDS for Resident #75 was reviewed and corrected and locked on 4/11/25. The assessment has since been transmitted and accepted. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the alleged deficient practice. On the Regional Director of Clinical Reimbursement 5/6/25 all in-house residents with diuretics; the MDS and Care plans have been audited for accuracy. No adverse finding noted. Systemic Changes made to ensure that the deficient practice will not recur. On 5/6/25, the Regional Director of Clinical Reimbursement completed education with the MDS nurses on the requirement of accuracy of the MDS. Any newly hired MDS staff will be educated on the requirement of accuracy as specified by the state and approved by CMS by the Administrator and/or the Director of Nursing during orientation. The Regional Director of Clinical Reimbursement will complete a weekly audit on all new admissions/readmissions with diuretics for 4 weeks to ensure the MDS and Care plans have been completed accurately as specified by the state and approved by CMS. Plans to monitor its performance to make sure that the solutions are sustained.	

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F 641	Continued From page 7 In an interview with the Administrator on 4/10/2025 at 4:10 pm, she stated the MDS assessment for Resident #75 should be coded accurately for the use of diuretics.	F 641	The Regional Director of Clinical Reimbursement will review all new admissions/readmissions for 4 weeks and then pick a sample of 5 new admissions/readmissions for two weekly audits and then a sample of 5 new admissions/readmissions monthly thereafter for 3 consecutive months to ensure compliance is maintained. The Regional Director of Clinical Reimbursement will report any findings of non-compliance to the Administrator to report to the Quality of Assurance and Performance Improvement Committee monthly for the next 3 months and then quarterly to ensure compliance is maintained. Date of compliance: 5/6/25	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 657		5/6/25

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F 657	Continued From page 8 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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident interview, resident's emergency contact interview, and staff interviews, the facility failed to conduct and document care plan meetings after completion of quarterly and significant change Minimum Data Set (MDS) assessments for 1 of 31 residents reviewed for care planning (Resident #62). The findings included: Resident #62 was admitted to the facility on 8/01/2023. The last care plan meeting documented in Resident #62's medical record was dated 3/4/2024. MDS assessments were completed for Resident #62 on the following dates: 6/8/2024 (quarterly), 7/8/2024 (significant change), 9/30/2024 (quarterly), 12/31/2024 (significant change) and 4/2/2025 (quarterly). The quarterly MDS dated 4/2/2025 indicated Resident #62 was cognitively intact.	F 657	F657 Care Plan Timing and Revision Corrective action for the residents found to be affected by the deficient practice. Resident # 62 was re-admitted to the facility on 6/6/24. The interdisciplinary team (IDT) held a care plan meeting on 4/25/25 with the resident to review her current comprehensive care plan. Corrective action for other residents having the potential to be affected by the same deficient practice. A new Social Worker began employment on April 18, 2025. The Social Services department initiated the care plan review process to include resident and/or Responsible Party (RP) participation. As of 5/5/24, the Social Services department has reviewed and conducted comprehensive care meetings with all current residents and/or Responsible Parties.	

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F 657	Continued From page 9 Resident #62 was listed as the responsible party on Resident #62's medical record. In an interview with Resident #62 on 4/7/2025 at 11:10 am, Resident #62 was not able to recall receiving invitations or having meetings with interdisciplinary members of the staff to discuss Resident #62's plan of care. In a phone interview with Resident #62's emergency contact #1 on 4/10/2025 at 9:54 am, she stated the last care plan meeting for Resident #62 was held in January 2024 and she had not received any written invitations or calls from the facility to attend a care plan meeting since January 2024. In a phone interview with MDS Coordinator on 4/10/2025 at 2:42 pm, she stated care plan meetings were to be scheduled after the completion of MDS assessments quarterly by the Social Worker. She explained upon the completion of the MDS assessment, the Social Worker was to call or send out invitations for a care plan meeting with the interdisciplinary team. The MDS Coordinator stated she did not know why quarterly care plan meetings had not been held with Resident #62. There was no Social Worker available for an interview. In an interview with the Administrator on 4/8/2025 at 9:45 am, she explained after the Social Worker left the facility one and a half weeks ago, she was responsible for conducting care plan meetings. She stated she had conducted some care plan meetings over the phone until the new Social	F 657	Systemic Changes made to ensure that the deficient practice will not recur. The Social Services department will schedule the comprehensive care plan meeting for each resident as assigned quarterly, annually and with a significant change and distribute the care plan letter invitation to the resident and /or Responsible Party (RP). The Social Worker will discuss the assigned care plans during the Interdisciplinary Team (IDT) meeting. The Interdisciplinary Team (IDT) will review each care plan during care plan meeting with resident and/or Responsible Party (RP). The Social Worker (SW) will review and document via a log all scheduled care plan meetings weekly x4 weeks and then monthly x 3 months ensuring care plans are conducted quarterly, annually and with significant change with the resident and/or Responsible Party (RP). In-servicing was conducted by the Administrator on 5/5/24 with the Social Woker and other members of the Interdisciplinary Team (IDT) on the care plan meeting process to include mailing care plan invitations quarterly, annually and with significant change and including the resident and/or Responsible Party (RP) participation of the comprehensive care plan. Any newly hired staff will be educated on the requirement of comprehensive care plans as specified by the state and approved by CMS by the Administrator and/or the Director of Nursing during	

