	MENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218	A (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETE 08/14/2025	
	F PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFIC	I SHOULD BE TO THE	(X5) COMPLETION DATE
E0000	Initial Comments The survey team entered the conduct a recertification and survey. The survey was cond 8/7/25. Additional information 8/8/25 through 8/13/25. The sfacility on 8/14/25 to validate removal. Therefore, the exit of facility was found in complian CFR 483.73, Emergency Pre 1D2417-H1.	complaint investigation ucted onsite 8/4/25 through was obtained offsite on survey team returned to the immediate jeopardy late was 8/14/25. The uce with the requirement	E0000			08/25/2025
F0000	INITIAL COMMENTS The survey team entered the conduct a recertification and survey. The survey was cond through 8/7/25. Additional infoffsite on 8/8/25 through 8/13 returned to the facility on 8/1 credible allegations of immed Therefore, the exit date was a 1D2147-H1.	complaint investigation ucted onsite on 8/4/25 ormation was obtained 8/25. The survey team 4/25 to validate liate jeopardy removal.	F0000			08/25/2025
	The following intakes were in 795676, 795678, 795679, 79 complaint allegations resulted Immediate Jeopardy was ide CFR 483.10 at tag F580 at a CFR 483.12 at tag F600 at a CFR 483.25 at tag F684 at a CFR. 483.35 at tag F726 at a The tags F600 and F684 conformation of Care. Immediate Jeopardy began controlled the survey 8/12/25. An extended survey	5680. and 795682. 5 of the 8 d in deficiency. Intified at: Intified at				
F0550 SS = D	Resident Rights/Exercise of I		F0550	F550 Resident Rights/Exercise of Righ	ts	09/01/2025

safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

NAME (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		STI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329		
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F0550 SS = D	Continued from page 1 CFR(s): 483.10(a)(1)(2)(b)(1 §483.10(a) Resident Rights. The resident has a right to a self-determination, and common to persons and services insignately, including those specificality, including those specificality and care manner and in an environment or enhancement of his or her recognizing each resident's in must protect and promote the second maintain identical policie transfer, discharge, and the punder the State plan for all repayment source. §483.10(b) Exercise of Right to rights as a resident of the factor resident of the United State shall be supported by the facility. §483.10(b)(1) The facility muncesident can exercise his or language in the facility. §483.10(b)(2) The resident has the right to resident can exercise his or language in the facility. §483.10(b)(2) The resident has the right to resident can exercise his or language in the facility. §483.10(b)(2) The resident has the right to resident can exercise his or language in the facility in exercising to be supported by the facility or her rights as required und this REQUIREMENT is NOT Based on observations, reconstructions,	dignified existence, munication with and access de and outside the fied in this section. Itreat each resident with for each resident in a ent that promotes maintenance requality of life, individuality. The facility enghts of the resident. Its provide equal access to agnosis, severity of each facility must establish as and practices regarding provision of services are active as a citizen test. Exercise his or her collity and as a citizen test. Its ensure that the mer rights without mination, or reprisal his or her rights and y in the exercise of his er this subpart. If MET as evidenced by: Indicate the mer residents of maintain a residents placed a meal tray at the aired resident (Resident staff for feeding assistance)	F0550	Continued from page 1 The facility failed to maintain a resident when Nurse Aide #3 placed a meal tray a cognitively impaired resident (Resider dependent on staff for feeding assistant away. Nurse Aide #3 did not return to feed from page 2 Resident #52 for 40 minute then attempted to feed Resident #52 the the meal tray. This occurred for 1 of 3 reviewed for dignity. A reasonable personable to get assistance to eat their meal. 1. Corrective action for resident(s) affect alleged deficient practice: On 8/4/2025, Nurse Aide #4 who was in asked to go get a fresh hot meal tray from Resident #52 was pointing at the meal at Aide #3 was sitting there. Nurse Aide #3 started feeding her the potato salad whis served cold while waiting on another minutes with a hot tray. Nurse Aide #3 to Resident #52 at 1:45 PM. Nurse Aide #3 is no longer employed at 2. Corrective action for residents with the affected by the alleged deficient practice. On 8/22/2025, an audit was conducted Nursing and Nurse management team of who require dependent dining services ensure that meals served timely and wittemperatures to promote dignity, nutritic comfort. Results included: 19 of 19 resimals timely with no identified concerns 3. Measures /Systemic changes to prevalleged deficient practice: On 8/27/2025, the Staff Development Ceducation will all Full time, Part time, and staff to include agency on Residents Riand Respect. Topics included: Maintaining resident dignity and respect mealtimes, particularly for dependent residents and timely assessential components of quality care and essential compone	at the bedside of ht #52) who was ce and walked led Continued les. Nurse Aide #3 le cold food on lesidents on may feel ted at not being led by the led by the led by the leal tray while Nurse leal tray while Nurse leal tray to come led within 5 legan feeding let the facility. It is possible to the least tray to come led within 5 legan feeding let the facility. It is possible to the least tray to come led within 5 legan feeding let the facility. It is possible to the least tray to come let let let least to come let let let let let let let let let le	

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	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
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F0550 SS = D	6/13/25 revealed Resident #5 impaired. She required exten with eating. During dining observations o Resident #52 was observed was awake, alert, and the he in an upright position. Reside hearing and non-verbal. Nursuand placed the lunch meal trabedside table located on the and within her sight and the bear reach. Nurse Aide #3 did and turned and walked away, meal tray and watched Nurse room. A continuous observation wa	Nurse Aide #3 then 52 the cold food on the of 3 residents reviewed on may feel helpless, ated at not being able to eal. The the facility on 10/12/18 neimer's dementia and Wealed Resident #52 The goal of care ff assistance with eating Interventions included eals and promote dignity. So quarterly assessment dated 52 was severely cognitively sive one-person assistance In 8/04/25 at 12:55 PM sitting up in her bed. She ad of the bed was elevated eath #52 was hard of the Aide #3 entered the room ay on Resident #52's left side of Resident #52 bedside table was out of not set up the meal tray Resident #52 looked at the eath Aide #3 walk out of the so conducted on 8/4/25 from from 411 where Resident #52 bedside table was out of not set up the meal tray Resident #52 looked at the eath Aide #3 walk out of the so conducted on 8/4/25 from from 411 where Resident #52 bedside the food was out of the bedside and the sident #52 her meal. The eath of the food which the bedside and the stated the food was cold the room for 40 the was in the hallway, was the latray from the kitchen. The was a stated the food was cold the room for 40 the room for 40 the seal tray from the kitchen. The was a stated #3 went ahead and to salad which is to be	F0550	Continued from page 2 This in-service was incorporated in the facility orientation for the above-mention and also provided to agency staff working facility. This will be reviewed by the Quant Assurance process to verify that the chaustained. Any staff who does not receive schedul training will not be allowed to work until been completed by 08/31/2025. 4. Monitoring Procedure to ensure that a correction is effective and that specific cited remains corrected and/or in compregulatory requirements The Director of Nurse and/or designee Passes during meal times to ensure time assistance for dependent diners. This in be completed weekly x 4 weeks and the months or until resolved. Monitoring will of: 8/29/2025. Reports will be presented Quality Assurance committee by the Dito ensure corrective action is initiated a appropriate. Compliance will be monito ongoing auditing program reviewed at the Quality Assurance Meeting. The month Assurance Meeting is attended by the Aborector of Nursing, Minimum Data Set Manager, Therapy Manager, Health Info Social Service Director, and the Dietary Date of Compliance:9/1/2025	ned employees ng in the ality ange has been ed in-service training has the plan of deficiency liance with will audit Tray nely delivery and nonitoring will en monthly times 2 I begin week d to the monthly rector of Nurses s red and the he monthly ly Quality Administrator, Coordinator, Unit ormation Manager,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY CONSTRUCTION A. BUILDING B. WING		Y COMPLETED					
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329			
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F0550 SS = D	Continued from page 3 from the kitchen. Nurse Aide minutes with a hot tray. Nurse Resident #52 at 1:45 PM. During an interview on 8/4/25 stated she had three resident needed to be fed by staff. She meal tray to Resident #52's rethe resident in room 415A white resident in 415 B. She stated the residents in 415 then she Resident #52. She reported to knew who needed to be fed by Nurse Aide #5 on the unit whould not have known to conthe residents. Nurse Aide #3 informed the agency nurse ai assist with feeding Resident to do that. During an interview on 8/4/25 stated there were three residented to be fed by staff. Shenurse aides would feed the thout today they had an agency was not told to assist with feeding residents. During an interview on 8/4/25 stated she was an agency nunot informed that there were hall that needed to be fed by with their meals. She indicate Resident #52. She stated she residents their breakfast this told to do so, but she was not feeding residents their lunch. During an interview on 8/4/25 of Nursing (DON) stated wait Resident #52 was too long. The Aide #3 should have informed (Nurse Aide #5) to assist her residents. She stated Nurse Aide #3 to assist her residents. She stated Nurse Aide #3 to assist her residents. She stated Nurse Aide #3 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents. She stated Nurse Aide #40 to assist her residents.	at 1:40 PM Nurse Aide #3 ats on her assignment that a stated she delivered the com then left to go feed hile Nurse Aide #4 fed the it took a while to feed hat her and Nurse Aide #4 by staff but today they had o was agency staff and he and assist with feeding stated she should have ide (Nurse Aide #5) to #52, but she did not think at 2:10 PM Nurse Aide #4 ents on the hall that a stated typically three here residents during meals or nurse aide that probably adding residents their at 2:20 PM Nurse Aide #5 here residents on the staff or to assist them and she was not assigned to be assisted with feeding morning without being at told to assist with hereal. at 2:30 PM the Director ing 40 minutes to feed the DON stated that Nurse de the agency nurse aide with feeding the Aide #3 should not have of Resident #52 and not	F0550				
F0580 SS = J	Notify of Changes (Injury/Dec	·	F0580	F 580 POC Physician Notification of Ch		09/01/2025	
	CFR(s): 483.10(g)(14)(i)-(iv)(§483.10(g)(14) Notification of	•		Corrective Action for Affected Residents The facility failed to ensure physician was a significant change for Resident #119.			

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	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
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F0580 SS = J	Continued from page 4 (i) A facility must immediately consult with the resident's phronsistent with his or her aut representative(s) when there (A) An accident involving the injury and has the potential for intervention; (B) A significant change in the mental, or psychosocial status deterioration in health, mental in either life-threatening concomplications); (C) A need to alter treatment need to discontinue an existint to adverse consequences, or treatment); or (D) A decision to transfer or of from the facility as specified in (ii) When making notification (g)(14)(i) of this section, the fathat all pertinent information §483.15(c)(2) is available and the physician. (iii) The facility must also provesident and the resident repartment in formation section. (iv) The facility must also provesident and the resident repartment in formation section. (iv) The facility must also provesident and the resident repartment in formation section. (iv) The facility must also provesident and the resident repartment in facility must record at the address (mailing and emerished in section. (iv) The facility must record at the address (mailing and emerished in section). (iv) The facility must record at the address (mailing and emerished in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose in its admission configuration, including the vomprise the composite distinct part (a must disclose	rinform the resident; rysician; and notify, hority, the resident is- resident which results in or requiring physician e resident's physical, is (that is, a al, or psychosocial status litions or clinical significantly (that is, a ng form of treatment due to commence a new form of discharge the resident in §483.15(c)(1)(ii). under paragraph facility must ensure specified in d provided upon request to mptly notify the resentative, if any, when mmate assignment as ts under Federal or State and in paragraph (e)(10) of and periodically update ail) and phone number of the stinct part. A facility that as defined in §483.5) in agreement its physical arious locations that	F0580	Continued from page 4 Resident #119's Life Vest shocked her the early morning hours (beginning shomidnight) of 2/11/25. Nurse #1 observed the device deliver stresident and did not notify the physiciar physician was not notified until 2/13/25 #119's Cardiologist contacted the facilit recommended the resident be sent to the evaluation after being notified by the Lift manufacturer that the resident had a serventricular tachycardia. Resident #119 did not return to the facilitischarge on 2/13/25. Facility has not been able to contact Nuis no longer working in the facility. The A and Director of Nursing attempted to coon 8/6/25, but the number was not open. On 8/6/25, the facility initiated a compreresponse to address the identified noncrelated to failure to notify provider of an change in Resident # 119's condition. Corrective action for potentially affected. The Direct care nurses conducted an irrassessment of 100% of current resident acute changes in condition that had not communicated to the appropriate medicincluded symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrepreviously prescribed measures Indicative of respiratory distress (e.g., obreathing, low oxygen saturation, new ocongestion, decreased appetite) During the audit, it is noted that no residents identified with acute changes For each of these residents, the provide and appropriate medical orders were in	multiple times in ortly after hocks to the n. The when Resident y and he hospital for re Vest's evere episode of lity after urse #1, and she Administrator ontact Nurse #1 rational. ehensive compliance acute d residents. mmediate this to identify any to been call provider. This lieved by difficulty onset cough or dents were rices. here were 5 in condition. er was notified,	

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MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
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F0580 SS = J	#119 had significant fluid over congestive heart failure and another hospital for further ethe discharge summary from indicated that Resident #119 critical care unit on 2/13/25 a 2/27/25. Discharge diagnose failure, cardiogenic shock, can hypoxic respiratory failure, as sustained ventricular tachycate death dated 2/27/25 at 10:41 cause of death was acute hy and acute on chronic congestapproximate interval of onse immediate causes was 2 were condition contributing to death this deficient practice occurrieviewed for notification of chronic congestations.	m changes between its 3.15(c)(9). TMET as evidenced by: staff, Medical Director #1, ent Representative and es, the facility failed to e #1 when Resident #119's ator designed to detect heart rhythms and, if er a treatment shock to eleivered treatment shocks arly morning hours on ent Representative contacted e on 2/13/25 about Resident entricular tachycardia, a ate. The Cardiologist ted to talk to the logist recommended that the tal for evaluation. The espital #1 determined Resident erload with severe she was transferred to evaluation and monitoring. In hospital #2 dated 2/27/25 I was admitted to the and was deceased on es included acute heart ardiac arrhythmia, acute cute kidney failure, and ardia. The certificate of I AM indicated the immediate poxic respiratory failure estive heart failure with the to death for the eks. Other significant the was cardiogenic shock. Fed for 1 of 1 resident enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #119). In 2/11/25 when Resident #119 Eshocks from the external acility failed to consult enange (Resident #10). In 2/11/25 when Resident #10 I with potential for more mediate jeopardy) to ensure	F0580	Additionally, on 8/10/25, the Director of reviewed the progress notes to include transfer and change in condition assess resident transfers to an acute care hosp past 30 days to ensure provider notification occurred for any acute change in condition confirmed that provider notification was timely for 14 out of 14 residents. Systemic Changes To prevent recurrence, the DON began licensed nurses (Register Nurses and L Nurses) and certified nursing assistants including full-time, part-time, PRN (as nagency staff, on 8/6/25. The training emimportance of timely provider notification acute change in condition. This included signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed method in the sum of the sum o	the E -interact sments for all bital within the tion had tion. The audit completed in-servicing all ticensed Practical (CNAs), seeded), and sphasized the n for any disymptoms or servicing all ticenses the negative for any disymptoms or servicing all ticensed Practical (CNAs), seeded), and sphasized the n for any disymptoms or service was not the device is service would require the on 8/8/25 and to instructional tregivers. In the device is service would require the tion and time time time time time time time time	

