PRINTED: 04/14/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	00/1//2020
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 000	INITIAL COMMENTS	5	F 000		
	onsite from 03/11/25 information was obta	ation survey was conducted through 03/13/25. Additional ined on 03/17/25. ate was 03/17/25. Event ID#			
	NC00227546, NC002	were investigated: 226379, NC00227824, 223712.,NC00227948, 225321, NC00225285, and			
	2 of the 14 complain deficiency.	t allegations resulted in			
F 760 SS=E		f Significant Med Errors	F 760		4/8/25
	medication errors. This REQUIREMENT by:	nts are free of any significant			
	Nurse Practitioner, and Pharmacist interview Humulin Regular (she Resident #7's the blood 150 mg/dl (milligrams and less than 120 mg/PM. 2.) hold Resident lispro) short acting in a blood glucose less Resident #9 Humalog for premeal blood glugive Resident #10 and Humalog insulin for premeal blood insulin for premeal plood glugive Resident #10 and Humalog insulin for premeal blood glugive Resident #10 and Humalog insulin for premeal Blood glugive Resident #10 and Humalog insulin for premeal Blood glugive Resident #10 and Humalog insulin for premeal Blood glugive Resident #10 and Humalog insulin for premeal Blood glugive Resident #10 and Humalog glugive Resident #10 and Humalog glugive Resident #10 and Humalog glugive Resident #10 and Humalo	s the facility failed to 1.) hold ort acting) insulin when od glucose was less than sper deciliter) at 7:30 AM g/dl at 11:00 AM and 5:00 at #8's Humalog (insulin sulin 5 units before meals for than 100 mg/dl. 3.) give g insulin 5 units before meals loose over 150 mg/dl. 4.)		The statements made on this plan of correction are not an admission to an not constitute an agreement with the alleged deficiencies.  To remain in compliance with all feder and state regulations the facility has to or will take the actions set forth in this plan of correction. The plan of correct constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  F760 the facility failed to 1.) hold Hum Regular (short acting) insulin when Resident #7's the blood glucose was less than the state of the sta	al aken ion
ABODATORY		SLIPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u>	TITLE	(X6) DATE

Electronically Signed 04/06/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345218	B. WING			С	
NAME OF D		343216	B. WING	OTDEET ADDRESS SITV STATE 710 SODE		3/17/2025	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=		
MARY GR	AN NURSING CENTER			120 SOUTHWOOD DRIVE			
				CLINTON, NC 28329			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 760	Continued From page	÷ 1	F 76	0			
1 700	the physician's order Resident#12 when the than 120 mg/dl. 6.) and antihypertensive medias needed for increase Resident #3 and Resident #4 and Resident #4 and Resident #5 was a 04/01/22 with a diagn Mellitus and long term Review of the medical 2024, December 2022 2025 and March 2025 the following active of the following active of the Multiple Multipl	for Resident #11 and e blood glucose was less dminister the ication Clonidine prescribed sed blood pressure to ident#13 when the systolic reater than 160 and 170 y (mmHg). The residents icant outcome. This sidents reviewed for ation.  admitted to the facility on losis of Type 2 Diabetes in use of insulin.  If records for November 4, January 2025, February 5 revealed Resident #7 had reders:  R Injection Solution 100 filliliter) (Insulin Regular it subcutaneously in the pe 2 Diabetes Mellitus i. Hold for blood glucose less  M Humulin R Injection L (Insulin Regular (Human)) eously two times a day	F 76	than 150 mg/dl (milligrams per 7:30 AM and less than 120 mg AM and 5:00 PM. 2.) hold Res Humalog (insulin lispro) short insulin 5 units before meals for glucose less than 100 mg/dl. 3 Resident #9 Humalog insulin 5 before meals for premeal blood over 150 mg/dl. 4.) give Resid additional 4 units of Humalog premeal blood glucose over 20 hold Humalog insulin accordin physician's order for Resident Resident#12 when the blood gless than 120 mg/dl. 6.) admin antihypertensive medication Coprescribed as needed for increpressure to Resident #3 and F when the systolic blood pressure to Resident #3 and F when the systolic blood pressure to Resident #3 and F when the systolic blood pressure to Resident #3 and F when the systolic blood pressure for 8 of 8 residents remedication administration.  1. A corrective action for the reinvolved  On 3/17/2025 the Clinical Mal Team assessed Resident #7, #11, #12, #13 for changes in cowith no identified concerns and provider/Responsible party of medication error related to adrof medication outside of order parameters. No new orders comparameters.	g/dl at 11:00 sident #8's acting r a blood 3.) give 5 units d glucose ent #10 an insulin for 00 mg/dl. 5.) g to the #11 and glucose was sister the clonidine eased blood Resident #13 ure was meters of ts come. This eviewed for sident magement #8, #9, #10, condition d notified the ministration ed		
	120 mg/dl.  Review of the Medica	or blood glucose less than tion Administration Records received 7 units of insulin at		Corrective action for resider potential to be affected by the deficient practice.  All residents in the facility who medications have the potentia	alleged take		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
					С		
		345218	B. WING _			03/	17/2025
NAME OF PRO	OVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