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F 657	Continued From page 10 Worker started in a week. In a follow up interview with the Administrator on 4/10/2025 at 4:39 pm, she stated there was no documentation of a care plan meeting for Resident #62 since 3/4/2024 and she had not conducted a care plan meeting with Resident #62. She stated care plan meetings were to be held after admission and after quarterly, annual, and significant change MDS assessments. She explained there had been seven different Social Workers, who were responsible for conducting care plan meetings in the last year, as the reason Resident #62 had not been invited to a care plan meeting and a care plan meeting had not been conducted since 3/4/2024.	F 657	orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Administrator will audit/review the scheduled care plan meetings log with the census and MDS schedule to ensure they are receiving a comprehensive care plan as assigned quarterly, annually and with significant change. Results of the audit/review will be presented by the Administrator to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and revision x 3 months or until substantial compliance is achieved. Date of compliance: 5/6/25	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff and resident interviews, the facility failed to provide care according to accepted professional standards when a nurse administered medication but did not observe the resident take her medications and left them at the bedside for 1 of 1 resident with medications observed at bedside (Resident #93).	F 658	F658 Services Provided Meet Professional Standards Corrective action for the residents found to be affected by the deficient practice. Resident #93 still resides in the facility An immediate sweep of resident rooms was conducted to ensure there were no	5/6/25

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F 658	Continued From page 11 Findings included: Resident #93 was admitted to the facility on 3/30/23. Her active diagnoses included bilateral primary osteoarthritis of the hip, muscle weakness, lymphedema, major depressive disorder, abdominal hernia, hypertension, anxiety disorder, iron deficiency anemia, gastro-esophageal reflux disease, insomnia, other pulmonary embolism, overactive bladder, vitamin D deficiency, pain in right shoulder, syncope and collapse, and prediabetes. Review of Resident #93's Minimum Data Set assessment dated 3/2/25 revealed she was assessed as cognitively intact. Review of Resident #93's electronic health record on 4/8/25 at 10:43 AM revealed there was no physician's order for self-administration of medications and no self-administration of medication assessment. During observation on 4/8/25 at 8:59 AM Nurse #11 was observed to enter Resident #93's room with a medication cup containing medications, a cup of water, and eyedrops. The nurse was heard telling the resident she would be back to check on Resident #93 in a while and left the items including the medications at bedside. During an interview on 4/8/25 at 8:59 AM Resident #93 stated new nurses would never leave medications at her bedside because they were supposed to watch her take it, Resident #93 did not take the medications during the observation but instead left them on her bedside table.	F 658	additional medications at bedside unless the self-administer medication policy/procedure had been implemented by Director of Nursing. Immediately for resident #93 it was determined resident did not want to self-administer medications by the Director of Nursing on April 10, 2025. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. Systemic Changes made to ensure that the deficient practice will not recur. All licensed staff/ licensed agency staff were educated by the Director of Nursing/designee on the requirements of F658; specifically on the importance of completing the self-administration assessment if applicable before any resident self-administer medication, this includes leaving medications at bedside for residents to take later. This education was completed on 5/6/25. On-going monitoring of items in the resident room by all staff to make sure items are secured in resident locked cabinet if applicable or in the medication cart. Any newly hired staff will be educated on the importance of completing the self-administration assessment if	

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F 658	Continued From page 12 During an interview on 4/8/25 at 9:02 AM Nurse #11 stated the resident was not allowed to take medications on her own and she should have taken the medications out of the room since the resident was not ready to take the medications yet instead of leaving the medications at bedside. She stated the medications she left at bedside were refresh tears, fluticasone propionate nasal spray 50 micrograms, Wellbutrin XL oral tablet extended release 24 hour 150 milligram tablet, Diphenhydramine HCl capsule 25 milligrams, ferrous sulfate oral tablet delayed release 325 milligrams, Rivaroxaban oral tablet 20 milligrams, pro-stat sugar free mixed in water 30 milliliters, Lyrica capsule 200 milligrams, acetaminophen oral tablet 975 milligrams, bumetanide tablet 2 milligrams, cetirizine tablet 10 milligrams, duloxetine capsule delayed release 60 milligrams, Gemtesa oral tablet 75 milligrams, Glycolax powder 17 grams in water, Singulair oral tablet 10 milligrams, and a Multivitamin tablet. During an interview on 4/8/25 at 3:06 PM the Director of Nursing stated Resident #93 was not ordered to self-administer medications and the nurse should have removed the medications when she left the room since the resident had not taken the medications.	F 658	applicable before any resident self-administer medication, this includes leaving medications at bedside for residents to take later as specified by the state and approved by CMS by the Administrator and/or the Director of Nursing during orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Nursing or designee will audit all new admissions and all in-house residents quarterly per MDS schedule for the self-administration assessment to ensure completion is appropriate. A self-administration audit tool was put in place to ensure all residents new and in-house were being monitored for compliance. The Director of Nursing will complete these audits three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. An environmental rounding tool was implemented; it includes checking residents' rooms for any medications that should be secure. The Director of Nursing will complete the environmental rounding and audit form three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement	

