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 _____	C 03/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite from 03/11/25 through 03/13/25. Additional information was obtained on 03/17/25. Therefore, the exit date was 03/17/25. Event ID# MHWF11. The following intakes were investigated: NC00224028, NC00226379, NC00227824, NC00227546, NC00223712.,NC00227948, NC00227217, NC00225321, NC00225285, and NC00225250. 2 of the 14 complaint allegations resulted in deficiency.	F 000		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: 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	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 the facility failed to 1.) hold Humulin Regular (short acting) insulin when Resident #7's the blood glucose was less	4/8/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/06/2025

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F 760	Continued From page 1 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. Findings included: 1.) Resident #7 was admitted to the facility on 04/01/22 with a diagnosis of Type 2 Diabetes Mellitus and long term use of insulin. 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: 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. 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. Review of the Medication Administration Records revealed Resident #7 received 7 units of insulin at	F 760	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. 1.A corrective action for the resident involved On 3/17/2025 the Clinical Management Team assessed Resident #7, #8, #9, #10, #11, #12, #13 for changes in condition with no identified concerns and notified provider/Responsible party of the medication error related to administration of medication outside of ordered parameters. No new orders obtained. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be	

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F 760	Continued From page 2 7:30 AM with a blood glucose result of less than 150 mg/dl: 11/05/24 at 7:30 AM blood glucose 136 mg/dl, 7 units of insulin was administered by Nurse #11 11/23/24 at 7:30 AM blood glucose 131 mg/dl, 7 units of insulin was administered by Nurse #22 11/24/24 at 7:30 AM blood glucose 132 mg/dl, 7 units of insulin was administered by Nurse #22 11/26/24 at 7:30 AM blood glucose 143 mg/dl, 7 units of insulin was administered by Nurse #11 11/28/24 at 7:30 AM blood glucose 131 mg/dl, 7 units of insulin was administered by Nurse #22 11/29/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #11 12/03/24 at 7:30 AM blood glucose 127 mg/dl, 7 units of insulin was administered by Nurse #22 12/06/24 at 7:30 AM blood glucose 110 mg/dl, 7 units of insulin was administered by Nurse #22 12/07/24 at 7:30 AM blood glucose 125 mg/dl, 7 units of insulin was administered by Nurse #22 12/08/24 at 7:30 AM blood glucose 115 mg/dl, 7 units of insulin was administered by Nurse #22 12/09/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #13 12/10/24 at 7:30 AM blood glucose 147 mg/dl, 7 units of insulin was administered by Nurse #22 12/11/24 at 7:30 AM blood glucose 137 mg/dl, 7 units of insulin was administered by Nurse #22 12/16/24 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #13 12/31/24 at 7:30 AM blood glucose 137 mg/dl, 7 units of insulin was administered by Nurse #22 01/15/25 at 7:30 AM blood glucose 133 mg/dl, 7 units of insulin was administered by Nurse #11 01/16/25 at 7:30 AM blood glucose 129 mg/dl, 7 units of insulin was administered by Nurse #11 01/20/25 at 7:30 AM blood glucose 144 mg/dl, 7 units of insulin was administered by Nurse #11	F 760	affected. On 3/15/2025 the Director of Nursing began auditing 100% of resident medication administration records for the past 14 days of residents with active orders for medications with parameters and to identify any medication errors related to not following ordered parameters. The results included there were 6 of 36 residents identified with medication administered outside of the ordered parameters. On 3/16/2025 the Director of Nursing implemented corrective action to include: completed assessments of the identified residents for change in condition, notification to the provider for review and implementation of any new interventions directed by the medical provider. 3. Systemic Changes On, 3/14/2025 he Staff Development Coordinator began in-servicing all full time, part time and as needed Nurses, Medication Aides (including agency) on Medication Administration errors including Provider parameters. This training included: • Preventing medication errors • Types of medication errors • 6 rights of medication administration • Following medication safety practices • Medications with parameters and Medication Errors • Examples of Medication orders with parameters • How to prevent medication errors • How to Document Medications with parameters in PCC • Chart Codes and accurate	