MADY 00 A	NAMEDONIO OFFITED			12	20 SOUTHWOOD DRIVE		
MARY GRA	N NURSING CENTER			С	LINTON, NC 28329		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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
	150 mg/dl:  11/05/24 at 7:30 AM bunits of insulin was ac 11/23/24 at 7:30 AM bunits of insulin was ac 11/24/24 at 7:30 AM bunits of insulin was ac 11/26/24 at 7:30 AM bunits of insulin was ac 11/28/24 at 7:30 AM bunits of insulin was ac 11/29/24 at 7:30 AM bunits of insulin was ac 11/29/24 at 7:30 AM bunits of insulin was ac 12/03/24 at 7:30 AM bunits of insulin was ac 12/06/24 at 7:30 AM bunits of insulin was ac 12/07/24 at 7:30 AM bunits of insulin was ac 12/08/24 at 7:30 AM bunits of insulin was ac 12/08/24 at 7:30 AM bunits of insulin was ac 12/10/24 at 7:30 AM bunits of insulin was ac 12/11/24 at 7:30 AM bunits of insulin was ac 12/11/24 at 7:30 AM bunits of insulin was ac 12/11/24 at 7:30 AM bunits of insulin was ac 12/31/24 at 7:30 AM bunits of insulin was ac 12/31/24 at 7:30 AM bunits of insulin was ac 12/31/25 at 7:30 AM bunits of insulin was ac 01/15/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/16/25 at 7:30 AM bunits of insulin was ac 01/20/25	glucose result of less than  blood glucose 136 mg/dl, 7  dministered by Nurse #11  blood glucose 131 mg/dl, 7  dministered by Nurse #22  blood glucose 132 mg/dl, 7  dministered by Nurse #22  blood glucose 143 mg/dl, 7  dministered by Nurse #11  blood glucose 131 mg/dl, 7  dministered by Nurse #22  blood glucose 148 mg/dl, 7  dministered by Nurse #11  blood glucose 127 mg/dl, 7  dministered by Nurse #22  blood glucose 110 mg/dl, 7  dministered by Nurse #22  blood glucose 115 mg/dl, 7  dministered by Nurse #22  blood glucose 115 mg/dl, 7  dministered by Nurse #22  blood glucose 148 mg/dl, 7  dministered by Nurse #22  blood glucose 148 mg/dl, 7  dministered by Nurse #22  blood glucose 147 mg/dl, 7  dministered by Nurse #22  blood glucose 137 mg/dl, 7  dministered by Nurse #22  blood glucose 137 mg/dl, 7  dministered by Nurse #13  blood glucose 137 mg/dl, 7  dministered by Nurse #13  blood glucose 137 mg/dl, 7  dministered by Nurse #13  blood glucose 137 mg/dl, 7  dministered by Nurse #13  blood glucose 137 mg/dl, 7  dministered by Nurse #11  blood glucose 129 mg/dl, 7  dministered by Nurse #11  blood glucose 144 mg/dl, 7  dministered by Nurse #11  blood glucose 144 mg/dl, 7  dministered by Nurse #11  blood glucose 144 mg/dl, 7  dministered by Nurse #11  blood glucose 144 mg/dl, 7  dministered by Nurse #11	F	760	affected. On 3/15/2025 the Director of Nursing began auditing 100% of resident medication administration records for the past 14 days of residents with active orders for medications with parameters and to identify any medication errors related to not following ordered parameters. The results included there were 6 of 36 residents identified with medication administered outside of the ordered parameters. On 3/16/2025 the Director of Nursing implemented corrective action to include: completed assessments of the identified residents change in condition, notification to the provider for review and implementation any new interventions directed by the medical provider.  3. Systemic Changes On, 3/14/2025 he Staff Development Coordinator began in-servicing all full time, part time and as needed Nurses, Medication Administration errors included:  • Preventing medication errors • Types of medication errors • 6 rights of medication errors • 6 rights of medication administration • Following medication safety praction • Medications with parameters and Medication Errors • Examples of Medication orders with parameters • How to prevent medication errors • How to Document Medications with parameters in PCC • Chart Codes and accurate	e check for of on ces	

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		345218	B. WING _			l	C / <b>17/2025</b>
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	1772023
					20 SOUTHWOOD DRIVE		
MARY GR	AN NURSING CENTER				ELINTON, NC 28329		
(X4) ID PREFIX			ID PREFIX	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	=	(X5) COMPLETION
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F 760	Continued From page	÷ 3	F 7	760			
	01/29/25 at 7:30 AM	blood glucose 121 mg/dl, 7			documentation		
		dministered by Nurse #11			Notification to Provider and RP		
		blood glucose 130 mg/dl, 7			What to do if Medication Error occ	urs	
		dministered by Nurse #11			and How to document		
		blood glucose 114 mg/dl, 7					
	units of insulin was a	dministered by Nurse #12			The Director of Nursing will ensure that	İ	
		blood glucose 123 mg/dl, 7			any of the above identified staff who do		
	units of insulin was a	dministered by Nurse #11			not complete the in-service training by		
	02/17/25 at 7:30 AM	blood glucose 148 mg/dl, 7			4/7/2025 will not be allowed to work un	til	
	units of insulin was ac	dministered by Nurse #11			the training is completed.		
		blood glucose 122 mg/dl, 7					
	units of insulin was a	dministered by Nurse #11			4. Monitoring Procedure to ensure that	İ	
	02/19/25 at 7:30 AM	blood glucose 127 mg/dl, 7			the plan of correction is effective and the	nat	
		dministered by Nurse #22			specific deficiency cited remains correc	ted	
		blood glucose 138 mg/dl, 7			and/or in compliance with regulatory		
	units of insulin was a	dministered by Nurse #11			requirements.		