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER: 345218			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COM 08/14/2025 STREET ADDRESS, CITY, STATE, ZIP CODE		EY COMPLETED
	GRAN NURSING CENTER) SOUTHWOOD DRIVE , CLINTON, Nort		
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F0580 SS = J	Continued from page 6 Review of the manufacturer's instructional videos for the Li defibrillator revealed that the for residents at risk for sudde condition that occurs without that something is about to ha malfunction of the heart caus heartbeat with no signs or sy electrodes to continuously melectrical activity and detect such as ventricular tachycard fibrillation. The device is desi electrical shock to the heart is detected to restore a norm manufacturer's instructions in treatment shock is delivered, called immediately, and an adevice with this instruction. If it means either the person ha (heartbeat) requiring immedi the device is malfunctioning, evaluation as soon as possib. An interview with the LifeVes 5:00 PM revealed that the decontinuous real time monitori professional. The LifeVest Tedevice was set with paramete was above the set parameter information from the device viculd be reviewed by the phystated that if a shock was de on the downloaded information that the information from the into the system every 24 hou sometimes issues with connecting indicated that the blue gel was shock being delivered. A butth the shock from being delivered administered, then if more should be delivered based on the technician stated that if an aldetected, the device emitted loud and identifiable. If the deshock, the blue gel was released technician stated that if the deshock, the physician and the should have been notified rige equipment. A technician is unablivia phone, a technician is unablivia phone, a technician will control to fix it or replace the device.	feVest external device is prescribed en cardiac death, a warning with no signs appen due to an electrical sing a dangerously fast emptoms. The LifeVest uses onitor the heart's dangerous heart rhythms, dia and ventricular gned to deliver an when an abnormal rhythm all heart rhythm. The indicated that if a the physician is to be encouncement is made by the the vest discharges, as an unstable arrythmia atte physician attention, or Both require medical ele. It Technician on 8/6/25 at exice does not provide ing by a medical chinician stated that the ears and if the heart rate extra the extra term of the extra term of the extra term of the extra the e	F0580	Continued from page 6 8/11/25 to continue caring for residents cardiac devices. Staff who do not complete the training I not be permitted to work until the trainir completed. The Director of Nursing and the Director Development will do a daily reconciliating schedule to ensure all licensed staff has the training. This in-service training has been incorportentation program for all new facility a staff. No staff shall work without this training Monitoring Procedure to ensure that the correction is effective and that specific cited remains corrected and/or in compregulatory Beginning the week of 8/18/25, the Addresignee will audit this process using the Assurance Tool for Monitoring Complian notification of change in condition. This completed weekly x 4 weeks, then more until resolved. Reports will be presented Quality Assurance committee by the Adensure corrective action is initiated as a Compliance will be monitored and the corrective action is initiated. So a compliance will be monitored and the corrective action in the Quality Assurance Meeting is a Administrator, Director of Nursing, Minit Coordinator, Therapy Manager, Unit Maliformation Manager and Dietary Manager. Date of compliance: 9/1/2025	by 8/11/25 will ang is or of Staff on of the eve completed or or additional agency after 8/11/25 or plan of deficiency liance with the audit will be audit will be audit will be audit will be athly x 2 months or d to the deministrator to appropriate. Ongoing auditing ance Meeting. The attended by the mum Data Set anager, Health	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CO A. BUILDING 08/14/2025 B. WING		EY COMPLETED	
	NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COI D SOUTHWOOD DRIVE , CLINTON, Nor		
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F0580 SS = J	Continued from page 7 Resident #119 was admitted which included ischemic card that occurs when the heart metale blood supply making it difficult requiring a LifeVest external hypertensive heart disease, a coronary artery disease, chroheart failure, acute on chroniand diabetes. Review of Resident #119's elephysician order dated 10/17/was to be worn at all times elephysician order dated 10/17/was to be worn at all times elephysician order revealed a indicated the LifeVest was to every shift. The order did not when to notify the provider. An interview conducted with 8/6/25 at 10:06 AM revealed Resident #119 on 2/10/25 from #2 stated that Resident #119 thought was to "kick start the that she recalled on the night #119's LifeVest device from 10 "going off all night." NA #2 condevice was beeping or if it was stated that she let Nurse #11 sounding and she did not know it or if the nurse went in to as Attempts were made to internunsuccessful with text messar PM and 8/8/25 at 12:31 PM in Nurse #1 was an agency nur the facility and was assigned 2/10/25 from 7:00 PM to	on 10/17/24 with diagnosis diomyopathy (a condition nuscle is damaged by lack of alt for the heart to pump) defibrillator device, atrial fibrillation, onic kidney disease with c systolic heart failure, dectronic record revealed a 24 which indicated LifeVest very shift. ed from the nursing home to diagnosis of and was readmitted on n order dated 1/20/25 be worn at all times contain directives for Nurse Aide (NA) #2 on that she was assigned to om 11:00 PM to 7:00 AM. NA 10 had a device that she heart." NA #2 stated to f2/10/25 Resident 11:00 PM to 7:00 AM was another sound. NA #2 know that the device was ow what the nurse did about seess the resident. View Nurse #1 were ages sent on 8/7/25 at 2:16 with no return call received. See that worked as needed at to Resident #119 on 10 PM. Nurse #1 no longer 11/25 at 8:32 PM written as shocking Resident #119 all indicated that Nurse #1	F0580			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING EET ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETED 08/14/2025	
				SOUTHWOOD DRIVE , CLINTON, Nort		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0580 SS = J	with the LifeVest and that Re An interview was conducted 1:15 PM. Nurse #5 was assig frequently and was assigned AM to 7:00 PM. Nurse #5 inc had a LifeVest cardiac defibr stated that on the morning of report from the off going nigh that Resident #119's LifeVes resident all night and that the night. Nurse #5 stated she as (Nurse #1) if she had notified Resident #119 and was told stated that Nurse #1 did not notified the provider or asses shocks occurred. Nurse #5 s to the room and observed Re the blue conducting gel on he from the LifeVest device. Nurse Aide cleaned the resic and reapplied the electrodes Nurse #5 indicated she inform was reported to her regardin and being shocked by the Life A follow up interview with Nu PM revealed that she did not 2/11/25 that Resident #119 v during the night shift. Nurse at thought Support Nurse #1 was provider, and that she did no the physician was notified. Voice mail messages and tex Nurse #7 on 8/6/25 at 11:25 8/8/25 at 12:35 PM. Nurse #5	ing in bed with brown dried und her mouth. The note did in was notified and there. The note stated that bads of the electrodes for onto Resident #119's skin ered in gel. Resident #119 ide pads were replaced. Ithe resident. Resident #119 if grunting. Nurse #5 ithe situation. Resident inot eat during the shift. #7) was informed of concerns sident #119 had vomited. with Nurse #5 on 8/6/25 at great to Resident #119 ito her on 2/11/25 from 7:00 illicated that Resident #119 ito her on 2/11/25, she received in int shift nurse (Nurse #5 if 2/11/25, she received in int shift nurse (Nurse #1) it device was sounding all sked the off going nurse if the provider or assessed ino, she had not. Nurse #5 indicate why she had not issed the resident when the stated she immediately went esident #119 was soaked with ear chest and upper body se #5 stated she and the ident, obtained vital signs and the LifeVest device. In med Support Nurse #1 what gresident #119's condition in the provident in the provident of the provident in the stated she immediately went in the stated she immediately went in the stated she in the stated she and the interpretation in the stated she in the stated she and the interpretation in the stated she in the state	F0580			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		EY COMPLETED
				SOUTHWOOD DRIVE , CLINTON, North		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0580 SS = J	LifeVest during the early mor that she thought Nurse #5 w Nurse #1 stated she should I #5 to be sure that she had no shock from the LifeVest. Sup was responsible for managin so she thought that the floor for notifying the provider of c An interview conducted with AM indicated that she was as	arse #1 on 8/6/25 at 12:05 at Resident #119 had a se #1 stated that if the ck was administered. on the morning of 2/11/25, on her chest which indicated upport Nurse #1 stated the otified that the LifeVest vas administered. Support should have been assessed provider should have been e shock occurred or as soon overed that it occurred. e did not notify a provider 19 received a shock from the rning hours and explained ould have done this. Support have followed up with Nurse otified the provider of the port Nurse #1 stated she g the residents on 3 halls, nurses were responsible hanges in condition. Nurse #8 on 8/7/25 at 11:41 ssigned to Resident #119 on 0 PM and was assigned to the e stated that she did not is in Resident #119's 00 AM to 7:00 PM. Nurse #8 that Resident #119 being muli, not eating and not been symptoms of a change ifying the provider. At Resident Representative and shared alerts and ctors and cardiologists. If Resident #119's informed him that the ular tachycardia (v tach), hm. The Representative a run of v tach greater delivered. The device can tepresentative stated that dent #119's LifeVest on dicated that v tach was stated that there were in the night of 2/11/25 and mation, she reached out to	F0580			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING REET ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVE 08/14/2025 DE	EY COMPLETED
MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
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F0580 SS = J	rhythm ventricular tachycardi rate, was detected. The Cardimmediately called the facility recommended that Resident for evaluation. A health status note dated 2/by Support Nurse #1 indicate received a call from the Cardimentely acquired EKG (electroceived from the LifeVest misevere episode of ventricular rapid heart rhythm). The Cardimentely acquired EKG (electroceived from the LifeVest misevere episode of ventricular rapid heart rhythm). The Cardimentel Director #1. Upon the recommendation due to the infection Medical Director #1 gave and to the emergency departmentel Emergency Medical Services #119 was transported to the	vice is designed to detect ing ventricular tachycardia dideliver an electrical a normal rhythm. The obysician should be vered a shock and if an, the resident should ospital for evaluation. The electived a call on 2/13/25 epresentative who stated exed by the device during the resident should have taked by the device during the resident stated he resident and the resident at the facility licilogist stated he resident and the resident and resident and resident stocardiogram) strip anufacturing company showed a tachycardia (a dangerous diologist spoke with the Cardiologist's resident not being stable, order to send Resident #119 and for further evaluation. It is was contacted, and Resident hospital. The resident #119. Support and resident #119	F0580			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			A. BUILDING 08/14/2025 B. WING		
				REET ADDRESS, CITY, STATE, ZIP COD SOUTHWOOD DRIVE , CLINTON, Nort		
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F0580 SS = J	Continued from page 11 that when the device shocke should have immediately ass to the hospital for evaluation provider. When the LifeVest shock to the resident, it mea unstable arrythmia requiring attention, or the device malfula shock when it was not requevaluation.	sessed the resident, sent her and notified the discharges an electrical ns the person had an immediate physician unctioned and administered	F0580			
	Review of an Emergency De hospital #1 dated 2/13/25 inc presented to the hospital wit Resident #119 presented aft cardiac arrhythmia and the cevaluation at the nearest em was somnolent, difficult to ur and was unresponsive on proceeding. The second was noted to type of swelling where when area a temporary indentation time after the pressure is reliabdomen. The impression in was evaluated due to a cardisignificantly fluid overloaded heart failure. Resident #119 hospital #2 for further evaluations.	dicated that Resident #119 h a LifeVest device on. er the LifeVest detected a ardiologist requested ergency room. Resident #119 hderstand with closed eyes esentation to the ED. have 4+ pitting edema (a pressure is applied on the n or pit remains for a short eased) from toes to dicated that Resident #119 hac arrhythmia and was with severe congestive was transferred to				
	Review of the discharge sum 2/27/25 indicated that Reside the critical care unit on 2/13/2/27/25. Resident #119's dis acute heart failure, cardioger arrhythmia, acute hypoxic rekidney failure, and sustained	ent #119 was admitted to 25 and was deceased on charge diagnoses included nic shock, cardiac spiratory failure, acute				
	Review of Resident #119's c 2/27/25 at 10:41 AM indicate death was acute hypoxic res on chronic congestive heart approximate interval of onse immediate causes was 2 we condition contributing to dea a life-threatening condition ir suddenly can't pump enough sudden, rapid heartbeat (tac	ed the immediate cause of piratory failure and acute failure with the to death for the eks. Other significant th was cardiogenic shock, a which the heart of blood characterized by				
	An interview was conducted the Director of Nursing (DON Director. The DON and Clinic that they expected that if sor the LifeVest delivered a shoo notified immediately for furth and Clinical Services Director	and the Clinical Services cal Services Director stated nething occurred such as ck, the provider would be er instructions. The DON				

NAME O	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		S	A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	`	N SHOULD BE O TO THE	(X5) COMPLETION DATE	
F0580 SS = J	Continued from page 12 should have been notified im alarmed. The DON was unabwas not notified other than the on the night of 2/10/25 was a longer worked at the facility. expected that the nurses rechanges in condition to the manages in condition the communicated to the approprincluded symptoms or signs: - Acute or sudden in onset	ole to state why the physician hat the nurse that worked an agency nurse who no The DON stated that she ognized and reported medical provider. In additional provider and the physician was ge for Resident #119. In a collider shocks to the ge physician. The titll 2/13/25 when Resident #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1 #1	F0580				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		Α	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CO A. BUILDING 08/14/2025 B. WING		EY COMPLETED
	OF PROVIDER OR SUPPLIER GRAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329			
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F0580 SS = J	Continued from page 13 - Markedly more severe than previously prescribed measured in the previously prescribed in the previously prescribed in the previously prescribed in the previously p	usual - Unrelieved by tres tress (e.g., difficulty tion, new onset cough or tite) noted that no residents able cardiac devices. 8/11/25. There were 5 e changes in condition. the provider was notified, ers were implemented by the 25. Director of Nursing (DON) to include the E -interact tion assessments for all e care hospital within the der notification had ge in condition. The audit cation was completed ints.	F0580	APPROPRIATE BEHICK	LINCI	
	To prevent recurrence, the D licensed nurses (Registered Practical Nurses) and certific including full-time, part-time, agency staff, on 8/6/25. The importance of timely provide acute change in condition. The signs that were: - Acute or sudden in onset - Markedly more severe than	Nurses and Licensed ed Nurse Aides (CNAs), PRN (as needed), and training emphasized the r notification for any his included symptoms or				
	- Unrelieved by previously pr - Indicative of respiratory dist breathing, low oxygen satura congestion, decreased appe Specific training for a resider	escribed measures tress (e.g., difficulty tion, new onset cough or tite)				

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE				
MARY	MARY GRAN NURSING CENTER		12	0 SOUTHWOOD DRIVE , CLINTON, Nor	th Carolina, 28329		
(X4) ID PREFIX TAG	I V		ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE	
F0580 SS = J	Continued from page 14 a person's LifeVest discharge have an unstable arrythmia or malfunctioning or both, and be immediate physician notificat. Training for licensed nursing includes viewing the 26-minuvideo designed for both patie Following the video, the Direct utilized a competency checkly understanding. This compete verbalization of understandin LifeVest purpose and function maintenance, emergency reseducation as well as the local quick reference guide for Life initiative was coordinated by All current staff must complete 8/11/25 to care for residents devices. Staff who do not complete the notion be permitted to work unticompleted. The Director of Nursing and the Development will do a daily reschedule to ensure all licensic completed the training as ind This in-service training has be orientation program for all nestaff. No staff shall work without the 8/11/25. Alleged date of Immediate Jeneral Process and medication aides win-services they received relapractice. All staff including the following for the process and function, application emergency response. Validation nurses had completed a comthe LifeVest device and the ir notify the physician. The nurse completed in the physician in the physician in the physician in the physician in the physician.	es, it means the person may or that the device is both of these would require iton. staff began on 8/8/25 and the LifeVest instructional ents and caregivers. Ector of Staff Education ist to validate staff ency checklist includes g of the knowledge of the n, application and sponse, communication and tion and contents of the EVest. This training the Director of Nursing. the this training by with wearable cardiac the training by 8/11/25 will the training is the Director of Staff econciliation of the ed staff and CNAs have licated above. the en incorporated into the experimental ency and agency is training after sopardy removal: 8/12/25 oval plan was validated on the Administrator, Director on Director, nurses, nurse exercited they had egarding the LifeVest extend and maintenance and dispersely checklist regarding and cation indicated that licensed expertency checklist regarding and cations for when to	F0580				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		A	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 08/14/2025 B. WING		EY COMPLETED	
	F PROVIDER OR SUPPLIER RAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329			
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F0580 SS = J	Continued from page 15 indicated that they had receive timely provider notification of condition.		F0580			
	The immediate jeopardy was	removed on 8/12/25.				
F0600	Free from Abuse and Neglec	t	F0600	F600 Abuse / Neglect		09/01/2025
SS = SQC-J	CFR(s): 483.12(a)(1)			Failure to protect Resident #119 from n		
	§483.12 Freedom from Abuse, Neglect, and Exploitation			cross-references to F580, F684, and F	726.	
	The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.			Address how corrective action will be a those residents found to have been affed deficient practice; On 2/11/25 the facility failed to adhere a buse/neglect policy and failed to prote #119 from neglect by not recognizing a	ected by the to its ect Resident	
	§483.12(a) The facility must- §483.12(a)(1) Not use verbal physical abuse, corporal pun seclusion;	, mental, sexual, or		a resident's change in condition. Specific did not notify the Medical Director; did the seriousness of resident's condition comprehensive medical evaluation; and staff were trained and competent to cal who wore a Life Vest, resulting in a failutimely medical intervention.	ically, staff not identify and need for a d did not ensure re for a resident	
	This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, LifeVest Technician, LifeVest Resident Representative, Medical Director #1 and Cardiologist interviews, the facility failed to protect Resident #119's right to be free from neglect. Resident #119 was admitted on 10/17/24 with a LifeVest (a wearable device designed to detect life-threatening rapid heart rhythm and, if needed, automatically deliver a treatment shock to restore normal heart rhythm). The nurses and nurse aides had no training on how to care for and manage a resident who required a LifeVest and staff neglected to provide necessary care and services after the LifeVest delivered several treatment shocks. Nurse #1 observed the device deliver treatment shocks to the resident in the early morning hours of 2/11/25 and took no action with the exception of notifying the oncoming first shift nurse that the Life Vest was "shocking the resident all through the night". The Physician was not contacted to evaluate Resident #119 after the treatment shocks were delivered as specified in the manufacturer's instructions. Due to ineffective staff communication and lack of comprehensive assessments Resident #119's significant change from her baseline was not recognized or acknowledged by the staff. On 2/13/25, Resident #119's			Upon learning of the allegation of negle the Administrator submitted an initial red Department of Health and Human Servadult Protective Services. Resident #11 from the facility on 02/13/25. Nurse #11 for the facility. The Administrator and the Nursing attempted to contact Nurse #11 the number was not operational. As of 8/8/25, a review conducted by the Nursing confirmed that there have been with a life vest residing in the facility sin 03/07/25. Address how the facility will identify oth having the potential to be affected by the deficient practice On 08/11/25 all current residents were changes in condition to ensure approprise vices were provided. The nurse mar consisting of the Director of Staff Education and Set Nurse Coordinator, and 3 Lice	port to the vices and report to 19 discharged no longer works e Director of on 8/6/25, but e Director of no residents are same assessed for riate care and nagement team ation, Minimum	

