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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Rehabilitation and Healthcare Center	6000 Fayetteville Road Durham, NC 27713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 13289 Based on record review and interviews with residents, staff, physician assistant, and pharmacists, the facility failed to ensure antibiotics were available for the nurses who were responsible for administering the antibiotics. This resulted in a delay of over 24 hours in initiating antibiotic therapy for two residents (Residents # 5 and # 6) out of five sampled residents whose medications were reviewed. The finding included: 1. Resident # 6 was admitted to the facility on [DATE]. According to Resident # 6's 5/17/24 hospital discharge summary, Resident # 6 had been hospitalized from 5/10/24 until 5/17/24 secondary to an infection of her left prosthetic knee joint. While hospitalized the resident underwent knee surgery and was followed by an infectious disease physician. Upon discharge from the hospital on 5/17/24, the resident was ordered to receive the antibiotic cefazolin intravenously every eight hours through the date of 6/21/24. Review of the discharging hospital's Medication Administration Record for the date of 5/17/24 revealed Resident # 6 last received the cefazolin at 8:35 AM on 5/17/24 at the hospital before being discharged . Review of facility admission orders revealed the order for cefazolin intravenously every eight hours was initiated in the electronic medical record on 5/17/24 at 3:04 PM. Review of Resident # 6's May 2024 Medication Administration Record (MAR) revealed the cefazolin was scheduled to be administered at 6:00 AM, 2:00 PM, and 10:00 PM. Further review of the MAR and electronic administration notes revealed the following information. There were no doses administered on 5/17/24. An x mark appeared by the 10:00 PM dose on 5/17/24. On 5/18/24 at 6:00 AM Nurse # 1 entered a 9 on the MAR by the cefazolin administration time. At 8:02 AM Nurse # 1 entered a note explaining the 9, which noted the medication was on order. On 5/18/24 at 2:00 PM Nurse # 2 entered a 9 on the MAR. At 2:06 PM Nurse # 2 entered a medication administration note explaining the 9, which noted the facility was awaiting the delivery of the cefazolin from the pharmacy. (continued on next page)

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

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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Rehabilitation and Healthcare Center	6000 Fayetteville Road Durham, NC 27713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/18/24 at 10:00 PM Nurse # 2 documented the first administration of the cefazolin. Resident # 6 was interviewed on 5/23/24 at 12:33 PM and reported the following information. She was admitted on [DATE] (Friday) and did not feel the facility was ready for her. She was supposed to get IV antibiotics and the antibiotics were not started until very late the following day. She was concerned about the length of time it took for the facility to get her antibiotics. Nurse # 2 was interviewed on 5/23/24 at 5:20 PM and reported the following information. She had worked on 5/18/24 (Saturday). The cefazolin had not been sent by the pharmacy on Friday when the resident was admitted . The nursing supervisor had called the pharmacy on 5/18/24 (Saturday). The pharmacy had told the supervisor they had sent the antibiotic on 5/17/24 (Friday). In turn, the supervisor told the pharmacy that it was not at the facility, and the facility still needed the antibiotic. The pharmacy said they would send it. Nurse # 2 further reported she was almost finished with her 3:00 to 11:00 PM shift on 5/18/24 when she saw the pharmacy courier deliver medications. The cephazolin doses, which should have been sent on 5/17/24 (Friday) were in the box when it was opened. Resident # 6 received her first cefazolin antibiotic near 11:00 PM on 5/18/24 (Saturday). The weekend nursing supervisor was interviewed on 5/24/24 at 10:15 AM and reported the following information. On 5/18/24 they looked everywhere in the facility for the cefazolin and found it had not been delivered to the facility on [DATE]. She had called the pharmacy on 5/18/24 (Saturday). She talked to the pharmacy and the pharmacy said they had already sent the cefazolin. When told that it was not at the facility, the pharmacy agreed they would deliver it again. It did not come in during the daytime. She called the on-call provider who said the cefazolin could be placed on hold until the facility could obtain the antibiotic. The DON (Director of Nursing) and facility corporate employee were interviewed on 5/24/24 at 2:45 PM and reported the following information. When a resident is anticipated to arrive, the orders are obtained before their arrival and placed in the computer. The orders are waitlisted until the resident arrives at the facility. They had researched Resident # 6's arrival time, and reported it was around 5:00 PM on 5/17/24. The antibiotic had not arrived from the pharmacy on 5/17/24. They had checked with Resident # 6's infectious disease physician who felt the missed doses were not significant and did not want to extend the number of doses the resident would receive due to the delay in starting it at the facility. (continued on next page)

