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	08/14/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews the facility failed to maintain a residents dignity when Nurse Aide #3 placed a meal tray at the bedside of a cognitively impaired resident (Resident #52) who was dependent on staff for feeding assistance and walked away. Nurse Aide #3 did not return to feed Resident #52 for 40 minutes. Nurse Aide #3 then attempted to feed Resident #52 the cold food on the meal tray. This occurred for 1 of 3 residents reviewed for dignity. A reasonable person may feel helpless, forgotten, and become frustrated at not being able to get assistance to eat their meal. Findings included.Resident #52 was admitted to the facility on [DATE] with diagnoses including Alzheimer's dementia and dysphagia. A care plan dated 6/13/25 revealed Resident #52 required staff assistance with eating. The goal of care was to receive necessary staff assistance with eating to promote adequate nutrition. Interventions included to provide assistance with meals and promote dignity. The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #52 was severely cognitively impaired. She required extensive one-person assistance with eating. During dining observations on 8/04/25 at 12:55 PM Resident #52 was observed sitting up in her bed. She was awake, alert, and the head of the bed was elevated in an upright position. Resident #52 was hard of hearing and non-verbal. Nurse Aide #3 entered the room and placed the lunch meal tray on Resident #52's bedside table located on the left side of Resident #52 and within her sight and the bedside table was out of her reach. Nurse Aide #3 did not set up the meal tray and turned and walked away. Resident #52 looked at the meal tray and watched Nurse Aide #3 walk out of the room. A continuous observation was conducted on 8/4/25 from 12:55 PM until 1:35 PM of room [ROOM NUMBER] where Resident #52 resided. No staff member entered the room during that time to feed Resident #52. At 1:35 PM Nurse Aide #3 returned to the room to feed Resident #52. Nurse Aide #3 set up the meal tray, sat down at the bedside and attempted to start feeding Resident#52 her meal. The surveyor intervened and asked if the food which consisted of meatballs, green beans, potato salad and bread was cold. Nurse Aide #3 stated the food was cold due to the meal tray sitting in the room for 40 minutes. Nurse Aide #4 who was in the hallway, was asked to go get a fresh hot meal tray from the kitchen. Resident #52 was pointing at the meal tray while Nurse Aide #3 was sitting there. Nurse Aide #3 went ahead and started feeding her the potato salad which is to be served cold while waiting on another meal tray to come from the kitchen. Nurse Aide #3 returned within 5 minutes with a hot tray. Nurse Aide #3 began feeding Resident #52 at 1:45 PM. During an interview on 8/4/25 at 1:40 PM Nurse Aide #3 stated she had three residents on her assignment that needed to be fed by staff. She stated she delivered the meal tray to Resident #52's room then left to go feed the resident in room [ROOM NUMBER]A while Nurse Aide #4 fed the resident in 415 B. She stated it took a while to feed the residents in 415 then she went down to feed Resident #52. She reported that her and Nurse Aide #4 knew who needed to be fed by staff but today they had Nurse Aide #5 on the unit who was agency staff and would not have known to come and assist with feeding the residents. Nurse Aide #3 stated she should have informed the agency nurse aide (Nurse Aide #5) to assist with feeding Resident #52, but she did not think to do that. During an interview on 8/4/25 at 2:10 PM Nurse Aide #4 stated there were three residents on the hall that needed to be fed by staff. She stated typically three nurse aides would feed the three residents during meals but today they had an agency nurse aide that probably was not told to assist with feeding residents their meals. During an interview on 8/4/25 at 2:20 PM Nurse Aide #5 stated she was an agency nurse aide. She stated she was not informed that there were three residents on the hall that needed to be fed by staff or to assist them with their meals. She indicated she was not assigned to Resident #52. She stated she assisted with feeding residents their breakfast this morning without being told to do so, but she was not told to assist with feeding residents their lunch meal.During an interview on 8/4/25 at 2:30 PM the Director of Nursing (DON) stated waiting 40 minutes to feed Resident #52 was too long. The DON stated that Nurse Aide #3 should have informed the agency nurse aide (Nurse Aide #5) to assist her with feeding the residents. She stated Nurse Aide #3 should not have placed the meal tray in front of Resident #52 and not return for 40 minutes to feed her and then attempt to feed her cold food.

