STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345349	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Wellness Center Inc	2778 Country Club Drive Hampstead, NC 28443

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 0567 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48007 Based on resident and staff interviews the facility failed to allow residents to withdraw money from their personal facility held account after normal banking hours. This was for 1 of 1 resident (Resident #10) sampled for personal funds and had the potential to affect all residents with personal funds accounts. The findings included: A review of Resident #10's quarterly Minimum Data Set, dated dated dated [DATE] indicated that he was cognitively intact. An interview conducted on 7/15/24 at 11:55 AM with Resident #10 revealed that he was unable to access his money the facility held for him after the business office closed for the day and on weekends. An interview conducted on 7/17/24 at 9:52 AM with the Business Office revealed that residents were able to access their money during normal banking hours. A resident who wanted money for the weekend had to let the Business Office know on Friday, so they were able to disperse the funds either by putting the money in a sealed envelope with the resident's name on it which was signed by the resident when they received the money, or they gave the money directly to the resident. If a resident required money in the evening during the week the request had to be made prior to the business office closing for the day. An interview conducted on 7/17/24 at 11:40 AM with the Administrator indicated that she was not aware of the standard not being met and that a new process would be developed to ensure residents had access to their funds after normal business hours.

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 0580 Level of Harm - Immediate jeopardy to resident health or safety 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** 43222 Based on record review, Medical Director interview and staff interviews, the facility failed to notify the on-call provider when Resident #69 had a hypoglycemic episode (blood glucose less than 70 milligrams [mg] per deciliter [dL]). Normal blood glucose ranges from 70 - 100, according to the lab used by the facility. On the morning of 7/6/24, Resident #69's blood glucose (sugar) values were less than 45 mg/dL from 6:03 AM until 7:15 AM. Standing orders were not followed. The on-call provider was not notified of the values or about the resident's refusal of snacks and meal intake, and there was no documentation that Nurse #2 continued to monitor Resident #69's blood glucose (BG) after 7:15 AM. Long-acting insulin was administered by Nurse #2 at 9:00 AM without a documented blood glucose. Uncorrected hypoglycemia could result in brain injury or death. This deficient practice affected 1 of 1 residents reviewed for notification of change (Resident #69). Immediate jeopardy began on Saturday, 7/6/24 when Resident #69 experienced severe hypoglycemia and the provider was not notified. Immediate jeopardy was removed on 7/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Review of the facility's Standing Orders revised 7/10/23 revealed that for residents with hypoglycemia (BG less than 70mg/dL), staff should repeat the (blood glucose) test. If the reading was below 70 mg/dL and the resident was responsive; give 15 grams of glucose or 4 ounces of orange juice with one sugar packet by mouth or g-tube. Recheck in 15 minutes. If the second reading remained below 70, notify the provider for orders. Resident #69 was readmitted to the facility on [DATE] with diagnoses that included type 1 diabetes (insulin-dependent diabetes), dementia, hypoglycemia, hypothyroidism, anorexia and weight loss. Review of physician orders for Resident #69 revealed the following insulin orders for diabetes: - 5/24/24 Insulin Aspart (short-acting), Inject as per sliding scale subcutaneously before meals and at bedtime: if the reading was 150 - 200 give 2 units; if the reading was 201 - 250 give 4 units; if the reading was 251 - 300 give 6 units; if the reading was 301 - 350 give 8 units; if the reading was 351 - 400 give 10 units; if the reading was greater than 401 give 12 units and notify the physician Review of Resident #69's vital sign record for 7/6/24 revealed the following BG measurements in the morning by Nurse #1: - 6:03 AM 37.0 mg/dL - 6:30 AM 44.0 mg/dL (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- 7:15 AM 44.0 mg/dL - 11:30 AM 134 mg/dL Review of a progress note written by Nurse #1 dated 7/6/24 at 7:29 AM showed Resident #69 had an initial BG of 37. She administered a nutritional shake and rechecked the BG of 44. Resident #69 drank most of a second nutritional shake with a third recheck of BG remaining at 44. The information was passed on to Nurse #2 who would reassess and determine the next course of action. There was no documentation that the physician was not notified. Nurse #1, who worked the overnight shift from 7/5/24 through 7/6/24, was interviewed on 7/16/24 at 5:34 PM, and she revealed that hypoglycemic was considered less than 60 mg/dL. If a resident was hypoglycemic, she stated she would give the resident a nutritional shake or orange juice with sugar to bring the BG above 60 mg/dL. She would then check the BG again within an hour, and if it was still low, then she would call the provider. Resident #69 had brittle diabetes with BG values of 30 mg/dL up to 430 mg/dL were normal for her. On 7/6/24, Resident #69's BG did not increase like it usually did in the past. The initial BG measurement of 37 mg/dL did not increase after Resident #69 drank two nutritional shakes. Nurse #1 stated she administered nutritional shakes because they contained protein and sugar so that Resident #69's BG would not spike and crash later in the day. Also, Resident #69 preferred nutritional shakes over other