

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Mary Gran Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Southwood Drive Clinton, NC 28329	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37673</p> <p>Based on record review, and staff, Physician, Nurse Practitioner, and the Consultant Pharmacist interviews the facility failed to 1.) hold Humulin Regular (short acting) insulin when Resident #7's the blood glucose was less than 150 mg/dl (milligrams per deciliter) at 7:30 AM and less than 120 mg/dl at 11:00 AM and 5:00 PM. 2.) hold Resident #8's Humalog (insulin lispro) short acting insulin 5 units before meals for a blood glucose less than 100 mg/dl. 3.) give Resident #9 Humalog insulin 5 units before meals for premeal blood glucose over 150 mg/dl. 4.) give Resident #10 an additional 4 units of Humalog insulin for premeal blood glucose over 200 mg/dl. 5.) hold Humalog insulin according to the physician's order for Resident #11 and Resident#12 when the blood glucose was less than 120 mg/dl. 6.) administer the antihypertensive medication Clonidine prescribed as needed for increased blood pressure to Resident #3 and Resident#13 when the systolic blood pressure was greater than 160 and 170 millimeters of mercury (mmHg). The residents experienced no significant outcome. This occurred for 8 of 8 residents reviewed for medication administration.</p> <p>Findings included:</p> <p>1.) Resident #7 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus and long term use of insulin.</p> <p>Review of the medical records for November 2024, December 2024, January 2025, February 2025 and March 2025 revealed Resident #7 had the following active orders:</p> <p>At 7:30 AM Humulin R Injection Solution 100 UNIT/ML (Units per Milliliter) (Insulin Regular (Human)) Inject 7 unit subcutaneously in the morning related to Type 2 Diabetes Mellitus without complications. Hold for blood glucose less than 150 mg/dl.</p> <p>At 11:00 AM & 5:00 PM Humulin R Injection Solution 100 UNIT/ML (Insulin Regular (Human)) Inject 4 unit subcutaneously two times a day related to Type 2 Diabetes Mellitus without complications. Hold for blood glucose less than 120 mg/dl.</p> <p>Review of the Medication Administration Records revealed Resident #7 received 7 units of insulin at 7:30 AM with a blood glucose result of less than 150 mg/dl:</p> <p>11/05/24 at 7:30 AM blood glucose 136 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>11/23/24 at 7:30 AM blood glucose 131 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>11/24/24 at 7:30 AM blood glucose 132 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>11/26/24 at 7:30 AM blood glucose 143 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>11/28/24 at 7:30 AM blood glucose 131 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>11/29/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>12/03/24 at 7:30 AM blood glucose 127 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/06/24 at 7:30 AM blood glucose 110 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/07/24 at 7:30 AM blood glucose 125 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/08/24 at 7:30 AM blood glucose 115 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/09/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #13</p> <p>12/10/24 at 7:30 AM blood glucose 147 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/11/24 at 7:30 AM blood glucose 137 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>12/16/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #13</p> <p>12/31/24 at 7:30 AM blood glucose 137 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>01/15/25 at 7:30 AM blood glucose 133 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>01/16/25 at 7:30 AM blood glucose 129 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>01/20/25 at 7:30 AM blood glucose 144 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>01/29/25 at 7:30 AM blood glucose 121 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>01/30/25 at 7:30 AM blood glucose 130 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>02/06/25 at 7:30 AM blood glucose 114 mg/dl, 7 units of insulin was administered by Nurse #12</p> <p>02/09/25 at 7:30 AM blood glucose 123 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>02/17/25 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>02/18/25 at 7:30 AM blood glucose 122 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>02/19/25 at 7:30 AM blood glucose 127 mg/dl, 7 units of insulin was administered by Nurse #22</p> <p>03/12/25 at 7:30 AM blood glucose 138 mg/dl, 7 units of insulin was administered by Nurse #11</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of Medication Administration Records revealed Resident #7 received 4 units of insulin at 11:00 AM and 5:00 PM with a blood glucose result of less than 120 mg/dl:</p> <p>11/14/24 at 11:00 AM blood glucose 113 mg/dl, 4 units of insulin was administered by Nurse #22</p> <p>11/27/24 at 5:00 PM blood glucose 116 mg/dl, 4 units of insulin was administered by Nurse #22</p> <p>11/28/24 at 11:00 AM blood glucose 107 mg/dl , 4 units of insulin was administered by Nurse #22</p> <p>12/08/24 at 11:00 AM blood glucose 101 mg/dl, 4 units of insulin was administered by Nurse #22</p> <p>12/10/24 at 5:00 PM blood glucose 118 mg/dl, 4 units of insulin was administered by Nurse #14</p> <p>12/11/24 at 11:00 AM