					The Director of Nursing and/or clinical		
		Administration Records			leadership team member will monitor		
		received 4 units of insulin at			completion of ongoing audits for F 760		
		M with a blood glucose			weekly X 4 weeks and then monthly X		
	result of less than 120				months or until resolved. This audit will		
		blood glucose 113 mg/dl, 4			completed by randomly auditing five nu	ırse	
		dministered by Nurse #22			med passes (to include all shifts and		
		plood glucose 116 mg/dl, 4			weekends) and electronic medication	_	
		dministered by Nurse #22			administration records will be audited a	S	
		blood glucose 107 mg/dl , 4			part of the clinical review process to	od	
		dministered by Nurse #22			assess that medications are administer	ea	
		blood glucose 101 mg/dl, 4			per order and hold parameters were		
		dministered by Nurse #22			followed. Any negative findings will	d	
		blood glucose 118 mg/dl, 4			immediately be addressed and reviewe		
		dministered by Nurse #14 blood glucose 103 mg/dl, 4			during the daily clinical review meeting interventions or additional training.	101	
		dministered by Nurse #22			Reports will be presented to the weekly	,	
		blood glucose 103 mg/dl, 4			Quality Assurance committee by the	1	
		dministered by Nurse #22			Administrator to ensure corrective action	n	
		blood glucose 100 mg/dl, 4			initiated as appropriate. Compliance wi		
		dministered by Nurse #11			be monitored and ongoing auditing		
		blood glucose 118 mg/dl, 4			program reviewed at the weekly Quality	,	
		dministered by Nurse #11			Assurance Meeting. The weekly Quality		

Facility ID: 923329

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345218	B. WING _			1	C <b>17/2025</b>
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		1 03/	17/2025
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 760	01/01/25 at 5:00 PM units of insulin was at 02/06/25 at 11:00 AM units of insulin was at 02/27/25 at 11:00 AM mg/dl, 4 units of insul Nurse #5 02/27/45 at 5:00 PM mg/dl, 4 units of insul Nurse #5 Review of the progres through 03/12/25 for documentation that the dates listed.  An interview was con 03/13/25 at 4:26 PM. the parameter of 120 order at 7:30 AM as we Resident #7. She cor insulin in error becausattention to the order.  A telephone interview #12 on 03/14/25 at 11 was used to working scales are used and parameters like at the explained that any insare written really smascreen, so she probal and administered Resinsulin. She conclude attention to the small.  A telephone interview #5 on 03/14/25 at 12:	blood glucose 109 mg/dl, 4 dministered by Nurse #11 I blood glucose 102 mg/dl, 4 dministered by Nurse #12 I blood glucose was 104 in was administered by blood glucose was 104 in was administered by blood glucose was 104 in was administered by ss notes from 11/05/24 Resident #7 revealed no ne insulin was held on the ducted with Nurse #11 on She stated that she thought mg/dl applied to the insulin well as before meals for icluded that she had given se she had not paid close parameters.  I was conducted with Nurse 1:00 AM. She stated that she at the hospital where sliding not a lot of different e nursing home. She structions for medications ill on the bottom of the bly missed the parameters sident #7 the wrong dose of id she needed to pay closer	F	760	Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therap Health Information Manager, and the Dietary Manager.  Date of Compliance: 4/8/2025	yy,	

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		345218	B. WING			C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	E	03/1//2023
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	( (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 760	the ordered parameter had immediate family diabetes and that she parameters on insulii thought she had click documenting and had insulin in error.  A telephone interview #14 on 03/14/25 at 1 knew to click on "mode could not remember insulin orders and the breakfast was rare. Some insulin orders are that had parameters.  A telephone interview #13 on 03/14/25 at 3 some insulin orders at did not. She thought parameters for the in had to click an additionstructions and see believed she did not order instructions and insulin orders had parameters for the in had to click an addition order instructions and see believed she did not order instructions and insulin orders had parameters for the incomplete the median order instructions and insulin orders had parameters for the incomplete steep and insulin or	ers. She explained that she members who had brittle e always looked for norders. She stated that she ted on the wrong box when do not administered any was conducted with Nurse 2:57 PM. She stated she re" to see the full order but seeing parameters set for at to give insulin before the stated she did not ring insulin to Resident #7  was conducted with Nurse 1:50 PM. She stated that had parameters and some she might have missed the sulin orders because she onal box to open the order the parameters. She click on the box to open the do had not realized that any	F 7	760		
	given the insulin to R A telephone interviev	www.conducted with Nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 120 SOUTHWOOD DRIVE CLINTON, NC 28329		5671772025
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 760	stated that nothing I Resident #7 had ex condition. She expla as a result of the me been hypoglycemia hyperglycemia (high could cause confusior death. She reporglucose levels were the latest laboratory had not suffered any the medication error.  A telephone interviee Medical Director on stated he was new a been there six week been reported to hir related to a change administration. He regulate the blood gand long acting insuregulate the blood gand long acting insuregulate the blood guitoo high which could stroke, mental statud disease, or death. Fresident at the facili negative outcome reor given in error.  A telephone interviee Pharmacist Consult She stated that she that staff were not for administering insuling	3/14/25 at 12:40 PM. She had been reported to her that perienced a change in ained that possible outcomes edication errors could have (low blood glucose) or a blood glucose) both of which on, lethargy, seizures, coma, ted that Resident #7's blood under control according to tests and that Resident #7 y poor outcome because of	F7	760		

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	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		33,117,2323	
4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETION DATE	
Unit Managers for for the Quality Improver each month and stat caused by not follow was specifically disc stated she knew the re-educating staff report because it had been a telephone interview. Manager #1 on 03/1 she received nursing from the pharmacist caused by nurses not related to insulin ord was provided to indivin February 2025 to agency nurses. She how to check insulin how to chart code are indicate the medicate administered. She corre-education had stated decrease in the num related to insulin.  2.) Resident #8 was 12/31/24 with a diag Mellitus with diabetic use of insulin.  Review of the medicate and February 2025 refollowing active order.	allow up. She also attended ment meetings at the facility and that medication errors in ing insulin parameter orders ussed each month. She facility had been garding insulin parameters discussed in the meetings.  We was conducted with Unit 7/25 at 4:34 PM. She stated grecommendations monthly and was aware of the errors of following parameters ers. She explained training vidual nurses and beginning all nursing staff including educated all the nurses on orders for parameters and norder with a 5 or an 11 to ion had not been concluded that since the arted there had been a sharp ber of medication errors  admitted to the facility on mosis of Type 2 Diabetes and norder with a domination or the error of medication errors.  admitted to the facility on mosis of Type 2 Diabetes and norder with and long term.	F 7	60			
