PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345349	B. WING _				24/2024
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 017	2-1/202-1
WOODBIII	RY WELLNESS CENTER	INC		27	78 COUNTRY CLUB DRIVE		
WOODBUI	RI WELLNESS CENTER	INC		HA	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducted through 7/18/24. Additional obtained remotely on the immediate jeopard conducted on 7/24/24 was 7/24/24. The fact compliance with the resemble of the immediate jeopard INITIAL COMMENTS. A recertification and obtained remotely on the immediate jeopard conducted on 7/24/24 was 7/24/24. Event III. One (1) of the 24 coma deficiency. The followinvestigated: NC0021 NC00211046, NC208 NC00207146, NC002 Immediate Jeopardy of CFR 483.10 at tag F5 (J). CFR 483.25 at tag F6 (J). The tag F684 constitutions.	tional information was 7/19/24. Onsite validation of dy removal plan was Therefore, the exit date dility was found in equirement CFR 483.73, ness. Event ID #ZV1Y11. Complaint investigation donsite from 7/15/24 dilitional information was 7/19/24. Onsite validation of dy removal plan was Therefore, the exit date D# ZV1Y11. Inplaint allegations resulted in lowing intakes were 9746, NC00212071, 725, NC00208321, 06773, and NC00205214. Invasi dentified at: 1880 at a scope and severity at the Substandard Quality of longer on 07/06/24 and was longer on 07/06/2	F	000			
ADODATES	An extended survey v	vas conducted. SUPPLIER REPRESENTATIVE'S SIGNATURI			TITLE		(X6) DATE

Electronically Signed

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

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		OMPLETED
		345349	B. WING			C
	ROVIDER OR SUPPLIER	1000		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		07/24/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 567 SS=B	CFR(s): 483.10(f)(1 §483.10(f)(10) The manage his or her f the right to know, in facility may impose funds. (i) The facility must deposit their person resident chooses to the facility, upon writesident, the facility resident's funds and adcount for the deposited with the fisection. (ii) Deposit of Funds (A) In general: Excello)(ii)(B) of this section and resident's person interest bearing separate from any caccounts, and that or esident's funds to taccounts, there must for each resident's simaintain a resident's simaintain a resident' exceed \$100 in a nointerest-bearing account (B) Residents whos The facility must defunds in excess of \$100 in a nointerest earned of account (In pooled separate accounting The facility must material singular than the facility must ma	resident has a right to inancial affairs. This includes advance, what charges a against a resident's personal not require residents to all funds with the facility. If a deposit personal funds with itten authorization of a must act as a fiduciary of the hold, safeguard, manage, personal funds of the resident acility, as specified in this	F 50	67		8/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
						С
		345349	B. WING _		07	7/24/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
WOODBII	DV WELLNESS CENT	TED INC		2778 COUNTRY CLUB DRIVE		
WOODBO	RY WELLNESS CENT	IER INC		HAMPSTEAD, NC 28443		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	E APPROPRIATE	COMPLETION DATE
F 567	Continued From p	age 2	F 5	67		
	_	ecount, or petty cash fund. ENT is not met as evidenced				
	,	t and staff interviews the facility		Preparation and submission	of this plan	
	failed to allow resid	dents to withdraw money from		of correction is in response to	the CMS	
	their personal facil	ity held account after normal		Form 2567 from the 07/24/20)24 survey. It	
	banking hours. Th	nis was for 1 of 1 resident		does not constitute an agree		
		mpled for personal funds and		admission by Woodbury Well		
	· •	o affect all residents with		of the truth of the facts allege	ed or of the	
	personal funds acc	counts.		correctness of the conclusior the statement of deficiency.		
	The findings include	ded:		reserves all rights to contest deficiencies, findings, conclu-	the	
	A review of Reside	ent #10's quarterly Minimum		actions of the Agency. This I		
		13/24 indicated that he was		Correction (and the attached		
	cognitively intact.			also functions as the facility allegation of compliance.	•	
	An interview condu	ucted on 7/15/24 at 11:55 AM				
	with Resident #10	revealed that he was unable to		#1 - Address how corrective	action will be	
	access his money	the facility held for him after		accomplished for those resid	ents found to	
	the business office	e closed for the day and on		have been affected by the de	eficient	
	weekends.			practice;		
	An interview cond	ucted on 7/17/24 at 9:52 AM		For Resident # 10:		
	with the Business	Office revealed that residents		" Signage for all residents	, staff and	
	were able to acces	ss their money during normal		visitors was posted on Financia	ce Office	
	banking hours. A r	esident who wanted money for		door on July 17th, 2024 by B	usiness	
	the weekend had t	to let the Business Office know		Office Manager/Assistant wit	h instructions	
	on Friday, so they	were able to disperse the funds		on how to access facility held	d personal	
	either by putting th	ne money in a sealed envelope		funds if business office was of	closed.	
		name on it which was signed		" Resident # 10 was provi	ded	
		en they received the money, or		information by Business Office		
		ney directly to the resident. If a		Manager/Assistant on Augus		
	, , ,	noney in the evening during the		facility held personal funds a		
		had to be made prior to the		when business office is open		
	business office clo			when it is closed and how to funds when desired.		
		ucted on 7/17/24 at 11:40 AM ator indicated that she was not		# - 2 Address how the facility	will identify	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		345349	B. WING			C	
	ROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		07/24/2024 E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE	DATE	
F 567	new process would b	d not being met and that a pe developed to ensure a to their funds after normal	F 56	other residents having the paffected by the same deficients. "Signage for all resident visitors was posted on Finat door on July 17th, 2024 by Office Manager/Assistant won how to access facility he funds if business office was "Resident Council Meet Activities Director on July 2's provide information that fact personal funds are available business office is open as wis closed and how to access when desired. "PCC Cliniconex messatitilized on August 12, 2024 call/message to inhouse Eleparty's informing of updated "Facility Held Personal Fundavailability of funds when be is not open, holidays, after I weekends. "By August 9, 2024 all or residents with facility held pwere met with by the Busines Manager/Assistant and provinformation that these funds when the business office is as when it is closed and how those funds when desired. "By August 9, 2024, all of that have made withdrawals held personal funds in the lawere met with by the Busines Manager/Assistant and provinformation that these funds when the business office is an august 12, 2024, all of the funds when desired.	ent practice; ts, staff and nce Office Business vith instructio eld personal closed. ing held by 9, 2024 to illity held e when the well as when s those funds anging syste to send out HR responsible facility policids", to includusiness officiency and cognitively intersonal funders Office vided are available open as well w to access other residers from facility ast 30 days ess Office ovided are available a	it s em ble by de e tact els le l	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345349	B. WING				04/0004		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		07/24/2024			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE		
F 567	Continued From pag	e 4	FS	567	as when it is closed and how to access those funds when desired. # -3 Address what measures will be pure into place or systemic changes made to the ensure that the deficient practice will not recur; " Business Office Manager developed inservice education on July 29, 2024 for staff on process for residents to access facility held personal funds, to include when business office is not open. " Business Office Manager inservice 600 Unit Manager who oversees 600 nurse position, on July 17, 2024 on management of Facility Managed Personal Fund petty cash bag and disbursements. " All staff educated on process for residents to access facility held person funds, to include when business office not open, by Business Office Manager/SDC/Designee by August 12, 2024. " Any staff not inserviced by this dat will be educated on next scheduled shi by Business Office Manager/SDC/Designee. " Any newly hired staff (to include agency staff) after August 12, 2024 will inserviced during the orientation/onboarding process by SDC/Designee. " Information on process for resident oaccess facility held personal funds, to include when business office is not oper included in all new resident admission packets by Business Office	t coot ed or s ed ed er s ed et s o et s o			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	JLTIPLE CONSTRUCTION DING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING			l	C
		345345	D. WING_			07	/24/2024
NAME OF P	ROVIDER OR SUPPLIER			S1	FREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBII	RY WELLNESS CENTER	RINC		27	778 COUNTRY CLUB DRIVE		
ПООВВО	IN WELLINEOU OLIVIEI			H	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 567	Continued From page	e 5	F	567	Manager/Designee effective August 9, 2024. "The facility policy, Facility Held Personal Funds, was reviewed/revised Administrator on August 9, 2024 to provide resident's access to their persofunds after the facility's business hours and on weekends. Residents will have access to their personal funds the sam day, regardless of time, for amounts letthan \$100.00 (\$50.00 for Medicaid Residents). Three banking days for amounts of \$100.00 (\$50.00 for Medicaid Residents) or more. Business Office Manager/Assistant were inserviced on revised policy on August 9, 2024 by Administrator. "The facility will keep \$ 200.00 in a petty cash box/bag located in a designated location for specific nursing employee position (600 Hall Nurse), whhave been granted access to resident fund balances, to dispense funds to residents when requested after busines hours and on weekends. "The Nursing employee will record amount of money dispensed, to whom and the date and resident/responsible party signature in a receipt book maintained in the petty cash box and reconciled at least weekly by the Busin Office Manager/Assistant. "A copy of the revised Facility Held Resident Funds policy will be included the next resident/responsible party newsletter, which is mailed monthly.	onal eess aid	
					# - 4 Indicate how the facility plans to monitor its performance to make sure t	hat	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				_		l .	С
		345349	B. WING _			07/	24/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTER	INC	2778 COUNTRY CLUB DR		778 COUNTRY CLUB DRIVE		
				H/	AMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 567	CFR(s): 483.10(g)(14 §483.10(g)(14) Notific (i) A facility must imm consult with the reside	jury/Decline/Room, etc.))(i)-(iv)(15)		580	solutions are sustained; and Include dates when corrective action will be completed. " Audit tool developed by Administration on August 9, 2024. " Business Office Manager/Assistant inserviced by Administrator on August 9, 2024 on Audit Tool use. with implementation week of August 12, 202. " At least 5 residents who have personal funds managed by the facility be interviewed by the Business Office personnel, Social Worker and / or designee to determine if they had acce to their personal funds the same day, regardless of time, for amounts less that \$100.00 (\$50.00 for Medicaid Resident The interviews will be completed month for three months. The results will be recorded on the audit tool for these interviews. ' Results of audit will be reviewed monthly by Administrator. " Results will be reported to the Qual Assurance Performance Committee by the Business Office Manager monthly a results reviewed and discussed. The Quality Assurance Committee will asse and modify the action plan as needed the ensure continued compliance.	t 9, 24. will ss an s). alty	8/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED		
			7 11 201231	_		(
		345349	B. WING			07/	24/2024	
	ROVIDER OR SUPPLIER RY WELLNESS CENTER	INC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 778 COUNTRY CLUB DRIVE IAMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	results in injury and h physician intervention (B) A significant chan mental, or psychosod deterioration in health status in either life-thic clinical complications (C) A need to alter trea need to discontinue treatment due to advecommence a new for (D) A decision to tran resident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proviphysician. (iii) The facility must a resident and the re	en there is- ving the resident which as the potential for requiring n; ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or); eatment significantly (that is, e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and	F	580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C 7/24/2024	
	ROVIDER OR SUPPLIER	RINC	STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	locations that compripart, and must specification room changes between under §483.15(c)(9). This REQUIREMENT by: Based on record revinterview and staff in notify the on-call prova hypoglycemic episor 70 milligrams [mg] peblood glucose ranges the lab used by the fa7/6/24, Resident #69 values were less than until 7:15 AM. Standi The on-call provider or about the resident meal intake, and then that Nurse #2 continu #69's blood glucose Long-acting insulin wat 9:00 AM without a Uncorrected hypogly injury or death. This of 1 residents review (Resident #69). Immediate jeopardy when Resident #69 ehypoglycemia and the Immediate jeopardy when the facility implication of immediate facility remains out or scope and severity less than the facility implication of immediate facility remains out or scope and severity less than the facility remains out	tion, including the various se the composite distinct by the policies that apply to en its different locations I is not met as evidenced siew, Medical Director terviews, the facility failed to vider when Resident #69 had ode (blood glucose less than er deciliter [dL]). Normal so from 70 - 100, according to acility. On the morning of 's blood glucose (sugar) in 45 mg/dL from 6:03 AM ing orders were not followed. Was not notified of the values 's refusal of snacks and re was no documentation and to monitor Resident (BG) after 7:15 AM. The sa administered by Nurse #2 documented blood glucose. Coemia could result in brain deficient practice affected 1 and for notification of change of the provider was not notified. Was removed on 7/19/24	F 58	F580 Notice of Changes Preparation and submission or correction is in response to the 2567 from the 07/24/24 survey not constitute an agreement of by Woodbury Wellness Center of the facts alleged or of the conclusions stated on the facts alleged or of the conclusions and actions of the This Plan of Correction (and the documents) also functions as credible allegation of complians # 1 - Address how corrective a accomplished for those reside have been affected by the definition of the practice; For Resident #69: Director of Nursing notifies Medical Director/Provider on Jacoba with no new orders receing # - 2 Address how the facility of the residents having the potential factor of the same deficient affected by the same deficient actions.	e CMS Form y. It does r admission r of the truth correctness ne statement erves all es, findings, e Agency. ne attached the facilitys nce. action will be ents found to icient d the luly 17, nt on July 6, ived. will identify ential to be		

PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345349	B. WING				C		
NAME OF D	20/4050 00 01 1001 150	345345	B. WING _	0.	TDEET ADDRESS OFTY STATE 7/D SODE	07	7/24/2024		
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
WOODBU	RY WELLNESS CEN	TER INC			778 COUNTRY CLUB DRIVE				
				Н	IAMPSTEAD, NC 28443				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 580	Continued From p	age 9	F 5	580					
	·	is put into place are effective.			A. The Facility Director of Nursing				
		ie pat into place are elicotive.			and/or her designee completed an aud	dit of			
	Findings included:				all in house residents identified as using insulin for control of diabetes				
	Review of the faci	lity's Standing Orders revised			management on July 18th, 2024, and				
		hat for residents with			identified 16 residents with blood suga	ars			
		less than 70mg/dL), staff			and using the sliding scale for insulins				
	should repeat the	(blood glucose) test. If the			which could require utilization with the				
	reading was belov	v 70 mg/dL and the resident			Standing Orders. If implementation of				
	was responsive; g	ive 15 grams of glucose or 4			Standing Order for Blood Glucose che	cks			
		juice with one sugar packet by			and Hypoglycemia occurred in the las				
		Recheck in 15 minutes. If the			days to identify if notification was mad				
		mained below 70, notify the			the Medical Provider. The results of th				
	provider for orders	S.			audit have been reported to the Medic	:al			
					Director, July 18, 2024 by the Quality				
	5/30/23 with diagr	readmitted to the facility on noses that included type 1			Assurance Nurse.				
		lependent diabetes), dementia,			B. The Director of Nursing/Designee				
		oothyroidism, anorexia and			audited all inhouse resident records by	y			
	weight loss.				August 11, 2024 for SBAR Tools				
					completed in last 30 days to ensure th				
		an orders for Resident #69			Notification of Change was reported to				
		ving insulin orders for diabetes:			Medical Provider. Any failure to notify				
		spart (short-acting), Inject as			Medical Provider of clinical change of				
		ubcutaneously before meals the reading was 150 - 200 give			condition revealed on audit will be reported to Medical Provider by Direct	or of			
		ing was 201 - 250 give 4 units;			Nursing/Designee by August 11, 2024				
		251 - 300 give 6 units; if the			Nursing/Designee by August 11, 2024	•			
		350 give 8 units; if the reading			# -3 Address what measures will be p	ut			
		e 10 units; if the reading was			into place or systemic changes made				
	_	give 12 units and notify the			ensure that the deficient practice will r				
	physician	,,			recur;				
		nt #69's vital sign record for			" The Facility Director of Nursing a				
		e following BG measurements			her designee have initiated the educa				
	in the morning by				for all Licensed Nurses currently on do	•			
		mg/dL			on 7/18/24 scheduled for 7am-3pm or				
		mg/dL			am-7pm. Nurses not scheduled for thi				
	- 7:15 AM 44.0	mg/dL			day shift will be contacted by phone b	V			

