

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345349	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/17/2025
NAME OF PROVIDER OR SUPPLIER Woodbury Wellness Center Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 3 residents (Resident #12) reviewed for respiratory care. The findings included: Resident #12 was admitted to the facility on [DATE]. Her diagnoses included asthma, and chronic obstructive pulmonary disease (COPD). Resident #12's care plan had a care focus area initiated on 7/11/25 that indicated that Resident #12 was at risk for altered respiratory status related to COPD and asthma. Interventions included administer oxygen per physician orders. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 was cognitively intact. Her diagnoses included asthma and chronic obstructive pulmonary disease. She was coded for shortness of breath or trouble breathing with exertion, sitting at rest and when lying flat. A physician order dated 8/6/25 indicated provide oxygen at 2 liters/minute via nasal cannula for shortness of breath to maintain oxygen saturations above 90%. During observation on 9/30/25 at 12:25 PM Resident #12 was observed with the oxygen nasal cannula in place. Resident #12's oxygen regulator on the concentrator was set at 5 liters/minute when viewed horizontally at eye level. Resident #12 indicated she could not reach the oxygen concentrator without staff assistance and that she had not adjusted the oxygen rate. During observation on 10/1/25 at 11:35 AM Resident #12 was observed with the oxygen nasal cannula in place. Resident #12's oxygen regulator on the concentrator was set at 5 liters/minute when viewed horizontally at eye level. Resident #12 stated that she had not adjusted the oxygen rate. Resident #12's oxygen regulator was verified with Nurse #1 to be set at 5 liters/minute. During an interview on 10/1/25 at 11:39 AM with Nurse #1, she stated that Resident #12 had a physician order for oxygen at 2 liters/minute via nasal cannula for shortness of breath to keep oxygen saturations above 90%. Nurse #1 stated she had not checked Resident #12's oxygen rate prior to this observation and that she would normally check it when she went to the room, but she had not checked it earlier that morning when she was in Resident #12's room. During an interview on 10/1/25 at 12:21 PM with the Unit Manager she indicated that Nurse #1 should have verified that the oxygen setting was at the physician's ordered rate at the beginning of the shift. An interview was conducted on 10/2/25 at 1:12 PM with the Nurse Practitioner (NP). She stated Resident #12 had an order for oxygen at 2 liters/minute via nasal cannula to keep oxygen saturations above 90%. The NP stated she expected nurses to ensure that oxygen was set at the ordered rate and if they needed to titrate the oxygen rate, she expected nurses to call the provider to request adjustment to the oxygen rate. An interview was conducted on 10/2/25 at 1:17 PM with the Director of nursing (DON). She stated that Nurse #1 should have validated that Resident #12's oxygen regulator was set at the physician ordered rate. The DON explained she expected nursing staff to follow physician orders and to request an updated order if there was a need to titrate the oxygen. She stated that nurses should verify oxygen rates at the beginning of their shifts and throughout their shift. During an interview on 10/2/25 at 1:23 PM with the Administrator, she stated she expected nurses to monitor the oxygen setting to ensure that it was set at the provider ordered setting.</p>

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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