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY 08/14/2025		Y COMPLETED
	RAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COD D SOUTHWOOD DRIVE , CLINTON, Nort		
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F0600 SS = SQC-J	Continued from page 16 Cardiologist contacted the fa resident be sent to the hospin being notified by the LifeVest resident had a severe episod tachycardia (a life-threatening 2/11/25. The emergency depidetermined Resident #119 with severe congestive heart #119 was somnolent, difficult eyes and was unresponsive ED. Resident #119 was transfor further evaluation and monhad a high likelihood of resuld death for Resident #119. Immediate jeopardy began or received multiple treatment is and the facility neglected to put care and services and consulant evaluation for a potential a jeopardy was removed on 8/2 implemented an acceptable premoval. The facility will remain a scope and severity of "D" (potential for more than minimity jeopardy) to ensure education monitoring systems are in plate. The findings included: This is cross-referred to:	cility and recommended the tal for evaluation after is manufacturer that the e of ventricular grapid heart rate) on artment (ED) at hospital #1 ad significant fluid overload failure and noted Resident to understand with closed on presentation to the ferred to another hospital nitoring. These failures ting in serious harm or 10 2/11/25 when Resident #119 hocks from the LifeVest provide the necessary lit with the physician about arrhythmia. Immediate 12/25 when the facility plan of immediate jeopardy ain out of compliance at no actual harm with hall harm that is immediate in is completed and	F0600	Continued from page 16 Nurse Support Staff conducted compre assessments of all residents with a Brie Mental Status (BIMS) score of 12 or les any signs of distress or neglect. No con identified. On 08/11/25, residents with a 13 or higher were interviewed by the nuteam regarding any concerns related to or care. All residents denied any such or care. All residents denied any such or residents to identify any unreported accondition. This included symptoms that - Acute or sudden in onset - Markedly more severe than usual - Unrelieved by previously prescribed more active of respiratory distress (e.g., breathing, low oxygen saturation, new or congestion, decreased appetite) On 08/11/25, corrective actions were cout of 116 residents who were identified change in condition. Providers were not orders were carried out by direct care severed.	ef Interview for as to identify acerns were a BIMS score of urse management to abuse, neglect, concerns. Inagement team 100% of current ute changes in were: Ineasures difficulty onset cough or Inagement for 5 d as having a tified, and	
	#119's Cardiologist on 2/13/2 severe episodes of ventricula life-threatening rapid heart racalled the facility and reques Medical Director. The Cardiol resident be sent to the hospi	eVest Resident Technician interviews, the Medical Director #1 est (an external ect certain eythms and, if needed, ment shock to restore ed treatment shocks to her erning hours on 2/11/25. esentative contacted Resident est about Resident #119's extrachycardia, a ette. The Cardiologist ed to talk to the elogist recommended that the etal for evaluation. The espital #1 determined Resident erload with severe eshe was transferred to evaluation and monitoring.		On 08/10/25, the Director of Nursing authospital transfers from the past 30 days provider notification occurred for any accondition. The audit confirmed that provinotification was completed for all 14 reserviewed. No corrective action was required. Address what measures will be put into systemic changes made to ensure that practice will not recur; On 08/08/25, the Administrator and Directonducted in-service training for all staff part-time, as needed, and agency) on the policy, including procedures for identifying reporting, and preventing abuse and neutraining was delivered in person and by who did not complete the training by 08 restricted from working until completion.	s to ensure cute changes in vider sidents uired. place or the deficient ector of Nursing if (full-time, he abuse/neglect ing, glect. This phone. Staff i/11/25 were	

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	MARY GRAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COD SOUTHWOOD DRIVE , CLINTON, Nort		
(X4) ID PREFIX TAG	1 '		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CONCROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0600 SS = SQC-J	Continued from page 17 indicated that Resident #119 critical care unit on 2/13/25 a 2/27/25. Discharge diagnose failure, cardiogenic shock, can hypoxic respiratory failure, ac sustained ventricular tachycadeath dated 2/27/25 at 10:41 cause of death was acute hy and acute on chronic conges approximate interval of onset immediate causes was 2 wecondition contributing to death This deficient practice occurrive reviewed for notification of chromic congestification of chromic congestification of chromic contributing to death this deficient practice occurrive weed for notification of chromic condition contributing to death this deficient practice occurrive weed for notification of chromic condition contributing to death this deficient practice occurrive weed for notification of chromic cardiate that the device of the cardiologist, Life LifeVest patient representative facility failed to obtain physicistaff about what to do when the shock, identify the seriousne cardiac status and the need the valuation when a LifeVest (a device designed to detect cerapid heart rhythms and, if not deliver a treatment shock to the resident and took notifying the oncoming first LifeVest was "shocking the resident and provide ongoing According to the manufacture resident and provide ongoing According to the manufacture resident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident with	was admitted to the and was deceased on a included acute heart ardiac arrhythmia, acute cute kidney failure, and ardia. The certificate of AM indicated the immediate poxic respiratory failure with the atto death for the eks. Other significant the was cardiogenic shock. The certificate and the indicated the immediate poxic respiratory failure with the atto death for the eks. Other significant the was cardiogenic shock. The indicated and monitoring. In hospital #2 dated 2/27/25 was admitted to the indicated acute heart included acute heart incl	F0600	Continued from page 17 On 08/06/25, the Director of Nursing be education for all licensed nurses (Regis Licensed Practical Nurses), and certifie assistants on the importance of notifyin any acute change in condition. Training emphasis on timely care and services, definition of neglect as failure to act dur medical emergency. The training also in Recognizing types of changes in condit Appropriate response protocols Notification procedures When to initiate Emergency Medical Set Additionally, beginning 8/8/25, all Regis (RNs) and Licensed Practical Nurses (It to complete education and competency to providing care to any resident with a cardiac device. This will be completed by of Nursing, Minimal Data Set Nurse and Staff Education. Specific training for a resident with a life if a person's life vest discharges, it mea may have an unstable arrythmia or that malfunctioning or both, and both of these immediate physician notification. Nurse training to complete a comprehensive anotify the medical provider of findings and on 8/6/2025 Nurses were trained on the response to include areas of: if the life is a shock, when to notify the physician are event and understanding of when to rerivest. On 8/6/2025 the Administrative nurses and the Minimum Data Set nurse the Regional Nurse Consultant to ensure the dical record to include: maintenance response. On 8/11/2025 the Minimum Data Set N Regional Nurse Consultant to do in the vest delivers a shock.	stered Nurses, and nursing g providers of included and the ring a included: and the ring a included: and the ring a included: and the revices Services Ser	

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		EY COMPLETED
MARY G	RAN NURSING CENTER		12	20 SOUTHWOOD DRIVE , CLINTON, North	th Carolina, 28329	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F0600 SS = SQC-J	Continued from page 18 hypoxic respiratory failure, ac sustained ventricular tachyca death dated 2/27/25 at 10:41 cause of death was acute hy and acute on chronic conges approximate interval of onset immediate causes was 2 wecondition contributing to deat This deficient practice occurr reviewed for professional state Director #1, Cardiologist, ResulfeVest technician, and LifeVerpresentative interviews the staff were trained and compe who wore a LifeVest (a device certain life-threatening rapid needed, automatically deliverestore normal heart rhythm) treatment shock multiple time wearing in the early morning after midnight) on 2/11/25. Not assigned to Resident #119, the treatment shocks to Resident #119, the treatment shocks to Resident with the exception of first shift nurse (Nurse #5) the "shocking the resident all throward to the first shift nurse (Nurse #8) was action with the exception of the shocking the resident all throward to the first shift nurse (Nurse #8) was action with the exception of the shocking the resident all throward to the first shift nurse (Nurse #8) was action with the exception of the shocking the resident all throward to the first shift nurse (Nurse #8) was action with the exception of the shocking the resident all throward to the first shift nurse (Nurse #8) was and an announcement was not instruction. Resident #119's (facility on 2/13/25 and recompensed to the hospital for evaluation to the hospital for evaluation to the hospital for evaluation to the hospital for further extended that a severe episod tachycardia (a life-threatening emergency department at how #119 had significant fluid over congestive heart failure and sanother hospital for further extended that Resident #119 critical care unit on 2/13/25 and sustained ventricular tachycan	aute kidney failure, and ardia. The certificate of AM indicated the immediate poxic respiratory failure tive heart failure with the to death for the eks. Another significant h was cardiogenic shock. ed for 1 of 1 resident andards (#119). We and staff, Medical sident Representative, fest patient facility failed to ensure the designed to detect heart rhythms and, if a treatment shock to as by the LifeVest she was hours (beginning shortly jurse #1, an agency nurse abserved the device deliver dent #119 and took no notifying the oncoming at the LifeVest was bough the night". The 7 of ar Resident #119 from an included Nurse #1, Nurse are Aide (NA) #2, NA #6, and an how to respond if the or how to respond if the treatment shock was to be called immediately, nade by the device with this Cardiologist contacted the mended the resident be ation after being suffacturer that the e of ventricular grapid heart rate). The spital #1 determined Resident and monitoring. In hospital #2 dated 2/27/25 was admitted to the not was deceased on a included acute heart radiac arrhythmia, acute acute kidney failure, and	F0600	Continued from page 18 On 8/7/25, the Director of Admissions of the Administrator that any prospective reports of the Administrator of the Ife vest, utilizing vest, with the Director of Nursing and the Staff Education. Instruction manual with resource documents were provided. On 8/10/25, the Director of Nursing crequick reference guide for each nursing Contents of the manual included a pating quick reference guide for trouble shooting educational overview for patients and for the Ife vest. The 24- hour help line number located on the outside and inside of the Ife vest. The 24- hour help line number located on the outside and inside of the Video designed for both patients and cateful to the Video designed for both patients and cateful to the Video designed for both patients and cateful the Video designed	esident with a a clinical review eptance. esentative came eview of the ga demone Director of a several ated a life-vest station. ent checklist, a ng, an amilies on use manual for the is also a manual. In on 8/8/25 and at instructional aregivers. If Education ate staff list includes nowledge of the cion and mmunication and ontents of the estants received Director of a Set Nurse or report to the fe vest any other the Administrator, Minimum Data Set urse, Therapy, ry Manager, Medical dof the neglect dicipated in the or of Staff	

AND F	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENTER		120	D SOUTHWOOD DRIVE , CLINTON, North	th Carolina, 28329	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETION DATE
F0600 SS = SQC-J	Continued from page 19 death dated 2/27/25 at 10:41 cause of death was acute hy and acute on chronic conges approximate interval of onset immediate causes was 2 were condition contributing to deat (medical emergency resulting to the body's organ due to dy The Administrator was notifies 8/11/25 at 12:10 PM. The facility provided the follor of Immediate Jeopardy remo Identify those recipients who likely to suffer, a serious adve of the noncompliance. Failure to protect Resident #* cross-references to F580, F6 On 2/11/25 the facility failed the abuse/neglect policy and faile #119 from neglect by not rece a resident's change in condition of notify the Medical Direct the seriousness of resident's comprehensive medical evaluated from the seriousness of resident's comprehensive medical evaluated from the facility of the legation the Administrator submitted at Department of Health and Hu Adult Protective Services. Refrom the facility. The Administration Upon learning of the allegation the Administrator submitted at Department of Health and Hu Adult Protective Services. Refrom the facility. The Administration unusing attempted to contact the number was not operation As of 8/8/25, a review conduct Nursing confirmed that there with a Life Vest residing in the 03/07/25. On 08/11/25 all current reside changes in condition to ensu services were provided. The consisting of the Director of Second of the Dire	tive heart failure with the to death for the eks. Another significant th was cardiogenic shock grom inadequate blood flow refunction of the heart). In the dof immediate jeopardy on wing credible allegation val: In the ave suffered, or are ease outcome as a result to adhere to its ed to protect Resident regizing and responding to ion. Specifically, staff ector; did not identify condition and need for a function; and did not ensure eatent to care for a resident regin a failure to provide In of neglect on 8/11/25, an initial report to the furnal services and report to esident #119 discharged works after and the Director of the Nurse #1 no longer works after and the Director of the Nurse #1 on 8/6/25, but nat. In the death for the death of the Director of the Nurse #1 on 8/6/25, but nat. In the death for the death of the Director of	F0600	Continued from page 19 will do a daily reconciliation of the sche ensure all staff have completed the trail education as indicated above. This training has been incorporated into orientation process for all new employes staff. All licensed nurse new hires, inclustaff, must complete mandatory training checks before being assigned to reside devices. The Administrator and Director of Nursi that any staff member who did not com training by 08/11/25 will not be able to a training is completed. Indicate how the facility plans to monito performance to make sure that solution Quality Assurance Beginning the week of 8/18/2025, The designee will monitor the abuse/neglect ensure residents are free from neglect identified reported and addressed acco policy using the QA Tool for Recognizin Abuse/Neglect. The Administrator or de interview 5 staff members to monitor if procedure for reporting alleged abuse/r and who to report to and 5 residents re abuse/neglect concerns. Also, the Adm designee will review allegation reports: State Survey Agencies to ensure repor facility policy. The monitoring will be cor weekly for 4 weeks and then monthly for until resolved. Reports will be presente. Quality Assurance Committee by the A Director of Nursing to ensure corrective initiated as appropriate. Compliance will be monitored and onge program reviewed at the weekly Quality Meeting. The weekly Quality Assurance Meeting is at Administrator, Director of Nursing, Nurs Minimum Data Set Coordinators, Unit S Therapy Director Social Worker, Mainte Health Information Management and D	o the es and agency ding agency g and competency nts using these Ing will ensure plete the required work until Administrator or t process to and any neglect rding to facility g and Reporting signee will staff know the neglect and when lated to inistrator or submitted to ts submitted per mpleted or 2 months or d to the weekly dministrator or e action loing auditing or Assurance tended by the the Managers, support nurse, nance Director,	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMP 08/14/2025		
	NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COD D SOUTHWOOD DRIVE, CLINTON, Nor		
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F0600 SS = SQC-J	Continued from page 20 Nurse Support Staff conductor assessments of all residents Mental Status (BIMS) score of any signs of distress or negles identified. On 08/11/25, resid 13 or higher were interviewed team regarding any concerns or care. All residents denied a	of 12 or less to identify ect. No concerns were ents with a BIMS score of d by the nurse management is related to abuse, neglect,	F0600	Continued from page 20 Date of Compliance: 9/1/2025		
	Additionally, on 08/11/25, the completed immediate assess residents to identify any unre condition. This included symp	sments of 100% of current ported acute changes in				
	- Acute or sudden in onset					
	- Markedly more severe than					
	Unrelieved by previously pre- Indicative of respiratory dist breathing, low oxygen satura congestion, decreased appet	ress (e.g., difficulty tion, new onset cough or				
	On 08/11/25, corrective actio out of 116 residents who wer change in condition. Provider orders were carried out by di	re identified as having a				
	On 08/10/25, the Director of I hospital transfers from the pa provider notification occurred condition. The audit confirme notification was completed fo reviewed. No corrective actio	ast 30 days to ensure I for any acute changes in d that provider r all 14 residents				
	Specify the actions the entity process or system failure to poutcome from occurring or reaction will be completed.	prevent a serious adverse				
	On 08/08/25, the Administrat conducted in-service training part-time, as needed, and ag policy, including procedures f reporting, and preventing abutraining was delivered in perswho did not complete the trairestricted from working until or	for all staff (full-time, ency) on the abuse/neglect for identifying, use and neglect. This son and by phone. Staff ning by 08/11/25 were				

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329			EY COMPLETED
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = SQC-J	to complete education and complete education and complete cardiac device. This will be complete of Nursing, Minimum Data Strategy Education. Specific training for a resider if a person's Life Vest discharmay have an unstable arryth malfunctioning or both, and be immediate physician notifical training to complete a compronotify the medical provider of On 8/6/2025 Nurses were trained to include areas of a shock, when to notify the pevent and understanding of vest. On 8/6/2025 the Administration the Director of Nursing, the Education, the 3 licensed pranurses and the Minimum Date the Regional Nurse Consultation care for residents wo obtained from the physician a medical record to include: maresponse.	Nursing began targeted ses (Registered Nurses, and certified nursing of notifying providers of in. Training included services, and the eto act during a ning also included: ges in condition scols Medical Services A Medical S	F0600			

NAME OF	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBE 345218 NAME OF PROVIDER OR SUPPLIER		ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING REET ADDRESS, CITY, STATE, ZIP COLUMN		
MARY GI	MARY GRAN NURSING CENTER		12	0 SOUTHWOOD DRIVE , CLINTON, Nor	th Carolina, 28329	
(X4) ID PREFIX TAG	\ \		ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICE	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0600 SS = SQC-J	Continued from page 22 On 8/7/25, the Director of Ad the Administrator that any prowearable cardiac device must to ensure staff competency by the facility to complete a hocare and function of the Life vest, with the Director of Nurstaff Education. Instruction more resource documents were proved to the facility to complete a hocare and function. Instruction more source documents were proved to the Life vest, with the Director of Nurstaff Education. Instruction more source documents were proved to the Life vest, and the manual inclustic reference guide for the Life vest, and the manual Life Vest. The 24- hour help list located on the outside and in video designed for both patients. The 24- hour help list located on the outside and in video designed for both patients. This compete verbalization of understanding. This compete verbalization of understanding. This compete verbalization of understanding. This compete verbalization as well as the located quick reference guide for Life on 08/06/25, all Certified Nureducation from the Director of Staff Education, and the Minic Coordinator on the need to instaff nurse when a resident understanding. The Interdisciplinary Team—Director of Nursing, Nurse Mocordinators, Unit Manager, Health Information Managem Director, and Pharmacist—wallegation on 08/11/25 and a removal plan. The Director of Nursing and the Education along with the individed on a daily reconciliation of will do a daily reconciliation of the province	missions was instructed by ospective resident with a at undergo a clinical review before acceptance. acturer representative came ands-on review of the West, utilizing a demo sing and the Director of annual with several ovided. ursing created a life-vest the nursing station, ded a patient checklist, a able shooting, an ents and families on use uffacturers manual for the ine number is also side of the manual. staff began on 8/8/25 and atte Life Vest instructional ents and caregivers, ctor of Staff Education ist to validate staff incy checklist includes g of the knowledge of the ine, application and sponse, communication and ston and contents of the Vest. resing Assistants received of Nurses, Director of mum Data Set Nurse inmediately report to the titlizing a Life Vest rexpresses any other including the Administrator, anagers, Minimum Data Set Support Nurse, Therapy, tent, Dietary Manager, Medical as informed of the neglect ctively participated in the	F0600			