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F 760	Continued From page 3 01/29/25 at 7:30 AM blood glucose 121 mg/dl, 7 units of insulin was administered by Nurse #11 01/30/25 at 7:30 AM blood glucose 130 mg/dl, 7 units of insulin was administered by Nurse #11 02/06/25 at 7:30 AM blood glucose 114 mg/dl, 7 units of insulin was administered by Nurse #12 02/09/25 at 7:30 AM blood glucose 123 mg/dl, 7 units of insulin was administered by Nurse #11 02/17/25 at 7:30 AM blood glucose 148 mg/dl, 7 units of insulin was administered by Nurse #11 02/18/25 at 7:30 AM blood glucose 122 mg/dl, 7 units of insulin was administered by Nurse #11 02/19/25 at 7:30 AM blood glucose 127 mg/dl, 7 units of insulin was administered by Nurse #22 03/12/25 at 7:30 AM blood glucose 138 mg/dl, 7 units of insulin was administered by Nurse #11 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: 11/14/24 at 11:00 AM blood glucose 113 mg/dl, 4 units of insulin was administered by Nurse #22 11/27/24 at 5:00 PM blood glucose 116 mg/dl, 4 units of insulin was administered by Nurse #22 11/28/24 at 11:00 AM blood glucose 107 mg/dl , 4 units of insulin was administered by Nurse #22 12/08/24 at 11:00 AM blood glucose 101 mg/dl, 4 units of insulin was administered by Nurse #22 12/10/24 at 5:00 PM blood glucose 118 mg/dl, 4 units of insulin was administered by Nurse #14 12/11/24 at 11:00 AM blood glucose 103 mg/dl, 4 units of insulin was administered by Nurse #22 12/11/24 at 5:00 PM blood glucose 103 mg/dl, 4 units of insulin was administered by Nurse #22 12/14/24 at 5:00 PM blood glucose 100 mg/dl, 4 units of insulin was administered by Nurse #11 12/24/24 at 11:00 AM blood glucose 118 mg/dl, 4 units of insulin was administered by Nurse #11	F 760	documentation • Notification to Provider and RP • What to do if Medication Error occurs and How to document The Director of Nursing will ensure that any of the above identified staff who does not complete the in-service training by 4/7/2025 will not be allowed to work until the training is completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nursing and/or clinical leadership team member will monitor completion of ongoing audits for F 760 weekly X 4 weeks and then monthly X 2 months or until resolved. This audit will be completed by randomly auditing five nurse med passes (to include all shifts and weekends) and electronic medication administration records will be audited as part of the clinical review process to assess that medications are administered per order and hold parameters were followed. Any negative findings will immediately be addressed and reviewed during the daily clinical review meeting for interventions or additional training. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality	

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F 760	Continued From page 4 01/01/25 at 5:00 PM blood glucose 109 mg/dl, 4 units of insulin was administered by Nurse #11 02/06/25 at 11:00 AM blood glucose 102 mg/dl, 4 units of insulin was administered by Nurse #12 02/27/25 at 11:00 AM blood glucose was 104 mg/dl, 4 units of insulin was administered by Nurse #5 02/27/45 at 5:00 PM blood glucose was 104 mg/dl, 4 units of insulin was administered by Nurse #5 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. 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. 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. 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	F 760	Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy, Health Information Manager, and the Dietary Manager. Date of Compliance: 4/8/2025	

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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.

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.

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.

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.

A telephone interview was conducted with Nurse

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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.

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.

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

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Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.

A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.

2.) Resident #8 was admitted to the facility on 12/31/24 with a diagnosis of Type 2 Diabetes Mellitus with diabetic neuropathy and long term use of insulin.

Review of the medical records for January 2025 and February 2025 revealed Resident #8 had the following active order:

Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes. Hold for BS (blood glucose) less than 100.

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F 760	Continued From page 8	F 760		

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:

01/23/25 at 11:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #7
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).
02/07/25 at 8:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #3
02/08/25 at 8:00 AM blood glucose 98 mg/dl, 5 units of insulin was administered by Nurse #3

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.

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.

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

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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.

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.

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.

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A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.

A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors related to insulin.