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F 658	Continued From page 13	F 658	(QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved. Date of compliance: 5/6/25	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to provide daily cholecystostomy (a surgical opening in the gallbladder to place a catheter for draining excess bile) dressings as ordered by the physician for a resident who had a biliary (a network of organs and vessels that make, store and transfer bile, a fluid the liver makes that helps digest food) tube inserted into the right upper abdominal wall for drainage of biliary fluid for 1 of 3 residents reviewed for professional standards of care (Resident #5). Findings included: Resident #5 was admitted to the facility on 9/24/2024 with diagnoses including chronic cholecystitis (persistent inflammation of the gallbladder) and an artificial opening of	F 684	F684 Quality of Care Corrective action for the residents found to be affected by the deficient practice. Resident #5 still resides in the facility. Resident #5 wound care was completed on 4/7/25, 4/8/25 and 4/10/25. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents with required wound care have the potential to be affected by the alleged deficient practice; none of the other residents were identified as being negatively impacted. Systemic Changes made to ensure that the deficient practice will not recur.	5/6/25

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F 684	Continued From page 14 gastrointestinal tract. Resident #5's care plan dated 9/25/2024 included a focus in the alteration in gastrointestinal status due to history of acute cholecystitis that was managed with a percutaneous cholecystostomy tube due to operative risks. The quarterly Minimum Data Set assessment dated 1/25/2025 indicated Resident #5 was severely cognitively impaired. Physician's orders dated 4/4/2025 for Resident #5 included an order to change the cholecystostomy dressing every twelve hours for skin integrity. Resident #5's April 2025 Medication Administration Record (MAR) recorded the cholecystostomy dressing had been changed by Nurse #13 on 4/6/2025 at 8:00 am and by Nurse #14 on 4/6/2025 at 8:00 pm. On 4/7/2025 at 1:02 pm, Resident #5's right upper abdominal dressing was observed dated 4/5/2025 as last changed. In a phone interview with Nurse #13 on 4/10/2025 at 2:46 pm, she stated she was assigned to Resident #5 on 4/6/2025 from 7:00 am to 3:00 pm. Nurse #13 stated she did not change the cholecystostomy dressing on 4/6/2025 as ordered and did not know why she did not change the dressing. In a phone interview with Nurse #14 on 4/10/2025 at 2:59 pm, she stated she was assigned to Resident #5 on 4/6/2025 from 3:00 pm to 11:00 pm. Nurse #14 stated she did not change the cholecystostomy dressing on 4/6/2025 and	F 684	All licensed staff/ licensed agency staff were educated by the Director of Nursing/designee on the importance of completing required wound care as ordered. Education completed as of 5/6/25. The Director of Nursing will observe wound care three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. Any newly hired staff will be educated on the importance of completing required wound care as ordered the Director of Nursing during orientation. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Nursing will observe wound care three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved. Date of compliance: 5/6/25	

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recorded on Resident #5's MAR for 4/6/2025 the cholecystostomy dressing was changed because there was a wound nurse in the facility on 4/6/2025 that would have changed the cholecystostomy dressing and she was unable to recall the name of the wound nurse on 4/6/2025.

In an interview with the Wound Nurse on 4/10/2025 at 11:01 am she stated she did not work on 4/6/2025 and there was a designated nurse to complete resident's wound care treatments and dressings on weekends when the Wound Nurse was not present in the facility. The Wound Nurse did not know what nurse was designated as the nurse to complete wound care treatments and change dressings on 4/6/2025.

In an interview with the Director of Nursing on 4/10/2025 at 4:14 pm, she was unable to identify the nurse assigned to change dressings and provide wound treatments on 4/6/2025.

Physician orders dated 4/7/2025 for Resident #5 included an order to change the dressing to the right biliary drain daily and as needed. The right biliary drain site was to be cleansed with normal saline with the application of a splint gauze that was secured with paper tape on the day shift and as needed.