	ROVIDER OR SUPPLIER  SUMMARY S (EACH DEFICIENC REGULATORY OR  Continued From page Unit Managers for for the Quality Improver each month and state caused by not follow was specifically disc stated she knew the re-educating staff repeacuse it had been A telephone interview Manager #1 on 03/1 she received nursing from the pharmacist caused by nurses not related to insulin ord was provided to indivin February 2025 to agency nurses. She how to check insulin how to chart code are indicate the medicate administered. She core-education had stated ecrease in the num related to insulin.  2.) Resident #8 was 12/31/24 with a diag Mellitus with diabetic use of insulin.  Review of the medicate and February 2025 of following active order thumalog Solution 10 (Human)) Inject 5 un meals for diabetes. Here	AN NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.  A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.  2.) Resident #8 was admitted to the facility on 12/31/24 with a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy and long term use of insulin.  Review of the medical records for January 2025 and February 2025 revealed Resident #8 had the following active order:  Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes. Hold for BS (blood glucose)	A BUILDIN  345218  B. WING _  SOVIDER OR SUPPLIER  AN NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. 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Resident #8 was admitted to the facility on 12/31/24 with a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy and long term use of insulin.  Review of the medical records for January 2025 and February 2025 revealed Resident #8 had the following active order:  Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes. Hold for BS (blood glucose)	ROUNDER OR SUPPLIER  AN NURSING CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.  A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.  2.) Resident #8 was admitted to the facility on 12/21/24 with a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy and long term use of insulin.  Review of the medical records for January 2025 and February 2025 revealed Resident #8 had the following active order:  Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes. Hold for BS (blood glucose)	A BUILDING  345218  ROWDER OR SUPPLIER  AN NURSING CENTER  SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 7  Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameters because it had been discussed each month. She stated she knew the facility had been re-education stem discussed in the meetings.  A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by not londividual nurses and beginning in February 2025 to all nursing staff including agency nurses. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She explained that include the medication had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administered. She concluded that since the re-education had not been administere	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	' '	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER    (X4) ID			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	· '	33/11/2020	
PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	Continued From pag	e 8	F 7	760		
	revealed Resident #8 8:00 AM with a blood 100 mg/dl and was r glucose over 100:  01/23/25 at 11:00 AM units of insulin was a 02/01/25 at 8:00 AM units of insulin was h a chart code of 11 (n 02/07/25 at 8:00 AM units of insulin was a 02/08/25 at 8:00 AM units of insulin was a 02/08/25 at 8:00 AM units of insulin was a Review of the progre through 02/08/25 for documentation that t dates listed or given  A telephone interview #7 on 03/14/25 at 1:: did not recall insulin explained she had b insulin orders becau- different tabs plus sh insulin that she gave recall that Resident a insulin order.  A telephone interview #3 on 03/14/25 at 7:: clicked on the medic to going into a reside	8 received 5 units of insulin at diglucose result of less than not given insulin with a blood.  M blood glucose 98 mg/dl, 5 administered by Nurse #7 blood glucose 108 mg/dl, 5 all held by Nurse #7 indicated by it insulin required per order). blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered by Nurse #3 blood glucose 98 mg/dl, 5 administered with Nurse 93 plus plus plus plus plus plus plus plus				
	had held the insulin.	wards to document that she Because of this she thought error but had not given the				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	PLE CONSTRUCTION  G	(X3	(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 02/47/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	l	03/17/2025
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 760	wrong dose of insulin her nursing judgemer administer fast acting less than 100. She not glucose was 100 or 1 the physician for guid A telephone interview Practitioner #2 on 03/s stated she had been February 17, 2025. S getting to know the reinsulin parameters we control blood glucose administered in error could lead to either hypoglycemia either of unconsciousness and She reported she had change in condition reaching in condition reaching in condition reaching in the six weeks been reported to him related to a change in administration. He no parameters for insulir regulate the blood glucon light which could stroke, mental status disease, or death. He resident at the facility	In addition, she explained at would tell her not to insulin for a blood glucose oted even if the blood 01 she would have called ance.  It was conducted with Nurse 17/24 at 12:28 PM. She working at the facility since the explained she was still esidents. She noted that the ere in place in an attempt to levels. She stated insulin was concerning because it yperglycemia and	F 76	60		

	С
345218 B. WING	03/17/2025
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	03/1//2023
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.  A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.  3.) Resident #9 was admitted to the facility on 12/02/19 with the following diagnoses: Type 2 Diabetes Mellitus with chronic kidney disease Stage 3 and long term use of insulin.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ` ′	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED		
		345218	B. WING		03/17/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	03/17/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 760	and February 2025 r following active orde  Humalog Solution 10 (Human)) Inject 5 un meals for diabetes for Review of Medication revealed Resident #5 with a blood glucose mg/dl:  01/01/25 at 6:00 AM units of insulin was a 01/08/25 at 6:00 AM units of insulin was a 01/12/25 at 11:00 AM units of insulin was a 01/12/25 at 6:00 AM units of insulin was a 01/22/25 at 6:00 AM units of insulin was a 01/25/25 at 6:00 AM units of insulin was a 01/30/25 at 6:00 AM units of insulin was a 02/05/25 at 6:00 AM units of insulin was a 02/05/25 at 6:00 AM units of insulin was a 02/05/25 at 6:00 AM units of insulin was a 02/12/25 at 6:00 AM units of insulin was a 02/12/25 at 6:00 AM units of insulin was a 02/12/25 at 6:00 AM units of insulin was a 02/14/25 at 6:00 AM units of insulin was a 02/14/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM units of insulin was a 02/18/25 at 6:00 AM	evealed Resident #9 had the	F 76			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED		