3.) Resident #9 was admitted to the facility on 12/02/19 with the following diagnoses: Type 2 Diabetes Mellitus with chronic kidney disease Stage 3 and long term use of insulin.

Review of the medical records for January 2025

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and February 2025 revealed Resident #9 had the following active order:

Humalog Solution 100 UNIT/ML (Insulin Lispro (Human)) Inject 5 units subcutaneously before meals for diabetes for premeal glucose over 150.

Review of Medication Administration Records revealed Resident #9 received 5 units of insulin with a blood glucose result of less than 150 mg/dl:

01/01/25 at 6:00 AM blood glucose 102 mg/dl, 5 units of insulin was administered by Nurse #15
01/08/25 at 6:00 AM blood glucose 134 ml/dl, 5 units of insulin was administered by Nurse #13
01/12/25 at 11:00 AM blood glucose 146 ml/dl, 5 units of insulin was administered by Nurse #11
01/13/25 at 6:00 AM blood glucose 134 ml/dl, 5 units of insulin was administered by the MDS Nurse
01/22/25 at 6:00 AM blood glucose 126 ml/dl, 5 units of insulin was administered by Nurse #16
01/25/25 at 6:00 AM blood glucose 101 ml/dl, 5 units of insulin was administered by Nurse #7
01/30/25 at 6:00 AM blood glucose 115 ml/dl, 5 units of insulin was administered by Nurse #17
02/05/25 at 6:00 AM blood glucose 119 ml/dl, 5 units of insulin was administered by Nurse #7
02/06/25 at 6:00 AM blood glucose 115 ml/dl, 5 units of insulin was administered by Nurse #14
02/08/25 at 6:00 AM blood glucose 108 ml/dl, 5 units of insulin was administered by Nurse #7
02/12/25 at 6:00 AM blood glucose 98 ml/dl, 5 units of insulin was administered by Nurse #14
02/14/25 at 6:00 AM blood glucose 101 ml/dl, 5 units of insulin was administered by Nurse #18
02/18/25 at 6:00 AM blood glucose 148 ml/dl, 5 units of insulin was administered by Nurse #13

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02/20/25 at 6:00 AM blood glucose 132 ml/dl, 5 units of insulin was administered by Nurse #14
02/21/25 at 5:00 PM blood glucose 141 ml/dl, 5 units of insulin was administered by Nurse #6
02/22/25 at 6:00 AM blood glucose 147 ml/dl, 5 units of insulin was administered by Nurse #7

Review of the progress notes from 10/01/25 through 02/22/25 for Resident #9 revealed no documentation that the insulin was held on the dates listed.

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 for Resident #9 not 150 mg/dl. She concluded that she had given insulin in error because she had not paid close attention to the order parameters.

An interview was conducted with the MDS Nurse on 03/13/25 at 4:48 PM. She stated she had not understood the way the order was written when she administered insulin to Resident #9. She explained that because most parameters were related to holding insulin if the blood glucose was under a certain number not to give insulin if the blood glucose level was above a certain number. She stated she had made a basic human error and had given the insulin when it should have been held.

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 also that giving insulin before breakfast was rare. She stated she did not remember giving insulin that had parameters to

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Resident #9.

A telephone interview was conducted with Nurse #15 on 03/14/25 at 1:11 PM. She stated she had no memory of the resident or that she had administered insulin that had set parameters.

A telephone interview was conducted with Nurse #16 on 03/14/25 at 1:15 PM. She stated that she always checked for parameters when administering insulin. She explained that some of the keys on the computer keyboards stuck and that she had found wrong numbers documented in the past that she corrected. She stated she felt the blood glucose that was recorded was not accurate and that she gave the insulin within the set parameters as ordered.

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 a sliding scale order for insulin that she gave. She stated she did not recall that Resident #9 had parameters in the insulin order.

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 #9.

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A telephone interview was conducted with Nurse #6 on 03/17/25 at 12:15 PM when she returned the call. She stated she worked at several different places and could not remember giving insulin at the facility to Resident #9. She explained she could not remember what she had given or why from memory.