Facility ID: 923206

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDII				С		
		345349	B. WING			١ ,	7/24/2024		
NAME OF P	ROVIDER OR SUPPLIER	1 2 3 2 3 2	 	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	11124/2024		
TO UNE OF TH	NOVIDEN ON OUT FEIEN				78 COUNTRY CLUB DRIVE				
WOODBU	RY WELLNESS CENT	TER INC							
				ПА	AMPSTEAD, NC 28443				
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE		
F 580	Continued From p	age 10	F 5	580					
	- 11:30 AM 134	-	'		Director of Nursing/Designee and				
	- 11.30 AW 134	mg/dL			provided verbal education and will be				
	Review of a progre	ess note written by Nurse #1			required to sign the education sign in				
		29 AM showed Resident #69			sheet, confirming receipt, prior to work	ina			
		of 37. She administered a			next scheduled shift. New hired Licens	-			
		and rechecked the BG of 44.			Nurses (including Agency nurses) will				
	Resident #69 dran	nk most of a second nutritional			educated during the hiring orientation				
	shake with a third	recheck of BG remaining at 44.			process. This education includes the				
	The information w	as passed on to Nurse #2 who			Standing Orders for Hypo/Hyper glyce	mia			
	would reassess ar	nd determine the next course of			and expectations regarding the use of				
	action. There was	no documentation that the			those orders, including notification of				
	physician was not	notified.			Medical Provider, and a Post Test to				
					assure knowledge of education provid	ed.			
		rked the overnight shift from							
		s/24, was interviewed on			Education provided Licensed Nurses				
		M, and she revealed that			includes, but not limited to:				
		considered less than 60			o Blood Glucose checks: May perfo	rm a			
		nt was hypoglycemic, she			fingerstick blood glucose level PRN				
		give the resident a nutritional uice with sugar to bring the BG			sign/symptoms of hyper/hypoglycemia o Hypoglycemia:				
		She would then check the BG			o Hypoglycemia: For Blood sugars less than 70mg/dl:				
	_	our, and if it was still low, then			a. Repeat the test				
	-	provider. Resident #69 had			b. If the second reading remains bel	ΟW			
		h BG values of 30 mg/dL up to			70, notify the MD for orders. If the read				
		ormal for her. On 7/6/24,			is below 70mg/dl and the resident is	9			
		did not increase like it usually			Responsive; may give 15gm of Glucos	se			
		e initial BG measurement of 37			or 4oz orange juice with one sugar pa				
	mg/dL did not incre	ease after Resident #69 drank			by mouth or g-tube. Recheck in 15				
	two nutritional sha	kes. Nurse #1 stated she			minutes and notify the MD. If the resid	ent			
	administered nutri	tional shakes because they			is Unresponsive, call 911 and adminis	ter			
		and sugar so that Resident			Glucagon1gm IM. Notify the MD.				
		ot spike and crash later in the			" Expectations given along with the	use			
		nt #69 preferred nutritional			of the Standing Orders:				
		liquids. Nurse #1 then tested			a. You will follow the Standing Order		 		
		ninutes later, and it did not			being utilized				
		ase. She stated she then			b. You will enter the orders as a				
	ļ · • • •	another nutritional shake and			telephone/verbal order				
		ugar within 30-40 minutes, and			c. You will execute those orders				
	∣ again, it did not ind	crease. At that point, Nurse #1		- 1	 d. You will notify the Medical Provide 	i OU	1		

	OF DEFICIENCIES CORRECTION	L. , IDENTIFICATION NI IMPED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING _				C 24/2024	
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	24/2024	
					778 COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	RINC			IAMPSTEAD, NC 28443			
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES					0.47)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page	e 11	F 5	580				
	stated she handed of				Call of initiating the standing orders be	ina		
		Nurse #2 was going to			initiated, obtain any additional orders a			
	check Resident #69's	0 0			transcribe into the clinical orders.	iid		
		ry. Nurse #1 stated she did			e. All and any interventions implemen	nted		
	not call the provider b				are to be documented into the clinical	nou		
		dent #69. Her BG dropped			record, whether nursing judgements,			
		20 mg/dL, and she remained			orders given or monitoring as related.			
		ally if the provider was			" Diabetes and Clinical Protocol whi	ch		
		ocument in progress notes of			includes the following:			
		e reason why they were			a. Assessment and Recognition			
	contacted.				b. Treatment and Management			
					c. Monitoring and Follow-up			
	On 7/17/24 at 1:40 Pl	M, the Medical Director was			" Nursing Care of the Resident with			
	interviewed. He revea	aled that if a resident was			Diabetes Mellitus which includes:			
	alert and conscious d	luring a hypoglycemic event,			A. Conditions associated with Diabet	es:		
	nursing staff should g	give them a liquid that			Hyperglycemia, Diabetic Ketoacidosis,			
	contained glucose or	added sugar, then check			Hypoglycemia			
	the BG within 30 min	utes and if it did not come up			B. Glucose Monitoring			
		MD should be notified. The ovider needed to be involved			C. Management of Hypoglycemia			
	in the decision makin	g when the BG was below			" Diabetic Management Protocol To-	ol		
	50 mg/dL with the sec	cond BG check due to a			developed by Director of Nursing on			
	possible transfer to the	•			August 9, 2024.			
	,	glycemia was not corrected,						
		e could be brain injury. He			" Clinical Change Of A Resident			
		t notified of Resident #69's			protocol developed by Director of Nurs	•		
		he morning of 7/6/24, and			on August 9, 2024, which includes use			
		I not do what they were			newly developed Diabetic Managemen	t		
		Resident #69's lack of			Protocol Tool in lieu of the SBAR			
		ound of nutritional shakes,			Assessment Tool used for all other			
		expected nursing to contact			Change of Conditions of Residents.	ĺ		
		vider. For 7/7/24, once the				ĺ		
	-	ed, Resident #69's BG			" All Licensed Nurses (including Age			
	_	monitored. If the insulin			Nurses) will be inserviced by Director			
		hold, then it would affect the			Nursing/Designee on Clinical Change of	ΣΤΑ		
		the BG was low, then short			Resident protocol and Diabetic	14		
	_	e to administer. The MD			Management Protocol Tool by August 1			
	stated that putting slid was the provider's de	ding scale insulin on hold cision.			2024. Any Licensed Nurses not inservi by this date will be inserviced by Direct			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING_		0.	C 07/24/2024	
NAME OF PE	ROVIDER OR SUPPLIER	1.00.00	 	STREET ADDRESS, CITY, STATE, ZIF		724/2024	
	101.52.1.011.001.1.2.2.1			2778 COUNTRY CLUB DRIVE	0052		
WOODBU	RY WELLNESS CENTER	RINC		HAMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 580	AM. He revealed that contacted the on-call 7/6/24, since Nurse # him with severely low Review of the July 20	ewed on 7/18/24 at 10:41 the could not recall if he provider the morning of the handed off Resident 69 to	F 5	of Nursing/Designee duri scheduled shift. Any new Nurses (including Agency educated during the hirin process by Staff Develop Coordinator/Designee.	vly hired Licensed y nurses) will be g orientation ment		
	corresponding times: - 4:30 PM: 143 mg/d	sulin administration at the L - insulin not administered ameters for short-acting		monitor its performance t solutions are sustained; a when corrective action w	and Include dates		
	The Director of Nursi on 7/17/24 at 2:19 Pl standing orders, the on the second attemprom a hypoglycemic that Nurse #1 should after the second BG	ng (DON) was interviewed M. She stated per the provider should be notified of to bring a resident's BG up episode. The DON indicated have contacted the provider check on 7/6/24, and Nurse municated with a provider to		" Audit tool developed Nursing on July 19, 2024 implementation on that do conducted by Director of Nursing/Designee of 100 residents using insulin for Management 5 times were then 5 times weekly ever month, then 5 times week month for two months for orders for Hypo/Hyper gly expectations regarding the orders, including notificat Provider. Medical Provider	with ate. Audit to be 0% of inhouse r Diabetic ekly for 6 weeks, y two weeks for 1 kly once per r use of standing ycemia and ne use of those ion of Medical		
	Administrator on 7/18 she would expect all orders for hypoglycer any hypoglycemic epcheck. On 7/18/2024 at 2:25	3/24 at 10:23 AM. She stated nurses to follow the standing mia and notify the provider of sisodes on the second BG 5 PM, the facility's formed of the immediate		by Director of Nursing/Decompletion of each audit concern noted. "Audit tool developed Nursing on August 9, 202 implemented week of Augusted Director of Nursing/Design audits of 25% of inhouse weekly times 4 weeks, the inhouse residents weeks to ensure notification of complete to the complete to the sure notification of complete to the sure notification of complete the complete to the sure notification of complete the complete th	esignee upon of any areas of by Director of 24 to be gust 12, 2024. gnee to conduct residents en 15% of dy times 7 weeks		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345349	B. WING _	B. WING			C / 24/2024
	ROVIDER OR SUPPLIER	RING		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443			27/2027
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 580	Continued From page		F!	580	condition utilizing the SBAR or Diabetic	:	
	1. Identify those recipare likely to suffer, a a result of the noncor. On July 6th, 2024, Rongy of the provided and the last 14 days to identified and the last 14 days to identified.	sients who have suffered, or serious adverse outcome as impliance. esident #69 had a is in the morning. The Facility anage these hypoglycemic 6/2024, Resident #69 Blood is in the morning in the properties by Nurse #1 by Nurse #1 by Nurse #1 by Nurse #2 was not notified by either in and there was not icate Nursing continued to its blood sugar after 7:15am. Intified the Medical July 17, 2024, of resident by 6th, 2024, with no new			Management Protocol Tool as per the Clinical Change in Resident Protocol guidelines. Medical Provider will be notified by Director of Nursing/Designe upon completion of each audit of any areas of concern noted Results of audits will be reviewed in Director of Nursing/Designee in weekly facility Clinical Risk Meetings Results of audits will be presented Director of Nursing for review and discussion in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	e by	