		345218	B. WING			C 03/17/2025	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		03/1//2023	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	units of insulin was a 02/21/25 at 5:00 PM units of insulin was a 02/22/25 at 6:00 AM units of insulin was a Review of the progrethrough 02/22/25 for documentation that t dates listed.  An interview was cor 03/13/25 at 4:26 PM the parameter of 120 order for Resident #8 concluded that she h because she had no order parameters.  An interview was cor on 03/13/25 at 4:48 I understood the way she administered insexplained that becaurelated to holding insunder a certain numblood glucose level with She stated she had and had given the inbeen held.  A telephone interview #14 on 03/14/25 at 1 knew to click on "mo could not remember insulin orders and als breakfast was rare. See the county of the could not remember insulin orders and als breakfast was rare.	blood glucose 132 ml/dl, 5 dministered by Nurse #14 blood glucose 141 ml/dl, 5 dministered by Nurse #6 blood glucose 147 ml/dl, 5 dministered by Nurse #7  ss notes from 10/01/25 Resident #9 revealed no he insulin was held on the  ducted with Nurse #11 on She stated that she thought mg/dl applied to the insulin	F 7	60			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING			C 03/17/2025	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 120 SOUTHWOOD DRIVE CLINTON, NC 28329		00/1//2020	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 760	#15 on 03/14/25 at 1: no memory of the resadministered insulint to A telephone interview #16 on 03/14/25 at 1: always checked for padministering insulinthe keys on the compathat she had found win the past that she cathe blood glucose the accurate and that she set parameters as or A telephone interview #7 on 03/14/25 at 1:3 did not recall insuling explained she had be insulin orders because different tabs plus a sthat she gave. She st Resident #9 had para A telephone interview #13 on 03/14/25 at 3: some insulin orders had to click an addition instructions and see to believed she did not order instructions and insulin orders had parameters had p	was conducted with Nurse 11 PM. She stated she had ident or that she had hat had set parameters.  was conducted with Nurse 15 PM. She stated that she arameters when She explained that some of outer keyboards stuck and rong numbers documented orrected. She stated she felt at was recorded was not a gave the insulin within the dered.  was conducted with Nurse 4 PM. She stated that she orders with parameters. She sen confused regarding the each had to click on two diding scale order for insulin ated she did not recall that ameters in the insulin order.  was conducted with Nurse 50 PM. She stated that had parameters and some she might have missed the sulin orders because she onal box to open the order the parameters. She click on the box to open the did had not realized that any	F 76	60			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025	
	ROVIDER OR SUPPLIER  AN NURSING CENTER	1		STREET ADDRESS, CITY, STATE, ZIP COD 120 SOUTHWOOD DRIVE CLINTON, NC 28329		30.11.72020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 760	#6 on 03/17/25 at 12 the call. She stated sifferent places and insulin at the facility explained she could given or why from m. An interview was no Attempts to contact vial phone and text r 03/17/25 at 11:59 Al An interview was no Nurse #17. She was available for interview Practitioner #2 on 03 stated she had been February 17, 2025. Sighting to know the r insulin parameters we control blood glucos administered in error could lead to either thypoglycemia either unconsciousness and	w was conducted with Nurse 2:15 PM when she returned she worked at several could not remember giving to Resident #9. She not remember what she had emory.  It conducted with Nurse #18. her on 03/14/25 at 1:40 PM message and again on which were not successful.  It conducted with Agency out of the country and not which were not successful.  It was conducted with Nurse 8/17/24 at 12:28 PM. She is working at the facility since She explained she was still residents. She noted that the were in place in an attempt to be levels. She stated insuling the was concerning because it	F7	760			
	A telephone interview Medical Director on stated he was new a been there six week been reported to him regarding a change administration. He n	w was conducted with the 03/17/25 at 3:36 PM. He the facility and had only so the stated nothing had in regarding Residents #9 in condition related to insulinoted the purpose of setting in administration was to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	•	03/1//2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	and long acting insulparameters for insulto prevent blood glutoo high which could stroke, mental status disease, or death. Hresident at the facilit negative outcome reor given in error.  A telephone interviee Pharmacist Consults She stated that she that staff were not for administering insulir sent pharmacy recording the Quality Improver each month and state caused by not follow was specifically disc stated she knew the re-educating staff rebecause it had been A telephone interviee Manager #1 on 03/1 she received nursing from the pharmacist caused by nurses no related to insulin ord was provided to indi	liucose using both fast acting lins in combination. The in were specifically intended coses from being too low or I lead to impaired vision, is change, coronary artery e was not aware of any y who had experienced a elated to insulin that was held with was conducted with the eart on 03/17/25 at 3:15 PM. had been notifying the facility belowing parameters when in She noted every month she is mmendations via fax to both sollow up. She also attended ment meetings at the facility ted that medication errors wing insulin parameter orders sussed each month. She	F7	760		
	how to check insulin how to chart code an indicate the medicat	educated all the nurses on orders for parameters and n order with a 5 or an 11 to ion had not been oncluded that since the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 02/47/2025	
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	I	03/17/2025	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 760	decrease in the nurrelated to insulin.  4.) Resident #10 wa 03/06/17 with the form of the medical series of th	arted there had been a sharp inber of medication errors  as admitted to the facility on allowing diagnoses: Type 2 ithout complications and long ithout complications and long cal records for December 2025 revealed Resident #10 octive order:  Solution 100 UNIT/ML (Insuling its subcutaneously before the 2 Diabetes Mellitus without the premail glucoses over 200 its. Do not call provider unless the than 450 mg/dL.  The Administration Records #10 had not received an insulin with a blood glucose	F 7				
	of insulin 12/30/24 at 8:00 AN Nurse #13 signed the of insulin 01/01/25 at 11:00 A	Il blood glucose 253 ml/dl, nat she gave a total of 10 units IM blood glucose 252 ml/dl, at she gave a total of 10 units					

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		C 02/47/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	03/17/2025	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 760	of insulin 01/01/25 at 4:00 PN Nurse #19 signed the of insulin 01/03/25 at 11:00 A Nurse #7 signed the of insulin Review of the progression of the	M blood glucose 207 ml/dl, nat she gave a total of 10 units  M blood glucose 230 ml/dl, at she gave a total of 10 units  ess notes from 12/04/24 r Resident #10 revealed no 4 additional units of insulin	F 76			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	COMF	(X3) DATE SURVEY COMPLETED	
		345218	B. WING _		1	C / <b>17/2025</b>
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	•	1172020