Resident #5's April 2025 Treatment Administration Record (TAR) recorded the cholecystostomy dressing had been changed by the Wound Nurse on 4/7/2025, 4/8/2025 and 4/9/2025.

On 4/10/2025 at 10:53 am, the Wound Nurse was observed changing Resident #5's cholecystostomy dressing located in the right

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upper abdominal area. Resident #5's dressing was observed dated 4/8/2025 with initials of the Wound Nurse. Resident #5's cholecystostomy site was observed with no redness or drainage and the biliary tubing was sutured to the abdominal wall. The Wound Nurse was observed providing care to Resident #5's cholecystostomy site as physician ordered and applying a new dressing dated 4/10/2025 with the Wound Nurse initials.

In an interview with the Wound Nurse on 4/10/2025 at 11:01 am, she verified the date on Resident #5's cholecystostomy dressing that was removed during observation of cholecystostomy care was dated 4/8/2025. She explained that on 4/9/2025 when she went into Resident #5's room to change the dressing, she was informed by an unknown nurse aide that Nurse #11 had changed Resident #5's cholecystostomy dressing. The Wound Nurse explained she did not check Resident #5's cholecystostomy dressing to ensure the dressing had been changed or verify with Nurse #11 that she had changed Resident #5's cholecystostomy dressing and recorded on Resident #5's TAR the cholecystostomy care and dressing had been completed.

In an interview with Nurse #11 on 4/10/2025 at 2:10 pm, she explained on 4/9/2025 she looked at the sutures at Resident #5's cholecystostomy site and did not change Resident #5's cholecystostomy dressing. She stated there was miscommunication from the nurse aide to the Wound Nurse that Nurse #11 had changed the Resident #5's cholecystostomy dressing.

In an interview with Nurse Aide #1 on 4/10/2025 at 12:26 pm, she stated she informed the Wound

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F 684	Continued From page 17 Nurse on 4/9/2025 that Nurse #11 had changed Resident #5's cholecystostomy dressing. She explained she heard Nurse #11 say, "she was going to take care of this" while looking at the sutures and assumed Nurse #11 had changed Resident #5's cholecystostomy dressing. In an interview with the Director of Nursing on 4/10/2025 at 4:14 pm, she stated Resident #5's cholecystostomy dressing should have been changed daily per the physician's orders by the Wound Nurse or Resident #5's assigned nurse.	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and resident and staff interviews, the facility failed to administer supplemental oxygen as prescribed by the physician (Resident # 83), obtain a physician order on a resident's medical record for the use of a Bilevel positive airway pressure machine, a device that helps a person breathe by delivering pressurized air into the airways, (Resident # 296) and apply signage indicating no smoking, the use of oxygen outside the resident's room for 4 of 4 residents reviewed for oxygen use (Resident #83, #296, #101 and #49).	F 695	F695 Respiratory /Tracheostomy Care and Suctioning Corrective action for the residents found to be affected by the deficient practice. Resident #83 still resides in the facility. On 4/9/25 Resident #83 order was verified and the O2 was to 3 liters set per order. Resident # 101 no longer resides in the facility. Resident # 49 still resides in the facility.	5/6/25

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F 695	Continued From page 18 Findings included: 1. Resident #83 was admitted to the facility on 9/11/2024 with diagnoses including chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and chronic respiratory failure with hypoxia (low levels of oxygen in the body tissues). Resident #83's care plan dated 1/31/2025 included a focus for altered respiratory status and difficulty breathing related to exacerbation of CHF. Interventions included oxygen via nasal cannula at 1 to 6 liters per minute as needed for hypoxia and to wean (to gradually stop or using something) as tolerated to keep oxygen saturations greater than 88 percent (%). The quarterly Minimum Data Set (MDS) assessment dated 2/6/2025 indicated Resident #83 was cognitively intact and was receiving oxygen therapy. Physician orders dated 2/20/2025 included an order for oxygen at three liters per minute by nasal cannula to maintain oxygen saturation (measurement of how much oxygen present in the blood) greater than 88% every shift and to wean as tolerated. There were no further physician orders for oxygen in Resident #83's medical record after 2/20/2025. A review of Resident #83's April 2025 Medication Administration Record (MAR) recorded Resident #83 received 3 liters of oxygen via nasal cannula each shift from 4/01/2025 through 4/09/2025 and recorded oxygen saturations ranged from 96% to 100%.	F 695	Resident # 296 no longer resides in the facility. On 4/8/25 an order was obtained for resident # 296 to receive Bipap. On 4/10/25 residents #83, # 101, #49 and #296 all had the oxygen signage placed on the perimeter of threshold of doorway of room. Corrective action for other residents having the potential to be affected by the same deficient practice. On 4/10/25 the Director of Nursing audited all residents with oxygen, Bipap, CPap and respiratory equipment orders to ensure compliance of orders; resident rooms were then audited for proper signage on the perimeter of threshold of doorway of room. No adverse findings noted. Systemic Changes made to ensure that the deficient practice will not recur. The Director of nursing educated all nursing staff on the importance of oxygen, rate, signage, and respiratory equipment and following Physician orders. This education was completed on 5/6/25. The Director of Nursing will audit all residents with oxygen orders, Bipap, CPap and respiratory equipment three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. All the new nursing staff hired will be educated during orientation by the Director of Nursing to ensure	

