STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425361	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southpointe Healthcare and Rehabilitation	35 Southpointe Drive Greenville, SC 29607

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on facility policy review, record review, observation, and interview, the facility failed to ensure staff provided nail care to residents unable to carry out activities of daily living (ADLs), which affected 1 (Resident (R)87) of 2 residents reviewed for ADL assistance. Findings included: Review of a facility policy titled, Activities of Daily Living, Optimal Function, revised 05/05/2023, indicated, The Facility provides necessary care to all residents that are unable to carry out activities of daily living on their own to ensure they maintain proper nutrition, grooming, and hygiene. Review of a Resident Face Sheet revealed the facility admitted R87 on 02/09/24. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of depression, chronic obstructive pulmonary disease, hypotension, and unspecified intellectual disabilities. An Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/15/2026, revealed R87 had a Brief Interview for Mental Status (BIMS) score of 9, which indicated the resident had moderate cognitive impairment. The MDS indicated that the resident required partial/moderate assistance for showering or bathing and required supervision or touching assistance for personal hygiene. R87's Care Plan, included a problem statement initiated 02/22/24, that indicated the resident required assistance with ADLs related to their intellectual disability and mobility impairment. Interventions initiated 02/22/24 directed staff to provide assistance with bathing and personal hygiene as needed with one to two staff members. During an interview on 03/23/26 at 9:43 AM, R87 stated that the nails on their thumb and fifth digit (little finger) on their left hand were longer than they wanted. The resident stated that their nails had been breaking off. An observation at this time revealed the resident had seven fingernails that were jagged, and three nails that were approximately 0.5 centimeters (cm) to 1 cm past their fingertip. An observation on 03/25/26 at 9:35 AMˆrevealed no change in R87's nails. During an interview at that time, the resident stated facility staff had not come to cut them. R87's electronic health record revealed staff documented that R87 received a bath on the following dates: - 03/22/2026 by Certified Nurse Aide (CNA)5 - 03/23/2026 by CNA6 - 03/25/2026 by CNA5 During an interview on 03/25/26 at 12:49 PM, CNA5 stated that she offered residents nail care daily when she got them up as well as when providing a bed bath or shower. She stated that she last provided nail care to the resident on 03/23/26 during a bed bath. CNA5 observed Resident #87's nails and stated that she thought they looked the same as they did on 03/23/26. R87 stated at this time that their nail on their fifth digit hurt them. CNA5 stated that they would cut the nail shorter that day. She stated that she thought the resident preferred to have longer nails. During an interview on 03/25/26 at 1:54 PM, CNA6 stated that nail care was provided every Sunday, when a resident requested, or if staff noticed nails being too long or having dirt under them. She stated that nail care was also provided when baths were provided if they needed it. She stated that she did not think R87 liked having long nails; she said she thought the resident preferred them short. CNA6 stated that she bathed the resident on 03/23/26 but did not remember what the resident's nails looked like. CNA6 stated that the provision of nail care was important so that residents did not cause an injury to themselves. On 03/25/26 at 2:35 PM, Licensed Practical Nurse (LPN)7 stated that she had taken care of the situation and cut R87's nails. During a follow up interview on 03/26/26 at 8:28 AM, LPN7 stated that R87 had several nails that were few centimeters long.ˆShe stated that resident nail care was provided with (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showers or if the nursing staff saw it in passing. She stated that she was a unit manager and expected nursing staff to check daily on if there was any need for nail care and if so, to provide it. She stated she would not want a resident to end up cutting themselves.ˆShe stated that situations that would necessitate nails to be trimmed included if the resident's nails were long or dirty, if a resident said their nail was hurting, if they had a hang nail, or if the resident asked.ˆ During an interview on 03/26/26 at 2:31 PM, the Director of Nursing (DON) stated she expected nursing staff to provide nail care when providing a shower or bed bath, or if the staff noticed long nails or dirty nails. She stated that if a resident was demented and there was a risk of harm by scratching oneself, she expected nails to be trimmed. The DON stated that if a resident was cognitively intact, then she expected their preference for nail length to be documented on the care plan. Per the DON, it was a part of ADL care.ˆShe stated that staff talked to her about R87's nails being a little long during the survey. She stated she directed them to start on nail care because staff reported to the DON that the surveyors were asking about nail care.ˆ During an interview on 03/26/26 at 3:06 PM, the Administrator stated that he expected facility staff to provide nail care as part of their routine. He stated that he expected them to identify if the resident's nails were dirty and long, and if so, to trim them. He stated that this was important because it could lead to ingrown nails, or the resident's nails snagging on their own skin.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were free from significant medication errors, which affected 1 (Resident (R)10) of 8 residents reviewed for medication administration. Findings included: A facility policy titled, Medication Management Program, revised 05/05/25, revealed, The Facility implements a Medication Management program to meet the pharmaceutical needs of patients and residents, according to established standards of practice and regulatory requirements.