STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	2401 Wayne Memorial Drive Goldsboro, NC 27534

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Physicians, and Nurse Practitioner, the facility staff failed to consult with the physician when a resident's fingerstick blood sugar result was 509. (A normal fasting blood sugar is typically 70 to 99 and a normal non-fasting blood sugar is typically less than 140. A blood sugar reading over 400 is considered severe hyperglycemia and can be a medical emergency). This was for 1 of 3 residents reviewed for notification to the physician (Resident # 2). The findings included:Review of Resident # 2's hospital Discharge summary, dated [DATE], revealed the following information. Resident # 2 was hospitalized from [DATE] until 4/23/26. Resident # 2 had a history of prior stroke and trigeminal neuralgia (chronic neuropathic pain condition that causes sudden, severe, electric shock-like or stabbing pain in the face). She was hospitalized on [DATE] secondary to worsening weakness and dysphagia (trouble swallowing). Resident # 2 was examined and found to have difficulty managing her own secretions and unable to swallow applesauce. In addition to dysphagia, Resident # 2 also had dysarthria (trouble speaking) secondary to her trigeminal neuralgia, and it was difficult to obtain information from her. While hospitalized , Resident # 2 underwent gastrostomy tube placement (tube inserted through the wall of the abdomen directly into the stomach) for her dysphagia with plans for follow up at another hospital for specialized surgery to address her trigeminal neuralgia. She was to receive her nutrition by means of the gastrostomy tube. Resident # 2 additionally had a diagnosis of diabetes. The hospital discharge summary further included the following information. Upon discharge, Resident # 2 was ordered to receive metformin 1000 mg (milligrams) twice per day (a diabetic medication). She was also ordered to receive Insulin Lispro 5 units three times per day. (Insulin lispro is a fast-acting insulin which typically starts working within 15-30 minutes after administration, peaks in about 1 hour, and lasts for 3-5 hours.) The discharge summary noted Resident # 2 should pause another insulin which she had been receiving until her future medical provider directed her to start taking the paused insulin. The paused insulin was insulin glargine 30 units every morning. (Insulin glargine is a long-acting insulin which is prescribed to help manage blood glucose levels in diabetic individuals by providing a steady release of insulin that lasts for 24 hours.) Resident # 2 was discharged on 4/23/26 for care at the facility.Record review revealed Resident # 2 resided at the facility for four days in April 2026 (4/23/26 to 4/26/26).Review of 4/23/26 facility admission orders revealed orders for Metformin 1000 mg (milligrams) via gastrostomy tube two times per day and Humalog 5 units subcutaneously three times per day. Additionally, the resident was ordered to receive all her nutrition by way of an enteral feeding.Review of Resident # 2's April 2026 MAR (Medication Administration Record) revealed with each Humalog 5 units of insulin administration the resident's fingerstick blood sugar was checked. Results on 4/24/26 and 4/25/26 were documented as follows:4/24/26 at 6:00 AM- 2914/24/26 at 12:00 PM- 2474/24/26 at 6:00 PM- 3034/25/26 at 6:00 AM- blank4/25/26 at 12:00 PM- 2204/25/26 at 6:00 PM- 509 (documented by Nurse # 1) Review of 4/25/26 and 4/26/26 nursing notes revealed no documentation the physician was contacted regarding the 6:00 PM fingerstick blood sugar on 4/25/26. Nurse # 1 had cared for Resident # 2 from 7:00 AM to 7:00 PM on 4/25/26. Nurse # 1 was interviewed on 6/10/26 at (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9:49 AM and reported the following information. She did not call the physician about the fingerstick blood sugar result of 509 and she did not retake the blood sugar after giving the scheduled insulin. At the time that Resident # 2's blood sugar registered 509, Resident # 2 appeared alert, talking, and without symptoms. Resident # 2 did say her mouth was dry, but she (the nurse) attributed that to the resident being on an enteral feeding and not having anything by mouth. The reason she did not recheck the blood sugar and call the physician was because the resident was not showing any symptoms or problems and she knew Resident # 2 had received some insulin. Since 4/25/26, she (the nurse) had received education that she should have called the physician, and she should have rechecked the resident's blood sugar. On 4/26/26 at 12:00 AM Nurse # 2 initialed on Resident # 2's MAR she administered Resident # 2's scheduled bolus enteral feeding of 300 ml (milliliters) of Diabetasource (tube feeding formula). On 4/26/26 at 6:00 AM Nurse # 2 initialed again that she administered Resident # 2's scheduled bolus enteral feeding of 300 ml of Diabetasource. Nurse # 2 also documented on the MAR that Resident # 2's fingerstick blood sugar was 233 at 6:00 AM and she initialed the scheduled Humalog Insulin 5 units was administered at 6:00 AM. Nurse # 2, who cared for Resident # 2 from 7:00 PM on 4/25/26 until 7:00 AM on 4/26/26, was interviewed on 6/10/26 at 12:31 PM and reported the following information. She (Nurse #2) did not recall specifics of a report during shift change. She did not recall any problems the resident had which would have caused her to call the physician during her shift. Resident # 2 had been alert at the beginning of the shift. The resident's only complaint was that since admission she had not been able to sleep at night, which the resident reported was due to being new to the facility. She had requested not to be disturbed earlier than 6:00 AM so that she could get some rest. Nurse # 2 did not recall any specifics of how the resident was when she gave the enteral feeding at 12:00 AM. To honor her request to get more sleep, she (Nurse # 2) had not disturbed her earlier than 6:00 AM for the 6:00 AM enteral feeding, fingerstick blood sugar, and insulin. At that time, Resident # 2 could barely open her eyes, but she (the nurse) did not think that was unusual given that Resident # 2 had reported she had not slept for two nights. A lot of her residents, who had blood sugar checks between 5:00 AM and 6:00 AM would keep their eyes closed, stick out their hand when it was explained what she was going to do, and continue to keep their eyes closed due to being sleepy. That is how she recalled Resident # 2. Resident # 2 did jerk back her hand when her finger was pricked for the blood sugar. She did not react to the insulin administration but that was not unusual for her either. Her skin was not cold or sweaty. That was the only blood sugar check she recalled doing that shift and the result had not been unusual for the resident. Nurse Aide (NA) # 1 cared for Resident # 2 beginning at 11:00 PM on 4/25/26 until 7:00 AM on 4/26/26. NA # 1 was interviewed on 6/10/26 at 11:38 AM and reported the following information. Resident # 2 was still awake at 11:00 PM when she first started caring for her. At that time the resident was alert and reported she did not need anything. Around 4:30 AM to 5:00 AM, Resident # 2 rang her call bell and requested a sip of water and to be assisted up in bed. She (NA # 1) provided incontinence care and helped Resident # 2 reposition further up in the bed. The resident appeared okay. Her last check was at the end of the shift and Resident # 2 appeared to be sleeping at that time and was not disturbed. NA # 2 was assigned to care for Resident # 2 on 4/26/26 beginning at 7:00 AM and was interviewed on 6/10/26 at 11:29 AM. NA # 2 reported the following information. She had checked on Resident # 2 at the beginning of the shift, and she appeared to be asleep in bed and therefore she did not awaken her. Later that morning she went back to the room and Resident # 2 did not awaken. She touched Resident # 2's shoulder and the resident still did not respond. She immediately got Nurse # 1 who went right away, got Resident # 2's vital signs and did what she was supposed to do. A review of the vital signs portion of the medical record revealed on 4/26/26 at 8:55 AM Nurse # 1 documented Resident # 2's blood pressure was 144/69 (normal ranges are typically between 90/60 to 120/80), pulse 129 (normal 60 to 100), respirations 18 (normal 12 to 20), and temperature 98.8 (taken on forehead by non-contact thermometer). Nurse # 1, who had cared for Resident # 2 on 4/26/26 beginning at 7:00 AM, was interviewed on 6/10/26 at 9:49 AM and reported the following information. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She had looked in on Resident # 2 at the beginning of the shift but did not awaken her. She (Nurse # 1) got report and started to give medications. While she was starting to give medications to other residents, the assigned Nurse Aide came to get her and let her know Resident # 2 was not responding. She got Resident # 2's vitals and tried doing a sternal rub, but the resident would not respond. She obtained the resident's temporal temperature. The resident's vitals seemed okay except for her pulse. Another Nurse (Nurse # 3) came in to help also. They checked her finger stick blood sugar, and it registered high. They called 911 for transport. It was only about 20 minutes from the time Resident # 2 was found to be nonresponsive and when EMS (Emergency Medical Services) arrived. She called the resident's RP who reported Resident # 2 had been sick the night before, but this had not been told to her (Nurse # 1). On 4/26/26 at 9:26 AM Nurse # 3 noted in the record that Resident # 2's emergency contact was informed Resident # 2 was being transferred to the hospital Emergency Department (ED). This nursing note did not include any information regarding why. Nurse # 3 was interviewed on 6/10/26 at 10:51 AM and reported the following information. She shared a nursing desk with Nurse # 1 and was at the desk when NA # 2 also grabbed her (Nurse # 3) to assist with Resident # 2 and Nurse # 1 also came. Resident # 2 did not respond, and they checked her blood sugar which registered high on the glucometer (A high reading typically indicates a blood sugar level has exceeded the device's measurable range and may indicate a dangerous level). Nurse #3 recalled she was the one to take the resident's blood pressure and heart rate. Resident #2's heart rate was elevated and her skin was pale but not mottled and they called EMS right away. Review of EMS (Emergency Medical Services) records revealed the following information. EMS received a call at 9:18 AM on 4/26/26 and were at patient at 9:21 AM. Upon arrival the paramedic noted Resident # 2 was unresponsive and tachypneic (elevated respirations). Her skin was hot to the touch and appeared mottled and pale. At 9:27 AM Resident # 2's respirations were 44. At 9:29 AM, the paramedic noted Resident # 2's heart rate was 129, blood pressure 63/35 and respirations 28. At 9:31 AM, the paramedic noted they obtained a manual blood pressure reading of 70/48 and respirations were 31. At 9:34 AM, the paramedic noted they obtained a temperature reading of 105.1 by a no touch infrared thermometer. Oxygen, intravenous fluids, and an intravenous antibiotic were administered by EMS, who transported the resident to the hospital with no sirens or lights by non-emergent transport. Review of hospital records for 4/26/26 to 5/8/26 revealed the following information. During transport from the facility to the hospital by EMS, Resident # 2 remained stable. Upon presentation to the hospital, she was largely unresponsive to stimulation. The resident's finger stick blood sugar was greater than 600 upon the first check. A serum blood draw glucose level was 1046 (noted in the timeline ED at 11:34 AM). The resident's blood pressure was low normal but did not require vasopressors (medications used to constrict blood vessels and thereby raise blood pressure). Her initial blood work showed an elevated white blood count of 17.1. (An elevated white blood count can indicate an infection at times with normal parameters between 3.5 to 10.5). Her blood urea nitrogen was 40 (normal 9-23) and creatinine results were 1.32 (normal 0.5 to .80). (Blood urea nitrogen and creatinine can indicate kidney function and level of hydration.) The resident's lactate level was 2.7 (normal .5 to 2.0.) (Levels can be elevated with lack of tissue perfusion). Resident # 2's admission history and physical noted the resident had diabetic ketoacidosis with an elevated Beta-hydroxybutyrate (a condition when there is insufficient insulin and an individual starts to break down fat and therefore produce ketones), hyperosmolar hyperglycemic state, febrile illness, leukocytosis (elevated white blood count), dehydration, depressed level of consciousness, and acute renal failure. She was admitted to ICU (Intensive care unit), given intravenous fluids and intravenous antibiotics, and Intravenous insulin infusion with titration. An infectious disease work during hospitalization revealed no source of the elevated white blood count although there had been a concern about possible aspiration. Upon discharge, Resident # 2 was documented as being alert and voicing wanting to go home. Her creatinine level had returned to her normal baseline. She was discharged with home health services. The facility's Nurse Practitioner (NP) was interviewed on 6/10/26 at 1:07 PM and reported the following. The staff should report any (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugar that was over 500. She or another provider had not been notified. If she had been notified, she would have ordered additional insulin coverage the evening of 4/25/26 so that the resident would have received treatment for the elevated reading of 509. For a blood sugar reading of 509, she would probably have ordered an additional 16 units of Humalog (the fast-acting insulin). She would have also talked to the staff about other things that might be going on with the resident when they called with a result that high. She was familiar with the resident, who had previous stays at the facility. The resident was able to make her needs known and had particular ways she liked things done. Based on her (the NP's) personal dealings with the resident, Nurse # 2's report of Resident # 2 requesting not to be disturbed during the night of 4/25/26, Nurse # 2's report of Resident # 2 keeping her eyes closed at 6:00 AM on 4/26/26 and sticking her hand out to Nurse # 2 without interacting, did seem like something the resident might possibly do. It did not make sense to her (the NP) that Resident # 2's finger stick blood sugar came down to 233 after a result the previous evening of 509 with only 5 units of Humalog Insulin. It also did not make sense to her (the NP) that on 4/25/26 the resident's blood sugar went from 233 at 6:00 AM to 1046 later that same morning in the emergency room. She had seen the resident on 4/24/26 (Friday) and her plan at that time was to see her again on 4/27/26 (Monday) and evaluate her blood sugar trends to see how the resident's blood sugars could best be managed, but she had not had a chance to evaluate the resident's blood sugars before she was sent back to the hospital. Given that Resident # 2 was both a newly admitted resident on 4/23/26 and additionally she had new orders for an enteral feeding for her nutrition, she (the NP) would not have changed any insulin orders right away upon admission until she had been able to evaluate her further and look at trends. The facility Medical Director was interviewed on 6/10/26 at 2:00 PM and reported the following information. If a resident did not have other parameters, he would want to be notified if a resident's blood sugar was greater than 400. He was not familiar with Resident # 2 and without knowing her history he was hesitant to comment on the fluctuation of her fingerstick blood sugar results. Infection can make a resident's blood sugar go up. Some residents can also be labile (Labile diabetics experience unpredictable, severe, wide blood sugar swings between high to low). The hospital ED physician, who saw Resident # 2, on 4/26/26 was interviewed by phone on 6/11/26 at 12:30 PM and reported the following information. It was really difficult to reconcile a 6:00 AM blood sugar reading of 233 with a serum blood sugar later the same morning of over a 1000. For some reason, the glucometer machine may not have read correctly and possibly the 233 was not correct. This was especially a possibility considering the resident's blood sugar was over 500 the previous evening. A blood sugar change from over 500 to 233 would be a