liquids. Nurse #1 then tested her BG again 30 minutes later, and it did not significantly increase. She stated she then probably provided another nutritional shake and tested her blood sugar within 30-40 minutes, and again, it did not increase. At that point, Nurse #1 stated she handed off Resident #69 to the oncoming Nurse #2. Nurse #2 was going to check Resident #69's BG again and give glucagon, if necessary. Nurse #1 stated she did not call the provider because it was not an emergency with Resident #69. Her BG dropped frequently as low as 20 mg/dL, and she remained asymptomatic. Normally if the provider was notified, she would document in progress notes of the medical record the reason why they were contacted. On 7/17/24 at 1:40 PM, the Medical Director was interviewed. He revealed that if a resident was alert and conscious during a hypoglycemic event, nursing staff should give them a liquid that contained glucose or added sugar, then check the BG within 30 minutes and if it did not come up the second time, the MD should be notified. The MD stated that the provider needed to be involved in the decision making when the BG was below 50 mg/dL with the second BG check due to a possible transfer to the hospital. The MD indicated that if hypoglycemia was not corrected, the negative outcome could be brain injury. He stated that he was not notified of Resident #69's hypoglycemic event the morning of 7/6/24, and Nurses #1 and #2 did not do what they were supposed to do. With Resident #69's lack of response to the first round of nutritional shakes, the MD would have expected nursing to contact him or the on-call provider. For 7/7/24, once the problem was corrected, Resident #69's BG needed to be closely monitored. If the insulin coverage was put on hold, then it would affect the BG later in the day. If the BG was low, then short acting insulin was fine to administer. The MD stated that putting sliding scale insulin on hold was the provider's decision. Nurse #2 was interviewed on 7/18/24 at 10:41 AM. He revealed that he could not recall if he contacted the on-call provider the morning of 7/6/24, since Nurse #1 handed off Resident 69 to him with severely low BG. Review of the July 2024 MAR for Resident #69 revealed that her BG values on 7/6/24 were as follows, along with insulin administration at the corresponding times: (continued on next page)

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	- 4:30 PM: 143 mg/dL - insulin not administered due to outside of parameters for short-acting insulin - 9:00 PM: 175 mg/dL - insulin not administered due to resident refusal The Director of Nursing (DON) was interviewed on 7/17/24 at 2:19 PM. She stated per the standing orders, the provider should be notified on the second attempt to bring a resident's BG up from a hypoglycemic episode. The DON indicated that Nurse #1 should have contacted the provider after the second BG check on 7/6/24, and Nurse #2 should have communicated with a provider to receive orders. An interview was conducted with the Administrator on 7/18/24 at 10:23 AM. She stated she would expect all nurses to follow the standing orders for hypoglycemia and notify the provider of any hypoglycemic episodes on the second BG check. On 7/18/2024 at 2:25 PM, the facility's Administrator was informed of the immediate jeopardy. The facility provided the following credible allegation of immediate jeopardy removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. On July 6th, 2024, Resident #69 had a hypoglycemic episode in the morning. The Facility failed to effectively manage these hypoglycemic episodes as noted. On the morning of 7/6/2024, Resident #69 Blood sugars were as follows: 6:03am 37.0 mg/dl by Nurse #1 6:30am 44.0 mg/dl by Nurse #1 7:15am 44.0 mg/dl by Nurse #1 11:30am 134 mg/dl by Nurse #2 The on-call Provider was not notified by either Nurse #1 or Nurse #2 and there was no documentation to indicate Nursing continued to monitor resident #69's blood sugar after 7:15am. Director of Nursing notified the Medical Director/Provider on July 17, 2024, of resident #69's incidents on July 6th, 2024, with no new orders received. The Facility Director of Nursing and/or her designee completed an audit of all in house residents identified as using insulin for control of diabetes management on July 18th, 2024, and identified 16 residents with blood sugars and using the sliding scale for insulins, which could require utilization with the Standing Orders. If implementation of Standing Order for Blood Glucose checks and Hypoglycemia occurred in the last 14 days to identify if notification was made to the Medical Provider. The results of this audit have been reported to the Medical Director, July 18, 2024, by the Director of Nursing or her designee. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Facility Director of Nursing and/or her designee have initiated the education for all Licensed Nurses currently on duty on 7/18/24 scheduled for 7am-3pm or 7 am-7pm. Nurses not scheduled for this day shift will be contacted by phone by Director of Nursing/Designee and provided verbal education and will be required to sign the education sign in sheet, confirming receipt, prior to working next scheduled shift. New hired Licensed Nurses (including Agency nurses) will be educated during the hiring orientation process. This education includes the Standing Orders for Hypo/Hyper glycemia and expectations regarding the use of those orders, including notification of Medical Provider. Date of immediate jeopardy removal: 7/19/24. The facility's credible allegation of Immediate Jeopardy removal was validated on 7/24/24. The validation was evidenced by staff interviews, record reviews, and review of competency training logs. The interventions included education on facility standing orders/notification of change for licensed nurses and audits of insulin-dependent residents. The immediate jeopardy's removal date was validated as 7/19/24.