ˆThe policy alsoˆindicated, Preparing for Medication Pass included, 4. Authorized staff must understand: A. Indications or reason for therapy, B. Effectiveness for achievingˆtherapeuticgoalˆ[sic], C. Drug actions, and D. The ?8 Rights' for administering medication, which included 1) The Right Patient/Resident, 2) The Right Drug, 3) The Right Dose, 4) The Right Time, 5) The Right Route, 6) The Right Charting, 7) The Right Results, and 8) The Right Reason.ˆThe policyˆrevealed, Administering the Medication Pass included, 5. The authorized staff memberˆvalidatesˆthe following informationˆis documentedˆon the MAR [medication administration record], which included, A. Correct physician's order and diagnosis for each medication and B. Medication and label are correct. The policy continued, 6. The authorized staff member reads the label on the medication three (3) times, which included, A. Before removing the medication from the drawer, B. Before dispensing the medication, and C. After dispensing the medication.ˆ A Resident Face Sheet revealed the facility admitted R10 on 03/14/25. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of pain, personal history of pulmonary embolism (a blood clot in a lung causing blockage of blood flow), paroxysmal atrial fibrillation (an intermittent irregular heartbeat that can last up to seven days), difficulty walking, muscle weakness, and abnormalities of gait and mobility. A significant change Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/26/26, revealed R10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated that the resident received a scheduled pain medication regimen and experienced occasional pain over the five days prior to the MDS assessment. R10's Care Plan included a focus area revised 03/19/26, that indicated the resident was at risk for pain related to a kidney stone and chronic pain related to fibromyalgia. Interventions initiated 03/14/25 directed staff to administer medications as ordered, monitor and record effectiveness, and report adverse side effects. The Care Plan also included a focus area revised 02/09/26, that indicated the resident was prescribed anticoagulant therapy with a history of pulmonary embolism and a history of deep vein thrombosis (a blood clot in one or more of the deep veins in the body). Interventions initiated 03/14/25 directed staff to administer anticoagulant medication as ordered, evaluate and record effectiveness, evaluate and report adverse side effects, and observe for signs of active bleeding. R10's Physician Order Report, for the timeframe from 03/01/26 to 03/26/26, contained an order, dated 12/23/25, for acetaminophen (an analgesic) 325 milligrams (mg), two tablets by mouth every eight hours for pain. The Physician Order Report also contained an order, dated 01/22/26, for apixaban (an anticoagulant) 5 mg, one tablet by mouth twice a day for paroxysmal atrial fibrillation. During an observation of medication administration on 03/25/26 at 7:45 AM, Licensed Practical Nurse (LPN)3 prepared medication to administer to Resident #10, which included removing two 325 mg tablets of aspirin (an antiplatelet medication) from the medication cart. LPN3 entered R10's room and handed the cup of medications to the resident. Prior to R10 taking the medications, the surveyor requested LPN3 to verify the resident's medication orders. LPN3 took the cup of medications from R10 and exited the room to review the resident's medication orders. LPN3 reviewed R10's medication orders and verified that the resident was ordered to receive two 325 mg tablets of acetaminophen, not two 325 mg tablets of aspirin. LPN3 stated that he normally verified the medication order by verifying the right dose, for the right resident, at the right time, the right medication, and the right route prior to administering a medication to a resident. R10's Physician Order Report, for the timeframe from 03/01/26 to 03/26/26, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed no order for aspirin. During a telephone interview on 03/27/26 at 10:07 AM, the Consultant Pharmacist (CP) stated medication errors occurred when nursing staff administered the wrong medication, the wrong dose of a medication, administered a medication outside of the ordered time, or several other factors. The CP stated there could potentially be an adverse reaction if a resident who was on apixaban was administered a dose of aspirin because the two medications were contraindicated in most cases. The CP stated that if a resident who was on apixaban was administered 650 mg of aspirin in error, he would consider it to be a significant medication error because it would require nursing staff to contact the resident's physician and a need for monitoring of potential increased bleeding or bruising issues for seven to 10 days. During an interview on 03/27/26 at 11:01 AM, the Director of Nursing (DON) stated that if a resident received a 650 mg dose of aspirin in error, she would consider it to be a significant medication error because it would increase the resident's likelihood of bleeding issues or a change in the resident's condition. During an interview on 03/25/26 at 3:28 PM, the DON stated nursing staff were educated to verify the five rights of medication administration, which included the right patient, right route, right time, right dose, and right medication when administering medications to a resident. The DON stated a medication error could occur if nursing staff did not follow the rights of medication administration when administering medications to residents. During an interview on 03/26/26 at 3:09 PM, the Administrator (ADM) stated he expected nursing staff to follow the physician's orders and follow the rights of medication administration that they were educated on. The ADM stated that a medication error could occur if the nursing staff did not follow the rights of medication administration.