big swing with only 5 units of Humalog insulin having been administered. Infrared (non-touch) thermometers can give incorrect results at times. They sometimes read high. Given that the facility staff obtained a temperature reading of 98.8 just prior to calling EMS, EMS obtained a temperature reading of 105.1, both the facility staff and EMS assessed the resident to have a high pulse/heartrate combined with the finding in the ED that Resident # 2's white blood count was elevated, indicated that Resident # 2 was probably febrile at the facility before EMS arrived. According to the ED physician, more accurate temperature readings were obtained by oral and rectal routes. It was not uncommon not to find a source of infection in a patient although infection was a causative problem of an illness, and given Resident # 2 had an elevated white blood count, she may have had an infection which led to her illness, hospitalization, and affected her blood sugars. As an individual's blood sugar rises, the body tries to expel the blood sugar by more frequent urination which in turn affects their hydration status, BUN and creatinine levels. It was possible for some individual's blood sugar to be elevated at 509 without showing evident symptoms. Even if the facility staff had called their provider on the evening of 4/25/26 when Resident # 2's blood sugar registered 509 and she received further assessment and treatment for the elevated blood sugar, she may still have developed illness stemming from an infection the next morning which required hospitalization and care. After treatment, diabetic ketoacidosis did not typically affect an individual long term and given that there might be an underlying problem of possible (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection, he did not feel it could be said by him that the resident was harmed by the facility's lack of follow up on the evening o 4/25/26. He would advise them to ensure their equipment was calibrated and working correctly. During interviews with the Director of Nursing (DON) on 6/10/26 at 9:00 AM, 6/10/26 at 6:30 PM, 6/11/26 at 4:35 PM and 4:40 PM, the DON reported the following information. When a resident was admitted to the facility and they are on insulin, the electronic MAR automatically populates to direct staff to check the resident's blood sugar when the insulin is due. There were no standing orders with parameters to call a physician for a certain level of blood sugar result. It was her expectation that Nurse # 1 should have called the provider on the evening of 4/25/26. She had taken corrective action by educating Nurse # 1 after the incident but had not implemented a plan that included all nurses.

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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** Based on record review, and interviews with staff, Responsible Party, Physician, and Nurse Practitioner, for a newly admitted resident whose insulin orders had recently been changed before facility admission in conjunction with the resident being changed from an oral diet to an enteral feeding (the delivery of nutrition directly into the gastrointestinal tract when a person cannot eat enough by mouth), the facility failed to recheck the resident's finger stick blood sugar result of 509 within the timeframe the resident's prescribed insulin typically worked to cover elevated blood sugar levels. (A normal fasting blood sugar is typically 70 to 99 and a normal non-fasting blood sugar is typically less than 140. A blood sugar reading over 400 is considered severe hyperglycemia and can be a medical emergency). This was for 1 of 3 residents reviewed for professional standards of practice (Resident # 2). The findings included:Review of Resident # 2's hospital Discharge summary, dated [DATE], revealed the following information. Resident # 2 was hospitalized from [DATE] until 4/23/26. Resident # 2 had a history of prior stroke and trigeminal neuralgia (chronic neuropathic pain condition that causes sudden, severe, electric shock-like or stabbing pain in the face). She was hospitalized on [DATE] secondary to worsening weakness and dysphagia (trouble swallowing). Resident # 2 was examined and found to have difficulty managing her own secretions and unable to swallow applesauce. In addition to dysphagia, Resident # 2 also had dysarthria (trouble speaking) secondary to her trigeminal neuralgia, and it was difficult to obtain information from her. While hospitalized , Resident # 2 underwent gastrostomy tube placement (tube inserted through the wall of the abdomen directly into the stomach) for her dysphagia with plans for follow up at another hospital for specialized surgery to address her trigeminal neuralgia. She was to receive her nutrition by means of the gastrostomy tube. Resident # 2 additionally had a diagnosis of diabetes. The hospital discharge summary further included the following information. Upon discharge, Resident # 2 was ordered to receive metformin 1000 mg (medication used to treat diabetes) twice per day. She was also ordered to receive Insulin Lispro 5 units three times per day. (Insulin lispro is a fast-acting insulin which typically starts working within 15-30 minutes after administration, peaks in about 1 hour, and lasts for 3-5 hours.) The discharge summary noted Resident # 2 should pause another insulin which she had been receiving until her future medical provider directed her to start taking the paused insulin. The paused insulin was insulin glargine 30 units every morning. (Insulin glargine is a long-acting insulin which is prescribed to help manage blood glucose levels in diabetic individuals by providing a steady release of insulin that lasts for 24 hours.) Resident # 2 was discharged on 4/23/26 for care at the facility.Record review revealed Resident # 2 resided at the facility for four days in April 2026 (4/23/26 to 4/26/26).Review of 4/23/26 admission orders revealed orders for Metformin 1000 mg (milligrams) via gastrostomy tube two times per day and Humalog 5 units subcutaneously three times per day. Additionally, the resident was ordered to receive all her nutrition by way of an enteral feeding.Review of Resident # 2's April 2026 MAR (Medication Administration Record) revealed with each Humalog 5 units of insulin administration the resident's fingerstick blood sugar was checked. Results on 4/24/26 and 4/25/26 were documented as follows:4/24/26 at 6:00 AM 2914/24/26 at 12:00 PM 2474/24/26 at 6:00 PM 3034/25/26 at 6:00 AM blank4/25/26 at 12:00 PM 2204/25/26 at 6:00 PM 509 (documented by Nurse # 1) On 4/25/26 at 6:35 PM Nurse # 1 documented a nursing entry with the following information noted. Resident # 2 continued to ask for ice chips and sips of water although she was NPO (nothing by mouth). Resident # 2's responsible party (RP) was present, and she (Nurse # 1) talked to both Resident # 2 and her RP about Resident # 2 not having anything by mouth. They voiced understanding. There was no documentation regarding notification of the physician regarding the resident's finger stick blood sugar result and any reassessment or intervention to address the resident's blood sugar reading of 509. Nurse # 1 had cared for Resident # 2 from 7:00 AM to 7:00 PM on 4/25/26. Nurse # 1 was interviewed on 6/10/26 at 9:49 AM and reported the following information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She did not call the physician about the fingerstick blood sugar result of 509 and she did not retake the blood sugar after giving the scheduled insulin. At the time that Resident # 2's blood sugar registered 509, Resident # 2 appeared alert, talking, and without symptoms. Resident # 2 did say her mouth was dry, but she (the nurse) attributed that to the resident being on an enteral feeding and not having anything by mouth. The resident did not vomit during her shift. The reason she did not recheck the blood sugar and call the physician was because the resident was not showing any symptoms or problems and she knew Resident # 2 had received some insulin. Since 4/25/26, she (the nurse) had received education that she should have called the physician, and she should have retaken the resident's blood sugar. Resident # 2's RP was interviewed on 6/9/26 at 7:50 PM and reported the following information. She had visited Resident # 2 between 5:00 PM and 8:00 PM on 