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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREMENT	**180 SOUTHWOOD DRIVE CLINTON, NC 28328**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation was conducted on 1/21/2025 through 1/24/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HIEP11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 1/21/2025 through 1/24/2025. Event ID #HIEP11. The following intakes were investigated NC00224862, NC00224159 and NC00221941. 1 of the 5 allegations resulted in a deficiency.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, Resident interview and staff interviews, the facility failed to obtain the blood sugar (BS) level and administer a Residents' insulin medication as ordered by the physician to treat hyperglycemia (a side effect of too much glucose (sugar) in the blood). This affected 1 of 5 residents reviewed for medication administration (Resident #25).	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility’s allegation of	2/11/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/11/2025

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.

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F 684 Continued From page 1

The findings included:

Resident #25 was readmitted to the facility on 10/21/2024 with diagnoses including type 2 diabetes mellitus.

The 5-day Minimum Data Set (MDS) dated 10/28/2024 had Resident #25 coded as cognitively intact and was receiving insulin injections.

The care plan dated 10/28/2024 had focus of a diagnosis of diabetes mellitus with risk for complications with interventions to include administration of diabetes medication as ordered by doctor and to monitor blood glucose levels as ordered by physician.

A review of the physician order dated 10/28/2024 revealed Humalog Solution (Humalog is a fast-acting insulin that starts to work about 15 minutes after injection and peaks in about 1 hour and keeps working for 2-4 hours). Inject as per sliding scale subcutaneously before meals for diabetes. Give 30 minutes before meals, 8:00 AM, 11:30 AM and 4:30 PM.
If BS is:
8 - 150 = 8 units
151 - 200 = 10 units
201 - 250 = 12 units
251 - 300 = 14 units
301 - 350 = 16 units
351 - 400 = 18 units
401+ Call provider Hours

On 10/30/2024 there was no documentation in the medical record for 11:30 AM.

An interview with the DON was conducted on

F 684

compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F684 Quality of care
The facility failed to obtain the blood sugar (BS) level and administer a Residents' insulin medication as ordered by the physician to treat hyperglycemia (a side effect of too much glucose (sugar) in the blood). This affected 1 of 5 residents reviewed for medication administration (Resident #25).
Corrective action for resident(s) affected by the alleged deficient practice:
On 1/21/2025 the Director of Nursing implemented corrective action for resident #25 to include assessment of resident for any adverse effects with none identified and notification to medical director of the failure to administer resident insulin per order. No new orders received at this time.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents requiring finger stick blood sugars with sliding scale insulin have the potential to be affected by this alleged deficient practice.

On 2/7/2025 the Director of Nurses and nursing team began auditing the past 7 days of resident's electronic medical record to ensure ordered finger stick blood sugars with sliding scale where completed as ordered. This will be completed by 2/10/2025. The results included: there were 0 of 9 residents

F 684 Continued From page 2

01/23/2025 at 2:46 PM. The DON stated on 10/30/2024 Resident #25 had an appointment and her Responsible Party (RP) came to pick her up. The Resident had gotten her BS checked at 11:05 AM and it was 128. The DON also stated she was not able to administer the Resident her sliding scale of 8 units because the RP came and got the Resident and left the building. The DON also stated she failed to document why there was a missed dosage of insulin.

On 11/16/2024 at 8:00 AM and at 11:30 AM, the MAR revealed Resident #25's BS was documented as 312 and 16 units of insulin was administered.

An interview with Nurse #1 was conducted on 01/23/2025 at 12:53 PM. The nurse stated she was the Nurse for Resident #25 on 11/16/2024. The Nurse also stated she followed the orders for Residents that needed BS checks. She got their BS and documented on a report sheet and then entered the amount in the MAR. If the Resident needed coverage, then she would gather her supplies and administer the dosage according to the sliding scale order. This documentation went straight to the MAR. The Nurse further stated the morning blood sugar documentation in the MAR was the accurate BS and she did not administer a second dose of 16 units of insulin at lunch time. If there was another BS level with the same amount at different times, then she would question it, especially since the Resident Received 16 units of Humalog at 8:30 AM. She could not recall what was happening at the facility at that time to make her put the same amounts in the MAR but the 11:30 AM BS could not be accurate, and she must have missed obtaining the BS.