AND PI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			
MARY GF	MARY GRAN NURSING CENTER			120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329			
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F0600 SS = SQC-J	Continued from page 23 ensure all staff have completed the training and education as indicated above.		F0600				
This training has been incorporated orientation process for all new empl staff. All licensed nurse new hires, ir staff, must complete mandatory train checks before being assigned to residevices.		w employees and agency hires, including agency ory training and competency					
	The Administrator and Direct that any staff member who d training by 08/11/25 will not be training is completed.	id not complete the required					
	The Administrator is respons implementation of the remov	· ·					
	Alleged date of Immediate Je	eopardy removal: 08/12/25					
	The removal plan of the Imm validated on 8/14/25.	ediate Jeopardy was					
	A sample of staff including the of Nursing, Support Nurse ## medication aides were intervitraining received related to the All staff interviewed stated the regarding the importance of all residents have a right to be they indicated that they under provide the necessary care a constituted neglect. The staff that the in-service training the failure to notify the physician including receiving shocks fred defibrillator device constitute.	1, nurses, nurse aides and riewed regarding in-service he deficient practice. He had been in serviced staff understanding that he free of neglect and perstood that failing to hand services to residents interviewed indicated hey received stated that of significant changes of a deficient of the hand services to residents of significant changes of a wearable					
	The removal date of 8/12/25	was validated.					
F0684	Quality of Care		F0684	F684 POC: Quality of Care		09/01/2025	
SS = SQC-J	CFR(s): 483.25			Corrective Action for Affected Residents	5		
	§ 483.25 Quality of care			Resident #119 was placed at serious ris			
	Quality of care is a fundament to all treatment and care proversidents. Based on the communities receive treatment and care in professional standards of pra	vided to facility prehensive assessment of a sure that residents n accordance with		facility's failure to recognize and respon appropriately to a critical change in con resident wore a Life Vest, an external deprescribed due to a severely reduced le ejection fraction. This device is intended and treat life-threatening arrhythmias.	dition. The efibrillator ift ventricular		

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
	RAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, Nort		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES I BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 24 person-centered care plan, a This REQUIREMENT is NOT Based on record review and Cardiologist, LifeVest technic representative interviews, the obtain physician directives fo when the LifeVest delivered a seriousness of Resident #119 need for a comprehensive me LifeVest (an external defibrilla detect certain life-threatening and, if needed, automatically to restore normal heart rhythmultiple times in the early mo shortly after midnight) of 2/11 the device deliver shocks to taction with the exception of first shift nurse that the LifeVeresident all through the night 2/13/25 the facility failed to cophysician regarding the LifeV treatment shocks to the resident shocks to the resident with a evaluated by a physician for personal tructions, a resident with a evaluated by a physician for personal tructions, a resident with a evaluated by a physician for personal tructions, a resident with a evaluated by a physician for personal tructions, a resident with a evaluated by a physician for personal tructions, a resident with a evaluated property and set the resident between tricular tachycardia (a liferate). The emergency departs the transferred to another hospits and monitoring. The discharged dated 2/27/25 indicated that to the critical care unit on 2/1 on 2/27/25. Discharge diagnostiancy cardiogenic shock, can hypoxic respiratory failure, active	MET as evidenced by: staff, Medical Director #1, ian and LifeVest patient e facility failed to r staff about what to do a shock, identify the 9's cardiac status and the edical evaluation when a ator device designed to r apid heart rhythms deliver a treatment shock m) shocked the resident forning hours (beginning 1/25. Nurse #1 observed he resident and took no notifying the oncoming est was "shocking the est having delivered ent and provide ongoing ing to the manufacturer's a LifeVest is to be cotential arrhythmia once shock. On 2/13/25, contacted the facility and e sent to the hospital for d by the LifeVest's int had a severe episode of threatening rapid heart ment at hospital #1 ad significant fluid overload failure and she was all for further evaluation re summary from hospital #2 Resident #119 was admitted 3/25 and was deceased obses included acute heart rediac arrhythmia, acute sute kidney failure, and urdia. The certificate of AM indicated the immediate poxic respiratory failure tive heart failure with the ets. Another significant h was cardiogenic shock. ed for 1 of 1 resident	F0684	Continued from page 24 This failure in clinical judgment and time notification to the physician, so that a comedical evaluation necessity determinated a high likelihood of seriod death, as the Life Vest's discharge indicunstable arrhythmia or device malfunctive requiring immediate medical evaluation. On 2/11/25, the Life Vest delivered multibeginning shortly after midnight. Nurse these events but failed to assess the renotify a physician, instead only informing shift nurse. No physician directives were regarding staff response to Life Vest discardiologist was only informed on 2/13. Life Vest manufacturer reported a sever ventricular tachycardia, at which point the was sent to the hospital and did not retracility. Facility has not been able to contact Nuis no longer working in the facility. The Amand Director of Nursing attempted to con 8/6/25, but the number was not open. Corrective action for potentially affected on 8/6/25, the facility initiated a compreresponse to address the facility's failure and respond appropriately to a critical condition for Resident #119. The Director of Staff Education, Minimuland 3 licensed support nurses conduct assessment of 100% of current resident acute changes in condition that had not communicated to the appropriate medic included symptoms or signs that were: Acute or sudden in onset Markedly more severe than usual Unrel previously prescribed measures Indicative of respiratory distress (e.g., obreathing, low oxygen saturation, new congestion, decreased appetite) During the audit, it is noted that no resident with a life vest residing facility since 03/07/25.	omprehensive ation could be bus harm or cates either an ion, both tiple shocks #1 witnessed sident and to get the incoming e in place scharges. The 25 after the re episode of the resident turn to the urse #1, and she administrator ontact Nurse #1 rational. If residents et a to recognize change in urm Data Set Nurse et an immediate et to identify any to been cal provider. This dieved by difficulty onset cough or dents were ices. The last there had	

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER: 345218		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 08/14/2025 B. WING		(X3) DATE SURVE 08/14/2025	EY COMPLETED
	F PROVIDER OR SUPPLIER RAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COD SOUTHWOOD DRIVE , CLINTON, Nort		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 25 received multiple treatment is defibrillator device which menhad an unstable arrythmia (in means the heart is not effect to the body's vital organs incomplications like heart failure sudden cardiac arrest) and seriousness of Resident #11 required immediate evaluation Immediate jeopardy was remfacility implemented an acceptiopardy removal. The facility compliance at a scope and sharm with potential for more immediate jeopardy) to ensure and monitoring systems are instructional videos for the Lidefibrillator revealed that the for residents at risk for sudde condition that occurs without that something is about to hamalfunction of the heart caus heartbeat with no signs or syelectrodes to continuously melectrical activity and detect such as ventricular tachycard fibrillation. The device is desielectrical shock to the heart is detected to restore a norm manufacturer's instructions in treatment shock is delivered, called immediately, and an and device with this instruction. If it means either the person had (heartbeat) requiring immediate device is malfunctioning. evaluations as soon as possis should be removed to bather, garment. The device comes battery is always to be charge Changing and charging the best of the device or at least of the device of th	chocks from the external cant the resident possibly regular heart rhythm that ively pumping enough blood reasing the risk of re, stroke, or even taff failed to identify the 9's cardiac status which in by a medical provider. It is into a the possible plan of immediate or will remain out of everity of "D" (no actual than minimal harm that is re education is completed in place and are effective. It information and the feVest external device is prescribed an cardiac death, a warning with no signs appen due to an electrical sing a dangerously fast and the heart's dangerous heart rhythms, the dicated that if a strong the heart should represent the physician is to be announcement is made by the other when an abnormal rhythm and heart rhythm. The indicated that if a strong the physician attention, or Both must have medical ble. The LifeVest device shower or change the with 2 batteries, and 1 ed while using the other. It is and the physician attention, or Both must have medical ble. The LifeVest device shower or change the with 2 batteries, and 1 ed while using the other. It is and the physician attention or Both must have medical ble. The LifeVest device shower or change the with 2 batteries, and 1 ed while using the other. It is and should not get the is to be downloaded as east weekly. If data is days, a prompt appears the time to send data." It Manufacturer Technician	F0684	Continued from page 25 The audit was completed on 8/11/25. The residents identified with acute changes For each of these residents, the provide and appropriate medical orders were in direct care staff on 08/11/2025. Additionally, on 8/10/25, the Director of reviewed the progress notes to include transfer and change in condition assess resident transfers to an acute care hosp past 30 days to ensure provider notification cocurred for any acute change in condition confirmed that provider notification was timely for 14 out of 14 residents. Systemic Changes To prevent recurrence, the Director of Nin-servicing all Registered Nurses and I Practical Nurses and certified nursing a including full-time, part-time, PRN (as nagency staff, on 8/6/25. The training enimportance of timely provider notification acute change in condition. This included signs that were: Acute or sudden in onset Markedly more severe than usual Unrelieved by previously prescribed medicative of respiratory distress (e.g., obteathing, low oxygen saturation, new ocongestion, decreased appetite) Specific training for a resident with a life if a person's life vest discharges, it mea may have an unstable arrythmia or that malfunctioning or both, and both of these immediate physician notification. Nurse training to complete a comprehensive anotify the medical provider of findings and on 8/6/2025 Nurses were trained on the response to include areas of: if the life of a shock, when to notify the physician event and understanding of when to revest. On 8/6/2025 the Administrative nurses the content of the sevent and understanding of when to revest. On 8/6/2025 the Administrative nurses the content of the sevent and understanding of when to revest. On 8/6/2025 the Administrative nurses the content of the sevent and understanding of when to revest. On 8/6/2025 the Administrative nurses the content of the sevent and understanding of when to revest. On 8/6/2025 the Administrative nurses the content of the sevent and understanding of when to revest.	in condition. In was notified, Inplemented by the Nursing (DON) In E -interact Is ments for all Initial within the Initial within the Initial within the Ition had Ition. The audit It completed It within the Ition had Ition and Ition and Itionsed Is sistants, In eeded), and In phasized the In for any It disymptoms or It was a served It was a ser	

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 26 provide continuous monitorin Manufacturer Technician stat with parameters and if the he parameter, the device alarms device goes into a server wh physician. The technician state delivered, it was recorded on information. The technician is from the device was download hours, however there are sor connectivity. The technician is released prior to a shock being be pressed to delay the shock Five shocks are administered indicated they will be delivered thythm. The technician state of the skin. The technician state of the skin. The technician state continuously sounded, the plum anufacturer should be notify a technician was available 2 week to walk through issues technician was unable to restechnician will come out with replace the device. Resident #119 was admitted which included ischemic card that occurs when the heart in blood supply making it difficure quiring a LifeVest external hypertensive heart disease, coronary artery disease, chroheart failure, acute on chroniand diabetes. Resident #119's care plan dathe resident had altered card to cardiomyopathy and coror a LifeVest. The goal indicate the free from signs or symptomatic problems through the Interventions included assessifit, enforce the need to call starts, assess for shortness every shift, monitor/document/report to the starts, assess for shortness every shift, monitor/document/report to the starts of the severy shift, monitor/document/report to the starts of the severy shift.	ag. The LifeVest ed that the device was set eart rate was above the set eart as the downloaded tated that if a shock was eart the downloaded tated that the information eart ed that the gel was eart gel wa	F0684	Continued from page 26 include the Director of Nursing, the Dire education, the 3 licensed practical nurs nurses and the Minimum set data nurse the Regional Nurse Consultant to ensure directing care for residents with life vest obtained from the physician and entere medical record to include: maintenance response. On 8/11/2025 the Minimum Data Set N Regional Nurse Consultant to ensure the with a life vest have a care plan moving will include directives of what to do in the vest delivers a shock. Training for licensed nursing staff begar includes viewing the 26-minute Life Vest video designed for both patients and care Following the video, the Director of Staff utilized a competency checklist to valida understanding. This competency check verbalization of understanding of the kn Life Vest purpose and function, applicat maintenance, emergency response, coneducation as well as the location and care quick reference guide for life vest. This initiative was coordinated by the Director On 08/06/25, all Certified Nursing Assisted education from the Director of Nurses, Staff Education, and the Minimum Data Coordinator on the need to immediately staff nurse when a resident utilizing a life receives a shock treatment or expressed concerns. The Director of Nursing and the Director Development will do a daily reconciliation schedule to ensure all licensed staff has the training and competency validation Certified Nursing Assistants received enindicated above. This in-service training indicated above the competency validation for licensed incorporated into the orientation prograficality and agency staff. The in-service training indicated above Certified Nursing Assistants has been in the orientation program for all new facility and agency staff.	ector of staff e support es were educated by re that orders es are d into the and emergency urse was educated by reat all residents forward that re event the n on 8/8/25 and t instructional regivers. If Education rate staff residents rowledge of the rion and munication and contents of the raining reformer of Nursing. Stants received Director of Set Nurse report to the re vest s any other or of Staff on of the recompleted and all ducation as in addition to estaff has been m for all new for the recorporated into	

Event ID: 1D2417-H1

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	F PROVIDER OR SUPPLIER RAN NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329			
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F0684 SS = SQC-J	Continued from page 27 signs or symptoms of corona pain or pressure especially we nausea and vomiting, shorthes weating, dependent edema, color or warmth of extremities problem indicated that Residatrial fibrillation (abnormal heincreased risk of stroke and of Interventions stated that Residassessed for chest pain or divital signs were to be obtained. There were no interventions management of the LifeVest resident required medical attractment shock was delived. Resident #119 was discharge the hospital on 1/4/25. Residwith lower gastrointestinal ble 1/20/25. Resident #119's physician or 1/20/25 that indicated the Life all times every shift. Resident #119's January and Administration Records (MAF LifeVest to be worn at all time electronically signed for each directives for the LifeVest, incall the provider if the alarms a LifeVest for showers or baths battery every 24 hours, chan every 1-2 days, manage post download data weekly. Resident #119's quarterly Mi assessment dated 1/23/25 in cognitively intact, had no behof a heart assistive device. Rependent on staff for toileting wheelchair mobility, required bed mobility and was non am A physician progress note dad Director #3 indicated Resident #20 and Particular Progress note dad Director #3 indicated Resident #119 was LifeVest in place, was to be not facility staff were to alert the changes in condition. Vital signs were recorded in the changes in condition.	ry artery disease: chest with activity, heartburn, ess of breath, excessive changes in capillary refill, s. An additional care plan ent #119 had a problem of eart rhythm) with or heart failure. ident #119 was to be scomfort every shift and ed weekly per protocol. disted in the care plan for device, indications when the ention or what to do after ered. The deformation of the entire of the ention or what to do after ered. The February 2025 Medication entire of the every shift was a shift. The MAR lacked cluding instructions to sounded, remove the entire of the entry of the entire of	F0684	Continued from page 27 No staff shall work without this training 8/11/25. Monitoring Procedure to ensure that the correction is effective and that specific cited remains corrected and/or in compregulatory Beginning the week of 8/18/25, the Adridesignee will audit this process using the Assurance Tool for Monitoring Complian notification of change in condition and the physician directives in place regarding to Life Vest discharges and routine care of Nursing will also monitor that any progresident with a wearable cardiac device clinical review to ensure staff competer acceptance This audit will be completed weekly x 4 monthly x 2 months or until resolved. Represented to the Quality Assurance cor Administrator to ensure corrective action as appropriate. Compliance will be morongoing auditing program reviewed at the Assurance Meeting. The monthly Quality Meeting is attended by the Administrator Nursing, Minimum Data Set Coordinate Unit Manager, Health Information Manamager. Date of Compliance: 9/1/2025	e plan of deficiency liance with ninistrator or ne Quality nce with the o ensure staff response e. The Director ospective e must undergo a ncy before weeks, then eports will be nmittee by the in is initiated hitored and the he Quality ty Assurance or, Director of or, Therapy Manager,	

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F0684 SS = SQC-J	the facility and was assigned 2/10/25 from 7:00 PM to 7:00 worked at the facility. An interview conducted with revealed that she was assign 2/11/25 from 7:00 AM to 3:00 Nurse #5 asked her to assist #119 on the morning of 2/11, observed blue gel from the L #119's upper body. NA #4 stacleaned Resident #119 and of the American A health status note dated 2/by Nurse #5 was a summary events during the 7:00 AM to stated in morning report that from the 7:00 PM to 7:00 AM that Resident #119's LifeVes #119 all through the night. The Nurse #1 stated that she challifeVest, and Resident #119 indicated that Nurse #5 immed Resident #119 and observed.	with Nurse Aide (NA) #2 on ed that she was assigned from 11:00 PM to 7:00 AM. #119 had a device that she heart." NA #2 stated to f2/10/25 Resident 11:00 PM to 7:00 AM was old not recall if the as another sound. NA #2 know that the device was ow what the nurse did about seess the resident. View Nurse #1 were ages sent on 8/7/25 at 2:16 with no return call received. The worked as needed at 1 to Resident #119 on 10 PM. Nurse #1 no longer NA #4 on 8/6/25 at 2:45 PM and to Resident #119 on 10 PM. Na #4 stated that the with cleaning Resident and Sees and Nurse #5 reapplied the LifeVest. With Cleaning Resident with cleaning Resident was shocking Resident to 7:00 PM shift. Nurse #5 day, the off going nurse 1 shift (Nurse #1) reported the was shocking Resident and the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that anged the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that anged the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that anged the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that anged the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that anged the battery for the was fine. The note ediately went to check the resident was lying in the note indicated that the pads of the was fine. The note ediately went to check the resident was lying in the note indicated that the pads of the was fine. The note ediately was covered in the decay of the pads of the ad leaked gel onto rupper body was covered in the decay and the electrode pads placed back on the	F0684			