	ND DI AN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION G	COMF	(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C / 24/2024
	ROVIDER OR SUPPLIER RY WELLNESS CENTER	INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	1 01.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	designee. 2. Specify the action process or system fare adverse outcome from when the action will be the Facility Director of designee have initiated. Licensed Nurses currently scheduled for 7 am-3 process composed verbal education of provided verbal education signed the education signereceipt, prior to working the educated during process. This educated Orders for Hypo/Hyporegarding the use of notification of Medication of Medication of Medication was eviden record reviews, and record reviews, and record reviews, and record reviews, and record for him education on facility of change for license insulin-dependent recipies insulin-dependent recipies in the discourse of the second record in the second recipies insulin-dependent recipies insulin-dependent recipies in the second recipies in the sec	the entity will take to alter the lure to prevent a serious in occurring or recurring, and re complete. of Nursing and/or her ed the education for all rently on duty on 7/18/24 om or 7 am-7pm. Nurses not by shift will be contacted by Nursing/Designee and ation and will be required to go in sheet, confirming and next scheduled shift. New is (including Agency nurses) and the hiring orientation on includes the Standing for glycemia and expectations those orders, including I Provider. I pardy removal: 7/19/24. allegation of Immediate is validated on 7/24/24. The fixed by staff interviews, eview of competency erventions included standing orders/notification di nurses and audits of sidents. The immediate	F 58	30		
F 641 SS=D	7/19/24. Accuracy of Assessm CFR(s): 483.20(g)	ents	F 64	41		8/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345349	B. WING		C 07/24/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
WOODBII	RY WELLNESS CENTE	2 INC		2778 COUNTRY CLUB DRIVE		
WOODBU	RT WELLNESS CENTER	RINC		HAMPSTEAD, NC 28443		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
F 641	Continued From pag	e 15	F 64 ⁻	1		
	§483.20(g) Accuracy	of Assessments.				
	1 - 1 - 1	st accurately reflect the				
	resident's status.	-				
	This REQUIREMEN	T is not met as evidenced				
	by:					
		view and staff interviews the		F641 Accuracy of Assessments		
		rately code the Minimum		Daniel and a description of their all	.	
	, ,	essment for 1 of 22 residents		Preparation and submission of this pla		
	Teviewed for MDS ac	ccuracy (Resident #15).		correction is in response to the CMS I 2567 from the 07/24/24 survey. It does		
	Findings including:			not constitute an agreement or admiss		
	i mangs morading.			by Woodbury Wellness Center of the		
	Resident #151 was a	admitted to the facility on		of the facts alleged or of the correctne		
	06/20/2023 with diag			of the conclusions stated on the state		
	_	ersonal history of malignant		of deficiency. The facility reserves all		
	neoplasm of larynx.			rights to contest the deficiencies, findi	ngs,	
				conclusions and actions of the Agency		
		d 06/26/2023 revealed		This Plan of Correction (and the attack	ned	
	Resident #151 did no	ot have a tracheostomy.		documents) also functions as the		
	The series in least desired.	07/44/0000 1 1 - 5 5 -		facility ☐s credible allegation of		
	T	07/11/2023 had a focus of a		compliance.		
	_	my related to a history of		# 1 Address how corrective action w	ill bo	
	larynx cancer.			# 1 - Address how corrective action w accomplished for those residents four		
	An interview with the	Quality Assurance (QA)		have been affected by the deficient	id to	
		d on 07/17/24 at 2:18 PM.		practice;		
		#151 was receiving trach		praedec,		
	I .	ave been coded as receiving		For resident # 151:		
	I .	ding error due to an oversite.		" The 5-day MDS dated June 26, 2	.023	
		-		tracheostomy coding was corrected by		
	An interview with the	Director of Nursing (DON)		MDS Coordinator on July 23, 2024 wi		
		7/18/24 at 10:16 AM. The		Modification to the coding of Section 0		
	_	t #151 did have a trach and		Item E and was transmitted and accep	oted	
		It was a coding error and		to the state on July 23, 2024		
	should have been co	ded correctly.		" Subsequent MDS's to the 5-day I		
				dated June 26, 2023 until discharge o		
	An interview with the			October 11, 2023 was reviewed by MI)S	
	conducted on 07/18/	24 at 12:33 PM. The		Coordinator on July 23, 2024 and		

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED				
		345349	B. WING _	B. WING			C 07/24/2024	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443			24/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 641		Resident #151 did have a as supposed to have trach	F	oaa # oa " DCccc " # irrere" " bAS" ((irro A # msw " b	ther coding errors of Section O, Item nd Modifications transmitted to state, pplicable. - 2 Address how the facility will identified ther residents having the potential to iffected by the same deficient practice. Audit completed on July 25, 2024 birector of Nursing/MDS coordinator/Designee of all MDS sompleted in last 30 days to ensure the ompletion of Section O, Item E was correct. No other errors were identified a -3 Address what measures will be pure to place or systemic changes made to nsure that the deficient practice will necur; MDS Coordinator(s) were in-served y Director of Nursing on July 29, 2022 accuracy of Assessments, to include the fection O Item E. Any newly hired MDS Coordinator or MDS Coordinator Agency Staff) will inservice during new employee rientation by Director of Nursing/SDC accuracy of Assessments. - 4 Indicate how the facility plans to nonitor its performance to make sure to olutions are sustained; and Include day then corrective action will be completed. Section O MDS Audit Tool develop y Director of Nursing/Designee on July 9, 2024	if ify be ; by at		

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345349	B. WING	B. WING		l	C 07/24/2024	
	ROVIDER OR SUPPLIER RY WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		<u> </u>	24/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	applies to all treatmen			684	" MDS Coordinator inserviced by Director of Nursing on July 29, 2024 on use of MDS Audit Tool with implementation on that date. " Audit to be completed by MDS Coordinator weekly times 4 weeks on a new admission assessments completed to verify that Section O Item E has bee correctly coded. " Audit tool to be reviewed by Direct of Nursing weekly in Facility Risk Week Meeting. " Results of audits will be presented Director of Nursing for review and discussion in the monthly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.	all d n or kly	8/13/24	
	assessment of a resident that residents received accordance with professor practice, the compreheare plan, and the resident REQUIREMENT by: Based on record revious Practitioner, Murse Practitioner, Murse facility failed to many that the facility failed to many that resident reside	dent, the facility must ensure treatment and care in essional standards of nensive person-centered			F684 Quality of Care Preparation and submission of this plan correction is in response to the CMS Fo			

OLIVILIV	O I OIT MEDIO/ IITE &	MEDIO/ ND OLIVIOLO				<u> </u>	7. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			T. BOILD	_		(·.
		345349	B. WING			1	24/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
				27	778 COUNTRY CLUB DRIVE		
MOODBU	RY WELLNESS CENTER	RINC		HAMPSTEAD, NC 28443			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From page	a 18	F	684			
	· -	ng] per deciliter [dL]) on the		00-	2567 from the 07/24/24 survey. It does	_	
		nd 7/7/24. Normal blood			not constitute an agreement or admissi		
	_	70 - 100, according to the			by Woodbury Wellness Center of the tr		
		y. On the morning of 7/6/24,			of the facts alleged or of the correctnes		
	-	glucose (sugar) values were			of the conclusions stated on the statem		
		om 6:03 AM until 7:15 AM.			of deficiency. The facility reserves all		
		not followed. The on-call			rights to contest the deficiencies, findin	gs,	
	provider was not notif	fied of the values or about			conclusions and actions of the Agency		
	the resident's refusal	of snacks and meal intake,			This Plan of Correction (and the attach	ed	
		cumentation that Nurse #2			documents) also functions as the		
	continued to monitor				facility□s credible allegation of		
	, ,	15 AM. Long-acting insulin			compliance.		
		Nurse #2 at 9:00 AM without					
		glucose. On the morning of			# 1 - Address how corrective action wil		
		Resident #69's BG (time			accomplished for those residents found	1 10	
	·	lue read "LO" on the blood han 20mg/dL). The BG was			have been affected by the deficient practice;		
	, -	M and measured 32.0			practice,		
		tacted the on-call provider			For Resident #69:		
	_	ered to administer glucagon,			i di redicone noc.		
	_	ten. There was no evidence			" Director of Nursing notified the Medic	al	
		ment until 11:30 AM with a			Director/Provider on July 17, 2024 of		
	measurement of 168.				resident #69□s incidents on July 6th a	nd	
		contacted (time unknown)			July 7th, 2024, with no new orders		
	and gave a verbal ord	der to only hold the			received.		
	long-acting insulin at	9:00 AM; however, Nurse #2					
	withheld the short-act	ting insulin at 11:30 AM			# - 2 Address how the facility will identi	fy	
		nave been administered.			other residents having the potential to l		
		alues in the afternoon were			affected by the same deficient practice	;	
	_	M and 400mg/dL at 9:00 PM.					
		cemia could result in brain			" The Facility Director of Nursing and/o		
		deficient practice affected 1			her designee completed an audit of all		
	ot 1 residents reviewe	ed for diabetes care (#69).			house residents identified as using insu		
	Immodiate iconordi:	oggan on Caturday, 7/6/04			for control of diabetes management on	ſ	
		pegan on Saturday, 7/6/24			July 18th, 2024, and identified 16	tho	
	when Resident #69 e	e provider was not consulted			residents with blood sugars and using sliding scale for insulins, which could	.i i C	
	to obtain orders for m	· ·			require utilization with the Standing		
		vas removed on 7/19/24			Orders. If implementation of Standing	ſ	
	, salato joopai ay v		1		2. 30.0. II III PIOTITOTICATION OF CLARICING		

PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING			С	
		345349	B. WING_			07/	24/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WOODBU	RY WELLNESS CENTI	ER INC			2778 COUNTRY CLUB DRIVE		
				H	HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pa	ige 19	F 6	684			
	-	plemented a credible			Order for Blood Glucose checks and		
		diate jeopardy removal. The			Hypoglycemia occurred or should have	د	
	_	of compliance at a lower			occurred in the last 14 days for these	•	
		level of D (no actual harm with			residents, any failure to implement or		
		han minimal harm that is not			follow these standing orders were		
	·	y) to ensure education and			reported to the Medical Provider for		
		s put into place are effective.			review by 4pm on July 18, 2024.		
	Findings included:				# 0 Address what are some will be a	4	
	D	d -d			# -3 Address what measures will be p		
		d glucose meter owner's			into place or systemic changes made t		
		y the facility revealed that a meant the BG measurement			ensure that the deficient practice will n	Dι	
	was less than 20 m				recur;		
					" The Director of Nursing/Designee		
	Review of the facilit	ty's Standing Orders revised			initiated the education for all Licensed		
	7/10/23 revealed th	at for residents with			Nurses currently on duty on 7/18/24		
	hypoglycemia (BG	less than 70mg/dL), staff			scheduled for 7am-3pm or 7 am-7pm.		
		blood glucose) test. If the			Nurses not scheduled for 7/18/24 were	;	
	_	70 mg/dL and the resident			contacted by phone by the Director of		
		ve 15 grams of glucose or 4			Nursing/Designee and provided verbal		
		uice with one sugar packet by			education and will be required to sign t	.he	
		echeck in 15 minutes. If the			education sign in sheet, confirming		
	second reading ren provider for orders.	nained below 70, notify the			receipt, prior to working their next scheduled shift.		
					" The Director of Nursing instructed	I the	
	Resident #69 was r	readmitted to the facility on			Staff Development Coordinator on 7/18	3/24	
		oses that included type 1			that all future Newly hired Licensed		
	,	ependent diabetes), dementia,			Nurses (including Agency nurses) will	be	
		othyroidism, anorexia and			educated during the hiring orientation		
	weight loss.				process. This education includes the		
					Standing Orders for Hypo/Hyper glyce		
		e plan in place 3/6/24 included			and expectations regarding the use of		
		at read, [Resident #69] had			those orders and a Post Test to assure	:	
		BG was low and/or high at			knowledge of education provided.		
		s included: Administer insulins					
		orders. Attempt to observe			Education provided Licensed Nurses		
		ed any signs/symptoms of			includes:		
	hypoglycemia.				" Blood Glucose checks: May perfo	rm a	

Facility ID: 923206

PRINTED: 08/22/2024 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER WOODBURY WELLNESS CENTER INC SIMMARY STATEMENT OF DEFICIENCES PREFEX TAG SIMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSG (DENTIFYING INFORMATION) F 684 Continued From page 20 F 684 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 201 - 250 give 4 units; if the reading was 201 - 350 give 8 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 50 give 8 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give 6 units; if the reading was 351 - 300 give		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER WOODBURY WELLNESS CENTER INC SIMMARY STATEMENT OF DEFICIENCIES (PREFIX TAG) SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 684 Continued From page 20 F 684 Review of physician orders for Resident #69 revealed the following insulin orders for diabetes: -5/24/24 Insulin Aspart (short-acting), linject as per sliding scale subcutaneously before meals and at bedtime: if the reading was 201 - 250 give 2 units; if the reading was 201 - 250 give 4 units; if the reading was 201 - 250 give 4 units; if the reading was 201 - 250 give 4 units; if the reading was 201 - 250 give 6 units; if the reading was 301 - 400 give 10 units; if the reading was 301 - 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 15 - 2.5 hours, and ends 4.5 - 6 hours after administration, peaks within 6 hours, and ends 18 - 26 hours after administration. Long-acting insulin starts 10-20 minutes 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. STREET ADDRESS PLAN OF CORRECTION (RAMPET) CLUB DRIVE HAMPSTEAD, NC 28443 PROVIDERS PLAN OF CORRECTION (GEACH CORRECTION) PROVIDERS PLAN OF CORRECTION (GEACH CORRECTION) PROVIDERS PLAN OF CORRECTION (GEACH CORRECTION) PROVIDERS PLAN OF CORRECTION (GEACH CACHOS) I PROVIDERS PLAN OF CORRECTION (GEACH CACHOS) PROVIDERS PLAN OF CORRECTION (GEACH CACHOS) I PROVIDERS PLAN OF CORRECTION (GEACH CACHOS) PROVIDER CACHOST ACTUAL CACHOST (GEACH CACHOST) I PROVIDER CACHOST ACTUAL CACHOST (GEACH CACHOST) I PROVIDER CACHOST ACTUAL CACHOST (GEACH CACHOST) I PROVIDER C				A. BOILDI				C	
CALL DEPTICE NOT SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY PAGE OF TAG			345349	B. WING				-	
CALID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	NAME OF P	ROVIDER OR SUPPLIER	•	•	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
CALID SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG RECULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REACH CORRECTURE ACTION SHOULD BE (EACH CORRECTURE ACTION SHOULD SHOULD SHOULD SHOULD SHOULD SHOU	WOODBU	RY WELLNESS CENTER	RINC		27	778 COUNTRY CLUB DRIVE			
F 684 Continued From page 20 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 251 - 300 give 6 units; if the reading was 351 - 400 give 10 units; if the reading was 351 - 300 give 8 units; if the reading was 350 give 8 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. Long-acting insulin starts 1 - 2 hours after administration, peaks within 1.5 - 2.5 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.	ПООВВО	NI WEELNEGO GENTEN	· iii		Н	AMPSTEAD, NC 28443			
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. fingerstick blood glucose level PRN sign/symptoms of hyper/hypoglycemia. " Hypogloguenia: 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. " Expectations given along with the use of the Standing Orders: a. You will follow the Standing Order being utilized b. Not will reverbed order c. You will execute those orders d. You will 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. " Expectations given along with the use of the Standing Orders: a. You will level the test b. If the reading was cash 1-400 give 10 units; if the reading is below 70mg/dl and the	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION	
Resident #69's quarterly Minimum Data Set (MDS) dated 6/2/24 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: 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,	F 684	Review of physician or revealed the following - 5/24/24 Insulin Aspaper sliding scale subtand at bedtime: if the 2 units; if the reading if the reading was 25 reading was 301 - 35 was 351 - 400 give 10 greater than 401 give physician - 5/29/24 for Insulin Gunits in the morning for According to diabetes starts 10-20 minutes within 1.5 - 2.5 hours after administration. If 2 hours after administration. Review of the manufanutritional shake (mig contained 20 grams of protein per 4 ounces of Resident #69's quarte (MDS) dated 6/2/24 in cognitively impaired a for all activities of dair received 7 insulin injeperiod.	orders for Resident #69 g insulin orders for diabetes: art (short-acting), Inject as cutaneously before meals reading was 150 - 200 give was 201 - 250 give 4 units; 1 - 300 give 6 units; if the 60 give 8 units; if the reading 0 units; if the reading was e 12 units and notify the Glargine (long-acting) 12 for diabetes. Senet.com, short-acting insulin after administration, peaks , and ends 4.5 - 6 hours Long-acting insulin starts 1 - etration, peaks within 6 26 hours after acturer's nutritional data for ghty shake) revealed that it of sugar and 4 grams of serving. erly Minimum Data Set indicated she was severely and was dependent on staff ly living (ADL). Resident #69 ections during the review #69's vital sign record for following BG measurements	F	684	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 read is below 70mg/dl and the resident is Responsive; may give 15gm of Glucosor 4oz orange juice with one sugar pact by mouth or g-tube. Recheck in 15 minutes and notify the MD. If the reside is Unresponsive, call 911 and administed Glucagon1gm IM. Notify the MD. Expectations given along with the 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 Provide Call of initiating the standing orders be initiated, obtain any additional orders a transcribe into the clinical orders. e. All and any interventions implementare to be documented into the clinical record, whether nursing judgements, orders given or monitoring as related. Diabetes and Clinical Protocol whi 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	e ket ent er use		