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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** 38702 Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessment for 1 of 22 residents reviewed for MDS accuracy (Resident #15). Findings including: Resident #151 was admitted to the facility on [DATE] with diagnoses including tracheostomy and personal history of malignant neoplasm of larynx. The 5-day MDS dated [DATE] revealed Resident #151 did not have a tracheostomy. The care plan dated 07/11/2023 had a focus of a long-term tracheostomy related to a history of larynx cancer. An interview with the Quality Assurance (QA) Nurse was conducted on 07/17/24 at 2:18 PM. She stated Resident #151 was receiving trach care and it should have been coded as receiving the care. It was a coding error due to an oversite. An interview with the Director of Nursing (DON) was conducted on 07/18/24 at 10:16 AM. The DON stated Resident #151 did have a trach and received trach care. It was a coding error and should have been coded correctly. An interview with the Administrator was conducted on 07/18/24 at 12:33 PM. The Administrator stated Resident #151 did have a tracheostomy and was supposed to have trach care coded correctly on the MDS.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 43222 Based on record review and interviews with the Nurse Practitioner, Medical Director, and staff, the facility failed to manage and assess Resident #69's hypoglycemic episodes (blood glucose less than 70 milligrams [mg] per deciliter [dL]) on the mornings of 7/6/24 and 7/7/24. Normal blood glucose ranges from 70 - 100, according to the lab used by the facility. On the morning of 7/6/24, Resident #69's blood glucose (sugar) values were less than 45 mg/dL from 6:03 AM until 7:15 AM. Standing orders were not followed. The on-call provider was not notified of the values or about the resident's refusal of snacks and meal intake, and there was no documentation that Nurse #2 continued to monitor Resident #69's blood glucose (BG) after 7:15 AM. Long-acting insulin was administered by Nurse #2 at 9:00 AM without a documented blood glucose. On the morning of 7/7/24, Nurse #1 took Resident #69's BG (time unknown) and the value read LO on the blood glucose meter (less than 20mg/dL). The BG was taken again at 5:30 AM and measured 32.0 mg/dL. Nurse #1 contacted the on-call provider and was verbally ordered to administer glucagon, but no order was written. There was no evidence of further BG assessment until 11:30 AM with a measurement of 168.0 mg/dL. The Nurse Practitioner (NP) was contacted (time unknown) and gave a verbal order to only hold the long-acting insulin at 9:00 AM; however, Nurse #2 withheld the short-acting insulin at 11:30 AM when 2 units should have been administered. Resident #69's BG values in the afternoon were 343 mg/dL at 4:30 PM and 400mg/dL at 9:00 PM. Uncorrected hypoglycemia could result in brain injury or death. This deficient practice affected 1 of 1 residents reviewed for diabetes care (#69). Immediate jeopardy began on Saturday, 7/6/24 when Resident #69 experienced severe hypoglycemia and the provider was not consulted to obtain orders for medical intervention. Immediate jeopardy was removed on 7/19/24 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Review of the blood glucose meter owner's manual provided by the facility revealed that a LO reading result meant the BG measurement was less than 20 mg/dL. Review of the facility's Standing Orders revised 7/10/23 revealed that for residents with hypoglycemia (BG less than 70mg/dL), staff should repeat the (blood glucose) test. If the reading was below 70 mg/dL and the resident was responsive; give 15 grams of glucose or 4 ounces of orange juice with one sugar packet by mouth or g-tube. Recheck in 15 minutes. If the second reading remained below 70, notify the provider for orders. Resident #69 was readmitted to the facility on [DATE] with diagnoses that included type 1 diabetes (insulin-dependent diabetes), dementia, hypoglycemia, hypothyroidism, anorexia and weight loss. Resident #69's care plan in place 3/6/24 included an area of focus that read, [Resident #69] had diabetes, and her BG was low and/or high at times. Interventions included: Administer insulins per the physician's orders. Attempt to observe and report as needed any signs/symptoms of hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of physician orders for Resident #69 revealed the following insulin orders for diabetes: - 5/24/24 Insulin Aspart (short-acting), Inject as per sliding scale subcutaneously before meals and at bedtime: if the reading was 150 - 200 give 2 