4/25/26. Resident # 2 vomited that evening, and her blood sugar was 500. She thought that the nurse was going to call the physician, but the nurse had not done so. Resident # 2 was not acting like herself. She (the RP) felt there was something wrong with her. After her visit, she called Resident # 2 around 9:30 PM and the resident was very sleepy and complained of being tired. She made unusual comments about letting people know she loved them, which the RP interpreted as Resident # 2 acting as if she felt she was going to die. She (the RP) tried to call and speak to a nurse but was unable to reach one that night. The next morning (4/26/26), she (the RP) was called around 9:30 AM and told that Resident # 2 was nonresponsive and going to the hospital. Following the nursing narrative entry on 4/25/26 at 6:35 PM, the next nursing narrative was entered on 4/25/26 at 8:00 PM by Nurse # 2. Nurse # 2 noted she reeducated the resident on safety concerns related to the resident wanting water and ice chips. The resident verbalized understanding but declined to be NPO (nothing by mouth). There was no notation of a recheck of the resident's blood sugar. On 4/26/26 at 12:00 AM Nurse # 2 initialed on Resident # 2's MAR she administered Resident # 2's scheduled bolus enteral feeding of 300 ml (milliliters) of Diabetasource (tube feeding formula). On 4/26/26 at 6:00 AM Nurse # 2 initialed again that she administered Resident # 2's scheduled bolus enteral feeding of 300 ml of Diabetasource. Nurse # 2 also documented on the MAR that Resident # 2's fingerstick blood sugar was 233 at 6:00 AM and she initialed the scheduled Humalog Insulin 5 units was administered at 6:00 AM. Nurse # 2, who cared for Resident # 2 from 7:00 PM on 4/25/26 until 7:00 AM on 4/26/26, was interviewed on 6/10/26 at 12:31 PM and reported the following information. She (the nurse) did not recall specifics of a report during shift change. She thought possibly it was told to her that the resident may have vomited, but she was not sure of that or any other specifics in report. She did not recall Resident # 2 having any problems on her shift. Resident # 2 had not vomited on her shift. Resident # 2 had been alert at the beginning of the shift. The resident's only complaint was that since admission she had not been able to sleep at night, which the resident reported was due to being new to the facility. She had requested not to be disturbed earlier than 6:00 AM so that she could get some rest. Nurse # 2 did not recall any specifics of how the resident was when she gave the enteral feeding at 12:00 AM. To honor her request to get more sleep, she (Nurse # 2) had not disturbed her earlier than 6:00 AM for the 6:00 AM enteral feeding, fingerstick blood sugar, and insulin. At that time, Resident # 2 could barely open her eyes, but she (the nurse) did not think that was unusual given that Resident # 2 had reported she had not slept for two nights. A lot of her residents, who had blood sugar checks between 5:00 AM and 6:00 AM would keep their eyes closed, stick out their hand when it was explained what she was going to do, and continue to keep their eyes closed due to being sleepy. That is how she recalled Resident # 2. Resident # 2 did jerk back her hand when her finger was pricked for the blood sugar. She did not react to the insulin administration but that was not unusual for her either. Her skin was not cold or sweaty. That was the only blood sugar check she recalled doing that shift and the result had not been unusual for the resident. Nurse Aide (NA) # 1cared for Resident # 2 beginning at 11:00 PM on 4/25/26 until 7:00 AM on 4/26/26. NA # 1 was interviewed on 6/10/26 at 11:38 AM and reported the following information. There had been no reports from the previous Nurse Aide on the 3:00 to 11:00 PM shift of Resident # 2 vomiting and she (NA # 1) had not noted any (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	2401 Wayne Memorial Drive Goldsboro, NC 27534

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problems. Resident # 2 was still awake at 11:00 PM when she first started caring for her. At that time the resident was alert and reported she did not need anything. Around 4:30 AM to 5:00 AM, Resident # 2 rang her call bell and requested a sip of water and to be assisted up in bed. She (NA # 1) provided incontinence care and helped Resident # 2 reposition further up in the bed. The resident appeared okay. She saw Nurse # 2 going in Resident # 2's room during different times of the night and she (NA # 1) also had checked on the resident throughout the night. Her last check was at the end of the shift and Resident # 2 appeared to be sleeping at that time and was not disturbed. NA # 2 was assigned to care for Resident # 2 on 4/26/26 beginning at 7:00 AM and was interviewed on 6/10/26 at 11:29 AM. NA # 2 reported the following information. She had checked on Resident # 2 at the beginning of the shift, and she appeared to be asleep in bed and therefore she did not awaken her. Later that morning she went back to the room and Resident # 2 did not awaken. She touched Resident # 2's shoulder and the resident still did not respond. She immediately got Nurse # 1 who went right away, got Resident # 2's vital signs and did what she was supposed to do. A review of the vital signs portion of the medical record revealed on 4/26/26 at 8:55 AM Nurse # 1 documented Resident # 2's blood pressure was 144/69 (normal ranges are typically between 90/60 to 120/80), pulse 129 (normal 60 to 100), respirations 18 (normal 12 to 20), and temperature 98.8 (taken on forehead by non-contact thermometer). Nurse # 1, who had cared for Resident # 2 on 4/26/26 beginning at 7:00 AM, was interviewed on 6/10/26 at 9:49 AM and reported the following information. She had looked in on Resident # 2 at the beginning of the shift but did not awaken her. She (Nurse # 1) got report and started to give medications. While she was starting to give medications to other residents, the assigned Nurse Aide came to get her and let her know Resident # 2 was not responding. She got Resident # 2's vitals and tried doing a sternal rub, but the resident would not respond. She obtained the resident's temporal temperature. The resident's vitals seemed okay except for her pulse. Another Nurse (Nurse # 3) came in to help also. They checked her finger stick blood sugar, and it registered high. They called 911 for transport. It was only about 20 minutes from the time Resident # 2 was found to be nonresponsive and when EMS arrived. She called the resident's RP who reported Resident # 2 had been sick the night before, but this had not been told to her (Nurse # 1). Following the nursing entry on 4/25/26 at 8:00 PM, the next nursing narrative note was entered by Nurse #3 on 4/26/26 at 9:26 AM noting that Resident # 2's emergency contact was informed Resident # 2 was being transferred to the hospital ED (Emergency Department). This nursing note did not include any assessment of the resident or reason the resident was being transferred. Nurse # 3 was interviewed on 6/10/26 at 10:51 AM and reported the following information. She shared a nursing desk with Nurse # 1 and was at the desk when NA # 2 also grabbed her (Nurse # 3) to assist with Resident # 2. Nurse # 1 also came. Resident # 2 did not respond, and they checked her blood sugar which registered high on the glucometer. (A high reading typically indicates a blood sugar level has exceeded the device's measurable range and may indicate a dangerous level). She recalled she was the one to take the resident's blood pressure and heart rate. Her heart rate was elevated. Her skin was pale but not mottled and they called EMS right away. Review of EMS (Emergency Medical Services) records revealed the following information. EMS received a call at 9:18 AM on 4/26/26 and were at patient at 9:21 AM. Upon arrival the paramedic noted Resident # 2 was unresponsive and tachypneic (elevated respirations). Her skin was hot to the touch and appeared mottled and pale. At 9:27 AM Resident # 2's respirations were 44. At 9:29 AM, the paramedic noted Resident # 2's heart rate was 129, blood pressure 63/35 and respirations 28. At 9:31 AM, the paramedic noted they obtained a manual blood pressure reading of 70/48 and respirations were 31. At 9:34 AM, the paramedic noted they obtained a temperature reading of 105.1 by