Facility ID: 923206

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDII				С	
		345349	B. WING _			07/24/2024		
NAME OF P	ROVIDER OR SUPPLIER		1	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 077	24/2024	
					S COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	INC			MPSTEAD, NC 28443			
	OLIMANA DV OT	ATEMENT OF DEFICIENCIES			·		0.470	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 21	F 6	684			'	
	- 6:30 AM 44.0 mg			·	B. Glucose Monitoring			
	- 7:15 AM 44.0 mg				C. Management of Hypoglycemia			
		y <u>-</u>		- 1	D. Nutritional Support			
	Review of a progress	note written by Nurse #1			**			
		AM showed Resident #69		'	' The Certified Nursing Assistants w	ere		
	had an initial BG of 3	7. She administered a		(educated by the Director of			
	nutritional shake and	rechecked the BG of 44.			Nursing/designee by 4pm on July 18,			
		nost of a second nutritional			2024. This included all which were on o			
		heck of BG remaining at 44.		- 1	7am-3pm or 7am-7pm. Certified Nursir	•		
	·	passed on to Nurse #2 who		- 1	assistants not on duty were contacted	-		
		determine the next course of			phone and provided the education with			
	action.				the understanding they needed to sign	for		
	Nivers #4 vols a voseles	d the averaginate shift forms			the education. Any certified nursing			
	I .	d the overnight shift from			assistants on vacation or Medical Leav			
	7/5/24 through 7/6/24 7/16/24 at 5:34 PM, a			- 1	will receive this education prior to the s of shift when they return. Any newly hir			
	1	nsidered less than 60			certified nursing assistants (including	eu		
	1	as hypoglycemic, she		- 1	Agency Staff) will be in-serviced during	,		
		e the resident a nutritional			orientation/onboarding process by			
	_	with sugar to bring the BG			SDC/Designee. This education include	d.		
		would then check the BG		- 1	What is diabetes, Type I and Type II	,		
		and if it was still low, then			Diabetes, Hypo-glycemia and			
		ovider. Resident #69 had			Hyper-glycemia, and things to rememb	er		
	brittle diabetes with B	G values of 30 mg/dL up to			reporting eating less than 25% and			
	430 mg/dL were norm	nal for her. On 7/6/24,		r	reporting a resident with signs or			
		d not increase like it usually			symptoms of hyper/hypoglycemia. The			
		itial BG measurement of 37			Certified Nursing Assistants also received	ed		
	-	e after Resident #69 drank		6	a post-test to validate their education.			
	2 nutritional shakes.			,	Dishatia Manananant Duata ad Ta	-1		
	I .	al shakes because they			Diabetic Management Frotocor To	וכ		
	· ·	I sugar so that Resident pike and crash later in the			developed by Director of Nursing on August 9, 2024.			
		69 preferred nutritional		',	August 9, 2024. ' All Licensed Nurses (including Age	encv		
	1 -	uids. Nurse #1 then tested		,	Nurses) will be inserviced by Director	- 1		
	1	utes later, and it did not			Nursing/Designee on Diabetic			
	significantly increase.			- 1	Management Protocol Tool by August	12.		
		other nutritional shake and			2024. Any Licensed Nurses not inservi			
		ar within 30-40 minutes, and		- 1	by this date will be inserviced by Direct			
	_	ase. At that point. Nurse #1		- 1	of Nursing/Designee during next			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
				_		(С
		345349	B. WING _			07/	24/2024
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				27	778 COUNTRY CLUB DRIVE		
WOODBU	RY WELLNESS CENT	ER INC		Н	AMPSTEAD, NC 28443		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI: TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 684	Continued From pa	age 22	F	584			
	-	off Resident #69 to the			scheduled shift. Any newly hired Licer	ised	
		2. Nurse #2 was going to			Nurses (including Agency nurses) will		
	_	9's BG again and give			educated during the hiring orientation		
		sary. Nurse #1 stated she did			process by Staff Development		
		er because it was not an			Coordinator/Designee.		
		esident #69. Her BG dropped			Ç		
	frequently as low a	s 20 mg/dL, and she remained			# - 4 Indicate how the facility plans to		
	asymptomatic. Nor	mally if the provider was			monitor its performance to make sure	hat	
		document in progress notes of			solutions are sustained; and Include da		
	the medical record	the reason why they were			when corrective action will be complete	∌d.	
	contacted.						
					" Audit tool developed by Director o	f	
		PM, Nurse Aide (NA) #1 was			Nursing on July 19, 2024 with		
		tated that she offered Resident			implementation on that date. Audit to l	Эе	
		d 8-9 PM on 7/6/24 (cookie			conducted by Director of		
		nal shake). Resident #69 did			Nursing/Designee of 100% of inhouse		
		nal signs or symptoms during from 7/6/24 PM to 7/7/24 AM.			residents using insulin for Diabetic Management 5 times weekly for 6 wee	ko	
	_	at she was aware Resident #69			then 5 times weekly every two weeks f		
		n the morning7/7/24. However,			month, then 5 times weekly once per	JI 1	
	I -	any signs or symptoms of			month for two months for use of standi	na	
		isea, sweating, vomiting, etc.).			orders for Hypo/Hyper glycemia and	.9	
	,p=g.,==a (a=				expectations regarding the use of thos	e	
	Review of the Med	ication Administration Record			orders, including notification of Medica		
	(MAR) during the n	nonth of July 2024 for Resident			Provider. Medical Provider will be notif		
		Nurse #2 administered			by Director of Nursing/Designee upon		
	long-acting insulin	at 9:00 AM on 7/6/24.			completion of each audit of any areas concern noted.	of	
	An interview was c	onducted with Nurse #2, the			" Audit tool developed by Director o	f	
		7/6/24 and 7/7/24, on 7/18/24			Nursing on August 9, 2024 to be		
	1	/6/24, he stated Resident #69's			implemented week of August 12, 2024		
	BG was monitored	every hour from 7:15 AM to			Director of Nursing/Designee to condu	ct	
		r, Nurse #2 stated he did not			audits of 25% of inhouse residents		
		vity due to "no time." Resident			weekly times 4 weeks, then 15% of		
		slow uptrend, but he could not			inhouse residents weekly times 7 wee	ks	
	recall the details of	the measurements.			to ensure utilizing of Diabetic Management Protocol Tool to include		
	Review of the July	2024 MAR for Resident #69			notification of Provider of change,		
		C values on 7/6/2/ were as			notification to Provider of meal/snack		

