STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood Nursing and Retirement	180 Southwood Drive Clinton, NC 28328

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 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** 38702 Based on record review, Resident interview and staff interviews, the facility failed to obtain the blood sugar (BS) level and administer a Residents' insulin medication as ordered by the physician to treat hyperglycemia (a side effect of too much glucose (sugar) in the blood). This affected 1 of 5 residents reviewed for medication administration (Resident #25). The findings included: Resident #25 was readmitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus. The 5-day Minimum Data Set (MDS) dated [DATE] had Resident #25 coded as cognitively intact and was receiving insulin injections. The care plan dated 10/28/2024 had focus of a diagnosis of diabetes mellitus with risk for complications with interventions to include administration of diabetes medication as ordered by doctor and to monitor blood glucose levels as ordered by physician. A review of the physician order dated 10/28/2024 revealed Humalog Solution (Humalog is a fast-acting insulin that starts to work about 15 minutes after injection and peaks in about 1 hour and keeps working for 2-4 hours). Inject as per sliding scale subcutaneously before meals for diabetes. Give 30 minutes before meals, 8:00 AM, 11:30 AM and 4:30 PM. If BS is: 8 - 150 = 8 units 151 - 200 = 10 units 201 - 250 = 12 units 251 - 300 = 14 units 301 - 350 = 16 units 351 - 400 = 18 units (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	401+ Call provider Hours On 10/30/2024 there was no documentation in the medical record for 11:30 AM. An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 10/30/2024 Resident #25 had an appointment and her Responsible Party (RP) came to pick her up. The Resident had gotten her BS checked at 11:05 AM and it was 128. The DON also stated she was not able to administer the Resident her sliding scale of 8 units because the RP came and got the Resident and left the building. The DON also stated she failed to document why there was a missed dosage of insulin. On 11/16/2024 at 8:00 AM and at 11:30 AM, the MAR revealed Resident #25's BS was documented as 312 and 16 units of insulin was administered. An interview with Nurse #1 was conducted on 01/23/2025 at 12:53 PM. The nurse stated she was the Nurse for Resident #25 on 11/16/2024. The Nurse also stated she followed the orders for Residents that needed BS checks. She got their BS and documented on a report sheet and then entered the amount in the MAR. If the Resident needed coverage, then she would gather her supplies and administer the dosage according to the sliding scale order. This documentation went straight to the MAR. The Nurse further stated the morning blood sugar documentation in the MAR was the accurate BS and she did not administer a second dose of 16 units of insulin at lunch time. If there was another BS level with the same amount at different times, then she would question it, especially since the Resident Received 16 units of Humalog at 8:30 AM. She could not recall what was happening at the facility at that time to make her put the same amounts in the MAR but the 11:30 AM BS could not be accurate, and she must have missed obtaining the BS. An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 11/16/2024, there was documentation of 16 units of insulin administered at 8:00 AM and 11:30 AM, but Nurse #1 would not administer a BS that was the same value after that much time had passed, so it had to be documented incorrectly. The DON stated she did not know how it happened, but Nurse #1 did not usually make documentation errors. The DON also stated her expectation was that they exercise accurate documentation according to the Residents orders. An interview with Resident #25 was conducted on 01/24/2025 at 9:07 AM. The Resident stated she had a couple of BS and insulin coverages missing but it did not cause her any issues. An interview with the Medical Director (MD) was conducted on 01/24/2025 at 2:14 PM. The MD stated she was familiar with Resident #25, and the Resident had type 2 diabetes mellitus and insulin was needed to help regulate hyperglycemia in the blood. The missed BS and the missing dose of insulin did not cause a negative reaction for the Resident. The MD also stated she expected the staff to follow physician orders. An interview with the Administrator was conducted on 01/24/2025 at 3:05 PM. The Administrator stated she expected the nursing staff to administer the Residents' medications accordingly.