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F 695	Continued From page 19 On 4/7/2025 at 11:35 am, Resident #83 was observed sitting on the side of the bed receiving oxygen by nasal cannula at four liters per minute. Resident #83 was observed with no signs or symptoms of respiratory distress. There was no signage observed outside Resident #83's door indicating no smoking/oxygen was in use in the room. In a phone interview on 4/10/20205 at 4:01 pm with Nurse #12, who was assigned to Resident #83 on 4/7/2025 from 7:00 am to 3:00 pm, she stated when she checked Resident #83's oxygen concentrator it was set at 3 liters per minute and Resident #83 adjusted the oxygen concentrator at times because Resident #83 had a pulse oximeter (a device that measures the oxygen saturation level of the blood) to checked her oxygen saturation. On 4/9/2025 at 8:38 am, Resident #83 was observed sitting on the side of the bed receiving oxygen at four liters per minute by nasal cannula. Resident #83 was observed with no signs or symptoms of respiratory distress. There was no signage observed outside Resident #83's door indicating no smoking, oxygen was in use in the room. In an interview with Nurse #11 on 4/9/2025 at 12:04 pm, she stated she had checked Resident #83's oxygen saturation on 4/9/2025 and it was 97% for the 7:00 am to 3:00 pm shift and she had not checked the oxygen concentrator setting for the 7:00 am to 3:00 pm shift. Nurse #11 stated based on the physician orders, Resident #83 oxygen concentrator should be set at three liters per minute and signage indicating no	F 695	understanding and importance of following Physician orders regarding oxygen. Plans to monitor its performance to make sure that the solutions are sustained. The Director of Nursing will audit oxygen orders, the rates being received, Bipap, Cpap, signage and respiratory equipment three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective. All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved. Date of compliance: 5/6/25	

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smoking/oxygen was in use should be posted outside Resident #83's door. She stated she had not recognized there was no signage for no smoking/oxygen in use outside Resident #83's door and stated any nursing staff could post the signage when oxygen was in use.

On 4/9/2025 at 12:08 pm, Nurse #11 was observed adjusting the oxygen concentrator that was observed set at four liters per minute to three liters per minute.

In an interview with Resident #83 on 4/9/2025 at 12:09 pm, Resident #83 stated the nursing staff adjusted the oxygen concentrator that controlled the amount of oxygen she received, and she did not adjust the oxygen concentrator herself. She explained she had her own personal pulse oximeter that she used to monitor her blood oxygen saturation.

In an interview with the Nurse #9 (Unit Manager) on 4/9/2025 at 5:10 pm, she stated she did not know why Resident #83 did not have a no smoking, oxygen in use signage on the door. She explained nursing staff should apply the oxygen in use/no smoking signage on admission or when any of the nursing staff recognized there was not a no smoking/oxygen in use signage outside Resident #83's door. She stated the nursing staff were responsible for monitoring the oxygen concentrator to ensure Resident #83 was receiving oxygen as ordered by the physician; to record the amount of oxygen Resident #83 received on the MAR each shift and she was not aware of Resident #83 adjusting the oxygen concentrator herself.

In an interview with the Director of Nursing (DON)

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on 4/10/2025 at 4:41 pm, she stated Resident #83 oxygen concentrator should be set at three liters per minute as ordered by the physician and signage for no smoking/oxygen in use should have been placed outside Resident #83's door.

2. Resident #296 was admitted to the facility on 4/3/25. Resident #296's diagnoses included acute and chronic respiratory failure with hypoxia (when the lungs struggle to transfer enough oxygen into the blood, leading to low oxygen levels in the body), pleural effusion (a condition where an excessive amount of fluid accumulates in the space between the lungs and the chest wall), chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung), and pneumonia (an infection of the lungs).

Resident #296's Minimum Data Set (MDS) information was unavailable at the time of the investigation.

Review of Resident #296's hospital discharge paperwork revealed a prescription for a Bilevel positive airway pressure machine (a device that helps a person breathe by delivering pressurized air into the airways) dated 4/3/25.

Review of Resident #296's physician's orders revealed there was no order for a Bilevel positive airway pressure machine.

Observations on 4/7/25 at 12:16 PM and 4/8/25 at 8:29 AM revealed Resident #296 was in his room and was sitting on the side of his bed. An oxygen concentrator and bilevel positive airway pressure machine were observed next to his bed and both were turned off. There was no signage

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

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outside Resident #296's room indicating oxygen was in use in this resident's room.