a no touch infrared thermometer. Oxygen, intravenous fluids, and an intravenous antibiotic were administered by EMS, who transported the resident to the hospital with no sirens or lights by non-emergent transport. Review of hospital records for 4/26/26 to 5/8/26 revealed the following information. During transport from the facility to the hospital by EMS, Resident # 2 remained stable. Upon presentation to the hospital, she was largely unresponsive to stimulation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's finger stick blood sugar was greater than 600 upon the first check. A serum blood draw glucose level was 1046 (noted in the timeline ED at 11:34 AM). The resident's blood pressure was low normal but did not require vasopressors (medications used to constrict blood vessels and thereby raise blood pressure). Her initial blood work showed an elevated white blood count of 17.1. (An elevated white blood count can indicate an infection at times with normal parameters between 3.5 to 10.5). Her blood urea nitrogen was 40 (normal 9-23) and creatinine results were 1.32 (normal 0.5 to .80). (Blood urea nitrogen and creatinine can indicate kidney function and level of hydration.) The resident's lactate level was 2.7 (normal .5 to 2.0.) (Levels can be elevated with lack of tissue perfusion). Resident # 2's admission history and physical noted the resident had diabetic ketoacidosis with an elevated Beta-hydroxybutyrate (a condition when there is insufficient insulin and an individual starts to break down fat and therefore produce ketones), hyperosmolar hyperglycemic state, febrile illness, leukocytosis (elevated white blood count), dehydration, depressed level of consciousness, and acute renal failure. She was admitted to ICU (Intensive care unit), given intravenous fluids and intravenous antibiotics, and Intravenous insulin infusion with titration. An infectious disease work during hospitalization revealed no source of the elevated white blood count although there had been a concern about possible aspiration. Upon discharge, Resident # 2 was documented as being alert and voicing wanting to go home. Her creatinine level had returned to her normal baseline. She was discharged with home health services. The facility's Nurse Practitioner (NP) was interviewed on 6/10/26 at 1:07 PM and reported the following. She was familiar with the resident, who had previous stays at the facility. The resident was able to make her needs known and had particular ways she liked things done. Based on her (the NP's) personal dealings with the resident, Nurse # 2's report of Resident # 2 requesting not to be disturbed during the night of 4/25/26, Nurse # 2's report of Resident # 2 keeping her eyes closed at 6:00 AM on 4/26/26 and sticking her hand out to Nurse # 2 without interacting, did seem like something the resident might possibly do. It did not make sense to her (the NP) that Resident # 2's finger stick blood sugar came down to 233 after a result the previous evening of 509 with only 5 units of Humalog Insulin. If she had been notified, she would have ordered additional insulin coverage the evening of 4/25/26 so that the resident would have received treatment for the elevated reading of 509. For a blood sugar reading of 509, she would probably have ordered an additional 16 units of Humalog (the fast-acting insulin). It also did not make sense to her (the NP) that on 4/25/26 the resident's blood sugar went from 233 at 6:00 AM to 1046 later that same morning in the emergency room. She had seen the resident on 4/24/26 (Friday) and her plan at that time was to see her again on 4/27/26 (Monday) and evaluate her blood sugar trends to see how the resident's blood sugars could best be managed, but she had not had a chance to evaluate the resident's blood sugars before she was sent back to the hospital. Given that Resident # 2 was both a newly admitted resident on 4/23/26 and additionally she had new orders for an enteral feeding for her nutrition, she (the NP) would not have changed any insulin orders right away upon admission until she had been able to evaluate her further and look at trends. The facility Medical Director was interviewed on 6/10/26 at 2:00 PM and reported the following information. He was not familiar with Resident # 2 and without knowing her history he was hesitant to comment on the fluctuation of her fingerstick blood sugar results. Infection can make a resident's blood sugar go up. Some residents can also be labile (Labile diabetics experience unpredictable, severe, wide blood sugar swings between high to low). He historically had one specific patient whose blood sugar fluctuated within a very short time period from 100 to 600 because this other resident was so labile, and although the fluctuation was wide, this other patient would report he felt well and was not symptomatic, According to the physician, it would be his expectation that he be informed if a resident's blood sugar went above 400 so that it could be addressed if there were no other individual parameters for a resident. The hospital ED physician, who saw Resident # 2, on 4/26/26 was interviewed by phone on 6/11/26 at 12:30 PM and reported the following information. It was really difficult to reconcile a 6:00 AM blood sugar reading of 233 with a serum blood sugar later the same morning of over a 1000. For some reason, the glucometer machine (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	may not have read correctly and possibly the 233 was not correct. This was especially a possibility considering the resident's blood sugar was over 500 the previous evening. A blood sugar change from over 500 to 233 would be a big swing with only 5 units of Humalog insulin having been administered. Infrared (non-touch) thermometers can give incorrect results at times. They sometimes read high. Given that the facility staff obtained a temperature reading of 98.8 just prior to calling EMS, EMS obtained a temperature reading of 105.1, both the facility staff and EMS assessed the resident to have a high pulse/heartrate combined with the finding in the ED that Resident # 2's white blood count was elevated, indicated that Resident # 2 was probably febrile at the facility before EMS arrived. According to the ED physician, more accurate temperature readings were obtained by oral and rectal routes. It was not uncommon not to find a source of infection in a patient although infection was a causative problem of an illness, and given Resident # 2 had an elevated white blood count, she may have had an infection which led to her illness, hospitalization, and affected her blood sugars. As an individual's blood sugar rises, the body tries to expel the blood sugar by more frequent urination which in turn affects their hydration status, BUN and creatinine levels. It was possible for some individual's blood sugar to be elevated at 509 without showing evident symptoms. Even if the facility staff had called their provider on the evening of 4/25/26 when Resident # 2's blood sugar registered 509 and she received further assessment and treatment for the elevated blood sugar, she may still have developed illness stemming from an infection the next morning which required hospitalization and care. After treatment, diabetic ketoacidosis did not typically affect an individual long term and given that there might be an underlying problem of possible infection, he did not feel it could be said by him the resident was harmed by the facility's lack of follow up on the evening o 4/25/26. He would advise them to ensure their equipment was calibrated and working correctly. During interviews with the Director of Nursing (DON) on 6/10/26 at 9:00 AM, 6/10/26 at 6:30 PM, 6/11/26 at 4:35 PM and 4:40 PM, the DON reported the following information. When a resident is admitted to the facility and they are on insulin, the electronic MAR automatically populates to direct staff to check the resident's blood sugar when the insulin is due. There were no standing orders with parameters to call a physician for a certain level of blood sugar result. It was her expectation that Nurse # 1 should have called the provider on the evening of 4/25/26 and rechecked the blood sugar to make sure it did come down. She had taken corrective action by educating Nurse # 1 after the incident but had not implemented a plan that included all nurses.