units; if the reading was 201 - 250 give 4 units; if the reading was 251 - 300 give 6 units; if the reading was 301 - 350 give 8 units; if the reading was 351 - 400 give 10 units; if the reading was greater than 401 give 12 units and notify the physician - 5/29/24 for Insulin Glargine (long-acting) 12 units in the morning for diabetes. According to diabetesnet.com, short-acting insulin starts 10-20 minutes after administration, peaks within 1.5 - 2.5 hours, and ends 4.5 - 6 hours after administration. Long-acting insulin starts 1 - 2 hours after administration, peaks within 6 hours, and ends 18 - 26 hours after administration. Review of the manufacturer's nutritional data for nutritional shake (mighty shake) revealed that it contained 20 grams of sugar and 4 grams of protein per 4 ounce serving. Resident #69's quarterly Minimum Data Set (MDS) dated [DATE] indicated she was severely cognitively impaired and was dependent on staff for all activities of daily living (ADL). Resident #69 received 7 insulin injections during the review period. Review of Resident #69's vital sign record for 7/6/24 revealed the following BG measurements in the morning by Nurse #1: - 6:03 AM 37.0 mg/dL - 6:30 AM 44.0 mg/dL - 7:15 AM 44.0 mg/dL Review of a progress note written by Nurse #1 dated 7/6/24 at 7:29 AM showed Resident #69 had an initial BG of 37. She administered a nutritional shake and rechecked the BG of 44. Resident #69 drank most of a second nutritional shake with a third recheck of BG remaining at 44. The information was passed on to Nurse #2 who would reassess and determine the next course of action. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse #1, who worked the overnight shift from 7/5/24 through 7/6/24, was interviewed on 7/16/24 at 5:34 PM, and she revealed that hypoglycemic was considered less than 60 mg/dL. If a resident was hypoglycemic, she stated she would give the resident a nutritional shake or orange juice with sugar to bring the BG above 60 mg/dL. She would then check the BG again within an hour, and if it was still low, then she would call the provider. Resident #69 had brittle diabetes with BG values of 30 mg/dL up to 430 mg/dL were normal for her. On 7/6/24, Resident #69's BG did not increase like it usually did in the past. The initial BG measurement of 37 mg/dL did not increase after Resident #69 drank 2 nutritional shakes. Nurse #1 stated she administered nutritional shakes because they contained protein and sugar so that Resident #69's BG would not spike and crash later in the day. Also, Resident #69 preferred nutritional shakes over other liquids. Nurse #1 then tested her BG again 30 minutes later, and it did not significantly increase. She stated she then probably provided another nutritional shake and tested her blood sugar within 30-40 minutes, and again, it did not increase. At that point, Nurse #1 stated she handed off Resident #69 to the oncoming Nurse #2. Nurse #2 was going to check Resident #69's BG again and give glucagon, if necessary. Nurse #1 stated she did not call the provider because it was not an emergency with Resident #69. Her BG dropped frequently as low as 20 mg/dL, and she remained asymptomatic. Normally if the provider was notified, she would document in progress notes of the medical record the reason why they were contacted. On 7/17/24 at 4:21 PM, Nurse Aide (NA) #1 was interviewed. She stated that she offered Resident #69 a snack around 8-9 PM on 7/6/24 (cookie and vanilla nutritional shake). Resident #69 did not display abnormal signs or symptoms during the overnight shift from 7/6/24 PM to 7/7/24 AM. NA #1 indicated that she was aware Resident #69 had very low BG on the morning7/7/24. However, she did not display any signs or symptoms of hypoglycemia (nausea, sweating, vomiting, etc.). Review of the Medication Administration Record (MAR) during the month of July 2024 for Resident #69 revealed that Nurse #2 administered long-acting insulin at 9:00 AM on 7/6/24. An interview was conducted with Nurse #2, the dayshift nurse for 7/6/24 and 7/7/24, on 7/18/24 at 10:41 AM. On 7/6/24, he stated Resident #69's BG was monitored every hour from 7:15 AM to 11:30 AM. However, Nurse #2 stated he did not document this activity due to no time. Resident #69's BG was on a slow uptrend, but he could not recall the details of the measurements. Review of the July 2024 MAR for Resident #69 revealed that her BG values on 7/6/24 were as follows, along with insulin administration at the corresponding times: - 4:30 PM: 143 mg/dL - insulin not administered due to outside of parameters for short-acting insulin - 9:00 PM: 175 mg/dL - insulin not administered due to resident refusal Review of the vital signs for Resident #69 on 7/7/24 revealed a blood sugar result of 32 mg/dL at 5:30 AM by Nurse #3. A nurse's progress note written by Nurse #3 dated 7/7/2024 at 8:12 AM revealed Resident #69 had a BG reading of LO on the blood glucose meter. Nurse #3 gave two nutritional shakes to Resident #69, and her BG increased to 32 mg/dL. Nurse #3 then gave glucagon (raises the concentration of glucose and fatty acids in the bloodstream) and two more nutritional shakes. The oncoming Nurse #2 was made aware. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of an orders administration note dated 7/7/2024 at 11:02 AM by Nurse #2 revealed that 12 units of long-acting insulin was held. Resident #69 consumed 0-25% of breakfast meal that morning. Review of Resident #69's vital signs for 7/7/24 at 11:10 AM revealed the BG measurement was 168 mg/dL. Review of an orders administration note dated 7/7/2024 at 11:10 AM by Nurse #2 revealed that the short-acting insulin was held for Resident #69. An interview was conducted with Nurse #3, who worked the overnight shift from 7/6/24 to 7/7/24, on 7/16/24 at 3:35 PM. She revealed if a resident's BG was less than 70 mg/dL, she would give the resident orange juice or regular soda to bring it up. She would then wait 15-30 minutes and recheck the BG. If it was still low, she would call the provider. On the morning of 7/7/24, Resident #69 had a low BG and was given one nutritional shake. Nurse #3 stated she checked the BG again and it was still low, so she gave Resident #69 another nutritional shake. Resident #69 had brittle diabetes, and it was not uncommon to find her hypoglycemic. She stated she could not recall if she notified the provider of the low BG measurements. If she notified the on-call provider, there would be documentation in the progress notes of the medical record. She should have notified the doctor on the second check and did not know why the documentation of doctor notification was missing. Nurse #3 stated she administered nutritional shakes because Resident #69 preferred them, and her BG value would not spike and crash throughout the day. During a follow-up interview with Nurse #3 on 7/17/24 at 3:29 PM, she revealed that she contacted the Medical Director (MD) on 7/7/24 at 8:00 AM. The MD instructed her to give Resident #69 glucagon on the second check due to severe hypoglycemia. She stated it was a verbal order; however, she did not transcribe the written order and just gave her glucagon. Nurse #2 was interviewed on 07/17/24 04:33 PM. When he came on shift the morning of 7/7/24, Nurse #3 gave him report about Resident #69's low BG levels, and he was not surprised. Nurse #2 was unsure if Nurse #3 called the provider before he arrived. Before he started passing medications to his assigned residents, he contacted the Nurse Practitioner (NP) and notified her of Resident #69's low BG. The NP gave him the order to hold all her insulin and monitor the blood sugar. He would have normally documented that the NP told him to hold all the insulin. Nurse #2 stated that he was supposed to put in a written order after given a verbal order. Resident #69 remained asymptomatic on 7/7/24, and she did not display any signs or symptoms as the day went on. During a follow-up interview with Nurse #2 on 7/18/24 at 10:41 AM, he revealed on 7/7/24, Resident #69's BG was monitored every hour from 5:30 AM to 11:30 AM. Nurse #2 stated he did not document this activity due to no time. Resident #69's BG was on a slow uptrend, but he could not recall the details of the measurements. The NP was interviewed on 7/17/24 at 4:46 PM. She stated she was not on call the weekend of 7/7/24, but she believed there was a delay in reaching out to the on-call provider. Nurse #2 reached out to her about Resident #69's low BG she had earlier that morning. The BG had increased after Nurse #2 reached out to her when asking about insulin administration, since she was not eating well. The NP stated that she told Nurse #2 to hold the long-acting insulin and continue with BG checks along with the short acting insulin. She was aware that Resident #69 had very low BG, but she found out later that the blood glucose meter read LO. (continued on next page)

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	345349	A. Building B. Wing	07/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Wellness Center Inc	2778 Country Club Drive Hampstead, NC 28443