(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 COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	have to see the order happened because  A telephone interviee #24 on 03/17/25 at knew the residents insulin order parame always followed the administering insulin incorrectly that she insulin to Resident #14 units as ordered.  A telephone interviee Practitioner #1 on 0 stated that nothing I Residents #10 had condition. She explass a result of the me been hypoglycemia hyperglycemia (high could cause confusior death. She report glucoses were under latest laboratory test not suffered any pomedication errors.  A telephone interviee Medical Director on stated he was new a been there six week been reported to hir	s to Resident #10 and would be to know what had she could not remember.  W was conducted with Nurse 4:33 PM. She stated she and knew which residents had be been she concluded that she parameters when an and must have documented administered 10 units of \$\frac{1}{2}\$10 when she knew she gave was conducted with Nurse 3/14/25 at 12:40 PM. She had been reported to her that experienced a change in a sined that possible outcomes edication errors could have (low blood glucose) or a blood glucose) both of which on, lethargy, seizures, coma, ted that residents #10's blood for control according to the ts and that Resident #10 had for outcome because of the was conducted with the 03/17/25 at 3:36 PM. He at the facility and had only its. He stated nothing had in regarding Residents #10	F 7			
	having had a chang insulin administratio setting parameters to regulate the blood	n regarding Residents #10 e in condition related to n. He noted the purpose of for insulin administration was d glucose using both fast ng insulins in combination.				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345218	B. WING		C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	03/1//2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 760	Continued From pag	je 19	F 76	0	
	intended to prevent too low or too high w vision, stroke, menta artery disease, or de resident at the facilit negative outcome re or given in error.	nsulin were specifically blood glucoses from being which could lead to impaired al status change, coronary eath. He was not aware of any y who had experienced a slated to insulin that was held we was conducted with the			
	Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended				
	the Quality Improver each month and state caused by not follow was specifically disc stated she knew the re-educating staff re	ment meetings at the facility ted that medication errors ring insulin parameter orders ussed each month. She			
	Manager #1 on 03/1 she received nursing from the pharmacist caused by nurses not related to insulin ord was provided to indict in February 2025 to agency nurses. She how to check insulin how to chart code at indicate the medicat administered. She core-education had stated	w was conducted with Unit 7/25 at 4:34 PM. She stated grecommendations monthly and was aware of the errors of following parameters ers. She explained training vidual nurses and beginning all nursing staff including educated all the nurses on orders for parameters and n order with a 5 or an 11 to ion had not been oncluded that since the arted there had been a sharp aber of medication errors			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345218	B. WING			03/	) 17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, C 120 SOUTHWOOD I CLINTON, NC 28:		1 03/	17/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH (	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	1/5/23 with diagnose long-term use of insular A physician's order d #11 revealed Insulin per milliliter. Inject 6 before dinner. Hold for 120 mg/dl.  Review of the Medica (MAR) dated Octobe revealed Insulin Lispi milliliter. Inject 6 units before dinner. Hold for 120 mg/dl and schedd 11:30 AM and 4:00 P administered outside on the following date:  10/16/24 at 11:30 AM units of insulin was a 10/29/24 at 4:00 PM units of insulin was a Review of the progrethrough 10/29/24 for documentation that the dates listed.  Review of the Medica (MAR) dated November 100 milling was a 10/29/24 for documentation that the dates listed.	as admitted to the facility on s including diabetes, and alin.  ated 6/24/24 for Resident Lispro (Humalog) 100 units units once a day and 10 units or blood glucose less than  ation Administration Record or 2024 for Resident #11  ro (Humalog) 100 units per sonce a day and 10 units or blood glucose less than units or blood glucose less than united for administration at the Humalog was of the ordered parameters	F	760			
	before dinner. Hold for	s once a day and 10 units or blood glucose less than luled for administration at l'M. Humalog was					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345218	B. WING		C 03/17/2025			
	ROVIDER OR SUPPLIER  AN NURSING CENTER	•		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION			
F 760	on the following date  11/01/24 at 4:00 PM units of insulin was a 11/03/24 at 4:00 PM units of insulin was a 11/07/24 at 4:00 PM units of insulin was a 11/15/24 at 4:00 PM units of insulin was a 11/29/24 at 4:00 PM units of insulin was a 11/29/24 at 4:00 PM units of insulin was a Review of the progrethrough 11/29/24 for documentation that the dates listed.  Review of the Medic (MAR) dated Decement a listed in the liste	blood glucose 111 mg/dl, 10 administered by Nurse #3 blood glucose 115 mg/dl, 10 administered by Nurse #3 blood glucose 112 mg/dl, 10 administered by Nurse #3 blood glucose 109 mg/dl, 10 administered by Nurse #3 blood glucose 109 mg/dl, 10 administered by Nurse #3 blood glucose 70 mg/dl, 10 administered by Nurse #3 blood glucose 70 mg/dl, 10 administered by Nurse #3 acceptable with the second beautiful to the insulin was held on the matter attention Administration Record ber 2024 for Resident #11 ro (Humalog) 100 units per sonce a day and 10 units for blood glucose less than aduled for administration at PM. Humalog was a of the ordered parameters	F 760					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		03/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	(MAR) dated Januar revealed Insulin Lisp milliliter. Inject 6 unit before dinner. Hold 120 mg/dl and schee 11:30 AM and 4:00 I administered outside on the following date 1/03/25 at 11:30 AM units of insulin was a 1/10/25 at 4:00 PM I units of insulin was a 1/11/25 at 4:00 PM I units of insulin was a 1/27/25 at 4:00 PM I units of insulin was a 1/28/25 at 11:30 AM units of insulin was a 1/28/25 at 4:00 PM I units of insulin was a 1/28/25 at 4:00 PM I units of insulin was a 1/28/25 for insulin was a 1/28/25 for locumentation that dates listed.  During a phone inter Nurse #3 stated shee Resident #11. She signal and scheet insulin was a stated shee Resident #11. She signal in the signal insulin was a stated shee Resident #11. She signal insulin was a stated shee Resident #11. She signal insulin was a stated shee Resident #11. She signal insulin was a stated shee Resident #11. She signal insulin was a stated shee Resident #11. She signal insulin was a stated shee Resident #11. She signal insulin was a stated sheet was a stated sh	cation Administration Record by 2025 for Resident #11 bro (Humalog) 100 units per its once a day and 10 units for blood glucose less than duled for administration at PM. Humalog was e of the ordered parameters	F 7	60		
	electronic medicatio don't left click twice	n administration record if you on the medication order. She o start paying closer attention				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		345218	B. WING _			C 03/17/2025
	ROVIDER OR SUPPLIER  AN NURSING CENTER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329		30.12020