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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** Based on record review, and interviews with staff, Pharmacists, and Medical Director the facility failed to 1) ensure they obtained medications from the pharmacy or the facility's back up supply for administration for a newly admitted resident and 2) upon admission clarify an order which directed a 12 hour extended release medication was to be administered via way of a gastrostomy tube so that the pharmacy would dispense an alternate form of the medication that was appropriate to be administered via gastrostomy tube (tube inserted through the wall of the abdomen directly into the stomach). This was for 1 of 1 resident whose medications were reviewed (Resident # 2).The findings included:Record review revealed Resident # 2 resided at the facility for four days in April 2026 (4/23/26 to 4/26/26). Resident # 2 had diagnoses which included history of stroke, trigeminal neuralgia, diabetes, and dysphagia with a gastrostomy tube placed for nutrition.On 4/23/26 at 4:19 PM Nurse # 4 documented in a nursing note that Resident # 2 had been admitted to the facility.1a. Review of 4/23/26 facility admission orders revealed an order for metformin 1000 mg (milligrams) one tablet via G-tube (gastrostomy tube) two times a day with meals. (Metformin is used to treat diabetes).On 4/23/26 at 11:52 AM Pharmacist # 1 was interviewed and reviewed the pharmacy's records for Resident # 2's dispensed metformin. Pharmacist # 1 reported they received the metformin order on 4/23/26 and it was sent to the facility the next day (on 4/24/26) around 8:30 PM during the regular delivery. Review of Resident # 2's April 2026 MAR (Medication Administration Record) revealed there were four scheduled times that appeared by the metformin order on the MAR. These were 6:00 AM, 8:30 AM, 6:00 PM, and 8:30 PM. The following was documented on the MAR and in the accompanying electronic MAR (EMAR) notes indicating no documentation Resident # 2 received the metformin on the day of admission and she missed one of two doses on the subsequent days of residency following admission.On 4/23/26 at 6:00 PM Nurse # 4 documented a 9 indicating other and see nursing note.(On 4/23/26 at 5:53 PM Nurse # 4 documented ordered from pharmacy in an EMAR note.)On 4/23/26 at 8:30 PM there was an xOn 4/24/26 at 6:00 AM, Nurse # 5 initialed and placed a check indicating administration.On 4/24/26 at 8:30 AM, there was an x.On 4/24/26 at 6:00 PM, Nurse # 1 documented a 5 indicating the metformin was held.(On 4/24/26 at 6:11 PM, Nurse # 1 documented the metformin was on order in an EMAR note.)On 4/24/26 at 8:30 PM there was an xOn 4/25/26 at 6:00 AM there was an xOn 4/25/26 at 8:30 AM Nurse # 1 documented a 5 indicating the metformin was held.(On 4/25/26 at 10:23 AM Nurse # 1 documented the metformin was on order In an eMAR note.)On 4/25/26 at 6:00 PM there was a x.On 4/25/26 at 8:30 PM Nurse # 2 initiated and checked administration. Nurse # 4, who had cared for Resident # 2 on the day of admission and written the medication was on order, was interviewed on 6/11/26 at 2:32 PM and reported the following information. She only filled in at the facility and did not recall anything about Resident # 2 or her medications. Nurse # 1, who had documented the metformin was on hold on 4/24/26 and 4/25/26, was interviewed on 6/10/26 at 9:49 AM and reported the following information. She was new in April 2026, and she did not realize that the metformin was in the facility's back up supply of medications. Therefore, she did not administer it when she put it was on hold on 4/24/26. Nurse # 1 was also interviewed about the held dose on 4/25/26 at 8:30 AM given that the medication had been delivered by the pharmacy on 4/24/26. Nurse # 1 reported that although the medications might be delivered, they were not always found on the cart for administration. Nurse # 1 also reported she was aware there was a backup pharmacy for medications and sometimes they would get needed medications from a backup pharmacy and in some instances the nurses had to leave work and go get the medication from the backup pharmacy. During the interview with Pharmacist # 1 on 4/23/26 at 11:52 AM, Pharmacist # 1 also reported the following information. Medications were filled and dispensed by the regular pharmacy if orders were sent in by 5:30 PM. If the facility needed medications before then, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they could look in their backup supply of medications. Metformin was in the backup supply of medications. The facility staff could also call the backup pharmacy if the medication was not in the backup supply of medications. There were two backup pharmacies for which arrangements had been made to fill after hours medications for the facility. There was a backup agency which fielded calls for the backup pharmacy for the facility after normal pharmacy hours. The backup pharmacy could arrange for a courier. Pharmacist # 1 was interviewed about what the nurses were to do if they could not leave work and go get the medication as Nurse # 1 reported they sometimes had to do, and Pharmacist # 1 replied that a courier should be arranged and if not then they (the main pharmacy) would fill the medication. The Director of Nursing (DON) was interviewed on 6/10/26 at 9:00 AM and on 6/10/26 at 3:20 PM and reported the following information. Metformin was a medication that was in their backup medications in the dosage of 500 mg and the nurses could have pulled two 500 mg tablets to equal the needed 1000 mg from the emergency backup supply of medications and administered the dosage on the evening when Resident # 2 was admitted and again on 4/24/26. The facility's records showed that Resident # 2's supply of metformin was delivered to them on the evening/night delivery of 4/24/26 and therefore the resident's own supply should have been available on 4/25/26 when the dose was held on that date. If the metformin had been depleted from the facility's backup supply, there was a backup pharmacy, and at times the facility did have to send a nurse to get medications rather than the pharmacy arranging a courier. The facility Medical Director was interviewed on 6/10/26 at 2:00 PM regarding the held metformin and reported he would not consider the held metformin doses to be significant or have negatively impacted the resident. 1b. Review of Resident # 2's 4/23/26 facility admission orders revealed the resident was ordered to receive gabapentin 100 mg three times per day via gastrostomy tube for the diagnosis of trigeminal neuralgia. (Trigeminal neuralgia is a neuropathic pain condition that causes sudden, severe, electric shock-like or stabbing pain in the face.) Review of a 4/23/26 hospital MAR (Medication Administration Record) revealed Resident # 2 last received the gabapentin at 2:10 PM before discharge to the facility on 4/23/26. Review of Resident # 2's April 2026 facility MAR revealed the gabapentin was scheduled to be given at 6:00 AM, 12:00 PM, and 6:00 PM. The MAR also showed the following documentation: On 4/23/26 at 6:00 PM Nurse # 4 documented a 9 indicating other see nursing note.(There was no accompanying EMAR note for the 4/23/26 6:00 PM dose.)On 4/24/26 at 6:00 AM Nurse # 5 initialed and placed a check mark indicating administration.On 4/24/26 at 12:00 PM Nurse # 1 initialed and placed a check mark indicating administration.On 4/24/26 at 6:00 PM Nurse # 1 documented a 5 indicating the medication was held.(There was no accompanying EMAR note)On 4/25/26 at 6:00 AM Nurse # 2 initialed and placed a check mark indicating administration.On 4/25/26 at 12:00 PM Nurse # 2 documented a 5 indicating the medication was held.On 4/25/26 at 6:00 PM Nurse # 2 documented a 5 indicating the medication was held.