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a follow-up interview with the NP on 7/18/24 at 9:16 AM, she revealed that she would have expected Nurse #2 to check Resident #69's blood sugar every 10-15 minutes on 7/7/24 until it reached 100 mg/dL, and that she was taking in something orally. On 7/17/24 at 1:40 PM, the MD was interviewed. He revealed that if a resident was alert and conscious during a hypoglycemic event, nursing staff should give them a liquid that contained glucose or added sugar, then check the BG within 30 minutes and if it did not come up the second time, the MD should be notified. The MD stated that the provider needed to be involved in the decision making when the BG was below 50 mg/dL with the second BG check due to a possible transfer to the hospital. The MD indicated that if hypoglycemia was not corrected, the negative outcome could be brain injury. He stated that he was not notified of Resident #69's hypoglycemic event the morning of 7/6/24, and Nurses #1 and #2 did not do what they were supposed to do. With Resident #69's lack of response to the first round of nutritional shakes, the MD would have expected nursing to contact him or the on-call provider. For 7/7/24, once the problem was corrected, Resident #69's BG needed to be closely monitored. If the insulin coverage was put on hold, then it would affect the BG later in the day. If the BG was low, then short acting insulin was fine to administer. The MD stated that putting sliding scale insulin on hold was the provider's decision. Resident #69 often refuses care (medications, meals, etc.), so her BG levels were all over the spectrum. She saw the endocrinologist on 7/12/24, and they reduced her long-acting insulin from 12 units to 9 units at 9:00 AM. During a follow-up interview with the MD on 7/18/24 at 10:56 AM, he stated he was called by Nurse #3 on the morning of 7/7/24 about Resident #69's low BG. The MD indicated he might have verbally ordered glucagon but could not say for sure. The Director of Nursing (DON) was interviewed on 7/17/24 at 2:19 PM. She stated per the standing orders, the provider would be notified on the second attempt to bring a resident's BG up from a hypoglycemic episode. Nurse #1 should have contacted the provider after the second BG check on 7/6/24, and Nurse #2 should have communicated with a provider to receive orders. On 7/7/24, if Resident #69's BG was 168 mg/dL at 11:10 AM, then Nurse #2 should have followed the order for short-acting sliding scale insulin. During a follow-up interview with the DON on 7/18/24 at 10:07 AM, she revealed that Nurse #2 should have retrieved more information from Nurse #1 on 7/6/24. She would have expected the oncoming nurse (Nurse #2) to check Resident #69's BG every 30 - 60 minutes until it increased to 70mg/dL on both mornings of 7/6 and 7/7. On 7/6/24, Nurse #1 told the DON that she continued to check Resident #69's BG and gave her snacks until her BG came back up to normal. However, Nurse #1 should have notified the provider on the second check of BG. The oncoming nurse (Nurse #2) should have continued to call the provider, check and document BG measurements, and give Resident #69 oral glucose (such as glucagon) to bring it up. All BG checks should have been documented. After the LO reading on the blood glucose monitor the morning of 7/7/24, the DON would have repeated the BG check or retrieved a different glucometer. Nurse #3 should have contacted the provider after the second BG check, and the oncoming nurse (Nurse #2) should have continued with treatment. After a verbal order was given, a written order should be entered. An interview was conducted with the Administrator on 7/18/24 at 10:23 AM. She stated she would expect all nurses to follow the standing orders for hypoglycemia. The Administrator stated that when orders were given verbally, they should have been written as well. On 7/7/24, the short-acting insulin should have been given per NP orders when Resident #69's BG was measured as 168 mg/dL at 11:10 AM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 7/18/2024 at 11:05 AM, the facility's Administrator was informed of the immediate jeopardy. The facility provided the following credible allegation of immediate jeopardy removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. A. On July 6th and 7th, 2024 Resident #69 had a hypoglycemic episode in the morning. The Facility failed to effectively manage these hypoglycemic episodes as noted. On the morning of 7/6/2024, Resident #69 Blood sugars were as follows: 6:03am 37.0mg/dl by Nurse #1 6:30am 44.0 mg/dl by Nurse #1 7:15am 44.0 mg/dl by Nurse #1 11:30am 134 mg/dl by Nurse #2 The on-call Provider was not notified by either Nurse #1 or Nurse #2 and there was no documentation to indicate Nursing continued to monitor resident #69's blood sugar after 7:15am. Nurse #2 did administer the Long- Acting