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on [DATE]. The LifeVest Resident Representative contacted Resident #119's Cardiologist on [DATE] about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated [DATE] indicated that Resident #119 was admitted to the critical care unit on [DATE] and was deceased on [DATE]. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated [DATE] at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119).Immediate jeopardy began on [DATE] when Resident #119 received multiple treatment shocks from the external defibrillator device and the facility failed to consult the physician immediately. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included:Review of the manufacturer's information and the instructional videos for the LifeVest external defibrillator revealed that the device is prescribed for residents at risk for sudden cardiac death, a condition that occurs without warning with no signs that something is about to happen due to an electrical malfunction of the heart causing a dangerously fast heartbeat with no signs or symptoms. The LifeVest uses electrodes to continuously monitor the heart's electrical activity and detect dangerous heart rhythms, such as ventricular tachycardia and ventricular fibrillation. The device is designed to deliver an electrical shock to the heart when an abnormal rhythm is detected to restore a normal heart rhythm. The manufacturer's instructions indicated that if a treatment shock is delivered, the physician is to be called immediately, and an announcement is made by the device with this instruction. If the vest discharges, it means either the person has an unstable arrythmia (heartbeat) requiring immediate physician attention, or the device is malfunctioning. Both require medical evaluation as soon as possible.An interview with the LifeVest Technician on [DATE] at 5:00 PM revealed that the device does not provide continuous real time monitoring by a medical professional. The LifeVest Technician stated that the device was set with parameters and if the heart rate was above the set parameter, the device alarmed. The information from the device went into a server which could be reviewed by the physician. The technician stated that if a shock was delivered, it was recorded on the downloaded information. The technician stated that the information from the device was downloaded into the system every 24 hours, however there were sometimes issues with connectivity. The technician indicated that the blue gel was released prior to a shock being delivered. A button can be pressed to delay the shock from being delivered. 5 shocks are administered, then if more shocks are indicated they will be delivered based on the heart rhythm. The technician stated that if an abnormal heart rhythm was detected, the device emitted a siren alarm which was loud and identifiable. If the device administered a shock, the blue gel was released onto the skin. The technician stated that if the device continuously sounded, the physician and the device manufacturer should have been notified right away to check the equipment. A technician is available 24 hours per day 7 days per week to walk through issues with the device and if the technician is unable to resolve the issue via phone, a technician will come out within 24 hours to fix it or replace the device. Resident #119 was admitted on [DATE] with diagnosis which included ischemic cardiomyopathy (a condition that occurs when the heart muscle is damaged by lack of blood supply making it difficult for the heart to

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] 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 [DATE], Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate) on [DATE]. The emergency department (ED) at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and noted Resident #119 was somnolent, difficult to understand with closed eyes and was unresponsive on presentation to the ED. Resident #119 was transferred to another hospital for further evaluation and monitoring. These failures had a high likelihood of resulting in serious harm or death for Resident #119. Immediate jeopardy began on [DATE] when Resident #119 received multiple treatment shocks from the LifeVest and the facility neglected to provide the necessary care and services and consult with the physician about an evaluation for a potential arrhythmia. Immediate jeopardy was removed on [DATE] when the facility implemented an acceptable plan of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. The findings included:This is cross-referred to:F580: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on [DATE]. The LifeVest Resident Representative contacted Resident #119's Cardiologist on [DATE] about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated [DATE] indicated that Resident #119 was admitted to the critical care unit on [DATE] and was deceased on [DATE]. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated [DATE] at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119). F684: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative interviews, the facility failed to obtain physician directives for staff about what to do when the LifeVest delivered a shock, identify the seriousness of Resident #119's cardiac status and the need for a comprehensive medical evaluation when a LifeVest (an external defibrillator device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) shocked the resident multiple times in the early morning hours (beginning shortly after midnight) of [DATE]. Nurse #1 observed the device deliver shocks to the resident and took no action with the