(On 4/25/26 at 6:04 Nurse # 1 noted in an EMAR note that the gabapentin was on order. Nurse # 4, who had cared for Resident # 2 on the day of admission, was interviewed on 6/11/26 at 2:32 PM and reported the following information. She only filled in at the facility and did not recall anything about Resident # 2 or her medications. Nurse # 1 was interviewed on 6/10/26 at 9:49 AM and reported the following information. She was new in April 2026, and she did not realize that the gabapentin was in the facility's back up supply of medications and how to obtain it. She also reported that at times after delivery from the pharmacy, sometimes medications could not be found on the cart. On 6/10/26 at 9:00 AM and 3:20 PM the DON provided the facility's list of dispensed medications for Resident # 2 which they had received from the pharmacy and was interviewed regarding the medications. The interview and delivery sheets revealed the following information. No gabapentin was documented as delivered to the facility on 4/23/26 although the pharmacy delivered four other medications on 4/23/26 for Resident # 2. The first delivery of gabapentin for Resident # 2 was on 4/24/26. According to the DON, the 4/24/26 delivery would have been delivered somewhere between the hours of 7:00 PM and 9:00 PM. During an interview with Pharmacist # 1 on 4/23/26 at 11:52 AM, Pharmacist # 1 reported gabapentin was in the facility's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	backup supply of medications and could have been obtained from there. If the backup supply of medications was depleted, then the facility could have called the backup pharmacy to obtain the medication. On 6/11/26 at 4:19 PM the DON provided the documentation of removal for any medications for Resident # 2 from the facility's backup supply of medications. There had been no documentation of removal of gabapentin for Resident # 2. The facility Medical Director was interviewed on 6/10/26 at 2:00 PM regarding the held gabapentin and reported that he would not consider the held doses to be significant or to have negatively impacted the resident. 1c. Review of Resident # 2's 4/23/26 facility admission orders revealed the resident was ordered to receive Tegretol-XR Extended Release 12-hour 200 mg via gastrostomy tube two times per day. (Tegretol-XR is specifically designed to release the medication slowly over 12 hours and crushing or chewing the tablet destroys this special mechanism, causing all of the medicine to enter an individual's body at once. The Tegretol was ordered for Resident # 2's trigeminal neuralgia). Review of Resident # 2's electronic record revealed the admission order on 4/23/26 for Tegretol XR was entered into the electronic record by Nurse # 4 on 4/23/26. Review of the record revealed no clarification on the day of admission [DATE]) regarding what to do given that the medication was ordered to be given by gastrostomy tube and therefore necessitated being crushed if administered by this route.) Review of the facility's medication delivery records revealed on 4/23/26 the facility received 12 doses of carbamazepine extended release 200 mg for Resident # 2. (Carbamazepine extended release is the generic form of Tegretol XR). Review of Resident # 2's April 2026 Medication Administration Record (MAR) revealed the Tegretol XR 200 mg by gastrostomy tube was scheduled for 6:00 AM and 6:00 PM. There were no directions by the order not to crush the medication. On 4/23/26 at 6:00 PM Nurse # 4 documented a 9 on the MAR with not corresponding EMAR note. On 4/24/26 at 6:00 AM Nurse # 5 initialed and placed a check indicating administration of the Tegretol-XR by way of the gastrotomy tube. Nurse # 4, who cared for Resident # 2 on the day of admission, was interviewed on 6/11/26 at 2:32 PM regarding whether she had sought clarification upon admission when the order indicated the Tegretol should be administered by gastrostomy tube, but an extended-release form would have indicated this was not to be done. Nurse # 4 reported she only filled in at the facility and did not recall anything about Resident # 2 or her medications. Nurse # 5 was interviewed on 6/11/26 at 10:00 AM and reported the following information. The pharmacy generally sent directions not to crush medications and if there were directions not to crush it, then she would not have done so when she administered it. She did not recall other specifics about the administration. Pharmacist # 2 and the DON were interviewed on 6/11/26 at 4:26 PM. The DON reported the following information. When Resident # 2 arrived, she was strict NPO (nothing by mouth) and all her medications had to be given by gastrostomy tube and orders were entered accordingly. The facility sends both the facility's admission orders and the discharge summary orders to the pharmacy and the pharmacy checks for discrepancies as they are filling to avoid errors. Pharmacist # 2 reported the following. On Resident # 2's discharge summary they received orders that the Tegretol was to be given by mouth and they also received the facility admission orders that it was to be given by gastrostomy tube. They sent a request to the facility to obtain clarification. Clarification was obtained on 4/24/26 and the pharmacy then dispensed on 4/24/26 a liquid form of Tegretol that could be administered by gastrostomy tube. Interview with Pharmacist # 1 on 6/10/26 at 11:52 PM revealed when Tegretol ER medication is dispensed then directions are routinely sent with the medication not to crush the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	2401 Wayne Memorial Drive Goldsboro, NC 27534

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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 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. Based on record review and staff interviews, the facility failed to ensure the medical record was complete regarding a change in condition for 1 of 3 residents reviewed for medical record accuracy (Resident #2).The findings included: On 4/25/26 at 8:00 PM Nurse # 3 documented a nursing narrative note on 4/26/26 at 9:26 AM noting that Resident # 2's emergency contact was informed Resident # 2 was being transferred to the hospital Emergency Department (ED). This nursing note and any nursing narrative note before this entry did not include any assessment of the resident on 4/26/26 or reason the resident was being transferred. Review of hospital records for 4/26/26 through 5/8/26 revealed Resident # 2 was assessed in the ED (Emergency Department) and admitted to the intensive care unit for diabetic ketoacidosis with an elevated Beta-hydroxybutyrate (a condition when there is insufficient insulin and an individual starts to break down fat and therefore produce ketones), hyperosmolar hyperglycemic state, febrile illness, leukocytosis (elevated white blood count), dehydration, depressed level of consciousness, and acute renal failure. Nurse # 3 was interviewed on 6/10/26 at 10:51 AM and reported she was not assigned to Resident # 2 on 4/26/26 but was assisting Nurse # 1, who was assigned, when Resident # 2 was found to be unresponsive and transferred to the hospital. Nurse # 1 was interviewed on 6/10/26 at 9:49 AM and reported the following information. Resident # 2 had been found unresponsive on the morning of 4/26/26 and a blood sugar check had registered too high to register on the facility's glucometer. She had assessed the resident and called emergency medical services. She tried to put her assessment and the events of the morning into the resident's electronic medical record, and she did not know why the computer system had not saved the information in the resident's electronic medical record. The Director of Nursing (DON) was interviewed on 6/10/26 at 9:00 AM and reported the following information. The care and assessment of Resident # 2 should have been documented on 4/26/26. She could not find a record of the documentation which Nurse # 1 had tried to enter. The DON indicated she was not sure what happened but reported at times the computer system would glitch, and it might have affected the nursing documentation being saved. The DON further reported that the staff were to complete a specific form called E-Interact for any resident that had a change in condition and she could not find that this was completed in the resident's record. The DON validated Resident # 2's record was incomplete without the information regarding the events and care by the staff on the morning of 4/26/26 prior to EMS transport and the resident's hospitalization.