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	stated that if she signal Administration Recondumalog when the bust 120 mg/dl that she do it was administered it was administered it was administered it was administered it was administered stated she Resident #11. She substituted Medication Administrated Humality was less than 120 min error.  During a phone inter Nurse #6 stated if she Medication Administrated Humality was less than 120 min error.  During a phone inter Nurse #6 stated if she Medication Administrated Humality was less than 120 min error.  During a phone inter Nurse Practitioner #evaluated Resident #11 on 2/11 #11 had no adverse Humalog outside of excessive low blood hypoglycemic reaction mortality rates which were ordered. She si	a for insulin parameters. She ned off on the Medication rd that she administered blood glucose was less than id administer the insulin, but in error.  View on 3/17/25 at 3:00 PM routinely provided care to tated if she signed off on the ration Record that she og when the blood glucose ig/dl then it was administered existence of the ration Record that she og when the blood glucose ig/dl then it was administered existence of the ration Record that she og when the blood glucose ig/dl then it was administered existence of the ration Record that she og when the blood glucose ig/dl then it was administered existence of the routinely for the reactions from receiving the the parameters and had no	F 7	760		
	the Medical Director	view on 3/14/25 at 2:00 PM stated he was new to the y 2025. He stated he had not ent #11, but Nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C <b>03/17/2025</b>
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	I	00/1//2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY 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 760	there had been no re regarding Resident are expected that physic and the Humalog sh according to the ord.  During an interview Director of Nursing (aware of the insulin the order when she monthly Pharmacy rout on leave in Dece of January 2025. Sh nursing staff in Febrimedication orders at further education to provided.  During a phone interunity Manager #1 stareviewed the monthly Pharmacist address according to paramete each month they defined and educated each stated she did not kn nurses continued to the parameters ever provided. She stated to not seeing the full Administration Recowould correct the ord.  b.) Resident #12 wa 8/14/24 with diagnostic stated she did not seeing the full Administration Recowould correct the ord.	evaluated him. He indicated eported decline or outcome #11 to him. He stated he cian orders were followed, ould have been held er.  on 3/13/25 at 3:00 PM the DON) stated she was made not being held according to reviewed the February 2025 eports. She stated she was ember 2024 through the end e stated she educated all uary 2025 on following and parameters. She stated all nursing staff would be  eview on 3/17/25 at 4:00 PM atted she and Unit Manager #2 y pharmacy reviews, and the ed the insulin not being held eters each month. She stated termined who the Nurse was nurse that was identified. She now at the time why the administer insulin outside of a after education had been at they later thought it was due order on the Medication rd (MAR). She stated they	F 7	60		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	, ,	ATE SURVEY DMPLETED
		345218	B. WING _			C <b>03/17/2025</b>
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	,	<u> </u>	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	#12 revealed Insulir per milliliter. Inject 5 meals. Hold for block mg/dl.  Review of the Medic (MAR) dated Januar revealed Insulin List milliliter. Inject 5 unit meals. Hold for block mg/dl and schedule AM, 11:00 AM and 4 administered outsid on the following date 1/04/25 at 11:00 AM units of insulin was 1/10/25 at 11:00 AM units of insulin was 1/19/25 at 4:00 PM units of insulin was 1/19/25 at 4:00 PM units of insulin was 1/31/25 at 4:00 PM units of insulin was 1/31/25 for documentation that dates listed.  Review of the Medic (MAR) dated Februar	dated 12/27/24 for Resident in Lispro (Humalog) 100 units is units subcutaneously before and glucose less than 120  cation Administration Record ry 2025 for Resident #12 pro (Humalog) 100 units per rts subcutaneously before and glucose less than 120 d for administration at 8:00 4:00 PM. Humalog 5units was re of the ordered parameters res and times:  I blood glucose 84 mg/dl, 5 radministered by Nurse #8 I blood glucose 99 mg/dl, 5 radministered by Nurse #3 I blood glucose 110 mg/dl, 5 radministered by Nurse #6 blood glucose 110 mg/dl, 5 radministered by Nurse #6 blood glucose 106 mg/dl, 5 radministered by Nurse #3 resident #12 revealed no rectation Administration Record	F 7	·		
	milliliter. Inject 5 uni meals. Hold for bloc mg/dl and schedule	pro (Humalog) 100 units per ts subcutaneously before od glucose less than 120 d for administration at 8:00 4:00 PM. Humalog 5units was				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY OMPLETED	
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NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	'	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	on the following date 2/11/25 at 8:00 AM & units of insulin was a Review of the progre Resident #12 reveal Humalog was held.  Review of the Medic (MAR) dated March revealed Insulin Lisp milliliter. Inject 5 unit meals. Hold for bloo mg/dl and scheduled AM, 11:00 AM and 4 administered outside on the following date 3/10/25 at 8:00 AM & units of insulin was a Review of the progre Resident #12 reveal Humalog was held.  During an interview of #8 stated if she sign Administration Reco Humalog to Residen parameters then it we  During a phone inter Nurse #3 stated if sh Medication Administ administered Humal	e of the ordered parameters es and times:  blood glucose 116 mg/dl, 5 administered by Nurse #9  ess notes on 2/11/25 for ed no documentation that the  ation Administration Record 2025 for Resident #12  bro (Humalog) 100 units per es subcutaneously before defor administration at 8:00 etc. 00 PM. Humalog 5 units was es of the ordered parameters es and times:  blood glucose 106 mg/dl, 5 administered by Nurse #6  ess notes on 3/10/25 for ed no documentation that the  on 3/13/25 at 4:50 PM Nurse ed off on the Medication rd that she administered it #12 outside of the ras done in error.	F 7			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		345218	B. WING		C 03/17/2025
	NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329	03/11/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 760	Nurse #9 stated sor complete order on the Administration Recording signed off on the Microsoft signed off on the Microsoft signed off on the Microsoft signed off on the Microsoft signed off on the Microsoft signed signe	erview on 3/16/25 at 4:00 PM metimes you can't see the the electronic Medication ord. She indicated if she edication Administration ministered Humalog when the less than 120 mg/dl then it in error.  erview on 3/17/25 at 3:30 PM the signed off on the tration Record that she alog to Resident #12 when the less than 120 mg/dl then it in error.  erview on 3/14/25 at 9:00 AM the stated she routinely #12. She last evaluated 17/25. She stated Resident the reactions from receiving the interest the parameters and had no disugars. She stated the ve been held when the blood	F 76	0	
	evaluated Resident #1 had evaluated h had been no reporteregarding Resident expected that physicand the Humalog staccording to the ordinate of the physical puring a phone interest.	#12, but Nurse Practitioner er recently. He indicated there ed decline or outcome #12 to him. He stated he cian orders were followed, hould have been held			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		345218	B. WING			C <b>03/17/2025</b>
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329		·	03/11/2023	