Insulin at 9am. On the morning of July 7th, 2024, Nurse #1 took Resident #69 Blood sugar (time unknown) and the value on the glucometer read LO. According to the manufacturer LO indicates less than 20mg/dl. The blood sugar was taken again at 5:30am and measured 32.0mg/dl. Nurse #1 contacted the on- call provider, and was ordered to administer glucagon, but no order was written. There was no evidence of further blood sugar assessment until 11:30am with a measurement of 168.0 mg/dl. The Nurse Practitioner was contacted (time unknown) and gave a verbal order to hold only the long-acting insulin at 9:00am; however, Nurse #2 withheld the short-acting insulin at 11:30am when 2 units should have been administered. Resident #69's blood sugars in the afternoon were as follows: 4:30pm 343 mg/dl 9:00pm 400 mg/dl The Standing Orders instructed nurses to contact the provider on-call if the blood sugar did not measure above 70mg/dl on the second blood check. B. Director of Nursing notified the Medical Director/Provider on July 17, 2024, of resident #69's incidents on July 6th and July 7th, 2024, with no new orders received. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C. The Facility Director of Nursing and/or her designee completed an audit of all in house residents identified as using insulin for control of diabetes management on July 18th, 2024, and identified 16 residents with blood sugars and using the sliding scale for insulins, which could require utilization with the Standing Orders. If implementation of Standing Order for Blood Glucose checks and Hypoglycemia occurred or should have occurred in the last 14 days for these residents, any failure to implement or follow these standing orders will be reported to the Medical Provider for review by 4pm on July 18, 2024. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. The Facility Director of Nursing and/or her designee have initiated the education for all Licensed Nurses currently on duty on 7/18/24 scheduled for 7am-3pm or 7 am-7pm. Nurses not scheduled for this day shift will be contacted by phone by Director of Nursing/Designee and provided verbal education and will be required to sign the education sign in sheet, confirming receipt, prior to working next scheduled shift. Staff Development Coordinator educated by Director of Nursing on 7/18/24 that all future Newly hired Licensed Nurses (including Agency nurses) will be educated during the hiring orientation process. This education includes the Standing Orders for Hypo/Hyper glycemia and expectations regarding the use of those orders. Education provided Licensed Nurses includes: - Blood Glucose checks: May perform a fingerstick blood glucose level PRN sign/symptoms of hyper/hypoglycemia. - Hypoglycemia: For Blood sugars less than 70mg/dl: a. Repeat the test b. If the second reading remains below 70, notify the MD for orders. If the reading is below 70mg/dl and the resident is Responsive; may give 15gm of Glucose or 4oz orange juice with one sugar packet by mouth or g-tube. Recheck in 15 minutes and notify the MD. If the resident is Unresponsive, call 911 and administer Glucagon1gm IM. Notify the MD. - Expectations given along with the use of the Standing Orders: a. You will follow the Standing Order being utilized b. You will enter the orders as a telephone/verbal order c. You will execute those orders d. You will notify the Medical Provider on Call of initiating the standing orders being initiated, obtain any additional orders and transcribe into the clinical orders. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. All and any interventions implemented are to be documented into the clinical record, whether nursing judgements, orders given or monitoring as related. - Diabetes and Clinical Protocol which includes the following: a. Assessment and Recognition b. Treatment and Management c. Monitoring and Follow-up - Nursing Care of the Resident with Diabetes Mellitus which includes: A. Conditions associated with Diabetes: Hyperglycemia, Diabetic Ketoacidosis, Hypoglycemia B. Glucose Monitoring C. Management of Hypoglycemia The Facility Director of Nursing and/or her designee have initiated the education for all Certified Nursing Assistants currently on duty on 7/18/24 scheduled for 7 am-7pm, and 3pm-11pm Certified Nursing Assistants not scheduled for today on these shifts will be contacted by phone by Director of Nursing/Designee on 7/18/24 and provided verbal education and will be required to sign the education sign in sheet, confirming receipt, prior to working next scheduled shift. Staff Development Coordinator educated by Director of Nursing on 7/18/24 that all future