An interview was conducted with Resident #296 on 4/8/25 at 3:38 PM. Resident #296 stated the oxygen concentrator was for his bilevel positive airway pressure machine that he used during night.

An interview was conducted on 4/8/25 at 3:52 PM with Nurse #2 who indicated oxygen in use signage should be present on Resident #296's door. Nurse #2 confirmed that Resident #296's bilevel positive airway pressure machine order was not put in his electronic medical record (EMR) and should have been entered when he was admitted. Nurse #2 stated Resident #296 used his bilevel positive airway pressure machine at night.

An interview was conducted on 4/10/25 at 11:32 AM with the Director of Nursing (DON). She stated oxygen in use sign should have been placed on Resident #296's door at the time of admission. The DON further stated it was her expectation that oxygen orders and orders for bilevel positive airway pressure machines were entered into a resident's EMR by nursing staff.

3. Resident #101 was admitted to the facility on 11/25/24. Resident #101's diagnoses included chronic obstructive pulmonary disease (a condition caused by damage to the airways or other parts of the lung), malignant neoplasm of bronchus and lung (lung cancer), and dependence on supplemental oxygen.

Review of Resident #101's physician's orders revealed he had an oxygen order dated 11/25/24

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for oxygen supplementation at 2L (liters) via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) continuously.

Resident #101's quarterly Minimum Data Set (MDS) dated 3/13/25 revealed he was cognitively intact, and he was coded for oxygen therapy.

Observations on 4/7/25 at 12:57 PM and 4/8/25 at 8:29 AM revealed Resident #101 was in his room, sitting on his bed, wearing a nasal cannula for supplemental oxygen set at 2L per minute. There was no signage outside Resident #101's room indicating supplemental oxygen was in use.

An interview was conducted on 4/10/25 at 3:56 PM with Nurse #3 who stated residents who received oxygen should have an oxygen sign on their door.

An interview was conducted on 4/10/25 at 11:32 AM with the Director of Nursing (DON). She stated oxygen in use sign should have been placed on Resident #101's door at the time of admission.

4. Resident #49 was admitted to the facility on 10/15/24 with diagnoses which included acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood) and congestive heart failure.

Review of Resident #49's physicians' orders revealed she had an oxygen order dated 11/7/24 for oxygen at 2L (liters) via nasal cannula (a device that delivers extra oxygen through a tube and into the nose) at bedtime and as needed.

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F 695	Continued From page 24 Review of Resident #49's quarterly Minimum Data Set (MDS) dated 3/10/25 revealed she was cognitively intact and coded for oxygen therapy. Observations on 4/7/25 at 1:01 pm, 4/10/25 at 8:38 am, and 4/10/25 at 9:14 am revealed Resident #49 sitting in her wheelchair in the hall outside of her room wearing a nasal cannula for oxygen. There was no signage outside Resident #49's room indicating oxygen was in use. An interview was conducted on 4/10/25 at 9: 11 am with Nurse # 1 who stated residents who received oxygen should have an oxygen sign on their door. She further stated the oxygen sign was put on the door upon a resident's admission. During an interview on 4/10/25 at 9:15 am with the Director of Nursing (DON), she stated a sign was placed on a resident's door for any resident on oxygen upon admission. She further indicated that an oxygen sign should have been placed on Resident #49's door.	F 695		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		5/6/25

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F 755	Continued From page 25 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain a secure medication cart and accurate controlled medication records for 1 of 2 residents (Resident #301) reviewed for use of controlled medications. The findings included: Resident #301 was admitted to the facility on 7/11/2024 and was discharged on 10/24/2024. Review of the facility reported incident investigation dated 10/3/24 revealed the narcotic count for 100 hall was not correct the morning of 10/2/24 during narcotic reconciliation completed by the off going Nurse #4 and oncoming Nurse #5. The 100-hall cart was found to be missing 1	F 755	F755 Pharmacy Corrective action for the residents found to be affected by the deficient practice. Resident # 301 no longer resides in the facility. The Director of Nursing ensured the resident # 301 had all their medications and no issues with the drug diversion by medication reconciliation with current physician's order. This occurred on 10/1/24. The Director of nursing completed 100% narcotic reconciliation completed on 10/02/24 on all medication carts/ storage, no other issue found.	