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative interviews, the facility failed to obtain physician directives for staff about what to do when the LifeVest delivered a shock, identify the seriousness of Resident #119's cardiac status and the need for a comprehensive medical evaluation when a LifeVest (an external defibrillator device designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) shocked the resident multiple times in the early morning hours (beginning shortly after midnight) of 2/11/25. Nurse #1 observed the device deliver shocks to the resident and took no action with the exception of notifying the oncoming first shift nurse that the LifeVest was shocking the resident all through the night. From 2/11/25 through 2/13/25 the facility failed to consult with the physician regarding the LifeVest having delivered treatment shocks to the resident and provide ongoing nursing assessment. According to the manufacturer's instructions, a resident with a LifeVest is to be evaluated by a physician for potential arrhythmia once the vest delivers a treatment shock. On 2/13/25, Resident #119's Cardiologist contacted the facility and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated 2/27/25 indicated that Resident #119 was admitted to the critical care unit on 2/13/25 and was deceased on 2/27/25. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated 2/27/25 at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for professional standards (#119).Immediate jeopardy began on 2/11/25 when Resident #119 received multiple treatment shocks from the external defibrillator device which meant the resident possibly had an unstable arrythmia (irregular heart rhythm that means the heart is not effectively pumping enough blood to the body's vital organs increasing the risk of complications like heart failure, stroke, or even sudden cardiac arrest) and staff failed to identify the seriousness of Resident #119's cardiac status which required immediate evaluation by a medical provider. Immediate jeopardy was removed on 8/12/25 when the facility implemented an acceptable plan of immediate jeopardy removal. The facility will remain out of compliance at a scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings included:Review of the manufacturer's information and the instructional videos for the LifeVest external defibrillator revealed that the device is prescribed for residents at risk for sudden cardiac death, a condition that occurs without warning with no signs that something is about to happen due to an electrical malfunction of the heart causing a dangerously fast heartbeat with no signs or symptoms. The LifeVest uses electrodes to continuously monitor the heart's electrical activity and detect dangerous heart rhythms, such as ventricular tachycardia and ventricular fibrillation. The device is designed to deliver an electrical shock to the heart when an abnormal rhythm is detected to restore a normal heart rhythm. The manufacturer's instructions indicated that if a treatment shock is delivered, the physician is to be called immediately, and an announcement is made by the device with this instruction. If the vest discharges, it means either the person has an unstable arrythmia (heartbeat) requiring immediate physician attention, or the device is malfunctioning. Both must have medical evaluations as soon as possible. The LifeVest device should be removed to bathe, shower or change the garment. The device comes with 2 batteries, and 1 battery is always to be charged while using the other. Changing and charging the batteries was to occur at the same time each day. The monitor, electrode belt or charger is not to be put in water and should not get wet. The data from the device is to be downloaded as directed by the device or at least weekly. If data is not sent in for greater than 7 days, a prompt appears on the monitor which states time to send data.An interview with the LifeVest Manufacturer Technician on 8/6/25 at 5:00 PM revealed that the device does not provide continuous monitoring. The LifeVest Manufacturer Technician stated that the device was set with parameters