blood glucose 103 mg/dl, 4 units of insulin was administered by Nurse #22</p> <p>12/11/24 at 5:00 PM blood glucose 103 mg/dl, 4 units of insulin was administered by Nurse #22</p> <p>12/14/24 at 5:00 PM blood glucose 100 mg/dl, 4 units of insulin was administered by Nurse #11</p> <p>12/24/24 at 11:00 AM blood glucose 118 mg/dl, 4 units of insulin was administered by Nurse #11</p> <p>01/01/25 at 5:00 PM blood glucose 109 mg/dl, 4 units of insulin was administered by Nurse #11</p> <p>02/06/25 at 11:00 AM blood glucose 102 mg/dl, 4 units of insulin was administered by Nurse #12</p> <p>02/27/25 at 11:00 AM blood glucose was 104 mg/dl, 4 units of insulin was administered by Nurse #5</p> <p>02/27/45 at 5:00 PM blood glucose was 104 mg/dl, 4 units of insulin was administered by Nurse #5</p> <p>Review of the progress notes from 11/05/24 through 03/12/25 for Resident #7 revealed no documentation that the insulin was held on the dates listed.</p> <p>An interview was conducted with Nurse #11 on 03/13/25 at 4:26 PM. She stated that she thought the parameter of 120 mg/dl applied to the insulin order at 7:30 AM as well as before meals for Resident #7. She concluded that she had given insulin in error because she had not paid close attention to the order parameters.</p> <p>A telephone interview was conducted with Nurse #12 on 03/14/25 at 11:00 AM. She stated that she was used to working at the hospital where sliding scales are used and not a lot of different parameters like at the nursing home. She explained that any instructions for medications are written really small on the bottom of the screen, so she probably missed the parameters and administered Resident #7 the wrong dose of insulin. She concluded she needed to pay closer attention to the small print.</p> <p>A telephone interview was conducted with Nurse #5 on 03/14/25 at 12:31 PM. She stated that she did not think she had given any insulin outside of the ordered parameters. She explained that she had immediate family members who had brittle diabetes and that she always looked for parameters on insulin orders. She stated that she thought she had clicked on the wrong box when documenting and had not administered any insulin in error.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with Nurse #14 on 03/14/25 at 12:57 PM. She stated she knew to click on more to see the full order but could not remember seeing parameters set for insulin orders and that to give insulin before breakfast was rare. She stated she did not remember administering insulin to Resident #7 that had parameters.</p> <p>A telephone interview was conducted with Nurse #13 on 03/14/25 at 3:50 PM. She stated that some insulin orders had parameters and some did not. She thought she might have missed the parameters for the insulin orders because she had to click an additional box to open the order instructions and see the parameters. She believed she did not click on the box to open the order instructions and had not realized that any insulin orders had parameters when she administered the medication to Resident #7 in error.</p> <p>A telephone interview was conducted with Nurse #22 on 03/17/25 a 12:27 PM. She stated she had just learned that when she clicked on the order on the computer screen she then had to click on more to see the parameters. She did not realize the insulin orders included parameters and had given the insulin to Resident #7 in error.</p> <p>A telephone interview was conducted with Nurse Practitioner #1 on 03/14/25 at 12:40 PM. She stated that nothing had been reported to her that Resident #7 had experienced a change in condition. She explained that possible outcomes as a result of the medication errors could have been hypoglycemia (low blood glucose) or hyperglycemia (high blood glucose) both of which could cause confusion, lethargy, seizures, coma, or death. She reported that Resident #7's blood glucose levels were under control according to the latest laboratory tests and that Resident #7 had not suffered any poor outcome because of the medication errors.</p> <p>A telephone interview was conducted with the Medical Director on 03/17/25 at 3:36 PM. He stated he was new at the facility and had only been there six weeks. He stated nothing had been reported to him regarding Resident #7 related to a change in condition related to insulin administration. He noted the purpose of setting parameters for insulin administration was to regulate the blood glucose using both fast acting and long acting insulins in combination. The parameters for insulin were specifically intended to prevent blood glucoses from being too low or too high which could lead to impaired vision, stroke, mental status change, coronary artery disease, or death. He was not aware of any resident at the facility who had experienced a negative outcome related to insulin that was held or given in error.</p> <p>A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.</p> <p>2.) Resident #8 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy and long term use of insulin.</p> <p>Review of the medical records for January 2025 and February 2025 revealed Resident #8 had the following active order:</p> <p>Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes. Hold for BS (blood glucose) less than 100.