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff and Physician, the facility failed to ensure a system was in place to check the accuracy of resident care equipment used to check blood pressure readings and temperature readings. Additionally, per interview with a Nurse Practitioner and a Physician, a facility's glucometer reading was difficult to reconcile with other known details regarding a resident's condition and treatment. This affected 1 of 3 sampled residents reviewed for change in condition and had the capability to affect all residents (Resident #2).The findings included:Record review revealed Resident # 2 resided at the facility for four days in April 2026 (4/23/26 to 4/26/26). Review of Resident # 2's hospital Discharge summary, dated [DATE], revealed Resident # 2 had diagnoses including diabetes mellitus.Review of facility blood sugar results on 4/24/26 through 4/26/26 were documented as follows:4/24/26 at 6:00 AM 2914/24/26 at 12:00 PM 2474/24/26 at 6:00 PM 3034/25/26 at 6:00 AM blank4/25/26 at 12:00 PM 2204/25/26 at 6:00 PM 5094/26/26 at 6:00 AM was 233 According to orders and Resident # 2's Medication Administration Record (MAR), Resident # 2 received a scheduled dose of 5 units of Humalog insulin on 4/25/26 at 6:00 PM when her blood sugar registered 509. On 4/25/26 she was documented as only receiving one of two doses of scheduled metformin 1000 mg on 4/25/26. (An 8:30 AM metformin dose was held and an 8:30 PM dose was documented as administered.) These were the last diabetic medications administered prior to Resident # 2's blood sugar then registering 233 on 4/26/26 at 6:00 AM. Review of EMS (Emergency Medical Services) records revealed EMS received a call at 9:18 AM on 4/26/26 to respond for Resident # 2 who was unresponsive. Interview with Nurse # 1 on 6/10/26 at 9:49 AM revealed EMS had been called on 4/26/26 because Resident #2 was unresponsive and her blood sugar was too high to register on the facility glucometer. Review of 4/26/26 Emergency Department (ED) records for Resident # 2 revealed the resident's finger stick blood sugar was greater than 600 upon the first hospital check. Resident's serum blood draw glucose level was 1046 (noted in the timeline ED at 11:34 AM). The resident was admitted to Intensive Care Unit (ICU) with one of the diagnoses listed as diabetic ketoacidosis. (Diabetic ketoacidosis is a life-threatening complication of diabetes that occurs when the body lacks enough insulin to use blood sugar for energy.) The hospital ED Physician, who saw Resident # 2, on 4/26/26, was interviewed on 6/11/26 at 12:30 PM and reported the following information. It was really difficult to reconcile a 6:00 AM blood sugar reading of 233 with a serum blood sugar later the same morning of over a 1000. For some reason, the glucometer machine may not have read correctly and possibly the 233 was not correct. This was especially a possibility considering Resident #2's blood sugar was over 500 the previous evening. A blood sugar change from over 500 to 233 would be a big swing with an insulin dosage of only 5 units of Humalog insulin having been administered. The ED Physician indicated he would advise them to ensure their equipment was calibrated and working correctly. The facility's Nurse Practitioner (NP) was interviewed on 6/10/26 at 1:07 PM and reported the following. It did not make sense to her (the NP) that Resident # 2's finger stick blood sugar came down to 233 on 6/26/26 at 6:00 AM after a result the previous evening of 509 with only an insulin dosage of 5 units of Humalog Insulin. If she had been notified, she would probably have ordered an additional 16 units of Humalog insulin in addition to the regular insulin to get the blood sugar down. It also did not make sense to her (the NP) that on 4/25/26 the resident's blood sugar went from 233 at 6:00 AM to 1046 later that same morning in the emergency department. The Director of Nursing (DON) was interviewed on 6/11/26 at 1:40 PM and reported the following information. Each resident was given a glucometer from the facility upon admission. The glucometers were checked nightly by a nurse with control tests (a quality assurance check that uses a specially formulated liquid with a known glucose concentration). The results were then logged and the logs were not kept after a resident was discharged so she could not check the log data for Resident # 2. She (the DON) had not been made aware of any odd readings from facility glucometers. 1b. A review (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the vital signs portion of Resident # 2's medical record revealed on 4/26/26 at 8:55 AM Nurse # 1 documented Resident # 2's blood pressure was 144/69, pulse 129, respirations 18, and temperature 98.8 (taken on forehead by non-contact thermometer). Nurse # 1, who had cared for Resident # 2 on 4/26/26 beginning at 7:00 AM, was interviewed on 6/10/26 at 9:49 AM and reported she had obtained Resident # 2's temperature reading when Resident # 2 was found to be unresponsive by using a temporal thermometer. Nurse # 1 reported the resident did not have a fever. Nurse # 3 was interviewed on 6/10/26 at 10:51 AM and reported the following information. She recalled she was the one to take the resident's blood pressure and heart rate. She (Nurse # 3) had used her own blood pressure monitor. Nurse #3 stated Resident #2's heart rate was elevated but that was the only vital sign she recalled being abnormal. Review of the Emergency Medical Services (EMS) report revealed the following information. EMS received a call at 9:18 AM on 4/26/26 and were at patient at 9:21 AM. Upon arrival the paramedic noted Resident # 2 was unresponsive and tachypneic (elevated respirations). Her skin was hot to the touch and appeared mottled and pale. At 9:27 AM Resident # 2's respirations were 44. At 9:29 AM, the paramedic noted Resident # 2's heart rate was 129, blood pressure 63/35 and respirations 28. At 9:31 AM, the paramedic noted they obtained a manual blood pressure reading of 70/48 and respirations were 31. At 9:34 AM, the paramedic noted they obtained a temperature reading of 105.1 by a no touch infrared thermometer. According to EMS records intravenous fluids and an intravenous antibiotic were administered. There was not a notation regarding any medication for fever. Review of hospital Emergency Department (ED) notes revealed Resident # 2 had a temperature of 102.9 upon admission and her white blood count was elevated (which can indicate infection). The hospital ED Physician, who saw Resident # 2, on 4/26/26, was interviewed on 6/11/26 at 12:30 PM and reported the following information. Given that the facility staff obtained a temperature reading of 98.8 just prior to calling EMS, EMS obtained a temperature reading of 105.1, both the facility staff and EMS assessed the resident to have a high pulse/heartrate combined with the finding in the ED that Resident # 2's white blood count was elevated, indicated that Resident # 2 was probably febrile at the facility before EMS arrived. Given that Resident # 2's blood pressure registered 144/69 by facility staff at 8:55 AM prior to them calling EMS who arrived at 9:21 AM, and who obtained two low blood pressure readings of 63/35 and 70/48, it would appear the facility blood pressure may not have been correct. The ED Physician indicated he would advise them to check the calibration of the equipment they were using. The Director of Nursing (DON) was interviewed on 6/11/26 at 1:40 PM and reported the following information. The nurses supplied their own blood pressure equipment and their own thermometer. The facility had a thermometer if needed in backup that was stored in the Assistant Director of Nursing's office. The system of nurses supplying their own blood pressure equipment and thermometer had always been the facility's system since she was the DON and she did not know the reason. The DON was interviewed about how she knew the nurses' blood pressure machines and thermometers were accurate. The DON reported that since these two items were owned personally by the nurses, she could not say how often they were checked for accuracy and calibration. The Administrator was interviewed on 6/11/26 at 3:26 PM and reported the following information. He had begun as the Administrator during the current year, and it had just been that way that the nurses supplied their own blood pressure machines and thermometers. The Administrator indicated the Nurse Aides did not do vital signs at the facility. The Administrator was interviewed regarding how the equipment was deemed to be correct and accurate and replied that was a good question.