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, staff, Nurse Practitioner (NP), and Medical Director interviews, the facility failed to lock the left brake on Resident #3's wheelchair during a one person stand-pivot transfer on 3/14/25. The left wheelchair brake mechanism was worn and did not engage with the rubber on the tire. The resident could not stand independently or stop the wheelchair when it started to roll. Nurse Aide (NA) #1 lowered Resident #3 to the floor. Both Resident #3 and NA#1 heard a pop. Nurse #3 assessed Resident #3 who denied pain and wanted to go to a scheduled dialysis appointment. During the dialysis appointment, Resident #3 experienced left knee pain. A portable x-ray taken at the facility was negative. Resident #3 continued to have pain and was sent to an orthopedic clinic where he had another x-ray with a negative result. He was treated with a left knee steroid injection for pain. Pain continued after the injection. On 3/28/25 Resident #3 was sent to the hospital for further evaluation. Resident #3 was diagnosed with a left femoral fracture and had an open reduction and internal fixation (ORIF) surgery to repair a bone fracture of his left femur. This deficient practice occurred for 1 of 5 residents (Resident #3) sampled for supervision to prevent accidents.The findings included:Resident #3 was admitted to the facility on [DATE]. His diagnosis included end stage renal disease stage 4 with dialysis, history of falls, anxiety, weakness, osteopenia, and peripheral vascular disease. A review of Resident #3's annual Minimum Data Set, dated [DATE] indicated Resident #3 had no cognitive impairment and required supervision to one-person assistance for activities for daily living (ADL) and one-person extensive assistance with transfers.The care plan last reviewed on 01/08/25 showed Resident #3 was care planned for falls and required assistance with activities of daily living due to chronic health conditions and weakness in extremities. The intervention included the use of a manual wheelchair for mobility, and extensive assistance with transfers using stand pivot method. The January 2025 physician orders showed that Resident #3 was not on any blood thinner medications and had scheduled dialysis on Mondays, Wednesday and Fridays. Nurse #3 completed an incident report dated Friday, 03/14/25 at 5:00 AM. The nurse stated Resident #3 reported pain upon return from dialysis at 8:30 AM. A report from dialysis of resident signing off machine early due to pain described from fall at the facility prior to transport to dialysis. Resident #3 stated, The Nursing Aide (NA #1) who had me went to get me up into the wheelchair and when she went to put me down in the wheelchair, it started to roll away, so I told her to sit me down on the floor. When she did, I heard something go 'pop'. I didn't think anything of it until I was at dialysis, and they wanted to move me, and it hurt like you know what. Facility's immediate action: Nurse #3 assessed resident with noted generalized edema to the left knee. Resident #3 described pain as 8 out of 10 and voiced inability to move due to pain. The Nurse Practitioner (NP) was notified of concern with orders given for x-ray of left knee and orthopedic consultation. No injuries were observed at the time of incident. Resident #3's wheelchair rolled away with break levers in place to lock. Resident's family members and physicians were notified on the morning of 03/14/25. Root cause of fall was determined by facility to be wheelchair malfunction, with intervention for maintenance to repair the wheelchair for safety, care plan reviewed and updated, with physician and Responsible Party (RP) aware and agreed with intervention.An interview and observation were conducted on 08/04/25 at 11:10 AM with Resident #3 revealed the resident sitting up in bed, fully dressed, alert and oriented, TV on, room clean, had bilateral bed rails for positioning, his wheelchair was next to the bed on right side. Resident stated he had dialysis that morning and was just resting up in bed. His wheelchair was checked. It had bald, worn wheels with rubber peeling off. The right brake functioned well and locked. The left wheel brake was not functioning and did not lock. Resident #3 stated on the morning of 03/14/25, Nurse Aide #1 was helping him transfer from the side of his bed, with assist to stand, and pivot to his wheelchair. The wheelchair started to slide back on the left side, when NA #1 started to lower him onto the wheelchair seat. Resident #3 stated he told NA not to lift him up, but to lower him to the floor, which she did. When he was on the floor, they both heard a pop from his left knee. He said a nurse looked at his knee, which did not hurt at all until the dialysis staff used a mechanical lift, and straightened his leg to put him into their dialysis lift, and it was then that he said his knee started to hurt. He stated he had two knee x-rays, which were negative for knee injury, and had doctor visits and an orthopedic visit and they thought his knee was the issue and the reason for his pain, which the facility was medicating him for. During a follow-up orthopedic visit, the orthopedic nurse observed that his left foot was turned inward, and they sent him to the hospital for further testing and evaluation on 03/27/25. It was at that time that the x-rays revealed a fractured