Newly hired Certified Nursing Assistants (including Agency CNAs) will be educated during the hiring orientation process. Education provided to CNAs includes, but may not be limited to: - What is Diabetes - Causes of Diabetes - Types of Diabetes - Typical treatment of Hypo and Hyperglycemia - Signs and symptoms of Hypo/Hyperglycemia, and reporting to nurse of these signs and symptoms - Importance of meal intake (undereating/overeating, etc) with reporting to nurse meal intake of less than 25% Alleged immeidate jeopardt removal date: July 19, 2024 (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's credible allegation of immediate jeopardy removal was validated on 7/24/24. The validation was evidenced by staff interviews, record reviews, and review of competency training logs. The interventions included education on the facility's policies and protocols for Nursing Care of the Resident with diabetes which included the signs and symptoms of a resident experiencing hypoglycemia and hyperglycemia (high blood sugar level). The education also included a review of the facility's Standing Orders related to hypoglycemia and hyperglycemia, when to call the doctor, and chronological documentation of the episode and notifications made. The immediate jeopardy removal date was verified as 07/19/24.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on staff interviews and record review, the facility failed to maintain a complete and accurate medical record for 1 of 22 residents' medical records reviewed (Residents #69). The findings included: Resident #69 was readmitted to the facility on [DATE] with diagnoses including dementia and diabetes. A nurse's progress note written by Nurse #3 dated 7/7/2024 at 8:12 AM revealed Resident #69 had a BG reading of LO on the blood glucose meter. Nurse #3 gave 2 nutritional shakes to Resident #69, and her BG increased to 32mg/dL. Nurse #3 then gave glucagon and 2 more nutritional shakes. The oncoming Nurse #2 was made aware. The medical record included no evidence that verbal orders were transcribed for glucagon to be administered and long-acting insulin to be held on 7/7/24 due to severe hypoglycemia. There was also no documentation that the provider was notified or that Resident #69's blood glucose levels were monitored after 8:12 AM. Nurse #3 was interviewed on 7/16/24 at 3:35 PM. She revealed that if she notified the provider, there would be documentation in the progress notes of Resident #69's medical record. Nurse #3 stated she should have notified the provider when she checked Resident #69's blood glucose (sugar) for the second time. She indicated that she did not know why the documentation of provider notification was missing, and she should have documented all BG levels after 5:30 AM. During a follow-up interview with Nurse #3 on 7/17/24 at 3:29 PM, she revealed that she called the Medical Director (MD) on 7/7 at 8:00 AM. She was given a verbal order to administer glucagon to Resident #69 when her blood glucose was considered severely hypoglycemic. Nurse #3 stated the verbal order was not entered into physician orders as it should have been. An interview was conducted with Nurse #2 on 07/17/24 at 4:33 PM revealed when he came on shift the morning of 7/7/24, Nurse #3 gave him report about Resident #69's low blood glucose levels, and he contacted the Nurse Practitioner (NP) and notified her of Resident #69's low BG. The NP gave him the order to hold all her insulin and monitor the blood sugar. He would have normally documented that the NP told him to hold all the insulin. Nurse #2 stated that he was supposed to put in a written order after given a verbal order. He should have documented all BG levels after he came on shift at 7:00 AM. During a follow-up interview with Nurse #2 on 7/18/24 at 10:41 AM, he revealed on 7/7/24, Resident #69's blood glucose was monitored every hour from 5:30 AM to 11:30 AM. Nurse #2 stated he did not document this activity due to no time. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The NP was interviewed on 7/17/24 at 4:46 PM. The NP stated that she told Nurse #2 to hold the long-acting insulin and continue with blood glucose checks along with the short acting insulin. The verbal order should have been documented in Resident #69's physician orders. The Director of Nursing (DON) was interviewed on 7/18/24 at 10:07 AM. She revealed that all blood glucose checks should have been documented. The DON stated that after a verbal order was given, a written order should be entered. The Administrator was interviewed on 7/18/24 at 10:23 AM. She stated that when orders were given verbally, they should have been written as well.