24/2024
(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
						С	
		345349	B. WING _			07/24/2024	
	ROVIDER OR SUPPLIER RY WELLNESS CEN	TER INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 684	give the resident of bring it up. She we and recheck the E call the provider. Or Resident #69 had nutritional shake. The BG again and Resident #69 anou #69 had brittle dia uncommon to find she could not recathe low BG meast on-call provider, the progress notes should have notific check and did not of doctor notificatis stated she administed because Resident BG value would not the day. During a follow-up 7/17/24 at 3:29 Pt contacted the Med 8:00 AM. The MD #69 glucagon on the hypoglycemia. She however, she did and just "gave her Nurse #2 was inter When he came or Nurse #3 gave him to the side of the she was interested the med and just gave her when he came or Nurse #3 gave him to the side of t	sless than 70 mg/dL, she would brange juice or regular soda to build then wait 15-30 minutes as G. If it was still low, she would on the morning of 7/7/24, a low BG and was given one Nurse #3 stated she checked it was still low, so she gave ther nutritional shake. Resident betes, and it was not her hypoglycemic. She stated all if she notified the provider of urements. If she notified the nere would be documentation in sof the medical record. She ed the doctor on the second know why the documentation on was missing. Nurse #3 stered nutritional shakes at #69 preferred them, and her of spike and crash throughout of interview with Nurse #3 on M, she revealed that she dical Director (MD) on 7/7/24 at instructed her to give Resident the second check due to severe e stated it was a verbal order; not transcribe the written order glucagon."	F	684			
	hypoglycemia. Sh however, she did and just "gave her Nurse #2 was inte When he came or Nurse #3 gave hir low BG levels, and #2 was unsure if N before he arrived.	e stated it was a verbal order; not transcribe the written order glucagon." erviewed on 07/17/24 04:33 PM. a shift the morning of 7/7/24,					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C 07/24/2024	
	ROVIDER OR SUPPLIER RY WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	I	07/24/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 684	contacted the Nurse her of Resident #69's the order to hold all h blood sugar. He would documented that the insulin. Nurse #2 stat put in a written order Resident #69 remain and she did not displate the day went on. During a follow-up int 7/18/24 at 10:41 AM, Resident #69's BG w from 5:30 AM to 11:3 did not document this Resident #69's BG w could not recall the document the She stated she was r 7/7/24, but she believ reaching out to the or reached out to her abshe had earlier that m increased after Nurse asking about insulin a was not eating well. Nurse #2 to hold the continue with BG che acting insulin. She was had very low BG, but blood glucose meter. During a follow-up int 7/18/24 at 9:16 AM, shave expected Nurse blood sugar every 10	Practitioner (NP) and notified a low BG. The NP gave him er insulin and monitor the d have normally NP told him to hold all the ed that he was supposed to after given a verbal order. End asymptomatic on 7/7/24, any any signs or symptoms as a serview with Nurse #2 on the revealed on 7/7/24, as monitored every hour to AM. Nurse #2 stated he activity due to "no time." as on a slow uptrend, but he etails of the measurements. Wed on 7/17/24 at 4:46 PM. The told on call the weekend of the revealed out to her when administration, since she are that she told long-acting insulin and tocks along with the short as aware that Resident #69 she found out later that the	F 6	84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345349	B. WING				24/2024
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 778 COUNTRY CLUB DRIVE AMPSTEAD, NC 28443	<u> </u>	24/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	He revealed that if a conscious during a hystaff should give them glucose or added sug 30 minutes and if it ditime, the MD should be that the provider need decision making whem g/dL with the secon possible transfer to the indicated that if hypogothe negative outcomes stated that he was not hypoglycemic event to Nurses #1 and #2 did supposed to do. With response to the first in the MD would have endominated that putting slice was the provider's derefuses care (medica BG levels were all over the endocrinologist of her long-acting insuling 9:00 AM. During a follow-up interfalls of the provider of the provider of the provider of the provider of the endocrinologist of the long-acting insuling 9:00 AM.	M, the MD was interviewed. resident was alert and ypoglycemic event, nursing in a liquid that contained gar, then check the BG within id not come up the second one notified. The MD stated ded to be involved in the in the BG was below 50 and BG check due to a ne hospital. The MD glycemia was not corrected, is could be brain injury. He of notified of Resident #69's he morning of 7/6/24, and if not do what they were in Resident #69's lack of found of nutritional shakes, expected nursing to contact evider. For 7/7/24, once the end, Resident #69's BG monitored. If the insuling hold, then it would affect the end of the BG was low, then short the to administer. The MD ding scale insuling on hold ecision. Resident #69 often tions, meals, etc.), so her er the spectrum. She saw in 7/12/24, and they reduced in from 12 units to 9 units at the review with the MD on the stated he was called by	F	684			
	Nurse #3 on the more Resident #69's low B	ning of 7/7/24 about G. The MD indicated he					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345349	B. WING _			C 07/24/2024
	ROVIDER OR SUPPLIER	RINC		STREET ADDRESS, CITY, STATE, Z 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	ZIP CODE	0112412024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TO THE APPROPRIA	DATE
F 684	might have verbally on to say for sure. The Director of Nursion 7/17/24 at 2:19 Pl standing orders, the the second attempt to from a hypoglycemic have contacted the process of the proce	ing (DON) was interviewed M. She stated per the provider would be notified on to bring a resident's BG up repisode. Nurse #1 should provider after the second BG I Nurse #2 should have a provider to receive orders. Int #69's BG was 168 mg/dL purse #2 should have followed betting sliding scale insulin. Iterview with the DON on I she revealed that Nurse #2 Id more information from She would have expected (Nurse #2) to check Resident I would have expected (Nurse #2) to check Resident I the DON that she continued I the DON that she cont	F	684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3)	(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C
	ROVIDER OR SUPPLIER RY WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		07/24/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	should be entered. An interview was con Administrator on 7/18 she would expect all orders for hypoglycer that when orders werhave been written as short-acting insulin sh NP orders when Resi measured as 168 mg On 7/18/2024 at 11:0 Administrator was infigeopardy. The facility provided the allegation of immediated 1. Identify those recipare likely to suffer, as a result of the noncor A. On July 6th and 7th hypoglycemic episode failed to effectively mepisodes as noted. On the morning of 7/6 sugars were as follow 6:03am 37.0mg/dl 6:30am 44.0 mg/dl 7:15am 44.0 mg/dl 11:30am 134 mg/dl b. The on-call Provider of Nurse #1 or Nurse #2 documentation to indimonitor resident #69!	ducted with the 8/24 at 10:23 AM. She stated nurses to follow the standing mia. The Administrator stated e given verbally, they should well. On 7/7/24, the nould have been given per dent #69's BG was /dL at 11:10 AM. 5 AM, the facility's ormed of the immediate the following credible the jeopardy removal: sients who have suffered, or serious adverse outcome as impliance. th, 2024 Resident #69 had a e in the morning. The Facility anage these hypoglycemic 6/2024, Resident #69 Blood /s: by Nurse #1 by Nurse #1 by Nurse #1 by Nurse #1 y Nurse #2 was not notified by either	F 6	84		