An interview was not conducted with Nurse #18. Attempts to contact her on 03/14/25 at 1:40 PM vial phone and text message and again on 03/17/25 at 11:59 AM were not successful.

An interview was not conducted with Agency Nurse #17. She was out of the country and not available for interview.

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 #9.

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 #9 regarding a change in condition related to insulin administration. He noted the purpose of setting parameters for insulin administration was to

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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.

A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.

A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the

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re-education had started there had been a sharp decrease in the number of medication errors related to insulin.

4.) Resident #10 was admitted to the facility on 03/06/17 with the following diagnoses: Type 2 Diabetes Mellitus without complications and long term use of insulin.

Review of the medical records for December 2025 and January 2025 revealed Resident #10 had the following active order:

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.

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:

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
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
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
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
01/01/25 at 11:00 AM blood glucose 252 ml/dl, Nurse #7 signed that she gave a total of 10 units

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of insulin
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
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

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.

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.

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.

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

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that had parameters to Resident #10 and would have to see the order to know what had happened because she could not remember.

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.

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.

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.

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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.

A telephone interview was conducted with the Pharmacist Consultant on 03/17/25 at 3:15 PM. She stated that she had been notifying the facility that staff were not following parameters when administering insulin. She noted every month she sent pharmacy recommendations via fax to both Unit Managers for follow up. She also attended the Quality Improvement meetings at the facility each month and stated that medication errors caused by not following insulin parameter orders was specifically discussed each month. She stated she knew the facility had been re-educating staff regarding insulin parameters because it had been discussed in the meetings.

A telephone interview was conducted with Unit Manager #1 on 03/17/25 at 4:34 PM. She stated she received nursing recommendations monthly from the pharmacist and was aware of the errors caused by nurses not following parameters related to insulin orders. She explained training was provided to individual nurses and beginning in February 2025 to all nursing staff including agency nurses. She educated all the nurses on how to check insulin orders for parameters and how to chart code an order with a 5 or an 11 to indicate the medication had not been administered. She concluded that since the re-education had started there had been a sharp decrease in the number of medication errors

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related to insulin.

5a.) Resident #11 was admitted to the facility on 1/5/23 with diagnoses including diabetes, and long-term use of insulin.

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.

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:

10/16/24 at 11:30 AM blood glucose 93mg/dl, 6 units of insulin was administered by Nurse #3
10/29/24 at 4:00 PM blood glucose 102 mg/dl, 10 units of insulin was administered by Nurse #3

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.

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

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administered outside of the ordered parameters on the following dates and times:

11/01/24 at 4:00 PM blood glucose 111 mg/dl, 10 units of insulin was administered by Nurse #3
11/03/24 at 4:00 PM blood glucose 115 mg/dl, 10 units of insulin was administered by Nurse #3
11/07/24 at 4:00 PM blood glucose 112 mg/dl, 10 units of insulin was administered by Nurse #3
11/15/24 at 4:00 PM blood glucose 109 mg/dl, 10 units of insulin was administered by Nurse #3
11/29/24 at 4:00 PM blood glucose 70 mg/dl, 10 units of insulin was administered by Nurse #3

Review of the progress notes from 11/01/24 through 11/29/24 for Resident #11 revealed no documentation that the insulin was held on the dates listed.

Review of the Medication Administration Record (MAR) dated December 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:

12/03/24 at 11:30 AM blood glucose 99 mg/dl, 6 units of insulin was administered by Nurse #6
12/22/24 at 4:00 PM blood glucose 98 mg/dl, 10 units of insulin was administered by Nurse #6
12/24/24 at 11:30 AM blood glucose 115 mg/dl, 6 units of insulin was administered by Nurse #3

Review of the progress notes from 12/03/24 through 12/24/24 for Resident #11 revealed no documentation that the insulin was held on the

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dates listed.