F 684

noted with missed administration of Insulin. On 2/10/2025 the Director of Nursing implemented corrective action to include assessment of resident, review of resident chart for adverse effects, notification to medical director for further interventions and initiation of any new orders.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 2/7/2025 the Director of Nurses began education of all full time, part time, as needed nurses, medication aides to include agency on the following topics:

- Facility must ensure that resident receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan and the resident’s choices.
- Facility must ensure that all medications are completed per the physician order.
- Expectation that all medications be given as ordered during the hours scheduled.
- Ensuring rationale and notification to medical provider documented in the medical record for any missed medication.

This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has

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F 684	Continued From page 3 An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 11/16/2024, there was documentation of 16 units of insulin administered at 8:00 AM and 11:30 AM, but Nurse #1 would not administer a BS that was the same value after that much time had passed, so it had to be documented incorrectly. The DON stated she did not know how it happened, but Nurse #1 did not usually make documentation errors. The DON also stated her expectation was that they exercise accurate documentation according to the Residents orders. An interview with Resident #25 was conducted on 01/24/2025 at 9:07 AM. The Resident stated she had a couple of BS and insulin coverages missing but it did not cause her any issues. An interview with the Medical Director (MD) was conducted on 01/24/2025 at 2:14 PM. The MD stated she was familiar with Resident #25, and the Resident had type 2 diabetes mellitus and insulin was needed to help regulate hyperglycemia in the blood. The missed BS and the missing dose of insulin did not cause a negative reaction for the Resident. The MD also stated she expected the staff to follow physician orders. An interview with the Administrator was conducted on 01/24/2025 at 3:05 PM. The Administrator stated she expected the nursing staff to administer the Residents' medications accordingly.	F 684	been sustained. Any staff who does not receive scheduled in-service training by 2/10/2025 will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F684 Quality Assurance Tool for compliance by auditing 5 residents that require finger stick blood sugars with sliding scale to ensure physician orders were followed as prescribed weekly x 2 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/11/2025	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		2/11/25

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F 695

Continued From page 4

tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and resident, staff and Nurse Practitioner interviews, the facility failed to administer oxygen at the physician prescribed rate for 1 of 3 residents reviewed for respiratory care (Resident #38).

The findings included:

Resident #38 was admitted to the facility on 05/29/18 with diagnoses which included chronic respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily functions) and dependence on supplemental oxygen.

A review of Resident #38's Physician Orders read, "O2 [oxygen] at 2L [liters] continuous via nasal cannula" (tubing that delivers oxygen from an oxygen source to the resident's nose) and was written on 11/21/23.

A review of Resident #38's quarterly Minimum Data Set (MDS), dated 10/29/24, revealed the resident was cognitively intact and was on oxygen therapy

A review of Resident #38's Care Plan, last revised 12/26/24, revealed a focus of "altered respiratory status/difficulty breathing related to an old healing

F 695

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.
To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F695 Respiratory/Tracheostomy Care and Suctioning
The facility failed to administer oxygen at the physician prescribed rate for 1 of 3 residents reviewed for respiratory care (Resident #38).
Corrective action for resident(s) affected by the alleged deficient practice:
On 1/21/2025 Nurse #1 implemented corrective action for resident #38 to include correction to setting on the oxygen concentrator to 2 liters and assessment of resident oxygen saturation rate with reading at 97% and no adverse effects.

1. Corrective action for residents with the potential to be affected by the alleged

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F 695	Continued From page 5	F 695		

trach [tracheostomy] site" and a focus of "receives oxygen therapy." Interventions included "provide oxygen as needed."

An observation of Resident #38 was made on 01/21/25 at 10:39 A.M. Resident #38 was observed awake, alert and sitting up in her bed. She was receiving oxygen via nasal cannula. The oxygen concentrator was placed next to her bed and was set to deliver oxygen at 1.5L per minute.

