Printed: 05/28/2025
Form Approved OMB
No. 0938-0391

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35930 Based on observations, record review, and resident, staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the physician prescribed rate for 1 of 3 residents reviewed for respiratory care (Resident #38). The findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses which included chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions) and dependence on supplemental oxygen. A review of Resident #38's Physician Orders read, O2 [oxygen] at 2L [liters] continuous via nasal cannula (tubing that delivers oxygen from an oxygen source to the resident's nose) and was written on 11/21/23. A review of Resident #38's quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident was cognitively intact and was on oxygen therapy A review of Resident #38's Care Plan, last revised 12/26/24, revealed a focus of altered respiratory status/difficulty breathing related to an old healing trach [tracheostomy] site and a focus of receives oxygen therapy. Interventions included provide oxygen as needed. An observation of Resident #38 was made on 01/21/25 at 10:39 A.M. Resident #38 was observed awake, alert and sitting up in her bed. She was receiving oxygen via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver oxygen at 1.5L per minute. A second observation and interview of Resident #38 was made on 01/21/25 at 12:36 P.M. Resident #38 was sitting up in her bed, awake and alert. Her oxygen concentrator was still set to deliver her oxygen at 1.5 L per minute. Resident #38 said it was supposed to be set at 2L per minute and denied changing the setting. She stated she was unaware of who changed the setting on the concentrator. (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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #1 on 01/21/25 at 2:56 P.M. Nurse #1 stated she was unaware of Resident #38's oxygen concentrator 1.5L setting and confirmed she had not changed the setting. Nurse #1 explained she had checked Resident #38's oxygen saturation using a pulse oximeter around 11:00 A.M. and it had been 97%. She stated that she had checked the oxygen concentrator setting earlier that morning and it had been set correctly at 2L per minute. She was unaware of who might have changed the setting. An observation of Resident #38's oxygen concentrator setting was conducted with Nurse #1 on 01/21/25 at 3:00 P.M. The oxygen concentrator remained at the 1.5L setting. Nurse #1 checked Resident #38's oxygen saturation using a pulse oximeter which read 94%. Nurse #1 was observed changing the setting on the oxygen concentrator to 2L and Resident #38's oxygen saturation was rechecked and had improved to 97%. A telephone interview with Nurse Practitioner (NP #1) was conducted on 01/24/25 at 3:35 P.M. NP #1 indicated Resident #38 did not experience any respiratory distress when the oxygen concentrator had been set at 1.5L per minute. NP #1 stated it was her expectation nurses follow the physician's orders for oxygen therapy. An interview with the Director of Nursing (DON) was conducted on 01/24/25 at 11:02 A.M. The DON stated it was her expectation nursing staff adhered to policy and procedures for residents on oxygen therapy, making sure they check the physician's orders and apply the prescribed setting on the oxygen concentrators. An interview with the Administrator was conducted on 01/24/25 at 2:00 P.M. The Administrator stated it was her expectation that nursing staff taking care of residents who are on oxygen therapy ensure the oxygen concentrators are set to the physician order for oxygen.

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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 38702

Based on record review and staff interviews, the facility failed to have a complete and accurate electronic medical record (EMR) for a Resident with type 2 diabetes mellitus. This affected 1 of 5 residents reviewed for medical record accuracy (Resident #25).

The findings included:

Resident #25 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus.

A review of the October and November Medication Administration Record (MAR) revealed an order for 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

401+ Call provider Hours

On 10/30/2024 at 8:00 AM, the MAR revealed Resident #25's BS was 172, and 10 units of insulin were administered, there was no documentation 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 at 11:30 AM, Resident #25's BS was 128. She was not able to administer the Resident's sliding scale of 8 units because the RP came to take the Resident to an appointment and left the building before administering the medication. The DON also stated she did let the RP know she needed the coverage. The DON further stated she was supposed to document the Residents' 11:30 AM BS and missed dosage of insulin in the MAR but failed to do so.

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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and the morning blood sugar documentation in the MAR at 8:30 AM was the accurate blood sugar level. She could not recall what was happening at the facility at that time to make her put the same amounts in the MAR twice, but the 11:30 AM blood sugar on 11/16/2024 could not be accurate. An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 11/16/2024, Nurse # 1 would not have given 16 units of insulin twice and it had to be documented incorrectly. 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 physicians' 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 document the EMRs accurately.