Review of the Medication Administration Record (MAR) dated January 2025 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:

1/03/25 at 11:30 AM blood glucose 107 mg/dl, 6 units of insulin was administered by Nurse #5
1/06/25 at 11:30 AM blood glucose 110 mg/dl, 6 units of insulin was administered by Nurse #3
1/10/25 at 4:00 PM blood glucose 110 mg/dl, 10 units of insulin was administered by Nurse #3
1/11/25 at 4:00 PM blood glucose 111 mg/dl, 10 units of insulin was administered by Nurse #3
1/27/25 at 4:00 PM blood glucose 109 mg/dl, 10 units of insulin was administered by Nurse #6
1/28/25 at 11:30 AM blood glucose 110 mg/dl, 6 units of insulin was administered by Nurse #5
1/28/25 at 4:00 PM blood glucose 109 mg/dl, 10 units of insulin was administered by Nurse #5

Review of the progress notes from 1/03/25 through 1/28/25 for Resident #11 revealed no documentation that the insulin was held on the dates listed.

During a phone interview on 3/14/25 at 10:30 AM Nurse #3 stated she routinely provided care to Resident #11. She stated during the medication pass you can't see the complete order in the electronic medication administration record if you don't left click twice on the medication order. She stated she needed to start paying closer attention

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to the order and look for insulin parameters. She stated that if she signed off on the Medication Administration Record that she administered Humalog when the blood glucose was less than 120 mg/dl that she did administer the insulin, but it was administered in error.

During a phone interview on 3/17/25 at 3:00 PM Nurse #5 stated she routinely provided care to Resident #11. She stated if she signed off on the Medication Administration Record that she administered Humalog when the blood glucose was less than 120 mg/dl then it was administered in error.

During a phone interview on 3/17/25 at 3:30 PM Nurse #6 stated if she signed off on the Medication Administration Record that she administered Humalog when the blood glucose was less than 120 mg/dl then it was administered in error.

During a phone interview on 3/14/25 at 9:00 AM Nurse Practitioner #1 stated she routinely evaluated Resident #11. She last evaluated Resident #11 on 2/19/25. She stated Resident #11 had no adverse reactions from receiving the Humalog outside of the parameters and had no excessive low blood sugars. She stated hypoglycemic reactions had higher morbidity and mortality rates which was why the parameters were ordered. She stated the Humalog should have been held when the blood sugar was less than 120 mg/dl.

During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated he was new to the facility as of February 2025. He stated he had not yet evaluated Resident #11, but Nurse

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MARY GRAN NURSING CENTER	120 SOUTHWOOD DRIVE CLINTON, NC 28329

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Practitioner #1 had evaluated him. He indicated there had been no reported decline or outcome regarding Resident #11 to him. He stated he expected that physician orders were followed, and the Humalog should have been held according to the order.

During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the insulin not being held according to the order when she reviewed the February 2025 monthly Pharmacy reports. She stated she was out on leave in December 2024 through the end of January 2025. She stated she educated all nursing staff in February 2025 on following medication orders and parameters. She stated further education to all nursing staff would be provided.

During a phone interview on 3/17/25 at 4:00 PM Unit Manager #1 stated she and Unit Manager #2 reviewed the monthly pharmacy reviews, and the Pharmacist addressed the insulin not being held according to parameters each month. She stated each month they determined who the Nurse was and educated each nurse that was identified. She stated she did not know at the time why the nurses continued to administer insulin outside of the parameters even after education had been provided. She stated they later thought it was due to not seeing the full order on the Medication Administration Record (MAR). She stated they would correct the order on the MAR.

b.) Resident #12 was admitted to the facility on 8/14/24 with diagnoses including diabetes with chronic kidney disease, and long-term use of insulin.

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A physician's order dated 12/27/24 for Resident #12 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 5 units subcutaneously before meals. Hold for blood glucose less than 120 mg/dl.

Review of the Medication Administration Record (MAR) dated January 2025 for Resident #12 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 5 units subcutaneously before meals. Hold for blood glucose less than 120 mg/dl and scheduled for administration at 8:00 AM, 11:00 AM and 4:00 PM. Humalog 5units was administered outside of the ordered parameters on the following dates and times:

1/04/25 at 11:00 AM blood glucose 84 mg/dl, 5 units of insulin was administered by Nurse #8
1/10/25 at 11:00 AM blood glucose 99 mg/dl, 5 units of insulin was administered by Nurse #3
1/19/25 at 11:00 AM blood glucose 110 mg/dl, 5 units of insulin was administered by Nurse #6
1/19/25 at 4:00 PM blood glucose 110 mg/dl, 5 units of insulin was administered by Nurse #6
1/31/25 at 4:00 PM blood glucose 106 mg/dl, 5 units of insulin was administered by Nurse #3

Review of the progress notes from 1/04/25 through 1/31/25 for Resident #12 revealed no documentation that the Humalog was held on the dates listed.