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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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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	08/14/2025

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 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, Medical Director #1, Cardiologist, Resident Representative, LifeVest 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 treatment shock multiple times by the LifeVest she was wearing in the early morning hours (beginning shortly after midnight) on [DATE]. Nurse #1, an agency nurse assigned to Resident #119, observed the device deliver the treatment shocks to Resident #119 and took no action with the exception of notifying the oncoming first shift nurse (Nurse #5) that the LifeVest was shocking the resident all through the night. The 7 of 7 staff members that cared for Resident #119 from [DATE] through [DATE] that included Nurse #1, Nurse #5, Nurse #6, Nurse #8, Nurse Aide (NA) #2, NA #6, and NA #7 had not been trained on how to respond if the LifeVest alarmed or sounded or how to respond if the LifeVest delivered a treatment shock. Per the manufacturer instructions, if a treatment shock was delivered, the physician was to be called immediately, and an announcement was made by the device with this instruction. Resident #119's Cardiologist contacted the facility on [DATE] and recommended the resident be sent to the hospital for evaluation after being notified by the LifeVest's manufacturer that the resident had a severe episode of ventricular tachycardia (a life-threatening rapid heart rate). The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated [DATE] indicated that Resident #119 was admitted to the critical care unit on [DATE] and was deceased on [DATE]. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated [DATE] at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Another significant condition contributing to death was cardiogenic shock (medical emergency resulting from inadequate blood flow to the body's organ due to dysfunction of the heart). Immediate Jeopardy began for Resident #119 on [DATE] when Resident #119 received a treatment shock from LifeVest and the staff did not demonstrate competency for delivering care according to the manufacturer's instructions. Immediate Jeopardy was removed on [DATE] when the facility implemented an acceptable plan of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is immediate jeopardy) to ensure education is completed and monitoring systems are in place and are effective. Findings:This tag is cross referred to:F580: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest Resident Representative and LifeVest Technician interviews, the facility failed to consult with Medical Director #1 when Resident #119's LifeVest (an external defibrillator designed to detect certain life-threatening rapid heart rhythms and, if needed, automatically deliver a treatment shock to restore normal heart rhythm) delivered treatment shocks to her multiple times in the early morning hours on [DATE]. The LifeVest Resident Representative contacted Resident #119's Cardiologist on [DATE] about Resident #119's severe episodes of ventricular tachycardia, a life-threatening rapid heart rate. The Cardiologist called the facility and requested to talk to the Medical Director. The Cardiologist recommended that the resident be sent to the hospital for evaluation. The emergency department at hospital #1 determined Resident #119 had significant fluid overload with severe congestive heart failure and she was transferred to another hospital for further evaluation and monitoring. The discharge summary from hospital #2 dated [DATE] indicated that Resident #119 was admitted to the critical care unit on [DATE] and was deceased on [DATE]. Discharge diagnoses included acute heart failure, cardiogenic shock, cardiac arrhythmia, acute hypoxic respiratory failure, acute kidney failure, and sustained ventricular tachycardia. The certificate of death dated [DATE] at 10:41 AM indicated the immediate cause of death was acute hypoxic respiratory failure and acute on chronic congestive heart failure with the approximate interval of onset to death for the immediate causes was 2 weeks. Other significant condition contributing to death was cardiogenic shock. This deficient practice occurred for 1 of 1 resident reviewed for notification of change (Resident #119). F684: Based on record review and staff, Medical Director #1, Cardiologist, LifeVest technician and LifeVest patient representative