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 760	addressed the Huma being followed in her She stated the facility recommendations earlied education to the nurse education on following was needed.  6a.) Resident #3 was hypertensive heart and A physician's order of revealed Clonidine 0 tablet by mouth every systolic blood pressure. Review of Resident #1 record revealed the fivererecord revealed the fivererecord revealed the fivererecord the fivererecord from the fiverent following the fiverent following the fiverent following the fiverent following the fiverent following following the fiverent following following the fiverent following fol	alog insulin parameters not monthly pharmacy reports. In y did follow up on her arch month and provided ses. She stated ongoing and medication parameters admitted to the facility and chronic kidney disease.  In ated 1/07/25 for Resident # 3 and milligrams (mg). Take one y 8 hours as needed for are greater than 170 mm/Hg.  It is electronic medical following blood pressures 198/81 mmHg to the #10 alood pressure 193/76 mmHg to the #4 altion Administration Record y 2025 for Resident #3 and make the monthly to the monthly to the provided was not administered.	F 70	60		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345218	B. WING _			C 03/17/2025
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE CLINTON, NC 28329	<b>_</b>	03/1//2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	on 1/22/25. She stated needed Clonidine or remembered to give pressure was over 1 must have been bust to administer the dorecall Resident #3 b She stated she did relevated blood pressure was provided in the levated blood pressure was provided in the levated blood pressure would an as needed on she did not recall Respective because she would practitioner or Physical have administered to 1/13/25 with a blood During a phone intended the Medical Director facility as of February yet evaluated Residus been reported to him having a change in the blood pressures cau attack or stroke. He Clonidine as needed should have been as During an interview Director of Nursing (aware of the Clonidifollowing the Januar stated 1:1 education and Nurse #10. She Clonidine should have	orked 7:00 AM until 7:00 PM and she was aware of the as ider. She stated she usually Clonidine if his blood 70 systolic. She stated she by on 1/22/25 and just forgot se. She indicted she did not eing symptomatic on 1/22/25 and not notify the physician of the sure.  The was not aware Resident #3 and refer for Clonidine. She stated asident #3 being symptomatic shave reported it to the Nurse cian. She stated she should the as needed Clonidine on pressure of 198/81.  The was not aware Resident #3 and the was new to the sy 2025. He stated he had not ent #3. He stated nothing had an regarding Resident #3 and the stated if Resident #3 had the for high blood pressure it	F7	760		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345218	B. WING		C 03/17/2025
NAME OF PROVIDER OR SUPPLIER  MARY GRAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  120 SOUTHWOOD DRIVE  CLINTON, NC 28329		03/17/2025	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY 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)	LD BE COMPLETION
F 760	was to notify the phypressure was greated b.) Resident #13 wa 4/19/23 with diagnosheart disease with he A physician's order #13 revealed Clonidevery 12 hours as no systolic greater than 90 mmHg.  Review of Resident record revealed the were recorded:  2/04/25 at 1:28 PM documented by Nur 2/08/25 at 1:38 PM mmHg documented  Review of the Medic (MAR) dated Februar revealed Clonidine (at any time on 2/04/25 revealed no 0.1 mg as needed with the medical stated she routing #13.  During an interview #2 stated she routing #11. She stated she needed Clonidine on checked Resident #4	ysician if the systolic blood er than 200 mmHg.  Is admitted to the facility on sees including hypertensive heart failure.  Idated 2/01/25 for Resident line 0.1 mg. Give one tablet eeded for hypertension and in 160 and diastolic greater  #13's electronic medical following blood pressures  blood pressure 168/92 mmHg se #2  blood pressure 180/101  by Nurse #2  cation Administration Record any 2025 for Resident #13  0.1 mg was not administered	F 76		

F760 Continued From page 31 other scheduled antihypertensive medications. She indicated Resident #13 was not symptomatic or she would have administered the as needed Clonidine if should have been administered according to the order.  During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated the as needed dose of Clonidine should have been administered according to the order.  During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the Clonidine not being administered to Resident #13 following the February Pharmacy review. She stated the as needed Clonidine should have been administered for elevated blood pressures. She stated education would be provided to all nursing staff on medication administration and following ordered parameters.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
MARY GRAN NURSING CENTER    X41   D			345218	B. WING _			
F760 Continued From page 31 other scheduled antihypertensive medications. She indicated Resident #13 was not symptomatic or she would have administered the as needed Clonidine if she had seen the order.  During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated the as needed dose of Clonidine should have been administered according to the order.  During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the Clonidine not being administered to Resident #13 following the February Pharmacy review. She stated the as needed Clonidine should have been administered for elevated blood pressures. She stated education would be provided to all nursing staff on medication administration and following ordered parameters.					120 SOUTHWOOD DRIVE		00/11/2020
other scheduled antihypertensive medications. She indicated Resident #13 was not symptomatic or she would have notified the Physician. She stated she would have administered the as needed Clonidine if she had seen the order.  During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated nothing had been reported to him regarding Resident #13 having a change in condition. He stated the as needed dose of Clonidine should have been administered according to the order.  During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the Clonidine not being administered to Resident #13 following the February Pharmacy review. She stated 1:1 education was provided to Nurse #2. She stated the as needed Clonidine should have been administered for elevated blood pressures. She stated education would be provided to all nursing staff on medication administration and following ordered parameters.	PRÉFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
During a phone interview on 3/17/25 at 3:30 PM the Consultant Pharmacist stated that she addressed the Clonidine for Resident #3 and Resident #13 in her monthly reviews in January and February 2025. She stated Clonidine was prescribed to lower blood pressure, it was absorbed rapidly, and onset was typically 30- 60 minutes. She stated the as needed Clonidine should have been administered according to the physician's order.	F 760	other scheduled and She indicated Resider she would have restated she would have restated she would have deded Clonidine if  During a phone intest the Medical Director reported to him regard change in condition dose of Clonidine shaccording to the ordinal desire of Nursing aware of the Clonid Resident #13 follow review. She stated Nurse #2. She state should have been a blood pressures. She provided to all nursi administration and for During a phone intest the Consultant Pharaddressed the Clon Resident #13 in her and February 2025, prescribed to lower absorbed rapidly, aminutes. She stated should have been a should have been a should have been a should have been a should have been a should have been a stated should have should have been a stated should have been a stated should have been a stated should have shoul	inhypertensive medications. In the H13 was not symptomatic potified the Physician. She we administered the as she had seen the order.  In the were administered the as she had seen the order.  In the were administered to the as needed and the weak and the as needed and the weak are administered to the weak and the stated the as needed and the weak and the	F7	760		