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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Rehabilitation and Healthcare Center	6000 Fayetteville Road Durham, NC 27713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Director of the facility's pharmacy and another facility pharmacist were interviewed via phone simultaneously on 5/24/24 at 5:55 PM. The pharmacists reported the following information. They deliver twice to the facility on Monday through Friday. They deliver once on Saturday and Sunday. They have an on-call pharmacist who triages whether special deliveries need to be sent to facilities outside of scheduled deliveries. The pharmacists refer to the deliveries as launches. Weekday orders received by 11:00 AM are launched by them to the facility at 2 PM. Weekday orders received by the pharmacy by 7:30 PM are launched at 9:30 PM to the facility. On Saturday and Sunday their launch time is 7:30 PM daily. During a launch the medications are picked up by a third -party contracting courier who is responsible for delivering them to facilities. The pharmacy's computer system showed that the pharmacy received Resident # 6's cefazolin antibiotic order at 3:39 PM on 5/17/24. The order was filled and the cefazolin was placed in the pharmacy tote for delivery to the facility at 5:26 PM on 5/17/24 (Friday) and should have been delivered that night or in the early morning hours of 5/18/24 to the facility. Their paperwork showed that the cefazolin antibiotic had not been dropped off by the courier to the facility although it was in the tote on 5/17/24 (Friday). The first time the pharmacy records showed a phone call from the facility about the missing cefazolin was on 5/18/24 (Saturday) at 2:17 PM. The cefazolin was sent Saturday night again by the pharmacy to the facility. As of the time of the 5/24/24 interview, the pharmacists did not know what the problem had been which contributed to the cefazolin not being delivered on 5/17/24. An attempt was made to talk to Resident # 6's infectious disease physician without a return call received. 2. Resident # 5 resided at the facility from 2/16/24 until her discharge home on 4/29/24. Resident # 5's admission Minimum Data Set assessment, dated 4/19/24 coded the resident as cognitively intact. Review of Physician Assistant notes revealed a note on 4/26/24 (Friday) noting the resident was complaining of pus draining from her right ear since the previous day. On 4/26/24 at 3:59 PM an order was entered into the electronic record for Resident # 5 to receive ofloxacin otic solution 10 drops in the right ear one time a day for otitis media. Review of Resident # 5's April 2024 Medication Administration Record (MAR) revealed the ofloxacin ear antibiotic was scheduled to be administered at 8:00 PM on a daily basis. On 4/26/24 an x was by the 8:00 PM ofloxacin administration. On 4/27/24 Nurse # 3 documented a 9 by the 8 PM ofloxacin administration. On 4/27/24 at 7:52 PM, Nurse # 3 entered a medication administration note explaining the 9, which noted she was still awaiting the medication from the pharmacy. Nurse # 3 could not be reached for interview during the survey. On 4/28/24 (Sunday) at the 8 PM dosage time, Resident # 5 was documented to receive her first dose of the ofloxacin solution. (continued on next page)

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	05/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpoint Rehabilitation and Healthcare Center	6000 Fayetteville Road Durham, NC 27713

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/24 Resident # 5 was seen by the physician's assistant who noted the following information. The resident was continuing to complain of ongoing pus draining from her right ear. She had been prescribed the antibiotic ear drops but they had not come in from the pharmacy until 4/28/24. Resident # 5 was interviewed via phone on 5/23/24 at 2:58 PM and reported the following information. Her ear had started draining on 4/25/24 (Thursday). She had spoken to the physician's assistant the following day (Friday). She was supposed to get antibiotic ear drops but only received them one time before her discharge date of [DATE]. The one time she received them was on 4/28/24 (Sunday). She had been concerned about the length of time it took to get the ear drops. Resident # 5's physician's assistant was interviewed on 5/24/24 at 9:40 AM and reported the following information. He had used an otoscope to view Resident # 5's ear while she resided at the facility with the ear problem. She was having drainage, but her ear drum was okay. Her hearing was intact, and she had not shown signs of systemic infection. Her cognition was intact, and therefore he felt she would accurately recall details of when the ear drops were initiated. According to a packing slip of medications delivered to the facility from the pharmacy on 4/26/24 at 9:00 PM, the ofloxacin had been delivered to the facility on [DATE]. During an interview with a facility corporate employee and Administrator on 5/24/24 at 6:50 PM, the facility's system is that the packing slip is checked by a nurse when the medications are delivered. The nurse is to ensure the medications are actually in the delivery and signs that they are so. According to their records, the medication had been delivered by the pharmacy on 4/26/24.