</p> <p>Review of Medication Administration Records revealed Resident #8 received 5 units of insulin at 8:00 AM with a blood glucose result of less than 100 mg/dl and was not given insulin with a blood glucose over 100:</p> <p>01/23/25 at 11:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #7</p> <p>02/01/25 at 8:00 AM blood glucose 108 mg/dl, 5 units of insulin was held by Nurse #7 indicated by a chart code of 11 (no insulin required per order).</p> <p>02/07/25 at 8:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #3</p> <p>02/08/25 at 8:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #3</p> <p>Review of the progress notes from 01/23/25 through 02/08/25 for Resident #8 revealed no documentation that the insulin was held on the dates listed or given on 02/01/25.</p> <p>A telephone interview was conducted with Nurse #7 on 03/14/25 at 1:34 PM. She stated that she did not recall insulin orders with parameters. She explained she had been confused regarding the insulin orders because she had to click on two different tabs plus she had sliding scale orders for insulin that she gave. She stated she did not recall that Resident #8 had parameters in the insulin order.</p> <p>A telephone interview was conducted with Nurse #3 on 03/14/25 at 7:30 PM. She stated that she clicked on the medication to be administered prior to going into a resident's room and did not go back to the tab afterwards to document that she had held the insulin. Because of this she thought she documented in error but had not given the wrong dose of insulin. In addition, she explained her nursing judgement would tell her not to administer fast acting insulin for a blood glucose less than 100. She noted even if the blood glucose was 100 or 101 she would have called the physician for guidance.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with Nurse Practitioner #2 on 03/17/24 at 12:28 PM. She stated she had been working at the facility since February 17, 2025. She explained she was still getting to know the residents. She noted that the insulin parameters were in place in an attempt to control blood glucose levels. She stated insulin administered in error was concerning because it could lead to either hyperglycemia and hypoglycemia either of which could lead to unconsciousness and in extreme cases death. She reported she had not been notified of any change in condition regarding Resident #8.</p> <p>A telephone interview was conducted with the Medical Director on 03/17/25 at 3:36 PM. He stated he was new at the facility and had only been there six weeks. He stated nothing had been reported to him regarding Residents #8 related to a change in condition related to insulin administration. He noted the purpose of setting parameters for insulin administration was to regulate the blood glucose using both fast acting and long acting insulins in combination. The parameters for insulin were specifically intended to prevent blood glucoses from being too low or too high which could lead to impaired vision, stroke, mental status change, coronary artery disease, or death. He was not aware of any resident at the facility who had experienced a negative outcome related to insulin that was held or given in error.</p> <p>A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.</p> <p>A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.</p> <p>3.) Resident #9 was admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus with chronic kidney disease Stage 3 and long term use of insulin.</p> <p>Review of the medical records for January 2025 and February 2025 revealed Resident #9 had the following active order:</p> <p>Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes for premeal glucose over 150.</p> <p>Review of Medication Administration Records revealed Resident #9 received 5 units of insulin with a blood glucose result of less than 150 mg/dl:</p> <p>01/01/25 at 6:00 AM blood glucose 102 mg/dl, 5 units of insulin was administered by Nurse #15</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.</p> <p>A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.</p> <p>4.) Resident #10 was admitted to the facility on [DATE] with the following diagnoses: Type 2 Diabetes Mellitus without complications and long term use of insulin.</p> <p>Review of the medical records for December 2025 and January 2025 revealed Resident #10 had the following active order:</p> <p>Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 10 units subcutaneously before meals related to Type 2 Diabetes Mellitus without complications. For premeal glucoses over 200 give additional 4 units. Do not call provider unless blood glucose greater than 450 mg/dL.</p> <p>Review of Medication Administration Records revealed Resident #10 had not received an additional 4 units of insulin with a blood glucose result greater than 200 mg/dl:</p> <p>12/04/24 at 11:00 AM blood glucose 261 ml/dl, Nurse #7 signed that she gave a total of 10 units of insulin</p> <p>12/15/24 at 11:00 AM blood glucose 217 ml/dl, Nurse #24 signed that she gave a total of 10 units of insulin</p> <p>12/26/24 at 4:00 PM blood glucose 237 ml/dl, Nurse #19 signed that she gave a total of 10 units of insulin</p> <p>12/30/24 at 8:00 AM blood glucose 253 ml/dl, Nurse #13 signed that she gave a total of 10 units of insulin</p> <p>01/01/25 at 11:00 AM blood glucose 252 ml/dl, Nurse #7 signed that she gave a total of 10 units of insulin</p> <p>01/01/25 at 4:00 PM blood glucose 207 ml/dl, Nurse #19 signed that she gave a total of 10 units of insulin</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Mary Gran Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Southwood Drive Clinton, NC 28329	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>01/03/25 at 11:00 AM blood glucose 230 ml/dl, Nurse #7 signed that she gave a total of 10 units of insulin</p> <p>Review of the progress notes from 12/04/24 through 01/03/25 for Resident #10 revealed no documentation that 4 additional units of insulin was given on the dates listed.