STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345218	A. Building B. Wing	08/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mary Gran Nursing Center	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)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40044 Based on observations, record review, resident, staff, and the Nurse Practitioner's interviews the facility failed to implement an order for Metoprolol 50 milligrams daily (a beta blocker indicated for the treatment of hypertension and heart failure) that was prescribed for atrial fibrillation (irregular heart rhythm) following a cardiology appointment. The medication error resulted in 25 missed doses. This occurred for 1 of 1 resident (Resident #55) reviewed for medication administration. Findings included. Resident #55 was admitted to the facility on [DATE] with diagnoses including chronic atrial fibrillation and chronic systolic congestive heart failure. Review of a cardiology consult report dated 07/11/24 revealed Resident #55 had permanent atrial fibrillation. The electrocardiogram (ECG) showed atrial fibrillation with mildly increased ventricular rate at 114 beats per minute. The recommended best medical therapy was to add Metoprolol Succinate 50 milligrams (mgs) daily to help with ventricular rate control. Medication changes included: to add Metoprolol Succinate 50 mgs take one tablet by mouth daily with a start date of 07/11/24 and end date 07/11/25. Review of the Medication Administration Record (MAR) dated July 2024 for Resident #55 revealed no order for Metoprolol Succinate 50 mgs daily. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #55 was cognitively intact. He experienced no shortness of breath. During an interview on 08/05/24 at 11:34 AM Resident #55 was observed lying in bed. He was alert and oriented to person, place, and time. He stated he felt okay today but had not been up yet. He stated he did not have difficulty breathing, chest pain or dizziness at this time. During an interview on 08/06/24 at 01:58 PM Nurse #1 indicated Resident #55 did not have Metoprolol 50 mgs ordered for administration. She stated he was not on blood pressure medications. She stated she assessed Resident #55 today and his lungs were clear, his oxygen saturation was within normal limits, and he had no shortness of breath or complaints of chest pain. She stated Nurse Practitioner #1 also evaluated Resident #55 today and reported no shortness of breath or chest pain. She indicated she was not aware of an order for Metoprolol 50 mgs for Resident #55. (continued on next page)

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

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 08/12/2024
NAME OF PROVIDER OR SUPPLIER: Mary Gran Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 120 Southwood Drive Clinton, NC 28329	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 08/07/24 at 9:55 AM the Director of Nursing (DON) stated the Nurse Practitioner evaluated Resident #55 yesterday on 08/06/24 and reviewed the cardiology report and that was when it was realized that Metoprolol 50 mgs daily had not been implemented for Resident #55 following the cardiology visit on 07/11/24. She stated when residents returned from an appointment the consult reports with any new orders were placed into the physician or Nurse Practitioners box. She stated that the delay in getting the medication ordered was because the order was placed in the box of a temporary physician who no longer worked for the facility. She stated the order was overlooked and not followed up on which was done in error. She stated the order for Metoprolol 50 mgs was entered yesterday on 08/06/24 for Resident #55 and acknowledged that the Metoprolol order should have been initiated on 07/11/24 following the cardiology appointment. During a phone interview on 08/07/24 at 11:15 AM Nurse Practitioner #1 stated she saw the cardiology notes just yesterday on 08/06/24 to order Metoprolol 50 mgs daily for Resident #55. She stated once she read the cardiology consult and saw that Resident #55 was not on Metoprolol she wrote the order. She reported the cardiologist ordered Metoprolol for Resident #55 for the treatment of atrial fibrillation. She stated there had been no significant outcome from not receiving the medication and Resident #55's heart rate was never elevated enough to cause concern. She indicated his heart rate and blood pressure were within normal limits. She stated she was not aware of the facility process regarding getting physician consultation orders to her but expected the physician consultation notes would get to her for review within a reasonable timeframe. She indicated the order should have been implemented following the cardiology appointment on 07/11/24.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32968 Based on observation and staff interviews the facility failed to maintain sanitizing solutions used in the kitchen at the strength recommended by the manufacturer and failed to repair peeling paint hanging from the ceiling above 2 of 2 food preparation tables. These practices had the potential to affect 90 of 91 residents' food quality and kitchen sanitation safety. Findings included: 1) The initial tour of the kitchen conducted on 08/05/24 at 11:35 AM the Dietary Manager (DM) said the staff used the solution in the red bucket to wipe down the main food preparation table area after food preparation and prior to manning the tray line. DM said their stainless-steel food preparation tables were wiped down before breakfast and again just before lunch tray line set-up using the sanitizing solution kept in the only red sanitizing bucket kept under the kitchen's food preparation tables. At 11:45 AM on 08/05/24 strips were used to check the sanitizing solution in the kitchen's only red sanitizing bucket. The solution in the bucket registered 0-parts per million (PPM) of quaternary sanitizer. DM reported she or her staff did not check the strength of the sanitizing solution in the bucket when it was filled that morning, prior to wiping down all [NAME]. preparation table services. She said her dietary kitchen aide was new and did not know how to add sanitizing solution to the red bucket or how to test strip the solution's strength throughout the day, to keep it between 200 - 300 PPM. The DM then demonstrated with the help of the new dietary kitchen aide how to properly fill the red sanitizing bucket, by first filling the bucket with clean tap water, then she added the proper amount of sanitizing solution to the bucket, and finally she tested the red bucket's solution with a test strip that read 200 - 300 PPM, which the DM said was acceptable for disinfecting food preparation services. DM was interviewed on 08/05/24 at 11:50 AM said she preferred the quaternary solution in the red sanitizer bucket to register 200 - 300 PPM when checked with the appropriate strips. She reported when the strength was less than this there was a chance that the surfaces being wiped down were not properly disinfected. She commented the strength of the solution in the bucket should be checked when the bucket was made up and should not have registered 0-PPM. 2) A follow-up interview and observation were conducted of the kitchen on 08/05/24 at 12:00 PM revealed the ceiling above 2 of the food preparation tables and tray line table had chipped and peeling paint hanging from the ceiling above the tables. An interview was conducted on 08/06/24 at 9:00 AM with the Maintenance Director. He stated he was not aware of the kitchen's peeling ceiling paint. He stated the Dietary Manager had recently spoken to him about the need to repair the peeling ceiling paint area above the food preparation area. When the Maintenance Director observed the peeling paint on the kitchen's ceiling, he stated it needed to be repaired and he would see to it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview was conducted on 08/06/24 at 9:15 AM with the Administrator. She reported it was her expectation for the facility's kitchen staff to follow all regulatory guidelines for food and kitchen sanitation safety by testing disinfectant solution and keeping painted areas repaired per kitchen sanitation guidelines. She said the peeling ceiling in the kitchen needed to be repaired and will instruct the Maintenance Director to begin the process of repairing the ceiling. An interview was conducted on 08/06/24 at 12:15 PM with the Dietary Manager. She stated the Maintenance Director was notified of the kitchen's peeling ceiling paint and the need to be repaired. She said the peeling ceiling paint could be a food or sanitation hazard, if it fell on to the preparation tables or into residents' food.