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F0684 SS = SQC-J	Continued from page 29 grunting. The note indicated was beeping with a message the gel. Nurse #5 notified Sursituation. The note stated that technician was notified of the and the technician attempted without success because of in The technician informed Nurswould come to the facility to equipment later that day or the vomited again and did not ear oncoming nurse (Nurse #7) with the LifeVest and that Resider On 2/11/25 at 12:29 PM Reswere, blood pressure 123/78 respirations 18 breaths per m 97.0. An interview was conducted 1:15 PM. Nurse #5 was assig frequently and was assigned AM to 7:00 PM. Nurse #5 indicated that she was familiar was she had worked with one past. Nurse #5 indicated that provided an alert if an irreguld detected and the screen on the do. Nurse #5 stated that elect attached to the vest that the interest that the interest was shocking the resident all was sounding all night. Nurse off going nurse (Nurse #1) if provider or assessed Resident was released when a shocking the resident all was sounding all night. Nurse off going nurse (Nurse #1) if provider or assessed Resident was released when a shocking the resident all was sounding all night. Nurse off going nurse (Nurse #1) if provider or assessed Resident LifeVest device was soaked with the stated she and the Nurse Asi stated she and the Nurse #5 indicated that was released when a shocking the resident all was reported. Nurse #5 indicated that the goldered. Nurse #5 indicated that the gresident and that the gel released was #5 indicated that the gresident and that the gel released with a shock. A follow up interview with Nu	that the LifeVest monitor which stated to replenish poport Nurse #1 of the at the LifeVest support elissues with the LifeVest at to do a system check internet connection issues. Se #5 that a technician check the LifeVest he next day. Resident #119 at during the shift. The was informed of concerns with hat #119 had vomited. ident #119's vital signs , pulse 94 beats per minute, hinute, and temperature with Nurse #5 on 8/6/25 at gned to Resident #119 to her on 2/11/25 from 7:00 dicated that Resident #119 fillator device. Nurse #5 with the LifeVest device at another facility in the the LifeVest device ar heart rate was he device indicated what to trodes are applied and resident wears at all in the morning of 2/11/25, he off going night shift ent #119's LifeVest device night and that the device he #5 stated she asked the she had notified the in #119 was soaked, her with the blue conducting gel ock was received. Nurse #5 de cleaned the resident, plied the electrodes and is stated that there was a indicated that shocks were if she informed Support to her regarding Resident hocked by the LifeVest. Hel was all over the assed when the device	F0684				

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MARY GI	RAN NURSING CENTER		120	O SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
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F0684 SS = SQC-J	NA #7 indicated that she did the LifeVest or what it did unt when the technician came to the equipment. NA #7 stated informed her on 2/11/25, that defibrillator that shocked the abnormal heart rate was dete surprised when she found ou had no idea about the seriou 2/11/25, NA stated she just k to always wear the LifeVest. An interview with the Staff Do on 8/7/25 at 3:00 PM reveale 2/11/25 that Resident #119 wher LifeVest indicating that a SDD stated that she was pre 2/11/25 when the representa arrived. The SDD indicated the orientation or any training regiment.	notify the physician on was shocked by the LifeVest #5 stated that she in that the off going nurse in 19 was shocked by the port Nurse #1 was going to its stated that she did in #1 to ensure that the esident #119 was shocked. (NA) #7 on 8/8/25 at 1:20 is signed to Resident #119 in 1:00 PM shift and that she in that the esident #119 in 2/11/25, 2/12/25 in that Resident #119 was in that Resident #119 had become it that the ted that Resident #119 had become it that the ted that Resident #119 had become it that the technician in the LifeVest device. In that the technician is the LifeVest device was a resident's heart if an exted. NA #7 stated she was in this information as she is sness of this device. Until snew that Resident #119 was revelopment Director (SDD) in that the technical in the LifeVest device. Until snew that Resident #119 was revelopment Director (SDD) in that she was informed on was noted with blue gel on shock was delivered. The sent on the evening of the from the manufacturer in the she did not conduct any garding the LifeVest and he had not provided ing the LifeVest and he had not provided ing the device. It messages were sent to AM, 8/7/25 at 12:24 PM, was assigned to Resident M to 7:00 AM. Nurse #7 was belonger employed at the incomplex in the incomplex in the life in	F0684			

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MARY GI	RAN NURSING CENTER		120) SOUTHWOOD DRIVE , CLINTON, Nort	n Carolina, 28329	
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F0684 SS = SQC-J	followed up with Nurse #5 to assessed Resident #5 and n shock from the LifeVest. Sup Cardiologist called the facility adamant that he speak with regarding Resident #119. A health status note dated 2/by Nurse #8 indicated Resideresting with eyes closed mosindicated that Resident #119 herself, showed no interest in attempted to assist with feed respond to verbal stimuli. Star Resident #119 engaged, but Resident #119's urinary cath yellow urine with sediment. For interest in any activities. The	se, an administrative d for any emergency 5, was Support Nurse #1. Ation in a resident chart mation and is used to bout the need for follow up) itten by the Support Nurse #19 refused meal. The note issive assessment was nat the physician was ital signs. Arse #1 on 8/6/25 at 12:05 at Resident #119 had a se #1 stated that the itter box that sounded a abnormal rhythm. If a bock was administered. It is the talked to the er regarding the device on at if the gel was released, support Nurse #1 stated that ad gel on her chest which shock. Support Nurse #1 are been notified that the shock was administered. It Resident #119 should have including vital signs and at that she thought that the have done this. Support notify a provider on eccived a shock from the he thought Nurse #5 would se #1 stated she should have be sure that she had obtified the provider of the port Nurse #1 stated the on 2/13/25 and was Medical Director #1 At 2/25 at 7:07 PM written ent #119 had been in bed at of the shift. The note had difficulty feeding in food when staff ing and was slow to off attempted to keep she showed no interest. eter was patent draining desident #119 showed a lack	F0684			

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	NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			TREET ADDRESS, CITY, STATE, ZIP COI		
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F0684 SS = SQC-J	Continued from page 32 not indicate that the physicial not include vital signs. Review of Resident #119's m documentation of vital signs. An interview conducted with AM indicated that she was as 2/12/25 from 7:00 AM to 7:00 resident frequently. Nurse #8 familiar with the LifeVest devi experience with it. Nurse #8 sreceiving in service education regarding the device. Nurse #8 119 was unable to manage there were no directives for h Nurse #8 stated that she did Resident #119 had any signif from 7:00 AM to 7:00 PM and had been demonstrating a gr #8 was unable to explain why full assessment of Resident #1 An interview was conducted the Nurse Aide (NA) #6 who Resident #119 on 2/11/25 and 7:00 AM. NA #6 stated Residual LifeVest that she wore" and sissues with it. NA #6 stated she with resident's heart and if it the nurse. NA #6 stated she instructions about the device. An interview with Nurse #6 or indicated that she was assign 2/12/25 from 7:00 PM to 7:00 was familiar with the LifeVest residents at other facilities with #6 stated there were no issue the night of 2/12/25. If the dewould have called for assista Medical Services, the provide party. An interview with the Resident LifeVest manufacturer on 8/7 worked with the physician and the doctors and cardiologists called the Cardiologist on 2/1 that Resident #119 had a sustachycardia (v tach) on 2/11/2 indicated that if a resident had greater than 1 minute, a shoot and the provide and the physician in the greater than 1 minute, a shoot and the provide and the greater than 1 minute, a shoot and the provide and the greater than 1 minute, a shoot and the provide and the and	nedical record revealed no on 2/12/25. Nurse #8 on 8/7/25 at 11:41 asigned to Resident #119 on on PM and was assigned to the stated that she was ice as she had personal stated she did not recall in at the facility #8 stated that Resident the device herself and that how to manage the device. In not recall whether ficant changes on 2/12/25 is stated that the resident redual, slow decline. Nurse y she did not complete a #119. on 8/6/25 at 1:45 PM with stated she was assigned to ad 2/12/25 from 11:00 PM to be did not recall any he did not recall any he did not received any he did not received any. In 8/7/25 at 2:20 PM he did not received any he did not received he device.	F0684			

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				SOUTHWOOD DRIVE , CLINTON, North		
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F0684 SS = SQC-J	The representative stated that the manufacturer came to the serviced the equipment, ther stored information from the costated that the strip from 2/1 indicated that v tach was det stated that there were multip the night of 2/11/25 and whe information, she reached out. An interview with the Cardiol revealed that the LifeVest dedangerous arrhythmias incluand ventricular fibrillation. The that the device can be disambeing administered. If the rest the device, a shock is deliver stated that the physician shoul for evaluation. Following an elifeVest device, evaluation is the heart has returned to a reaction that the facility and recommendation the hospital for evaluation and facility and recommended the facility and recommended to the facility and recommended the facility and recommended the f	shocks. The a LifeVest device does not monitoring of the ning that there was not a the information for each therefore if an alarm imperative to respond to adical provider. If the then the information was when it was plugged in again. at when the technician for a facility on 2/11/25 and a the monitor generated the levice. The representative 1/25 just after midnight ected. The representative le episodes of v tach from a she received that a to the Cardiologist. logist on 8/6/25 at 3:36 PM vice is designed to detect ding ventricular tachycardia the Cardiologist stated and to prevent a shock from sident is unable to disarm and the Cardiologist and be notified when the diffunable to contact the diffunable to contact the diffunable to contact the diffunable to determine if the cardiologist stated and the received a call on ive for the LifeVest the Resident #119 was shocked formal heart rhythm Cardiologist stated he mended that Resident #119 aluation. 1/13/25 at 5:00 PM written and that the facility fologist who stated that a cardiologist space with a cardiologist's resident not being stable, an	F0684			

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MARY G				SOUTHWOOD DRIVE , CLINTON, North		
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F0684 SS = SQC-J	An interview was conducted 8/6/25 at 12:05 PM. She said the phone and requested to birector. She immediately we Director #1, who was in the bispeaking with the Cardiologic gave the order to send Residue to a dangerous heart arm. An interview with Medical Dir PM revealed that he had stare early February 2025. Medicanot notified that Resident #1 or shocked her due to arrhyth stated if the LifeVest alarms the resident should be sent then the provider should be resident, it means the person requiring immediate physicia malfunctioned and administer required. Both require evaluated 2/13/25 indicated that the hospital with a LifeVest discharges an electrosident, it means the person requiring immediate physicia malfunctioned and administer required. Both require evaluated 2/13/25 indicated that the hospital with a LifeVest discharge summer to the hospital with a LifeVest discharge in the resident, difficult to undersom was unresponsive on present #119 was noted to have 4+ pabdomen. The impression in was evaluated due to a cardisignificantly fluid overloaded heart failure. Due to her sevent was unresponsive on present #119 was noted to have 4+ pabdomen. The impression in was evaluated due to a cardisignificantly fluid overloaded heart failure. Due to her sevent Resident #119 was transferred further evaluation and monitor. The discharge summary from indicated that Resident #119 critical care unit on 2/13/25 at 2/27/25. Discharge diagnose failure, cardiogenic shock, can hypoxic respiratory failure and sustained ventricular tachycan sustained ventricular failure and sustained ventricular tachycan sustained ventricular tachycan sustained ventricular failure and sustained ventricular tachycan sustained ventricular failure and sustained ventricular tachycan hypoxic respiratory failure and sustained ventricular tachycan hypoxic respiratory failure and sustained ventricular	If the Cardiologist was on speak with the Medical ent and informed Medical outliding at the time. After st, Medical Director #1 dent #119 to the hospital rhythmia. If ector #1 on 8/6/25 at 3:52 red in the facility in all Director #1 stated he was 19's Life Vest had alarmed mia. Medical Director #1 ounded due to arrhythmia, or the emergency room and notified. Medical Director mocked the resident, the ely assessed the resident and valuation. When the rical shock to the in had an unstable arrythmia in attention, or the device ered a shock when it was not attion. IED) report from hospital #1 Resident #119 presented to evice on. Resident #119 detected a cardiac ist requested evaluation at in. Resident #119 was stand with closed eyes and tation to the ED. Resident sitting edema from toes to dicated that Resident #119 ac arrhythmia and was with severe congestive ere and acute condition, ed to another hospital for oring. In hospital #2 dated 2/27/25 was admitted to the and was deceased on sincluded acute heart ardiac arrhythmia, acute out in the cute kidney failure, and ardia. If 2/27/25 at 10:41 AM see of death was acute	F0684			

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPL A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329			EY COMPLETED
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F0684 SS = SQC-J	Continued from page 35 congestive heart failure with of onset to death for the imm Other significant condition or cardiogenic shock. An interview was conducted the Director of Nursing (DON Director. The DON stated that residents with a LifeVest in the came in with a booklet that pithe device and managed the not recall if Resident #119 cas about her device or if she was LifeVest when she was admi Services Director stated that something occurred such as shock, the provider would be further instructions. The DON Director stated that Resident full assessment completed in physician should have been further instructions when the the night on 2/11/25. The DO alarm on the device sounded heart rate was detected and of the physician. The DON with physician was not notified of who worked on the night of 2 who is no longer working at a further stated that when Resident should have been a should have been a should have been notified. The manufacturer provided an inadministrative nursing staff but it was not part of a plan of corrof correction was not implement investigation of the incident of the condition of the incident of the condition of the seriousness of directives for managing it. The Administrator was notified 8/11/25 at 12:10 PM. The facility provided the follo of Immediate Jeopardy remover.	the approximate interval dediate causes was 2 weeks. Sontributing to death was on 8/6/25 at 2:20 PM with and the Clinical Services at the facility had the past, and they usually provided instructions about it own device. The DON did are in with a booklet is able to manage her own they expected that if the LifeVest delivered a contified immediately for and Clinical Services at 119 should have had a coluding vital signs and the notified immediately for LifeVest alarmed during by stated that when the drift, it indicated an abnormal this required notification as unable to state why the her than that the nurse 2/10/25 was an agency nurse the facility. The DON ident #119 had a change in and lack of appetite the sessed, and the provider the DON stated that the eservice to the bollowing this incident, of correction. The DON election and stated a plan tented nor was an completed. Settrator on 8/7/25 at 4:00 accility admitted Resident as agency staff and the facility was a device. The Administrator is well as agency staff and the LifeVest device and the color of immediate jeopardy on wing credible allegation	F0684			

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CO A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, North	th Carolina, 28329	
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 36 Identify those recipients who likely to suffer, a serious advorage of the noncompliance. Resident #119 was placed at facility's failure to recognize a appropriately to a critical charesident wore a LifeVest, and prescribed due to a severely ejection fraction. This device and treat life-threatening arrhotification to the physician, medical evaluation necessity made, created a high likeliho death, as the LifeVest's dischunstable arrhythmia or device requiring immediate medical. On 2/11/25, the LifeVest delibeginning shortly after midnig these events but failed to associate anotify a physician, instead on shift nurse. No physician dire regarding staff response to L Cardiologist was only informatified to a sentify a physician, instead on shift nurse. No physician dire regarding staff response to L Cardiologist was only informatified to associate to the hospital and facility. The facility has not been ables he is no longer working in the Administrator and Director of contact Nurse #1 on 8/6/25, to operational. On 8/6/25, the facility initiated response to address the faciliand respond appropriately to condition for Resident #119. The Director of Staff Education and 3 licensed support nurse assessment of 100% of current acute changes in condition the communicated to the appropincluded symptoms or signs acute or sudden in onset	t serious risk due to the and respond inge in condition. The external defibrillator reduced left ventricular is intended to detect hythmias. Int and timely so that a comprehensive determination could be od of serious harm or harge indicates either an emalfunction, both evaluation. Interest multiple shocks ght. Nurse #1 witnessed sess the resident and to ally informing the incoming actives were in place if eVest discharges. The end on 2/13/25 after the end a severe episode of hich point the resident did not return to the incoming attempted to but the number was not but the number was not but a comprehensive lity's failure to recognize of a critical change in on, Minimum Data Set Nurse es conducted an immediate ent residents to identify any nat had not been riate medical provider. This	F0684			

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY G	RAN NURSING CENTER		12	20 SOUTHWOOD DRIVE , CLINTON, Nor	th Carolina, 28329	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	,	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 37 - Markedly more severe than previously prescribed measu - Indicative of respiratory dist breathing, low oxygen satura congestion, decreased appet During the audit, it is noted the found to be using wearable of Director of Nursing verified of been no residents with a Life facility since 03/07/25. The audit sharps in condition. For each provider was notified, and apwere implemented by the directory of transfer and change in conditions. For each past 30 days to ensure provide occurred for any acute changes and change in conditions and the past 30 days to ensure provide confirmed that provider notification for any acute change confirmed that provider notification will be completed. Specify the actions the entity process or system failure to poutcome from occurring or reaction will be completed. To prevent recurrence, the Diin-servicing all Registered Nu Practical Nurses (LPNs) and assistants (CNAs), including (as needed), and agency statemphasized the importance on otification for any acute change included symptoms or signs to the control of the province of the pro	ress (e.g., difficulty tion, new onset cough or tite) nat no residents were ardiac devices. The n 8/8/25 that there had Vest residing in the udit was completed on ints identified with acute the of these residents, the propriate medical orders ext care staff on Director of Nursing (DON) to include the E-interact tion assessments for all exare hospital within the der notification had ge in condition. The audit cation was completed ints. will take to alter the prevent a serious adverse executring and when the director of Nursing began arses (RNs) and Licensed certified nursing full-time, part-time, PRN ff, on 8/6/25. The training of timely provider inge in condition. This that were: usual exercised measures aress (e.g., difficulty tion, new onset cough or tite) at with a LifeVest was if	F0684			