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on manufacturer directions, observations, and staff interviews, the facility failed to remove 1 opened multi-dose insulin injector pen that was expired in 1 of 3 medication carts (200-hall medication cart), reviewed for medication storage and labeling.The findings included: The manufacturer's directions for insulin glargine 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 [DATE] at 8:45 AM. An opened insulin glargine injector pen dated [DATE] 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 [DATE] 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 Director of Nursing (DON) after the medication storage observation on [DATE] at 3:30 PM. The DON stated the insulin glargine pen that was opened and dated [DATE] should have been discarded by the night nursing staff after 28-days from [DATE] and was not.An interview was conducted with the Administrator on [DATE] at 4:00 PM. She stated the nursing staff were responsible for dating the insulin pen injector when it was opened and discarding it 28 days after opening. The Administrator further stated the nursing staff were responsible for checking and removing any expired medication from the medication carts.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to: a) label and date opened packages of food for 1 of 1 walk in freezers, b) label and date items in the large walk-in refrigerator and a smaller refrigerator for 2 of 2 refrigerators in the kitchen and c) discard expired items in 2 of 2 refrigerators in 2 of 2 nutrition rooms. This deficient practice had the potential to affect the food served to the residents. Findings included:An initial tour of the kitchen was conducted on 8/4/25 at 11:00 AM in the presence of the Dietary Manager.a) Observation of the walk-in freezer revealed the following:An open cardboard box containing an opened plastic bag of hamburger meat with no opened date, an opened plastic bag of tater tots with no opened dated and an opened plastic bag of diced potatoes with no opened date. The following were also observed in the walk-in freezer:An opened bag of chicken tenders with no opened date.An opened bag of frozen cookie dough with no opened date.An opened bag of garlic bread with no opened date. An interview with the Dietary Manager was completed on 8/4/25 at 11:05 AM. The Dietary Manager stated that all opened foods stored in the walk-in freezer should be labeled and dated with the date it was opened and the expiration date. b) Observation of the large walk-in refrigerator in the kitchen revealed the following: A tray with 7 individual salads with no prepared date and 1 of the salads had brown lettuce.An opened package of sliced deli ham with no opened date Observation of the small refrigerator in the kitchen revealed the following: 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 sausage links 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 bacon with no opened date. A list of Use By Dates for Refrigerator Items taped to the refrigerator stated thawed meats can be stored for 3 days. An interview was completed with the Dietary Manager on 8/4/25 at 11:30 AM. The Dietary Manager stated there was not supposed to be any expired food in the freezer or refrigerators. The Dietary Manager indicated there was not a consistent system to ensure that all foods were labeled, dated and discarded when the items expired. c-1) An observation of the refrigerator in the nutrition room on 700 and 800 Hall was conducted with the Dietary Manager on 8/5/25 at 3:00 PM. The following items were observed:An opened container of nectar thick sweet tea with an opened date of 4/3.An opened container of nectar thick water with an opened date of 3/3.The label on the containers of nectar thick liquids stated that after opening, the items may be kept up to 7 days under refrigeration.An opened bottle of prune juice with a date of 3/24.An opened carton of orange juice with no opened date.A plastic bag of fast food fried chicken with no name or date.An opened carton of apple juice with no opened date. A notice taped to the front of the refrigerator indicated juice in a carton was expired 7 days after being opened. c-2) An observation of the refrigerator in the nutrition room that is utilized for 100, 200, 300, 400, 500 and 600 halls was conducted with the Dietary Manager present on 8/5/25 at 3:10 PM and revealed the following:An opened bottle of prune juice dated 1/18.An opened bottle of prune juice dated 3/29.An unopened half gallon bottle of milk with a sell by date of 7/19/25.An opened carton of medication pass supplement with a date of 7/19/25. The label on the medication pass supplement stated consume within 4 days of opening. An opened carton of nectar thick tea dated 4/3.An opened carton of nectar thick apple juice dated 4/16.A disposable take-out container of food with a resident name and no date. An interview with the Dietary Manager on 8/5/25 at 3:15 PM revealed that she expected that all refrigerated foods, liquids and supplements would be labeled and dated properly and that expired items would be discarded. An interview with the Administrator on 8/7/25 at 4:45 PM revealed she expected all foods, liquids, and supplements would be labeled and dated and that expired items would be discarded. The Administrator further stated she expected the kitchen staff would check the dates on foods, liquids, and supplements in the freezer and the refrigerators in the kitchen and nourishment rooms and discard expired items.