A second observation and interview of Resident #38 was made on 01/21/25 at 12:36 P.M. Resident #38 was sitting up in her bed, awake and alert. Her oxygen concentrator was still set to deliver her oxygen at 1.5 L per minute. Resident #38 said it was supposed to be set at 2L per minute and denied changing the setting. She stated she was unaware of who changed the setting on the concentrator.

An interview was conducted with Nurse #1 on 01/21/25 at 2:56 P.M. Nurse #1 stated she was unaware of Resident #38's oxygen concentrator 1.5L setting and confirmed she had not changed the setting. Nurse #1 explained she had checked Resident #38's oxygen saturation using a pulse oximeter around 11:00 A.M. and it had been 97%. She stated that she had checked the oxygen concentrator setting earlier that morning and it had been set correctly at 2L per minute. She was unaware of who might have changed the setting.

An observation of Resident #38's oxygen concentrator setting was conducted with Nurse #1 on 01/21/25 at 3:00 P.M. The oxygen concentrator remained at the 1.5L setting. Nurse #1 checked Resident #38's oxygen saturation

deficient practice.
All residents requiring oxygen therapy have the potential to be affected by this alleged deficient practice.

On 2/7/2025 the Director of Nurses and nursing team began auditing 100 % of residents requiring oxygen therapy to ensure the rate set per prescribed physician orders. The results included: there were 0 of 15 residents noted error in concentrator settings. On 2/7/2025 the Director of Nursing and nurse supervisors implemented corrective action to include: correction to concentrator setting to reflect prescribed physician order, assessment of resident to include physical assessment, obtaining oxygen saturation rate and notification to medical provider of any adverse findings with implementation of new orders.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 2/7/2025 the Director of Nurses began education of all full time, part time, as needed nurses, medication aides to include agency on the following topics:
o Ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences.
o Risk of not ensuring Oxygen therapy is administered at the set rate per Medical

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F 695	Continued From page 6 using a pulse oximeter which read 94%. Nurse #1 was observed changing the setting on the oxygen concentrator to 2L and Resident #38's oxygen saturation was rechecked and had improved to 97%. A telephone interview with Nurse Practitioner (NP #1) was conducted on 01/24/25 at 3:35 P.M. NP #1 indicated Resident #38 did not experience any respiratory distress when the oxygen concentrator had been set at 1.5L per minute. NP #1 stated it was her expectation nurses follow the physician's orders for oxygen therapy. An interview with the Director of Nursing (DON) was conducted on 01/24/25 at 11:02 A.M. The DON stated it was her expectation nursing staff adhered to policy and procedures for residents on oxygen therapy, making sure they check the physician's orders and apply the prescribed setting on the oxygen concentrators. An interview with the Administrator was conducted on 01/24/25 at 2:00 P.M. The Administrator stated it was her expectation that nursing staff taking care of residents who are on oxygen therapy ensure the oxygen concentrators are set to the physician order for oxygen.	F 695	provider. o Signs and Symptoms of Hypoxia o Best practice for validating Oxygen concentrator settings. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 2/10/2025 will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F695 monitoring tool for compliance by auditing 5 residents that require Oxygen therapy to ensure Oxygen concentrator set per medical providers prescribed order weekly x 2 weeks and monthly x 3 months or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager,	

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F 695	Continued From page 7	F 695	and the Dietary Manager. Date of Compliance: 2/11/2025	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		2/11/25

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F 842	Continued From page 8 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a complete and accurate electronic medical record (EMR) for a Resident with type 2 diabetes mellitus. This affected 1 of 5 residents reviewed for medical record accuracy (Resident #25).	F 842	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken	

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The findings included:

Resident #25 was admitted to the facility on 10/21/2024 with diagnoses including type 2 diabetes mellitus.

A review of the October and November Medication Administration Record (MAR) revealed an order for Humalog Solution (Humalog is a fast-acting insulin that starts to work about 15 minutes after injection and peaks in about 1 hour and keeps working for 2-4 hours). Inject as per sliding scale subcutaneously before meals for diabetes. Give 30 minutes before meals, 8:00 AM, 11:30 AM and 4:30 PM.
If BS is:
8 - 150 = 8 units
151 - 200 = 10 units
201 - 250 = 12 units
251 - 300 = 14 units
301 - 350 = 16 units
351 - 400 = 18 units
401+ Call provider Hours

On 10/30/2024 at 8:00 AM, the MAR revealed Resident #25's BS was 172, and 10 units of insulin were administered, there was no documentation for 11:30 AM.