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COM A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
	RAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0684 SS = SQC-J	Continued from page 38 have an unstable arrythmia of malfunctioning or both, and be immediate physician notificat training to complete a compression notify the medical provider of On 8/6/2025 Nurses were trained response to include areas of a shock, when to notify the pevent and understanding of von 8/6/2025 the Administration the Director of Nursing, the Education, the 3 LPN support Data Set Nurse were educate Consultant to ensure that or residents with LifeVests are of physician and entered into the include: maintenance and entered into the include: maintenance and entered into the include directives of what vest delivers a shock. Training for licensed nursing includes viewing the 26-minuvideo designed for both paties Following the video, the Direct utilized a competency checkled understanding. This competed verbalization of understanding LifeVest purpose and function maintenance, emergency reseducation as well as the local quick reference guide for Life initiative was coordinated by On 08/06/25, all Certified Nuel education from the Director of Staff Education, and the Minic Coordinator on the need to instaff nurse when a resident understanding and competency concerns. The Director of Nursing and the Director of Staff Education, and the Minic Coordinator on the need to instaff nurse when a resident understanding and competency concerns. The Director of Nursing and the Director of Nursing and competency Certified Nursing Assistants indicated above. This in-service training indication in the directive training and competency Certified Nursing Assistants indicated above.	or that the device is both of these would require tion. Nurses received thensive assessment and if findings and concerns. Sined on the emergency if the LifeVest delivers thysician and document the when to remove the LifeVest. It we nursing team to include Director of Staff in the truit the Regional Nurse ders directing care for obtained from the team emedical record to the mergency response. Data Set Nurse was educated by the new endical record to the emedical record to the emedical record to the emedical record that to do in the event the staff began on 8/8/25 and the LifeVest instructional ents and caregivers. Cotor of Staff Education list to validate staff ency checklist includes and contents of the event the staff sponse, communication and contents of the evest. This training the Director of Nursing. The Director of Staff econciliation of the entitizing a LifeVest or expresses any other the Director of Staff feeconciliation and all received education and all received education and all received education as	F0684			

AND P	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CO A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329				
WARTG	RAN NURSING CENTER		120	SOUTHWOOD DRIVE, CLINTON, NOR	n Carolina, 26329		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE	
F0684 SS = SQC-J	Continued from page 39 the competency validation fo incorporated into the oriental facility and agency staff.	r licensed staff has been	F0684				
	The in-service training indical Certified Nursing Assistants the orientation program for a staff.	has been incorporated into					
	No staff shall work without th	is training after 8/11/25					
	Alleged Date of Immediate J	eopardy Removal: 8/12/25					
	The removal plan of the Imm validated on 8/14/25.	ediate Jeopardy was					
	A sample of staff including the Manager, nurses, nurse aide interviewed regarding in-service to the deficient practice. All so they had been in-serviced repurpose and function, application, emergency response. Validationaries had completed a complete the LifeVest device and the inphysician. A LifeVest reference the nurses' station.	s and medication aides were vices they received related taff interviewed stated garding the LifeVest ation and maintenance and tion indicated that licensed spetency checklist regarding indications to notify the					
	The immediate jeopardy rem validated.	oval date of 8/12/25 was					
F0689	Free of Accident Hazards/Su	pervision/Devices	F0689	F0689: Free of Accident Hazards/Super	rvision/Devices	09/01/2025	
SS = G	CFR(s): 483.25(d)(1)(2)			The facility failed to lock the left brake of #3's wheelchair during a one-person sta			
	§483.25(d) Accidents.			transfer on 3/14/25. The left wheelchair mechanism was worn and did not enga	brake		
	The facility must ensure that	-		on the tire.	9		
	§483.25(d)(1) The resident e of accident hazards as is pos			1.Corrective action for resident(s) affect alleged deficient practice:	ed by the		
	§483.25(d)(2)Each resident is supervision and assistance caccidents.			On 3/14/2025, Nurse #3 assessed Resipain and wanted to go to a scheduled dappointment. During the dialysis appoin #3 experienced left knee pain. A portabat the facility was negative. Resident #3	ialysis tment, Resident le x-ray taken		
	This REQUIREMENT is NOT	MET as evidenced by:		have pain and was sent to an orthopedi had another x-ray with a negative result	c clinic where he		
	Based on record review, and Practitioner (NP), and Medic facility failed to lock the left b wheelchair during a one pers 3/14/25. The left wheelchair I	al Director interviews, the rake on Resident #3's son stand-pivot transfer on		treated with a left knee steroid injection Pain continued after the injection. On 3/ #3 was sent to the hospital for further e Resident #3 was diagnosed with a left f and had an open reduction and internal	for pain. 28/25 Resident valuation. emoral fracture		

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLET 08/14/2025 STREET ADDRESS, CITY, STATE, ZIP CODE		
	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0689 SS = G	01/14/25 indicated Resident impairment and required sup assistance for activities for done-person extensive assistance for activities for done-person extensive assistance for activities assistance for activities assistance for activities and living donations and weakness in a intervention included the use for mobility, and extensive assusing stand pivot method. The January 2025 physician #3 was not on any blood thin scheduled dialysis on Mondath Nurse #3 completed an incid 03/14/25 at 5:00 AM. The nureported pain upon return from the proof of the prior to transport to dialysis. "The Nursing Aide (NA #1) we assistance for activities for the side of the prior to transport to dialysis."	rubber on the tire. The ependently or stop the ependently of the ependent	F0689	Continued from page 40 surgery to repair a bone fracture of his On 08/05/25, Director of Nursing remove with proper disposal. Resident was immove with a replacement wheelchair with probrake mechanism. 2. Corrective action for residents with the to be affected by the alleged deficient point of the proper brake functionality and to condition of tires for signs of damage of deterioration. The results included: 7 out wheelchairs with required corrective action was immediately implemented to defective equipment was repaired or reaction was immediately implemented to defective equipment was repaired or reaction was immediately implemented to defective equipment was repaired or reaction was immediately implemented to defective equipment was repaired or reaction of all mobility devices brake testing. On 8/8/2025, the Director of Nursing (Dimensional Manager conducted a 30-day retrospection of all mobility devices brake testing. On 8/8/2025, the Director of Nursing (Dimensional Manager conducted a 30-day retrospecting involving malfunctioning equipment, inclimited to improper wheelchair brake fur audit findings revealed no identified contonn-functioning equipment 3. Measures/Systemic changes to prevealleged deficient practice: On 8/8/2025, the Staff Development Coservicing of all nursing staff (including a Fall prevention, post fall care and Equipprocess. This training will include all cur including agency. The training included: What are the common causes of falls? Identifying Falls Risk and potential negation of the prevention of the	red old wheelchair hediately provided per functioning he potential ractice. Were inspected to be evaluate the rest of 80 tion. Corrective hinclude: Any placed. Is implemented for est, including he for all occurrences estive audit of all occurrences he hincles and the hincerns related hent reoccurrence of hordinator began in agency) on himment Safety trent staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER				(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING REET ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPLETE 08/14/2025	
	GRAN NURSING CENTER) SOUTHWOOD DRIVE , CLINTON, North		
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F0689 SS = G	to the left knee. Resident #3 of 10 and voiced inability to n Nurse Practitioner (NP) was orders given for x-ray of left k consultation. No injuries were incident. Resident #3's wheel break levers in place to lock. members and physicians were 03/14/25. Root cause of fall v to be wheelchair malfunction maintenance to repair the wholan reviewed and updated, v Responsible Party (RP) awar intervention.	oll away, so I told her When she did, I heard hink anything of it until anted to move me, and it illity's immediate action: with noted generalized edema described pain as 8 out move due to pain. The notified of concern with the eand orthopedic electric before a determined by facility, with intervention for the elchair for safety, care with physician and the eand agreed with and agreed with each of the with the electric hink to the bed on the morning of each dialysis that the principle of the with the electric hink to the bed on the morning of each dialysis that the principle of the elchair for safety, care with physician and the electric hink the elect	F0689	Continued from page 41 properly maintained and used approprise Malfunctioning equipment (e.g., wheeld immediately removed from use. This information has been integrated in orientation training and agency orientat staff identified above and will be review Quality Assurance process to verify that been sustained. The Director of Nursing will ensure that above identified staff who does not comin-service training by 8/31/2025 will not work until the training is completed. 4. Monitoring Procedure to ensure that correction is effective and that specific cited remains corrected and/or in compregulatory requirements. Beginning the week of 8/25/2025, the Diversity of the functionality of resident equivall include reviewing five residents with falls to verify that appropriate interventionitiated in a timely manner and that all involved was functioning properly. Repopresented to the QA committee by the Director of Nursing to ensure corrective initiated as appropriate. Compliance will and ongoing auditing program reviewed Meeting. The QA Meeting is attended by Administrator, DON, MDS Coordinator, the Dietary Manager. Date of Compliance: 9/1/2025	to the standard ion for all ed by the t the change has any of the applete the be allowed to the plan of deficiency liance with the offorts and ipment. This is a documented ons were equipment orts will be Administrator or action il be monitored at at the QA y the	

I .	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	A	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVE 08/14/2025	EY COMPLETED
	OF PROVIDER OR SUPPLIER GRAN NURSING CENTER			TREET ADDRESS, CITY, STATE, ZIP COD 20 SOUTHWOOD DRIVE , CLINTON, Nort		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	SHOULD BE TO THE	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 42 surgery and was doing fine in lowered him to the floor on 3 have bent at a strange angle. An interview was conducted NA #1. She said on 03/14/25 helping Resident #3 pivot fro wheelchair for his dialysis ap was lowering him onto his wheelchair started to slide be even though she thought he said she was going to lift him the resident said he did not vook back, and asked that she low she did without incident. She knee pop, but he denied any to go to his dialysis appointm stated she told Nurse #3 about nurse immediately assessed which was not painful or swo stated he still wanted to go of appointment, which he did. A nursing note written by Nur 7:10 AM for Resident #3 reverto facility from dialysis in whe was alert and oriented upon writer's questions appropriate "When the girl got me up this put me in my chair, the chair instead of her struggling, I to the floor and I guess my legging in my knee and I was fine it of got to dialysis and they put more I was very uncomfortable and to not scream because my knould not take it so I had to cresident's vital signs were ob The resident requested and medication. The resident stat straighten his leg without pai was notified and stated she if	on 08/05/25 at 8:15 AM with around 5:00 AM she was m his bed to the pointment and when she neelchair, she noted his ack some on the left side, had both wheels locked. She had both which he floor, which said she heard resident's injury or pain, and wanted hent, which he did. The NA but the incident, and the Resident #3's left knee, llen, so the resident not his dialysis The resident returned held the resident return and answered hely. The resident said, as morning around 5:00 AM to kept moving back, and lid her to sit me down on the wisted and I heard a population't hurt, but when I he in the mechanical lift did it took everything in mental her in the mechanical lift did it took everything in mental her her had and documented. The tained and documented her was unable to her Nurse Practitioner #1	F0689	+	ENCY)	
	#3 and given orders for Residence x-ray. This writer has pux-ray and notified resident an Party (RP) via voicemail. An interview was conducted Nurse #3 who stated Residence around 8:30 AM on 03/14/25 knee started to hurt at dialys that earlier when NA #1 was	at in order with portable and resident's Responsible on 08/05/25 at 1:20 PM with an #3 returned from dialysis and told her that his left is. The resident told her				

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		A. B.	2) MULTIPLE CONSTRUCTION BUILDING WING ET ADDRESS, CITY, STATE, ZIP COD	08/14/2025	
				DUTHWOOD DRIVE , CLINTON, North		
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F0689 SS = G	#3's wheelchair on 03/14/25, dialysis. He observed the wh not contact the brake on the slide back on the left side. He	the wheelchair moved, so a floor, and he heard his ated his knee did not hurt is dialysis appointment, hurt. Nurse #3 stated ome and assess the ored a portable x-ray and visit. They also asked for esident's wheelchair. The heelchair had locked ckwards on the left side #1 would not have had to r, and Resident #3's left I, resulting in further pain. Maintenance Director ceived a request to check brakes locking properly. If that the rubber piece on r, and the brake was not #3 was in bed at the time, aced. I removed the chair is room and took it to the elchair tire rubber did left side and could easily estated he removed the d brought in another one. He id monthly wheelchair airs. He said he might ent #3's if he was out of ector did not know how got back into his room. on 08/07/25 at 3:45 PM with the NP stated on 03/14/25 feer his fall and return from alysis appointment, he pain, so she ordered an he assessed his left knee, a pain, or injury of any eft knee x-ray was	F0689			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COM A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
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F0689 SS = G	Continued from page 44 gave him a cortisone steroid would stop his left knee from steroid injection, Resident #3 left knee pain. Orthopedics the a dislocated left hip, so they hospital for further work-up a the hospital's hip x-rays rever femur fracture. The NP #1 sta Resident #3 only complained nursing staff did what they we step. She voiced no staffing of A nursing note dated 03/20/2 #3 revealed the resident was orthopedic appointment. The facility with paperwork stating decreased range of motion a resident was given cortisone appointment, for left knee pa ligament tear, with additional be obtained at orthopedics a with orthopedics after x-rays A physician note dated 03/27 #1 for Resident #3 revealed it his left hip and knee pain for transitioning into his wheelch placed weight on that left kne lose balance and then the wh him, and he was lowered to t pain in the lateral left hip radi thigh to the left knee. He was weight on his left lower extree left hip without pain. His left I internally rotated with trace to specifically in ankles, unable left lower extremity due to pa significant decreased range of lower extremity internally rota consistent with a dislocation Services (EMS) transported for possible left hip dislocation staken to orthopedics where h treated with a left knee inject tria	pain. NP stated after the awas still complaining of hought he might then have ordered him to go to the and treatment. She stated aled the resident had a ated throughout time it of left knee pain. NP said ere trained to do, step by concerns. 25 at 05:10 PM for Resident out of facility for resident returned to gleft knee pain with and decreased strength. The injection in left knee at in to rule out left knee knee x-rays ordered to not resident to follow up obtained. 27/25 by the Medical Director resident complaints about the past 6 days. He was air and inadvertently see which caused him to neelchair moved away from the floor. He complains of iating down the lateral aurable to sustain any mity or turn or move the ower extremity is ower extremity is ower extremity edema to place weight upon the inj, left hip with of motion due to pain, left ated and foreshortened Emergency Medical Resident #3 to the hospital or or fracture. He was ion of lidocaine and edical procedure used to treat inflammation and pain). He is with left femoral fracture it femur on 03/28/25, with a	F0689			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLIANCE (X3) DATE SURVEY (X3) DATE			EY COMPLETED
MARY	GRAN NURSING CENTER		12	0 SOUTHWOOD DRIVE , CLINTON, Nor	th Carolina, 28329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFI) TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 45 the Medical Director #1. The when Resident #3 was lower 03/14/25, he initially had no p on to dialysis and there he fir knee pain. Upon his return fro obtained a portable x-ray of h negative for fracture. The Me resident was still complaining initial x-ray, so a second x-ray was negative for left knee fra Director stated Resident #3's initially had no pain from beir and later complained of left k possibly nerve pain that radia to a hairline fracture in his left the non-displaced fracture da Director stated after the secon orthopedics gave him a stero helped some, but his left kne the injection, so they sent him further evaluation and treatm dislocated hip, but a non-disp which was treated with ORIF #1 stated all of this might have facility had thrown out the resident with a continuous with good wheel tree The Administrator presented fall dated 03/14/25. It reveale stand-pivot transfer, Residen staff member (NA#1) to lowe wheelchair moved backward resident denied immediate pa proceeded to dialysis as schor returned from dialysis with co pain, with the resident being Nurse #3 with notification to to with order received for left kn management given per regim resident's wheelchair was rer replacement chair provided. #1) assessed the resident wi and orthopedic referral. Mobi resident's left knee revealed dislocations identified. On 03 assessment noted positive be of fluid in the sacs that cushio resident that the knee x-ray r fracture with recommendation orthopedic consult. On 03/20 orthopedics, with treatment r	Medical Director stated ed onto the floor on pain or swelling and went st complained of left om dialysis the facility his left knee, which was dical Director stated the gof pain after the y was taken, and it also cture. The Medical fall on 03/14/25 and lowered to the floor nee pain, which was stated to his left knee, due to the floor nee pain, which was stated to his left knee, due to the floor nee pain, which was stated to his left knee, due to the hospital for ent for possible hip to x-ray did not show a placed femur fracture, surgery. Medical Director we been prevented if the sident's worn-out and provided him with a lad. a timeline of Resident #3's did during a one-person to the floor when the during the transfer. The lain, refused assessment and eduled. The resident semmediately assessed by the medical provider, ee x-ray, and pain neen and effective. The moved by maintenance with the orders to include x-ray le x-ray on 03/14/25 of knee without fractures or 1/17/25 the NP follow-up ursa effusion (accumulation on joints), and updated esults were without in to continue with 1/25 Resident #3 was sent to	F0689			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLET 08/14/2025 STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	th Carolina, 28329	
(X4) ID PREFIX TAG	I V		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0689 SS = G	Continued from page 46 injection to the left knee, with at local diagnostic center. On assessed by the facility medi review of the 03/15/25 x-ray results to include: no fracture 03/21/25 the NP follow-up wi all extremities, left knee flexe complains of pain at whole knand minimum swelling. On 03 resident with continuation in treatment. On 03/25/25 the reoutpatient diagnostic center for results to include no fracture 03/27/25 Resident #3 complains or diagnostic center for sassessments. Nurse #3 orders of two view x-ray of left Medical Director #1 complete Resident #3 with new orders to local emergency department and treatment. On 03/27/25 Resident #3 had a left hip frafemoral shaft. On 03/28/25 Resident #3 had a left hip frafemoral shaft. On 03/28/25 Resident #3 confirmed the was his. The wheelchair local Resident #3 confirmed the was his. The wheelchair's two worn flat and peeling black rubrake worked well, but the left on tire allowing the tire to slice the locked position. The resident manual fixed in the locked position. The resident manual fixed in the locked position. The resident manual fixed in the locked position where the left to the worn tire tread, causin back resulting in NA #1 having the floor. An interview and follow-up with the floor. An interview and follow-up with administrator and Director conducted on 08/05/25 at 12 on 03/14/25 Resident #3 was because his wheelchair slid to and the left brake lock did now which was a wheelchair equition which was a wheelchair equition.	a order to repeat x-ray 103/20/25 Resident #3 was cal director with further results with notation of the or dislocation. On the notation resident moves deposition and thee, with no discoloration 3/24/25 NP #1 evaluated current plan of the esident was sent out to for left knee -ray with or dislocation noted. On the esident during the president during notified NP #1 with new for further evaluation to send Resident #3 the proximal esident #4 the fall on 03/04/25 at 3:00 PM with 10. The DON stated that the fall on 03/14/25 was a eff brake didn't lock due go the wheelchair to slide end to lower the resident to the proximal esident to slide end to lower the resident to the proximal esident to slide end to lower the resident to slide end to lower the proximal esident to slide end to lower the resident to slide end to lower the resident to slide end to lower the low	F0689			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COM A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
MARY	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, Nort		
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F0689 SS = G	Continued from page 47 stated Resident #3's old whe been in his room to use on 0 been discarded, and a prope put in its place. The DON and Resident #3's wheelchair to I wheelchairs in facility checke and tires to function properly, case, they missed. The Admi immediately removed Reside room after the 03/14/25 fall a one. They both stated they he #3's old wheelchair showed to	8/05/25, and should have rly functioning wheelchair d Administrator expected have been replaced, and all d monthly and for brakes, which in Resident #3's nistrator and DON said they ent #3's wheelchair from his and replaced it with a new and no idea how Resident	F0689			
F0726 SS = J	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficie the appropriate competencie nursing and related services and attain or maintain the hig physical, mental, and psychoresident, as determined by reindividual plans of care and cacuity and diagnoses of the fipopulation in accordance wit required at §483.71. §483.35(a)(3) The facility munurses have the specific comnecessary to care for resider through resident assessment of care. §483.35(a)(4) Providing care limited to assessing, evaluati implementing resident care president's needs. §483.35(d) Proficiency of nursident care president's needs.	s and skills sets to provide to assure resident safety ghest practicable asocial well-being of each esident assessments and considering the number, acility's resident the facility assessment ast ensure that licensed apetencies and skill sets ats' needs, as identified ts, and described in the plan includes but is not ang, planning and alans and responding to ase aides. nurse aides are able to skills and techniques ats' needs, as identified	F0726	Corrective action for resident Resident #119 was admitted on 10/17/2 physician-prescribed life vest. The clinic not receive adequate training or demon in the operation, monitoring, and emerg procedures associated with the device. preparedness created a significant risk adverse outcomes for Resident #119. Resident #119 was shocked by her Life times in the early morning hours (begin after midnight) of 2/11/25. Nurse #1 obs device deliver shocks to the resident an action with the exception of notifying the first shift nurse that the Life Vest was "s resident all through the night". On 2/13/25 Resident #119's Cardiologis facility and recommended the resident I hospital for evaluation after being notific Life Vest's manufacturer that the resider episode of ventricular tachycardia. Nurse #1 no longer works for the facility Administrator and the Director of Nursir contact Nurse #1 on 8/6/25, but the nur operational. Resident #119 did not return to the facil discharge on 2/13/25. Corrective action for residents with the be affected by the alleged deficient practice.	eal staff did strate competency pency response This lack of for serious Vest multiple ning shortly served the dd took no e oncoming hocking the est contacted the pe sent to the ed by the nt had a severe A. The ng attempted to niber was not lity after potential to ctice e Director of	09/01/2025