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		345349	B. WING		C 07/24/2024		
	ROVIDER OR SUPPLIER	ER INC	:	STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 684	at 9am. On the morning of a Resident #69 Blood the value on the gluto the manufacturer 20mg/dl. The blood 5:30am and measu contacted the on-cito administer glucay. There was no evide assessment until 11 168.0 mg/dl. The Nurse Practitio unknown) and gave the long-acting insu #2 withheld the showhen 2 units should Resident #69's bloowere as follows: 4:30pm 343 mg/dl 9:00pm 400 mg/dl The Standing Order the provider on-call measure above 70r check. B. Director of Nursin Director/Provider or #69's incidents on J with no new orders C. The Facility Directorsidents identified diabetes managemidentified 16 resider	July 7th, 2024, Nurse #1 took I sugar (time unknown) and incometer read "LO". According "LO" indicates less than sugar was taken again at red 32.0mg/dl. Nurse #1 all provider, and was ordered gon, but no order was written. Ince of further blood sugar 1:30am with a measurement of the averbal order to hold only lin at 9:00am; however, Nurse reacting insulin at 11:30am in the above has a display and the afternoon of the sugars in the afternoon of the blood sugar did not ing/dl on the second blood ing notified the Medical in July 17, 2024, of resident ling 6th and July 7th, 2024,	F 684				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C 7/24/2024	
	ROVIDER OR SUPPLIER RY WELLNESS CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		11/24/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 684	Glucose checks and I should have occurred residents, any failure standing orders will b Provider for review by	Hypoglycemia occurred or in the last 14 days for these to implement or follow these ereported to the Medical 44pm on July 18, 2024.	F 68	34			
	adverse outcome from when the action will be action will be action will be action will be action when the action will be action to designee have initiated Licensed Nurses currescheduled for 7am-3pt scheduled for this data phone by Director of I provided verbal education signereceipt, prior to working Staff Development Concept, prior to working or Newly hired Licensed nurses) will be educated orientation process. Standing Orders for hexpectations regarding	n occurring or recurring, and e complete. of Nursing and/or her ed the education for all ently on duty on 7/18/24 om or 7 am-7pm. Nurses not y shift will be contacted by Nursing/Designee and ation and will be required to gn in sheet, confirming ng next scheduled shift. Coordinator educated by n 7/18/24 that all future Nurses (including Agency ted during the hiring This education includes the dypo/Hyper glycemia and g the use of those orders.					
	fingerstick blood gluc- sign/symptoms of hyp - Hypoglycemia: For Blood sugars less a. Repeat the test b. If the second reading the MD for orders. If the	ose level PRN per/hypoglycemia.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345349	B. WING		C 07/24/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	1 07/24/2024
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 684	packet by mouth or minutes and notify: Unresponsive, call Glucagon1gm IM. N - Expectations give "Standing Orders": a. You will follow the b. You will enter the order" c. You will execute d. You will execute d. You will notify the initiating the "stand obtain any additions the clinical orders. e. All and any interbe documented into nursing judgements as related Diabetes and Clin the following: a. Assessment and b. Treatment and M c. Monitoring and F - Nursing Care of the Mellitus which inclu A. Conditions associated by the following: a. Assessment and form of the Facility Director of the	prange juice with one sugar getube. Recheck in 15 the MD. If the resident is 911 and administer Notify the MD. In along with the use of the e Standing Order being utilized e orders as a "telephone/verbal those orders e Medical Provider on Call of ing orders" being initiated, all orders and transcribe into ventions implemented are to be the clinical record, whether is, orders given or monitoring ical Protocol which includes Recognition lanagement follow-up the Resident with Diabetes des: ciated with Diabetes: abetic Ketoacidosis, ling	F 68	34	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
				_		(2
		345349	B. WING			07/	24/2024
	ROVIDER OR SUPPLIER RY WELLNESS CENTER	INC		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	sign the education signeceipt, prior to working receipt, prior to working Staff Development Corporation of Newly hired Certified (including Agency CN the hiring orientation provided to CNAs inclimited to: - What is Diabetes - Causes of Diabetes - Types of Diabetes - Typical treatment of - Signs and symptom and reporting to nurse symptoms - Importance of meal (undereating/overeating nurse meal intake of Interest of In	ation and will be required to gn in sheet, confirming and next scheduled shift. Doordinator educated by a 7/18/24 that all future Nursing Assistants (As) will be educated during process. Education (Indes, but may not be (Indes, but may not be (Indes) with reporting to ess than 25% (Indep) process and (Intake (Indes) with reporting to ess than 25% (Indep) process than 25% (Indes) pardt removal date: July (Indes) suitable of 7/24/24. The ced by staff interviews, eview of competency erventions included ity's policies and protocols ite Resident with diabetes gns and symptoms of a	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTII IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		345349	B. WING		07/24/2024	
	ROVIDER OR SUPPLIER	RINC		STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	1 011242024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION	
F 684	Continued From pag		F 68	34		
F 842 SS=D	removal date was ve Resident Records - I CFR(s): 483.20(f)(5)	dentifiable Information	F 84	12	8/13/24	
	(i) A facility may not resident-identifiable to (ii) The facility may reresident-identifiable to accordance with a coagrees not to use or	elease information that is				
	professional standard	rdance with accepted ds and practices, the facility al records on each resident nented; le; and				
	all information contains regardless of the form records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, paraperations, as perminal with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and	or their resident e permitted by applicable law; syment, or health care tted by and in compliance				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		345349	B. WING			C 7/ 24/2024	
NAME OF PROVIDER OR SUPPLIER WOODBURY WELLNESS CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2778 COUNTRY CLUB DRIVE HAMPSTEAD, NC 28443	•	11/24/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	medical examiners, fa serious threat to he by and in compliance §483.70(i)(3) The fact record information agunauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirement (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The medical record of the residing the comprehension of the resident review of determinations conductively Physician's, nurse professional's progree (vi) Laboratory, radio services reports as real three thre	purposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. Additional control of the coron of the co	F 84	TAG F842 Resident Records Preparation and submission of correction is in response to the 2567 from the 07/24/24 survey not constitute an agreement or by Woodbury Wellness Center of the facts alleged or of the co	e CMS Form v. It does r admission of the truth		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING _				C 24/2024
NAME OF PI	ROVIDER OR SUPPLIER			SI	FREET ADDRESS, CITY, STATE, ZIP CODE	1 017	24/2024
					778 COUNTRY CLUB DRIVE		
WOODBU	RY WELLNESS CENTER	INC			AMPSTEAD, NC 28443		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES		<u> </u>			0.47)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	e 35	F8	342			
	5/30/23 with diagnose diabetes.	es including dementia and			of the conclusions stated on the statem of deficiency. The facility reserves all rights to contest the deficiencies, finding		
	A nurse's progress no	ote written by Nurse #3			conclusions and actions of the Agency		
		2 AM revealed Resident #69			This Plan of Correction (and the attach		
		'LO" on the blood glucose			documents) also functions as the facilit	y's	
		e 2 nutritional shakes to			credible allegation of compliance.		
		er BG increased to 32mg/dL.			# 4 A - A - - - - - - - -		
	Nurse #3 then gave g	ilucagon and 2 more le oncoming Nurse #2 was			# 1 - Address how corrective action will accomplished for those residents found		
	made aware.	le offcorfiling Nurse #2 was			have been affected by the deficient	110	
	made aware.				practice;		
	The medical record ir	ecord included no evidence that					
	verbal orders were tra	anscribed for glucagon to be					
	administered and lon	g-acting insulin to be held on			For resident #69:		
		hypoglycemia. There was			" Medical Provider notified on July	17,	
		n that the provider was			2024 by Director of Nursing of		
		ent #69's blood glucose			documentation discrepancies noted		
	levels were monitored	d after 8:12 AM.			during survey.		
	** *	ewed on 7/16/24 at 3:35 PM.			# - 2 Address how the facility will identify	•	
		he notified the provider,			other residents having the potential to		
		nentation in the progress 9's medical record. Nurse #3			affected by the same deficient practice	;	
		ve notified the provider when			" The Facility Director of Nursing an		
		t #69's blood glucose			her designee completed an audit of all		
	, - ,	d time. She indicated that			house residents identified as using insu		
		the documentation of			for control of diabetes management on		
	'	vas missing, and she should			July 18th, 2024, and identified 16	tha	
	nave documented all	BG levels after 5:30 AM.			residents with blood sugars and using sliding scale for insulins, which could	ne	
	During a follow-up int	erview with Nurse #3 on			require utilization with the Standing		
		the revealed that she called			Orders. If implementation of Standing		
		(MD) on 7/7 at 8:00 AM. She			Order for Blood Glucose checks and	ĺ	
		der to administer glucagon			Hypoglycemia occurred or should have	,	
	_	n her blood glucose was			occurred in the last 14 days for these		
		nypoglycemic. Nurse #3			residents, any failure to document verb	al	
	-	er was not entered into			orders received and transcription of su		
	physician orders as it	should have been.			verbal orders, notification of physician		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345349 B. WING			0	07/24/2024	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				2778 COUNTRY CLUB DRIVE			
WOODBU	RY WELLNESS CENTER	RINC		HAMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	VE ACTION SHOULD BE COMPLETION DATE		
F 842	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		F 84	related to execution of Hypo standing orders and recordir monitoring of blood glucose following hypoglycemic episo	ng of levels ode. Findings		
	levels, and he contact (NP) and notified her The NP gave him the	at #69's low blood glucose cted the Nurse Practitioner of Resident #69's low BG. corder to hold all her insulin d sugar. He would have		of audit were reviewed with I July 18, 2024 by Quality Ass with no new orders received # -3 Address what measures	surance Nurse,		
	all the insulin. Nurse supposed to put in a verbal order. He sho	d that the NP told him to hold #2 stated that he was written order after given a uld have documented all BG		into place or systemic chang ensure that the deficient pra- recur;	ctice will not		
	7/18/24 at 10:41 AM Resident #69's blood every hour from 5:30	terview with Nurse #2 on he revealed on 7/7/24, I glucose was monitored AM to 11:30 AM. Nurse #2 cument this activity due to "no		" Diabetic Management F developed by Director of Nu August 9, 2024. Diabetic Ma Protocol Tool utilization will p accurate medical records do of verbal orders received and of such verbal orders related Hypoglycemic episode, notif	rsing on inagement provide cumentation d transcription I to ication of		
	The NP stated that s long-acting insulin ar glucose checks along insulin. The verbal or	wed on 7/17/24 at 4:46 PM. he told Nurse #2 to hold the nd continue with blood g with the short acting rder should have been dent #69's physician orders.		physician related to execution Hypoglycemic standing order recording of monitoring of bluevels following hypoglycemia. " Clinical Change Of A Reprotocol developed by Direction August 9, 2024, which income melly developed Diabetic M	ers and ood glucose ic episode. esident tor of Nursing cludes use of		
	on 7/18/24 at 10:07 A blood glucose check documented. The DO order was given, a w entered.	ON stated that after a verbal ritten order should be		Protocol Tool in lieu of the Si Assessment Tool used for al Change of Conditions of Res " All Licensed Nurses (ind Nurses) will be inserviced by Nursing/Designee on Clinical Resident protocol and Diabe	BAR I other sidents. cluding Agency / Director of al Change of A		
	10:23 AM. She state	as interviewed on 7/18/24 at d that when orders were should have been written as		Management Protocol Tool be 2024. Any Licensed Nurses by this date will be inserviced	not inserviced		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345349	B. WING	B WING		C		
NAME OF D	ROVIDER OR SUPPLIER	343349	B: *******		TREET ADDRESS CITY STATE ZID CODE	07/	24/2024	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
WOODBU	RY WELLNESS CENTER	RINC			778 COUNTRY CLUB DRIVE			
				H.	AMPSTEAD, NC 28443			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG				(X5) COMPLETION DATE	
F 842	Continued From page well.	e 37	F	842	of Nursing/Designee during next scheduled shift. Any newly hired Licen Nurses (including Agency nurses) will be educated during the hiring orientation process by Staff Development Coordinator/Designee. # - 4 Indicate how the facility plans to monitor its performance to make sure to solutions are sustained; and Include dawhen corrective action will be completed. "Audit Tool developed by Director of Nursing on August 9, 2024. Director of Nursing/Designee to conduct audit of 100% of inhouse residents using insuling for Diabetic Management 5 times week for 6 weeks, then 5 times weekly every two weeks for 1 month, then 5 times weekly once per month for two months use of Diabetic Management Protocol Tool to ensure accurate medical record documentation of verbal orders receive and transcription of such verbal orders related to Hypoglycemic episode, notification of physician related to execution of Hypoglycemic standing orders and recording of monitoring of blood glucose levels following hypoglycemic episode. Provider will be notified by Director of Nursing/Designe upon completion of each audit of any areas of concern noted. "Results of audits will be reviewed to Director of Nursing/Designee in weekly facility Clinical Risk Meetings" Results of audits will be presented the Director of Nursing for review and	hat lates ed. If the sed is a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345349	B. WING	B. WING		C 07/24/2024		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
					778 COUNTRY CLUB DRIVE			
WOODBURY WELLNESS CENTER INC				HAMPSTEAD, NC 28443				
(X4) ID PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX				(X5) COMPLETION	
TAG			TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE DATE		
F 842	Continued From page 38		F 8	42				
					discussion in the monthly Quality			
					Assurance Performance Improvement Committee meetings. The Quality			
					Assurance Committee will assess and			
					modify the action plan as needed to ensure continued compliance.			