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F 755	Continued From page 26 narcotic count sheet for oxycodone HCL (hydrochloride) for Resident #301. An investigation was initiated, all medication carts were audited, and the missing narcotic count sheet for Resident #301 was not found. On 4/9/25 at 12:17 PM an interview with the Director of Nursing (DON) was conducted. She stated the discrepancy with the narcotic count for the 100-hall cart was reported to her and an investigation was immediately started. The Administrator and Nurse #4's staffing agency were also notified. All medication carts were audited, and no additional missing narcotic count sheets were found. The DON stated that narcotic/medication cart keys were to be always kept with a nurse on their person. Two nurses are responsible for completion of the narcotic count at change of shifts: one outgoing and one oncoming nurse. She further stated any discrepancy found must be reported immediately and an investigation would be started. A telephone interview was conducted on 4/9/25 at 6:06 PM with Nurse #4 who stated she shared a medication cart with another nurse during her shift on 10/1/24-10/2/24. She could not recall the nurse's name or a description. She stated during her shift she took 2 breaks, and she left the narcotic keys on top of the narcotic/medication cart while she was gone. During the narcotic count with the oncoming Nurse #5, it was discovered that 1 narcotic count sheet for Resident #301 was missing from the cart. Nurse #4 could not explain why the sheet was missing. Review of Nurse #5's witness statement dated 10/2/24 indicated he arrived at the facility at approximately 7:00 AM and conducted the	F 755	Corrective action for other residents having the potential to be affected by the same deficient practice. All residents that have narcotics ordered have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted. Systemic Changes made to ensure that the deficient practice will not recur. The Director of Nursing or designee educated all licensed nurses, agency nursing staff and on new hire on how to properly document narcotics on MAR, narcotic sheet and progress notes, on properly securing cart, completing narcotic count per policy (also when on break). This education was completed on 5/6/25. The DON or designee will audit all narcotics reconciled every week and prn for 12 weeks, and bimonthly Medication cart/narcotic count audits. Audits include but are not limited to: • Medication carts locked and stored when not in use. • The narcotic drawer is always locked. • Containers of patient's medications labeled correctly, including the name of the patient, name of physician, name and address of pharmacy supplier, name and strength of each dose, serial number and date of prescription. Labels should be legible. • The Medication Cart is clean and	

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narcotic count with Nurse #4. A discrepancy was noted for a missing narcotic count sheet. This was reported to the Director of Nursing (DON).

An attempt was made to interview Nurse #5, however, was unsuccessful.

An attempt was made to interview Nurse #6 who worked with Nurse #4 from 11:00 PM on 10/1/24 through 7:00 AM on 10/2/24 but was unsuccessful.

On 4/10/25 at 11:05 AM an interview was conducted with the Pharmacy Consultant. She stated she was notified of the missing narcotic count sheet for Resident #301. She stated she reconciled all the medication carts after the incident. She further stated she regularly performed monthly random narcotic audits of medication carts and medication rooms. She stated she had no issues or concerns both before and after his incident.

An interview was conducted on 4/10/25 at 5:26 PM with Nurse #10 regarding receiving of narcotic stock. She stated narcotic medications are received from the pharmacy, counted and verified/confirmed the number of tablets were correct. The receiving nurse signed that the narcotics were received, locked them in the narcotic box in the medication cart, and placed the narcotic count sheet record in the narcotics book on the medication cart.

An interview was conducted with the Administrator on 4/10/25 at 5:06 PM. She stated her expectation was for the nursing staff to keep the narcotic drawer and medication cart locked at all times when not in use, medication cart keys on orderly.

- External use items should be stored separately from “Internal” use medications.
- Needles, syringes, hypodermic units and other Contaminated injectable equipment shall be placed, directly into a leak proof and rigid, puncture resistant containers.
- All stock items should be properly labeled.
- Medication room door locked.
- Narcotic count correct.
- Temps of freezer and refrigerator monitored.
- Cart keys/Narcotic key on nurse at all times.

Control Substance Random Audit completed by Pharmacist monthly.
All new nursing staff hired will be educated during orientation by the Director of Nursing to ensure understanding and importance on how to properly document narcotics on MAR, narcotic sheet and progress notes. Education on properly securing cart, completing narcotic count per policy (also when on break).

Plans to monitor its performance to make sure that the solutions are sustained.

The DON or designee will audit all narcotics reconciled every week and prn for 12 weeks, and bimonthly Medication cart/narcotic count audits. Pharmacist to complete the Control Substance Random Audits monthly. All findings of concern will be immediately addressed and

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F 755	Continued From page 28 nurses at all times, for nursing staff to count narcotics on the cart each shift, and both ongoing and oncoming staff sign off the narcotic count was completed and was correct. The facility presented a draft plan of correction for past noncompliance. Past noncompliance could not be substantiated due to the facility's failure to define the auditing and monitoring as related to ensuring narcotic count sheets present and accounted for and medication cart keys will be secured.	F 755	reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved. Date of compliance: 5/6/25	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		5/6/25