NAME O	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS DF PROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING REET ADDRESS, CITY, STATE, ZIP COD		Y COMPLETED
MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	NT OF DEFICIENCIES I BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	Based on record review and cardiologist, Resident Repre	This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Medical Director #1, Cardiologist, Resident Representative, LifeVest O3/07/25. Measures /Systemic charalleged deficient practice		· -	nt reoccurrence of	
	technician, and LifeVest patient representative interviews, the facility failed to ensure staff were trained and competent to care for a resident who wore a LifeVest (a device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm). Resident #119 received a			To prevent recurrence, a new protocol restablished requiring documented train competency validation for any wearable (e.g., cardioverter defibrillator) prior to radmission.	ing and cardiac device	
	treatment shock multiple time wearing in the early morning after midnight) on 2/11/25. No assigned to Resident #119, of the treatment shocks to Resident with the exception of no first shift nurse (Nurse #5) the	hours (beginning shortly urse #1, an agency nurse observed the device deliver dent #119 and took no otifying the oncoming		On 8/7/25, the Director of Admissions version that any prospective representation wearable cardiac device must undergo to ensure staff competency before access	esident with a a clinical review	
	"shocking the resident all thro 7 staff members that cared fo 02/11/25 through 02/13/25 th #5, Nurse #6, Nurse #8, Nurs NA #7 had not been trained of LifeVest alarmed or sounded	ough the night". The 7 of or Resident #119 from nat included Nurse #1, Nurse se Aide (NA) #2, NA #6, and on how to respond if the or how to respond if the		On 8/8/25, a life vest manufacturer repr to the facility to complete a hands-on re care and function of the life vest, utilizin vest, with the Director of Nursing and th Staff Education. Instruction manual with resource documents were provided.	eview of the og a demo ne Director of	
	LifeVest delivered a treatment manufacturer instructions, if a delivered, the physician was and an announcement was not instruction. Resident #119's (facility on 2/13/25 and recomposent to the hospital for evaluation to the hospital for evaluation of the hospital for evaluation	a treatment shock was to be called immediately, hade by the device with this Cardiologist contacted the mended the resident be ation after being sufacturer that the e of ventricular		On 8/10/25, the Director of Nursing crequick reference guide for each nursing contents of the manual included a patie quick reference guide for trouble shooti educational overview for patients and for the life vest, and the manufacturers relife vest. The 24- hour help line number located on the outside and inside of the	station. ent checklist, a ng, an amilies on use nanual for the is also	
	#119 had significant fluid over congestive heart failure and sanother hospital for further extra the discharge summary from indicated that Resident #119 critical care unit on 2/13/25 a	she was transferred to valuation and monitoring. n hospital #2 dated 2/27/25 was admitted to the nd was deceased on		Beginning 8/8/25, all Registered Nurses Licensed Practical Nurses (LPNs) are r complete education and competency vaproviding care to any resident with a wedevice.	equired to alidation prior to	
	2/27/25. Discharge diagnoses failure, cardiogenic shock, ca hypoxic respiratory failure, ac sustained ventricular tachyca death dated 2/27/25 at 10:41 cause of death was acute hy	rdiac arrhythmia, acute cute kidney failure, and irdia. The certificate of AM indicated the immediate		All licensed nurse new hires, including a must complete mandatory training and before being assigned to residents usin	competency checks	
	and acute on chronic conges approximate interval of onset immediate causes was 2 wee condition contributing to deat (medical emergency resulting to the body's organ due to dy	tive heart failure with the to death for the eks. Another significant h was cardiogenic shock g from inadequate blood flow		Training for licensed nursing staff begar includes viewing the 26-minute Life Ves video designed for both patients and ca Following the video, the Director of Staf utilized a competency checklist to valida understanding. This competency check verbalization of understanding of the kn	t instructional tregivers. if Education ate staff list includes	

AND	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS DEPROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218	1		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING EET ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVEY COMPL 08/14/2025	
MARY C	GRAN NURSING CENTER				SOUTHWOOD DRIVE , CLINTON, North		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES I BE PRECEDED BY FULL ENTIFYING INFORMATION)	IC PRE TA	FIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	Immediate Jeopardy began f when Resident #119 received LifeVest and the staff did not for delivering care according instructions. Immediate Jeop when the facility implemented Immediate Jeopardy removal out of compliance at a lower (no actual harm with potential harm that is immediate jeopal completed and monitoring sy effective.	d a treatment shock from demonstrate competency to the manufacturer's ardy was removed on 8/12/25 d an acceptable plan of I. The facility will remain scope and severity of "D" Il for more than minimal urdy) to ensure education is	F072	226	Continued from page 49 Life Vest purpose and function, applicat maintenance, emergency response, co education as well as the location and co quick reference guide for life vest. On 08/06/25, all Certified Nursing Assis education from the Director of Nurses, Staff Education, and the Minimum Data Coordinator on the need to immediately staff nurse when a resident utilizing a life receives a shock treatment or expresse concerns.	mmunication and ontents of the stants received Director of Set Nurse report to the fe vest	
	#119's Cardiologist on 2/13/2 severe episodes of ventricula life-threatening rapid heart ra called the facility and request Medical Director. The Cardiol resident be sent to the hospit emergency department at how #119 had significant fluid over congestive heart failure and another hospital for further expenses.	eVest Resident Technician interviews, the Medical Director #1 est (an external ct certain eythms and, if needed, ment shock to restore ed treatment shocks to her erning hours on 2/11/25. esentative contacted Resident est about Resident #119's er tachycardia, a ete. The Cardiologist eted to talk to the elogist recommended that the etal for evaluation. The espital #1 determined Resident erload with severe eshe was transferred to evaluation and monitoring.			Staff who do not complete the training in not be permitted to work until the training completed. The Director of Nursing and the Director Development will do a daily reconciliating schedule to ensure all licensed staff had the training and competency validation Certified Nursing Assistants received exindicated above. This in-service training indicated above the competency validation for licensed sincorporated into the orientation prograficality and agency staff. The in-service training indicated above Certified Nursing Assistants has been in the orientation program for all new facility staff. No staff shall work without this training Monitoring Procedure to ensure that the	or of Staff on of the ve completed and all ducation as in addition to staff has been m for all new for the incorporated into ty and agency after 8/11/25	
	The discharge summary from indicated that Resident #119 critical care unit on 2/13/25 a 2/27/25. Discharge diagnose failure, cardiogenic shock, ca hypoxic respiratory failure, ac sustained ventricular tachyca death dated 2/27/25 at 10:41 cause of death was acute hy and acute on chronic conges approximate interval of onset immediate causes was 2 were condition contributing to deat This deficient practice occurr reviewed for notification of ch	was admitted to the and was deceased on a included acute heart ardiac arrhythmia, acute article acute kidney failure, and ardia. The certificate of AM indicated the immediate poxic respiratory failure at the heart failure with the act to death for the eks. Other significant the was cardiogenic shock.			correction is effective and that specific cited remains corrected and/or in comp regulatory requirements Beginning the week of 8/18/25, the Dire will monitor that any prospective reside wearable cardiac device must undergo to ensure staff competency before acceaudit will be completed weekly x 4 weel x 2 months or until resolved. Reports w to the Quality Assurance committee by to ensure corrective action is initiated a appropriate. Compliance will be monitor ongoing auditing program reviewed at the Assurance Meeting. The monthly Quality	ector of Nursing on twith a clinical review eptance. This ks, then monthly ill be presented the Administrator is red and the he Quality	

	EMENT OF DEFICIENCIES PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218				EY COMPLETED
	OF PROVIDER OR SUPPLIER GRAN NURSING CENTER			REET ADDRESS, CITY, STATE, ZIP COD Disouthwood Drive , Clinton, Nort		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	evaluation when a LifeVest (a device designed to detect ce rapid heart rhythms and, if not deliver a treatment shock to rhythm) shocked the resident early morning hours (beginni of 2/11/25. Nurse #1 observed to the resident and took not a of notifying the oncoming first LifeVest was "shocking the renight". From 2/11/25 through failed to consult with the physicial treatment and provide ongoing According to the manufacture resident and provide ongoing According to the manufacture resident with a LifeVest is to physician for potential arrhyth delivers a treatment shock. Cardiologist contacted the faresident be sent to the hospibeing notified by the LifeVest resident had a severe episod tachycardia (a life-threatening emergency department at how #119 had significant fluid over congestive heart failure and another hospital for further etc. The discharge summary from indicated that Resident #119 critical care unit on 2/13/25 a 2/27/25. Discharge diagnose failure, cardiogenic shock, ca hypoxic respiratory failure, ac sustained ventricular tachyca.	w and staff, Medical eVest technician and ve interviews, the ian directives for the LifeVest delivered a ss of Resident #119's for a comprehensive medical an external defibrillator rtain life-threatening eeded, automatically restore normal heart the multiple times in the ing shortly after midnight) and the device deliver shocks of the device deliver shocks of the device deliver shocks of the sident all through the exident all through the exident all through the exit instructions, a she evaluated by a for evaluation after the evaluation after the exit instructions, a she evaluated by a for evaluation after the exit instructions and the exit in the	F0726	Continued from page 50 Meeting is attended by the Administrato Nursing, Minimum Data Set Coordinate Unit Manager, Health Information Mana Manager. Date of Compliance: Date of compliance: 09/01/2025	r, Therapy Manager,	

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER: 345218		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
	MARY GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
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F0726 SS = J	8/6/25 at 1:15 PM. Nurse #5 #119 frequently and was ass 7:00 AM to 7:00 PM. Nurse # #119 had a LifeVest cardiac #5 stated she had not receiv the LifeVest device and there management or when to not device on Resident #119's M Record (MAR). Nurse #5 sta knowledge of the LifeVest ar working with one at another indicated she had not asked LifeVest device. Attempts were made to inter unsuccessful with text messa PM and 8/8/25 at 12:31 PM Nurse #1 was an agency nu the facility and was assigned 2/10/25 from 7:00 PM to 7:00 worked at the facility.	entative stated that when he was unable to recall the last the extra battery for drawer or in a bag and was later (router) device was not entative stated that when a to Resident #119 or recall which staff members lest device, the staff members lest device, the staff mut it and to ask someone with staff nurse Nurse #5 on was assigned to Resident lest lest lest lest lest lest lest les	F0726	ATTION NAME DELIVER.	LINCTY	
		tated that the facility had lest devices in the past, led the device themselves, so le device or the management d Nurse #5 informed her on le LifeVest device had a le stated the gel was d that Support Nurse #1 call le Support Nurse #1 stated				

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETE 08/14/2025 B. WING (X3) DATE SURVEY COMPLETE 08/14/2025			EY COMPLETED
MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
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F0726 SS = J	#2 stated she had not receive the LifeVest device. An interview with Nurse #6, at the facility as needed, was 2:20 PM. Nurse #6 indicated Resident #119 on 2/12/25 fro #6 stated she knew what a L working with residents at oth device. Nurse #6 stated that training regarding the LifeVes it. Nurse #6 stated that training regarding the LifeVes it. Nurse #6 stated and she wear with the stated that she deside regarding the device since should she with the Staff Do on 8/6/25 at 12:25 PM revea much about the LifeVest Devadmitted with the device in C stated that she researched the about it. The SDD stated she the things to know about the nurses and nursing assistant which ones. The SDD stated managing the device should Medication Administration Renurse so that all nurses were of the device. The SDD state agency nurse or facility nurse the LifeVest device or the res SDD stated she did not comp LifeVest or orientation to the	blue gel observed on pper body indicated that an tered due to an abnormal Nurse Aide (NA) #2 on that she was assigned to om 11:00 PM to 7:00 AM. NA ed any training regarding an agency nurse that worked a conducted on 8/7/25 at that she was assigned to om 7:00 PM to 7:00 AM. Nurse ifeVest device was from er facilities with this she did not receive any st device or how to manage lid not ask for training ne only worked at the orked the 7:00 PM to 7:00 administrative staff evelopment Director (SDD) led that she did not know ince when Resident #119 was october 2024. The SDD ne device with a few of the special that information regarding have been entered on the exercity (MAR) by the admitting a ware of the management did she did not know how an exercity of the same and the conductive with a few of the special that information regarding have been entered on the exercity (MAR) by the admitting a ware of the management did she did not know how an exercity or procedures as assigned to Resident #119 SDD was unable to explain any training regarding the . The SDD stated she had be conducted in the position at 2025 and prior to the staff exercity of the staff or the position at 2025 and prior to the staff or the staff	F0726			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER: 345218			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING TREET ADDRESS, CITY, STATE, ZIP COD	(X3) DATE SURVE 08/14/2025	EY COMPLETED
	MARY GRAN NURSING CENTER			0 SOUTHWOOD DRIVE , CLINTON, North		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	Continued from page 53 defibrillator device in the faci #1 stated that the nursing statrained in the management of the seriousness of the device complications. An interview was conducted the Director of Nursing (DON Director. The DON stated that residents with a LifeVest in thad a booklet about the device. The DON did not recibooklet or if she was able to when she was admitted. The training about the LifeVest was Resident #119's admission in physician order for the LifeVest training completed upon Resident #119's stay at the fiprovide a plan of correction a correction was not implement of the incident completed. The staff should have been trained LifeVest and emergency proceeding that the LifeVest device responsible for managing the stated that the facility. An interview with the Administrator was not implement of the incident of the facility staff as that were assigned to Reside trained regarding the serious device and the directives for Administrator did not recall if Resident #119 had the LifeVest incident on 2/11/25. The Administrator was notified the DON and SDD were responsible for managing the serious device and the directives for Administrator did not recall if Resident #119 had the LifeVest incident on 2/11/25. The Administrator was notified the DON and SDD were responsible for managing the serious device and the directives for Administrator did not recall if Resident #119 had the LifeVest incident on 2/11/25. The Administrator was notified the DON and SDD were responsible for provided the folloof Immediate Jeopardy removed the folloof Immed	aff should have been if the LifeVest device due to and the potential for on 8/6/25 at 2:20 PM with and the Clinical Services it the facility had be past, and they usually be and managed their own all if Resident #119 had a manage her own LifeVest DON revealed that staff as not completed prior to an October 2024 with the est device nor was staff ident #119's readmission in ed that training regarding dat any time during accility. The DON did not and stated a plan of ted nor was an investigation be DON indicated that the ed in management of the did in management of the did in management of the did in management of the edures. There were no other did LifeVest in the strator on 8/7/25 at 4:00 accility admitted Resident and the facility was a device. The Administrator is well as agency staff and #119 should have been mess of the LifeVest managing it. The she was aware that est device prior to the inistrator revealed that indevices or equipment ion. But of Immediate Jeopardy on wing credible allegation val: have suffered, or are	F0726			