An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 10/30/2024 at 11:30 AM, Resident #25's BS was 128. She was not able to administer the Resident's sliding scale of 8 units because the RP came to take the Resident to an appointment and left the building before administering the medication. The DON also stated she did let the RP know she needed the coverage. The DON

F 842

or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.
F842 Resident Records
The facility failed to have a complete and accurate electronic medical record (EMR) for a Resident with type 2 diabetes mellitus. This affected 1 of 5 residents reviewed for medical record accuracy (Resident #25).
Corrective action for resident(s) affected by the alleged deficient practice:
On 1/21/2025 the Director of Nursing implemented corrective action for resident #25 to include assessment of resident for any adverse effects with none identified and notification to medical director of the failure to administer resident insulin per order. No new orders received at this time.

1. Corrective action for residents with the potential to be affected by the alleged deficient practice.
All residents requiring finger stick blood sugars with sliding scale insulin have the potential to be affected by this alleged deficient practice.

On 2/7/2025 the Director of Nurses and nursing team began auditing the past 7 days of resident's electronic medical record to ensure ordered finger stick blood sugars with sliding scale had completed and accurate documentation. This will be completed by 2/10/2025. The

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further stated she was supposed to document the Residents' 11:30 AM BS and missed dosage of insulin in the MAR but failed to do so.

On 11/16/2024 at 8:00 AM and at 11:30 AM, the MAR revealed Resident #25's BS was documented as 312 and 16 units of insulin was administered.

An interview with Nurse #1 was conducted on 01/23/2025 at 12:53 PM. The nurse stated she was the Nurse for Resident #25 on 11/16/2024 and the morning blood sugar documentation in the MAR at 8:30 AM was the accurate blood sugar level. She could not recall what was happening at the facility at that time to make her put the same amounts in the MAR twice, but the 11:30 AM blood sugar on 11/16/2024 could not be accurate.

An interview with the DON was conducted on 01/23/2025 at 2:46 PM. The DON stated on 11/16/2024, Nurse # 1 would not have given 16 units of insulin twice and it had to be documented incorrectly. She did not know how it happened, but Nurse #1 did not usually make documentation errors. The DON also stated her expectation was that they exercise accurate documentation according to physicians' orders.

An interview with the Administrator was conducted on 01/24/2025 at 3:05 PM. The Administrator stated she expected the nursing staff to document the EMRs accurately.

F 842

results included: there were 2 of 9 residents noted with incomplete and inaccurate documentation. On 2/10/2025 the Director of Nursing implemented corrective action to include assessment of resident, review of resident chart for adverse effects, notification to medical director for further interventions and initiation of any new orders.

2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
Beginning on 2/7/2025 the Director of Nurses began education of all full time, part time, as needed nurses, medication aides to include agency on the following topics:
Facility must maintain medical records on each resident that are Complete and Accurately documented
Ensure that all medications be given as ordered during the hours you are scheduled to work.
Ensure complete and Accurate documentation in medical record.
Ensure you have documented record of the resident's assessments in the medical record to include not limited to: completion of user defined assessment, Completed EMAR and Progress Notes.
Ensure you follow the comprehensive plan of care and services provided are documented in the Medical record.
Ensure you follow the physician prescribed orders when administrating medications or other therapy.
Ensure that residents receive treatment and care in accordance with

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREMENT	**180 SOUTHWOOD DRIVE CLINTON, NC 28328**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11	F 842	professional standards of practice. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training by 2/10/2025 will not be allowed to work until training has been completed. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or designee will monitor compliance utilizing the F842 Quality Assurance Tool for compliance by auditing 5 residents that require finger stick blood sugars with sliding scale to ensure physician orders were completed and accurately documented weekly x 2 and monthly x 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 2/11/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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