Review of the Medication Administration Record (MAR) dated February 2025 for Resident #12 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 5 units subcutaneously before meals. Hold for blood glucose less than 120 mg/dl and scheduled for administration at 8:00 AM, 11:00 AM and 4:00 PM. Humalog 5units was

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administered outside of the ordered parameters on the following dates and times:

2/11/25 at 8:00 AM blood glucose 116 mg/dl, 5 units of insulin was administered by Nurse #9

Review of the progress notes on 2/11/25 for Resident #12 revealed no documentation that the Humalog was held.

Review of the Medication Administration Record (MAR) dated March 2025 for Resident #12 revealed Insulin Lispro (Humalog) 100 units per milliliter. Inject 5 units subcutaneously before meals. Hold for blood glucose less than 120 mg/dl and scheduled for administration at 8:00 AM, 11:00 AM and 4:00 PM. Humalog 5units was administered outside of the ordered parameters on the following dates and times:

3/10/25 at 8:00 AM blood glucose 106 mg/dl, 5 units of insulin was administered by Nurse #6

Review of the progress notes on 3/10/25 for Resident #12 revealed no documentation that the Humalog was held.

During an interview on 3/13/25 at 4:50 PM Nurse #8 stated if she signed off on the Medication Administration Record that she administered Humalog to Resident #12 outside of the parameters then it was done in error.

During a phone interview on 3/14/25 at 10:30 AM Nurse #3 stated if she signed off on the Medication Administration Record that she administered Humalog when the blood glucose was less than 120 mg/dl then it was administered in error.

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During a phone interview on 3/16/25 at 4:00 PM Nurse #9 stated sometimes you can't see the complete order on the electronic Medication Administration Record. She indicated if she signed off on the Medication Administration Record that she administered Humalog when the blood glucose was less than 120 mg/dl then it was administered in error.

During a phone interview on 3/17/25 at 3:30 PM Nurse #6 stated if she signed off on the Medication Administration Record that she administered Humalog to Resident #12 when the blood glucose was less than 120 mg/dl then it was administered in error.

During a phone interview on 3/14/25 at 9:00 AM Nurse Practitioner #1 stated she routinely evaluated Resident #12. She last evaluated Resident #12 on 2/17/25. She stated Resident #12 had no adverse reactions from receiving the Humalog outside of the parameters and had no excessive low blood sugars. She stated the Humalog should have been held when the blood sugar was less than 120 mg/dl.

During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated he had not yet evaluated Resident #12, but Nurse Practitioner #1 had evaluated her recently. He indicated there had been no reported decline or outcome regarding Resident #12 to him. He stated he expected that physician orders were followed, and the Humalog should have been held according to the order.

During a phone interview on 3/17/25 at 3:30 PM the Consultant Pharmacist stated that she

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addressed the Humalog insulin parameters not being followed in her monthly pharmacy reports. She stated the facility did follow up on her recommendations each month and provided education to the nurses. She stated ongoing education on following medication parameters was needed.

6a.) Resident #3 was admitted to the facility hypertensive heart and chronic kidney disease.

A physician's order dated 1/07/25 for Resident # 3 revealed Clonidine 0.1 milligrams (mg). Take one tablet by mouth every 8 hours as needed for systolic blood pressure greater than 170 mm/Hg.

Review of Resident #3's electronic medical record revealed the following blood pressures were recorded:

1/13/25 at 5:03 AM blood pressure 198/81 mmHg documented by Nurse #10
1/22/25 at 8:29 AM blood pressure 193/76 mmHg documented by Nurse #4
1/22/25 at 5:41 PM blood pressure 174/77 mmHg documented by Nurse #4

Review of the Medication Administration Record (MAR) dated January 2025 for Resident #3 revealed Clonidine 0.1 mg was not administered at any time on 1/13/25, or 1/22/25.

