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	04/10/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 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 #300). The findings included: Resident #300 was admitted to the facility on [DATE]. She was discharged on [DATE]. 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 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. (continued on next page)

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

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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). 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 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. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 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 assessment were reviewed (Resident #75). Findings included: Resident #75 was admitted to the facility on [DATE] 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 [DATE] 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 [DATE] 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. 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.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 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 [DATE]. 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 [DATE] indicated Resident #62 was cognitively intact. 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 faciity on e 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 Worker started in a week. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37468 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). Findings included: Resident #93 was admitted to the facility on [DATE]. 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 [DATE] 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. 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.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 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 [DATE] with diagnoses including chronic cholecystitis (persistent inflammation of the gallbladder) and an artificial opening of 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 [DATE] 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41387 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). Findings included: 1. Resident #83 was admitted to the facility on [DATE] 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 [DATE] 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%. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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) 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. 49159 2. Resident #296 was admitted to the facility on [DATE]. 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. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 [DATE]. 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 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 [DATE] 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. 49502 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #49 was admitted to the facility on [DATE] 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. Review of Resident #49's quarterly Minimum Data Set (MDS) dated [DATE] 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.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 49159 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 [DATE] and was discharged on [DATE]. 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 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 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 41387 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 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 miscommunication from the nurse aide to the Wound Nurse that Nurse #11 had changed the Resident #5's cholecystostomy dressing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.