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

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

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

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

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F 842	Continued From page 30 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain a complete and accurate medical record when documenting cholecystostomy care for 1 of 31 residents who medical records were reviewed (Resident #5). Findings included: Resident #5's April 2025 Medication Administration Record (MAR) recorded the cholecystostomy dressing had been changed by Nurse #13 on 4/6/2025 at 8:00 am and by Nurse #14 at 8:00 pm. On 4/7/2025 at 1:02 pm, Resident #5's right upper abdominal dressing was observed dated 4/5/2025 as last changed. In a phone interview with Nurse #13 on 4/10/2025 at 2:46 pm, she stated she was assigned to Resident #5 on 4/6/2025 from 7:00 am to 3:00 pm and the documentation on Resident#5's MAR on 4/6/2025 that recorded she provided the scheduled 8:00 am cholecystostomy dressing change was inaccurate documentation. Nurse #13 stated she did not change Resident #5's cholecystostomy dressing on 4/6/2025 and should not have recorded the cholecystostomy dressing was changed when the care was not provided. In a phone interview with Nurse #14 on 4/10/2025 at 2:59 pm, she stated she was assigned to Resident #5 on 4/6/2025 from 3:00 pm to 11:00 pm. Nurse #14 stated she did not change the	F 842	F842 Resident Records – Identifiable Information Corrective action for the residents found to be affected by the deficient practice. Resident #5 still resides in the facility. Wound care completed on Resident #5 on 4/7/25, 4/8/25 and 4/10/25 and documented upon completion. Corrective action for other residents having the potential to be affected by the same deficient practice. All residents with required wound care have the potential to be affected by the alleged deficient practice; none of the other residents were identified as being negatively impacted. Systemic Changes made to ensure that the deficient practice will not recur. All licensed staff/ licensed agency staff were educated by the Director of Nursing/designee on the importance of completing required wound care and document upon completion as ordered to ensure accuracy in the resident record. This education was completed on 5/6/25 The Director of Nursing will observe wound care and audit documentation upon completion three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are	

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cholecystostomy dressing on 4/6/2025 scheduled at 8:00 pm and was only recording on Resident #5's MAR for 4/6/2025 at 8:00pm that the cholecystostomy dressing was changed by the Wound Nurse. Nurse #14 was unable to recall the name of the Wound Nurse on 4/6/2025 and stated she did not know how to document on the MAR when resident care was provided by another nurse.

Resident #5's April 2025 Treatment Administration Record (TAR) recorded the cholecystostomy dressing had been changed by the Wound Nurse on 4/7/2025, 4/8/2025 and 4/9/2025.

In an interview with the Wound Nurse on 4/10/2025 at 11:01 am, she verified the date on Resident #5's cholecystostomy dressing that was removed during observation of cholecystostomy care on 4/10/2025 was dated 4/8/2025. She explained that on 4/9/2025 when she went into Resident #5's room to change the dressing, she was informed by an unknown nurse aide that Nurse #11 had changed Resident #5's cholecystostomy dressing. The Wound Nurse explained she did not check Resident #5's cholecystostomy dressing to ensure the dressing had been changed or verify with Nurse #11 that she had changed Resident #5's cholecystostomy dressing and recorded on Resident #5's MAR the cholecystostomy care and dressing had been completed.

In an interview with Nurse #11 on 4/10/2025 at 2:10 pm, she explained on 4/9/2025 she looked at the sutures at Resident #5's cholecystostomy site and did not change Resident #5's cholecystostomy dressing. She stated there was

effective.
All new nursing staff hired will be educated during orientation by the Director of Nursing to ensure understanding and the importance of completing required wound care and document upon completion as ordered to ensure accuracy in the resident record.

Plans to monitor its performance to make sure that the solutions are sustained.

The Director of Nursing will observe wound care and audit documentation upon completion three times a week for three weeks, then weekly for two weeks and monthly for the following two months, to ensure the systemic changes are effective.
All findings of concern will be immediately addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the DON for review monthly x 3 months or until substantial compliance is achieved.

Date of compliance: 5/6/25

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miscommunication from the nurse aide to the Wound Nurse that Nurse #11 had changed the Resident #5's cholecystostomy dressing.

In an interview with Nurse Aide #1 on 4/10/2025 at 12:26 pm, she stated she informed the Wound Nurse on 4/9/2025 that Nurse #11 had changed Resident #5's cholecystostomy dressing. She explained she heard Nurse #11 say "she was going to take care of this" while looking at the sutures and assumed Nurse #11 had changed Resident #5's cholecystostomy dressing.

In an interview with the Director of Nursing on 4/10/2025 at 4:14 pm, she stated Resident #5's cholecystostomy dressing change should be accurately documented on Resident #5's MAR and TAR when cholecystostomy care was provided. She stated the Wound Nurse, Nurse #13 and Nurse #14 were not to document on the MAR and TAR cholecystostomy care was provided if they did not provide the cholecystostomy care.