Review of the progress notes dated 1/13/25 and 1/22/25 revealed no documentation that Clonidine 0.1 mg as needed was administered to Resident #3.

During a phone interview on 3/14/25 at 10:15 AM Nurse #4 stated she routinely provided care to

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Resident #3. She worked 7:00 AM until 7:00 PM on 1/22/25. She stated she was aware of the as needed Clonidine order. She stated she usually remembered to give Clonidine if his blood pressure was over 170 systolic. She stated she must have been busy on 1/22/25 and just forgot to administer the dose. She indicted she did not recall Resident #3 being symptomatic on 1/22/25. She stated she did not notify the physician of the elevated blood pressure.

During a phone interview on 3/17/25 at 1:40 PM Nurse #10 stated she was not aware Resident #3 had an as needed order for Clonidine. She stated she did not recall Resident #3 being symptomatic because she would have reported it to the Nurse Practitioner or Physician. She stated she should have administered the as needed Clonidine on 1/13/25 with a blood pressure of 198/81.

During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated he was new to the facility as of February 2025. He stated he had not yet evaluated Resident #3. He stated nothing had been reported to him regarding Resident #3 having a change in condition. He stated high blood pressures caused increased risk of heart attack or stroke. He stated if Resident #3 had Clonidine as needed for high blood pressure it should have been administered.

During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the Clonidine not being administered following the January Pharmacy review. She stated 1:1 education was provided to Nurse #4 and Nurse #10. She stated the as needed Clonidine should have been administered for elevated blood pressures. The facility protocol

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was to notify the physician if the systolic blood pressure was greater than 200 mmHg.

b.) Resident #13 was admitted to the facility on 4/19/23 with diagnoses including hypertensive heart disease with heart failure.

A physician's order dated 2/01/25 for Resident #13 revealed Clonidine 0.1 mg. Give one tablet every 12 hours as needed for hypertension and systolic greater than 160 and diastolic greater than 90 mmHg.

Review of Resident #13's electronic medical record revealed the following blood pressures were recorded:

2/04/25 at 1:28 PM blood pressure 168/92 mmHg documented by Nurse #2
2/08/25 at 1:38 PM blood pressure 180/101 mmHg documented by Nurse #2

Review of the Medication Administration Record (MAR) dated February 2025 for Resident #13 revealed Clonidine 0.1 mg was not administered at any time on 2/04/24 or 2/08/25.

Review of the progress notes dated 2/04/25 and 2/08/25 revealed no documentation that Clonidine 0.1 mg as needed was administered to Resident #13.

During an interview on 3/13/25 at 4:30 PM Nurse #2 stated she routinely provided care to Resident #11. She stated she was not aware of the as needed Clonidine order. She stated when she checked Resident #13's blood pressure on 2/04/25 and 2/08/25 she realized the blood pressure was high, but she knew he received

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other scheduled antihypertensive medications. She indicated Resident #13 was not symptomatic or she would have notified the Physician. She stated she would have administered the as needed Clonidine if she had seen the order.

During a phone interview on 3/14/25 at 2:00 PM the Medical Director stated nothing had been reported to him regarding Resident #13 having a change in condition. He stated the as needed dose of Clonidine should have been administered according to the order.

During an interview on 3/13/25 at 3:00 PM the Director of Nursing (DON) stated she was made aware of the Clonidine not being administered to Resident #13 following the February Pharmacy review. She stated 1:1 education was provided to Nurse #2. She stated the as needed Clonidine should have been administered for elevated blood pressures. She stated education would be provided to all nursing staff on medication administration and following ordered parameters.

During a phone interview on 3/17/25 at 3:30 PM the Consultant Pharmacist stated that she addressed the Clonidine for Resident #3 and Resident #13 in her monthly reviews in January and February 2025. She stated Clonidine was prescribed to lower blood pressure, it was absorbed rapidly, and onset was typically 30- 60 minutes. She stated the as needed Clonidine should have been administered according to the physician's order.