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on facility policy review, record review, observation, and interview, the facility failed to ensure staff provided food that accommodated residents' food allergies and preferences, which affected 1 (Resident (R)110) of 1 resident reviewed for food concerns. Findings included: A facility policy titled Food Preferences; Diet History, revised 10/15/25, indicated, Food Preferences will be completed upon admission for each patient/resident and documented in the medical record. The policy indicated Procedures included, D. If the preference list is not completed on or prior to admission, the Certified Dietary Manager (CDM) or designee reviews and updates food preferences with the patient/resident within 72 hours of admission as part of the initial patient/resident visit and documents in the medical record, and G. The CDM refers to the preferences list when making the tray ticket and when collecting data. A Resident Face Sheet indicated the facility admitted R110 on 03/03/26. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of constipation, type 2 diabetes mellitus, heart disease, gastro-esophageal reflux disease (GERD), and dementia. The Resident Face Sheet indicated R110 had an intolerance to dairy, milk, and peppermint. R110's hospital After Visit Summary, dated 03/03/26, indicated R110 had allergies that included corn-containing products, milk-containing products (dairy), and mint flavor. An admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 03/09/26, indicated R110 had a Brief Interview for Mental Status (BIMS) of 14, which indicated the resident had intact cognition. The MDS indicated that R110 had clear speech and was usually able to make themself understood. R110's Care Plan included a problem statement initiated 03/03/26, that indicated the resident was at nutritional risk related to dementia, diabetes mellitus, seizure disorder, altered mental status, and heart disease. Interventions directed staff to honor the resident's food preferences as feasible (likes/dislikes/food allergies). R110's Nutritional Assessment, completed 03/08/26, indicated that the assessment was completed based on a medical record review. Per the assessment, R110 had food allergies that included dairy, milk, and peppermint. The Nutritional Assessment revealed no food preferences were noted. The Nutritional Assessment included interventions, which included honoring the resident's food preferences as able and omitting listed allergens from the resident's diet. During an interview on 03/23/26 at 7:41 AM, R110 stated that breakfast was not good because they had food allergies and the facility was not paying attention to their allergies. R110 stated that their caregiver had notified the facility of their allergies, but nothing was done about it. During an observation and interview on 03/23/26 at 1:12 PM, R110's lunch tray included chicken tenders, dinner roll, creamed corn, and fruit cobbler. R110 stated they could not eat corn. An observation on 03/25/26 at 7:59 AM revealed R110's breakfast tray included oatmeal with brown sugar, a biscuit or roll with cream sausage gravy, and juice. During an interview at that time, R110 stated they could not eat the oatmeal because there was sugar in it. During an interview on 03/25/26 at 1:18 PM, the Dietary Manager (DM) stated she was in the process of linking allergies to recipe ingredients that were in the electronic tray card program so the system would correctly identify any food allergies and remove the food from a resident's tray card. The DM stated she met with residents when they were admitted in order to obtain food preferences or when they had concerns. The DM stated that when she updated a care plan, she indicated that the facility honored resident food preferences. The DM stated that nursing staff entered any food allergies into the medical record. The DM stated she had not met with Resident #110 to obtain food preferences. The DM stated that R110 should not have had the creamed corn if the resident was allergic to corn. During an interview on 03/26/26 at 1:34 PM, Licensed Practical Nurse (LPN)1 stated that if a resident received a food item they did not like, she would get them a substitute and report it to the DM so the DM could meet with the resident to update their food preferences. During an interview on 03/26/26 at 1:44 PM, Registered Nurse (RN)2 stated that the certified nurse aides (CNAs) checked the meal trays for accuracy but may not always know what they (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were looking for. RN2 stated if a resident did receive something listed as an allergy, she would remove it immediately and notify the DM. RN2 stated if a resident received something that they did not like on their tray, she would get them a substitute. RN2 stated that if a resident continued to receive items they did not like, it could lead to weight loss. During a telephone interview on 03/26/26 at 10:56 AM, the Registered Dietitian (RD) stated she started working for the facility one week prior and had not had a chance to meet with R110. The RD stated that she expected the DM to meet with new residents within 48 hours of admission to obtain food preferences and enter the preferences into the tray card program. The RD stated residents should not receive any food item that was listed as an allergy, and the facility tried to honor food preferences as much as possible. During an interview on 03/26/26 at 2:40 PM, the Director of Nursing (DON) stated that if a resident had food allergies, she expected the allergies to be entered on the resident's profile so that all staff would be aware of it. The DON stated that the CNAs checked the meal trays for accuracy. The DON stated that if a resident communicated food preferences to staff, the staff member should communicate those preferences to the DM. The DON stated that if a resident received food that they were not going to eat, it could lead to weight loss. During an interview on 03/26/26 at 3:04 PM, the Administrator (ADM) stated the DM should meet with residents upon admission and as needed to update food preferences. The ADM stated he expected resident food allergies and preferences to be care planned and followed. The ADM stated that food was important to residents, and if they received things they did not like, it could lead to weight loss.