</p> <p>A telephone interview was conducted with Nurse #7 on 03/14/25 at 1:34 PM. She stated that she did not recall insulin orders with parameters. She explained she had been confused regarding the insulin orders because she had to click on two different tabs plus she had sliding scale orders for insulin that she gave. She stated she did not recall that Resident #10 had parameters in the insulin order.</p> <p>A telephone interview was conducted with Nurse #13 on 03/14/25 at 3:50 PM. She stated that some insulin orders had parameters and some did not. She thought she might have missed the parameters for the insulin orders because she had to click an additional box to open the order instructions and see the parameters. She believed she did not click on the box to open the order instructions and had not realized that any insulin orders had parameters when she administered the medication to Resident #10.</p> <p>A telephone interview was conducted with Nurse #19 on 03/14/25 at 4:10 PM. She stated she knew that she had to click on the word more to see the full order. She did not recall giving insulin that had parameters to Resident #10 and would have to see the order to know what had happened because she could not remember.</p> <p>A telephone interview was conducted with Nurse #24 on 03/17/25 at 4:33 PM. She stated she knew the residents and knew which residents had insulin order parameters. She concluded that she always followed the parameters when administering insulin and must have documented incorrectly that she administered 10 units of insulin to Resident #10 when she knew she gave 14 units as ordered.</p> <p>A telephone interview was conducted with Nurse Practitioner #1 on 03/14/25 at 12:40 PM. She stated that nothing had been reported to her that Residents #10 had experienced a change in condition. She explained that possible outcomes as a result of the medication errors could have been hypoglycemia (low blood glucose) or hyperglycemia (high blood glucose) both of which could cause confusion, lethargy, seizures, coma, or death. She reported that residents #10's blood glucoses were under control according to the latest laboratory tests and that Resident #10 had not suffered any poor outcome because of the medication errors.</p> <p>A telephone interview was conducted with the Medical Director on 03/17/25 at 3:36 PM. He stated he was new at the facility and had only been there six weeks. He stated nothing had been reported to him regarding Residents #10 having had a change in condition related to insulin administration. He noted the purpose of setting parameters for insulin administration was to regulate the blood glucose using both fast acting and long acting insulins in combination. The parameters for insulin were specifically intended to prevent blood glucoses from being too low or too high which could lead to impaired vision, stroke, mental status change, coronary artery disease, or death. He was not aware of any resident at the facility who had experienced a negative outcome related to insulin that was held or given in error.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345218	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/17/2025
NAME OF PROVIDER OR SUPPLIER Mary Gran Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Southwood Drive Clinton, NC 28329	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.</p> <p>A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.</p> <p>40044</p> <p>5a.) Resident #11 was admitted to the facility on [DATE] with diagnoses including diabetes, and long-term use of insulin.</p> <p>A physician's order dated 6/24/24 for Resident #11 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 6 units once a day and 10 units before dinner. Hold for blood glucose less than 120 mg/dl.</p> <p>Review of the Medication Administration Record (MAR) dated October 2024 for Resident #11 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 6 units once a day and 10 units before dinner. Hold for blood glucose less than 120 mg/dl and scheduled for administration at 11:30 AM and 4:00 PM. Humalog was administered outside of the ordered parameters on the following dates and times:</p> <p>10/16/24 at 11:30 AM blood glucose 93mg/dl, 6 units of insulin was administered by Nurse #3</p> <p>10/29/24 at 4:00 PM blood glucose 102 mg/dl, 10 units of insulin was administered by Nurse #3</p> <p>Review of the progress notes from 10/16/24 through 10/29/24 for Resident #11 revealed no documentation that the insulin was held on the dates listed.</p> <p>Review of the Medication Administration Record (MAR) dated November 2024 for Resident #11 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 6 units once a day and 10 units before dinner. Hold for blood glucose less than 120 mg/dl and scheduled for administration at 11:30 AM and 4:00 PM. Humalog was administered outside of[TRUNCATED]</p>		