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY CON A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
MARY	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	h Carolina, 28329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	Continued from page 54 Resident #119 was admitted physician-prescribed LifeVes not receive adequate training in the operation, monitoring, procedures associated with the preparedness created a sign adverse outcomes for Resider Resident #119 was shocked times in the early morning he after midnight) of 2/11/25. Note device deliver shocks to the action with the exception of first shift nurse that the LifeVersident all through the night on 2/13/25 Resident #119's facility and recommended the hospital for evaluation after be LifeVest's manufacturer that episode of ventricular tachyon Nurse #1 no longer works for Administrator and the Direct contact Nurse #1 on 8/6/25, operational. Resident #119 did not return discharge on 2/13/25. As of 8/8/25, a review condu Nursing confirmed that there with a LifeVest residing in the 03/07/25. Specify the action the entity process or system failure to poutcome from occurring or reaction will be complete. To prevent recurrence, a new established requiring docume competency validation for an (e.g., cardioverter defibrillato admission. On 8/7/25, the Director of Ad the Administrator that any preventable cardiac device must on ensure staff competency to the facility to complete a head of the complete and the facility to complete a head of the facility to comp	t. The clinical staff did g or demonstrate competency and emergency response he device. This lack of ificant risk for serious ent #119. by her LifeVest multiple burs (beginning shortly urse #1 observed the resident and took no notifying the oncoming est was "shocking the ". Cardiologist contacted the resident be sent to the reing notified by the the resident had a severe ardia. If the facility. The period of Nursing attempted to but the number was not to the facility after to the facility since will take to alter the prevent a serious adverse excurring, and when the resident with a serious was instructed by the prior to resident with a serious was instructed by the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious was instructed by the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious acceptance. In the facility after the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious acceptance. In the facility after the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious acceptance. In the facility after the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious acceptance. In the facility after the protocol has been ented training and y wearable cardiac device r) prior to resident with a serious acceptance.	F0726			

NAME (EMENT OF DEFICIENCIES PLAN OF CORRECTIONS OF PROVIDER OR SUPPLIER GRAN NURSING CENTER	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218	A ST 120	EY COMPLETED		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED	SHOULD BE	(X5) COMPLETION DATE
F0726 SS = J	Continued from page 55 care and function of the Life's vest, with the Director of Nur Staff Education. Instruction in resource documents were proposed for each Contents of the manual inclusive reference guide for rowed ucational overview for pation of the Life's, and the manual Life's. The 24- hour help ling on the outside and inside of the outside and inside of the outside and inside of the dife's. The 24- hour help ling on the outside and inside of the outside outside outside outside outside outside outside of the outside outsid	Vest, utilizing a demo sing and the Director of nanual with several rovided. Itursing created a LifeVest ch nursing station. It is a patient checklist, a puble shooting, an ents and families on use pufacturers manual for the ne number is also located the manual. Fired Nurses (RNs) and puterney validation prior to interest with a wearable cardiac including agency staff, and and competency validation prior to interest with a wearable cardiac including agency staff, and the LifeVest instructional ents and caregivers. It is to validate staff ency checklist includes and caregivers. It is to validate staff ency checklist includes and contents of the evest. Firsing Assistants received of Nurses, Director of immum Data Set Nurse immediately report to the putilizing a LifeVest or expresses any other in the training is in the Director of Staff free enciliation of the ed staff have completed validation and all	F0726	APPROPRIATE DEFICI	ENCY)	

AND	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETE 08/14/2025 STREET ADDRESS, CITY, STATE, ZIP CODE		
	GRAN NURSING CENTER			SOUTHWOOD DRIVE , CLINTON, North		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	SHOULD BE TO THE	(X5) COMPLETION DATE
F0726 SS = J	Continued from page 56 This in-service training indicathe competency validation for incorporated into the oriental facility and agency staff. The in-service training indicate Certified Nursing Assistants the orientation program for a staff. No staff shall work without the 8/11/25. Alleged date of Immediate Jeff The removal plan of the Immediate on 8/14/25. A sample of staff including the Support Nurse #1, SDD, nursinterviewed regarding in-service to the deficient practice. All sithey received in-service train LifeVest purpose and functionand emergency response. Valicensed nurses had complet regarding the LifeVest device notify the physician. A LifeVec created and was observed a The immediate jeopardy rem	ated above in addition to r licensed staff has been tion program for all new ated above for the has been incorporated into II new facility and agency are received removal: 8/12/25 are Administrator, the DON, sees, and nurse aides were vices they received related taff interviewed stated aing regarding the n, application, maintenance alidation indicated that are da competency checklist and the indications to st reference manual was the nurses' station.	F0726			
F0761 SS = D	validated. Label/Store Drugs and Biologicals (Proceedings) Labeled in accordance with comprofessional principles, and in accessory and cautionary insexpiration date when applicate (Procedings) §483.45(h) Storage of Drugs §483.45(h)(1) In accordance laws, the facility must store a in locked compartments undirected.	s and Biologicals In the facility must be urrently accepted include the appropriate structions, and the ble. Is and Biologicals with State and Federal ill drugs and biologicals	F0761	F761: Label/Store Drugs and Biological The facility failed to remove 1 opened minsulin injector pen that was expired on medication cart). 1. Corrective action for resident(s) affect alleged deficient practice: On 8/6/2025, Nurse #5 removed and dimulti-dose insulin injector pen from the 2. Corrective action for residents with the to be affected by the alleged deficient pen All residents in the facility who take medithe potential to be affected.	nulti-dose the (200-hall sted by the scarded the expired cart. se potential tractice.	09/01/2025

NAME (EMENT OF DEFICIENCIES PLAN OF CORRECTIONS DF PROVIDER OR SUPPLIER GRAN NURSING CENTER	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 345218	ST	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 08/14/2025 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329		
(X4) ID PREFIX	SUMMARY STATEME	NT OF DEFICIENCIES T BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF	RRECTION	(X5) COMPLETION
TAG		ENTIFYING INFORMATION)	TAG	CROSS-REFERENCED APPROPRIATE DEFICI	TO THE	DATE
F0761 SS = D	1976 and other drugs subject facility uses single unit packs systems in which the quantity missing dose can be readily. This REQUIREMENT is NOTE Based on manufacturer direct staff interviews, the facility factories opened multi-dose insulin injin 1 of 3 medication carts (20 reviewed for medication stores). The findings included: The manufacturer's direction	st provide separately compartments for storage of nedule II of the Prevention and Control Act of it to abuse, except when the age drug distribution y stored is minimal and a detected. TMET as evidenced by: ctions, observations, and iled to remove 1 ector pen that was expired 20-hall medication cart), age and labeling.	F0761	Continued from page 57 Beginning on 8/15/2025, The Director of Development Coordinator (SDC), Nurse the Unit Support Nurses audited all metreatment carts, and medication rooms expired or undated medications. Correct immediately where indicated to include any expired medications. This was come 8/15/2025. 3. Measures/Systemic changes to prevealleged deficient practice: Education: On 8/27/2025, the Staff Development Ceducating all full time, part time, and PF Nurses, Registered Nurses (RNs), Lice Nurses (LPN), and Medication Aides in staff on the following topics: Checking medications for expiration data administering the medication.	e Supervisor, and dication carts, to identify any stions were made discarding of pleted on ent reoccurrence of coordinator began RN Licensed nsed Practical cluding agency	
	injector pen stated once opened, the product is good for 28-days. Discard after 28 days: Even if there's insulin left in the pen after 28-days, discard it. The insulin may have lost potency after this time. An observation of the 200-hall medication cart and interview with Nurse #5 were conducted on 08/06/25 at 8:45 AM. An opened insulin glargine injector pen dated 07/02/25 was found in the cart. The insulin glargine pen had a label on it which stated the insulin pen was to be discarded 28 days after opening. Nurse #5 stated the expired insulin glargine pen dated 07/02/25 should have been removed after 28-days by the night nurse on the 200-hall medication cart and was not. An interview was conducted with the Interview with the		Labeling medications when opened with indicated. McNeill's Pharmacy recommended stortiems. This in-service was incorporated in the facility orientation for the above-mention and also provided to agency staff workifacility. This will be reviewed by the Quanch Assurance process to verify that the chasustained.	rage for selected new employee ned employees ng in the		
	Director of Nursing (DON) af observation on 08/06/25 at 3 insulin glargine pen that was should have been discarded after 28-days from 07/02/25 An interview was conducted 08/07/25 at 4:00 PM. She staresponsible for dating the inswas opened and discarding in Administrator further stated to responsible for checking and medication from the medicate	ter the medication storage :30 PM. The DON stated the opened and dated 07/02/25 by the night nursing staff and was not. with the Administrator on ated the nursing staff were sulin pen injector when it t 28 days after opening. The he nursing staff were removing any expired		Any staff who does not receive schedul training will not be allowed to work until been completed by 08/31/2025. 4. Monitoring Procedure to ensure that correction is effective and that specific cited remains corrected and/or in compregulatory requirements. Beginning the week of 8/25/2025, The I Nursing or designee will monitor complete F761 Quality Assurance Tool weekl monthly x 2 months. The DON or designee	training has the plan of deficiency liance with Director of lance utilizing y x 4 weeks then	

AND F	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER. IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		A (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPL A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE			EY COMPLETED
MARY G	GRAN NURSING CENTER		120	SOUTHWOOD DRIVE , CLINTON, Nort	th Carolina, 28329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0761 SS = D			F0761	Continued from page 58 for compliance with labeling medication when opened and ensuring the medica carts and the medication room is free of medications. Reports will be presented Assurance committee by the Director of ensure corrective action is initiated as a Compliance will be monitored and the oprogram reviewed at the Quality Assura Quality Assurance Meeting is attended Administrator, Director of Nursing, MDS Therapy Manager, Unit Support Nurses Information Manager, and the Dietary Manage	tion and treatment of expired to the Quality of Nursing to appropriate. ongoing auditing ance Meeting. The by the of Coordinator, of Health	
				Date of Compliance: 9/1/2025		
F0812	Food Procurement, Store/Prepare/Serve-Sanitary		F0812	The statements made on this plan of co an admission to and do not constitute a		09/01/2025
SS = E	CFR(s): 483.60(i)(1)(2)			the alleged deficiencies.	ar agreement with	
	§483.60(i) Food safety requirements The facility must - §483.60(i)(1) - Procure food considered satisfactory by fe authorities.	from sources approved or		To remain in compliance with all federal regulations the facility has taken or will actions set forth in this plan of correctio of correction constitutes the facility's all compliance such that all alleged deficie have been or will be corrected by the definition of the facility of the definition of the facility is all the facility of the definition of the facility	take the n. The plan egation of encies cited	
	(i) This may include food iten local producers, subject to aplaws or regulations.			For dietary services, a corrective action on 8/04/2025.	was obtained	
	(ii) This provision does not produce gardens, subject to complian growing and food-handling proving and food-handling proving and foods not procure foods not procure for the foods of the	grown in facility ice with applicable safe ractices. reclude residents from		Based on initial tour of kitchen, nourish observations, and interviews; it was not had failed to store food properly in 2 of rooms as well in the main kitchen in wa walk-in freezer, and reach-in fridge. On expired and improperly labeled items th kitchen areas and nourishment rooms.	ed the facility 2 nourishment lk-in fridge, 8/04/2025	
	§483.60(i)(2) - Store, prepare food in accordance with professervice safety.			Corrective action for residents with the be affected by the alleged deficient practice.		
	This REQUIREMENT is NOT Based on observations and s facility failed to: a) label and of food for 1 of 1 walk in free items in the large walk-in refirefrigerator for 2 of 2 refrigerand c) discard expired items	staff interviews, the date opened packages zers, b) label and date rigerator and a smaller ators in the kitchen		All residents have the potential to be af alleged deficient practice. On 8/06/2025 Service Director and Dietitian complete of the kitchen and nourishment rooms t areas met standards to store, prepare, sanitary food/beverages.	o the Dietary ad a walk-through so ensure all	

NAME (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER: 345218 NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER		ST	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329		
MARY	SKAN NURSING CENTER		120) SOUTHWOOD DRIVE , CLINTON, NON	in Carolina, 28329	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	NT OF DEFICIENCIES T BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED APPROPRIATE DEFICI	I SHOULD BE TO THE	(X5) COMPLETION DATE
F0812 SS = E	of hamburger meat with no oplastic bag of tater tots with opened plastic bag of diced date. The following were also freezer: An opened bag of chicken te An opened bag of frozen coodate. An opened bag of garlic breat	was conducted on 8/4/25 of the Dietary Manager. In freezer revealed the aining an opened plastic bag opened date, an opened no opened dated and an opotatoes with no opened to observed in the walk-in anders with no opened date. Okie dough with no opened and with no opened date. If Manager was completed on tary Manager stated that all walk-in freezer should be ate it was opened and the walk-in refrigerator in the g:	F0812	APPROPRIATE DEFICE Continued from page 59 Systemic changes In-service education was provided to D Nursing Staff, and Environmental Servi 8/26/2025. Topics included: Procedures and policies for handling per Labeling and Dating policies and proce This information has been integrated in orientation training and in the required in refresher courses for all staff and will be the Quality Assurance process to verify has been sustained. Quality Assurance monitoring procedures for storage in kitchen and nourishment roo weeks then weekly x 4 weeks using the Dating/Labeling QA Tool which will obest supplements are labeled, dated, within and stored properly. Reports will be preweekly Quality Assurance committee by to ensure corrective action initiated as a Compliance will be monitored and ongo program reviewed at the weekly Quality Meeting. The weekly QA Meeting is atte Administrator, Director of Nursing, MDS	ietary Staff, ce Staff on ersonal food. dures to the standard in-service ereviewed by that the change e. Service Director proper food ms daily x 2 erood erve that all proper dates, sented to the year that the change of the proper dates of the year that the change of the proper dates of the year that all proper dates of the year that the change of the proper dates of the year that the year that all proper dates of the year that	
	and 1 of the salads had brow An opened package of sliced date			Therapy, Health Information Manager, a Manager. Date of Compliance: 9/1/2025	and the Dietary	
	Observation of the small refr revealed the following:	igerator in the kitchen				
	An opened box of thawed sausage patties with an opened date of 7/2/25. The outside of the box stated the product was to be kept frozen.					
	An opened box of thawed sa date of 7/2/25. The outside of					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS NAME OF PROVIDER OR SUPPLIER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING TREET ADDRESS, CITY, STATE, ZIP COE				
MARY GRAN NURSING CENTER			120 SOUTHWOOD DRIVE , CLINTON, North Carolina, 28329					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F0812 SS = E	Continued from page 60 product was to be kept frozer. An opened box of thawed bar. A list of Use By Dates for Ref the refrigerator stated thawed 3 days. An interview was completed 8/4/25 at 11:30 AM. The Diet was not supposed to be any or refrigerators. The Dietary N was not a consistent system were labeled, dated and disc expired. c-1) An observation of the ref nutrition room on 700 and 80 the Dietary Manager on 8/5/2 items were observed: An opened container of nects opened date of 4/3. An opened container of nects opened date of 3/3. The label on the containers of stated that after opening, the 7 days under refrigeration. An opened bottle of prune juil An opened carton of orange A plastic bag of fast food fried or date. An opened carton of apple juil A notice taped to the front of indicated juice in a carton was being opened. c-2) An observation of the refunction room that is utilized 500 and 600 halls was condumanager present on 8/5/25 a following: An opened bottle of prune juil	frigerator Items taped to dimeats can be stored for with the Dietary Manager on ary Manager stated there expired food in the freezer Manager indicated there to ensure that all foods arded when the items frigerator in the 0 Hall was conducted with 25 at 3:00 PM. The following ar thick sweet tea with an ar thick water with an arthick water water water water water water	F0812					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS (X1) PROVIDER/SUPPLIER/CIDENTIFICATION NUMBER: 345218		A	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 08/14/2025 B. WING		VEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER MARY GRAN NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 SOUTHWOOD DRIVE, CLINTON, North Carolina, 28329					
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F0812 SS = E	REGULATORY OR LSC IDENTIFYING INFORMATION)		F0812					