STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION				IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
345126			B. WING _	1	12/06/2018		
NAME OF PROVIDER OR SUPPLIER MOUNT OLIVE CENTER				STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
				228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 925 SS=E		est Control Program	FS	25		12/21/18	
	program so that the far rodents. This REQUIREMENT by: Based on observatio interview the facility far activity in the facility. The findings included Interview with cognitive residing in room #11 revealed she had see stated she would see or would come from u Resident #5 indicated aware of the insect the Interview with a famili- impaired Resident #3 A on 11:10am revealed family members room made the facility awa insects in Resident #3 Interview with cognitive resided in room #124 revealed commonly of room. She stated that them on her wind sea further indicated the f insects and would co- observed any.	vely intact resident #5 on 10/25/18 at 11:03am en insects in her room. She the insects in the bathroom underneath the door. d she had made the facility hat she had observed. y member of cognitively residing in room #124 bed ed he had seen insects in his h. He stated that he had re of his observation of		"This Plan of Correction is submitted as required by la submitting this Plan of Corr Olive Center does not admit deficiency listed on this forr does the Center admit to ar findings, facts, or conclusio the basis for the alleged de Center reserves the right to legal and/or regulatory or ar proceedings the deficiency, facts, and conclusions that for the deficiency." F925E While no specific resident w the deficient practice, the id had the potential to affect re staff. Problem areas identifi survey have been treated a monitored for effectiveness All residents have the poter affected by the deficient pra- goal to keep the facility as f possible. Routine pest com are scheduled and special of treatments will be arranged when pests are observed.	w. By ection, Mount t that the n exist, nor ny statements, ns that form ficiency. The challenge in dministrative statements, form the basis vas affected by lentified issue esidents and fied during the nd are being ntial to be actice. It is the ree of pests as trol treatments off-cycle as necessary		

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.

STATEMENT	OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
	345126		A. BUILDING B. WING				С
						12/06/2018	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
MOUNT OLIVE CENTER			228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	K	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 925	pest in her room (roo revealed room cleane treated by the outside Review of the facilitie correspondence report as "cockroach/rodent serviced were 104, 1 station 1 nurse station noted at the time of s indicated not cockroat the inspection and or summary for target p breakroom- interior, a Review of the facilitie correspondence report as "cockroach/rodent rodent or insect activity inspection and or ser indicated no cockroat the inspection and or ser indicated no cockroat the inspection and or summary for the targ- stated bathroom/lock interior and patient/gu Review of the facilitie correspondence report as Cockroach/rodent rodent or insect activity inspection and or ser for the target pest of bathrooms/locker, de area and maintenance			ar th m (C be so Id m w ar ar m M g c c th pr ac c th pr ac c th pr ac c th so c c th m W ar ar m M e so c th m W W W W W W W W W W W W W W W W W W	-house staff will spot treat problem reas as may be necessary. Addit the Center Executive Director (CEI net with the Director of Dining Ser DDS) to assure that dietary staff h een trained to report any pest sig to the issue can be promptly addred lentified problem areas will be clo nonitored. Dietary is completing a eek pest audit to monitor identified and to identify additional problem at the assures are effective. Additional laintenance staff in conjunction w eneral staff and the public are conducting audits 3 times per week proughout the building to assure at roblems are promptly identified and ddressed. Pest control issues will continue to be addressed in our da the addressed in our da the addressed in dur da the addressed in our da the	ionally, D) has vices ave htings essed. sely 5-day a d areas areas ly, ith c ny nd l ily staff otocols being ed daily d ed itely ly at the	

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	MENT OF HEALTH AN					FORM): 01/09/2019 MAPPROVED). 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345126		B. WING	_	C 12/06/2018					
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE				
MOUNT OLIVE CENTER			228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 925	for pest and deep cleat Interview with the fact on 12/5/18 at 2:05pm an outside agency for pest control agency p times a month but mo which insect activity is pest control was in the was told by the agence a list of rooms that ne residents or staff told activity he included the rooms to be serviced. previous employment recalled being directe wall so that pest control directly into the walls. were sealed following indicated that some o arise from residents the rooms. Observation of the face 2:37pm revealed larger medium sized insects sink/preparation table on the wall in a group had a bowl of raw shr Interview with dietary 2:40pm revealed she kitchen. She further r her supervisors. Interview with dietary	IVIDER OR SUPPLIER IVE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 for pest and deep cleaning by housekeeping. Interview with the facility Maintenance Assistant on 12/5/18 at 2:05pm revealed the facility utilized an outside agency for pest control. The outside pest control agency provided services at least 2 times a month but more often in instances in which insect activity is observed. He stated that pest control was in the building last week and he was told by the agency representative to provide a list of rooms that need to be sprayed. When residents or staff told him of instances of insect activity he included the concerns on the list of rooms to be serviced. He indicated that during a previous employment with the facility he had recalled being directed to drill holes in the kitchen wall so that pest control could put insecticide directly into the walls. He indicated the holes were sealed following pest control services. He indicated that some of the insect activity would arise from residents that have food items in their rooms. Observation of the facility kitchen on 12/5/18 at 2:37pm revealed large number of small and medium sized insects under a 2-compartment sink/preparation table. He insects were observed on the wall in a group. The 2-compartment sink had a bowl of raw shrimp sitting in water. Interview with dietary staff #1 on 12/5/18 at 2:40pm revealed she always saw insects in the kitchen. She further revealed she had notified			JEFICIENCY)				

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES					FORM OMB NC	0: 01/09/2019 APPROVED 0. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				(X3) DATE SURVEY COMPLETED C		
345126		B. WING				06/2018			
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE				
MOUNT OLIVE CENTER			228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE	
F 925	Maintenance Assistan revealed he was unaw underneath the 2-com table. He indicated it 60 insects under the 2 sink/preparation table During an interview an Dietician on 12/5/18 a had been discussed in was unware of the ins 2-compartment sink/p it appeared to be at le observed on the wall. they were coming from behind the wall or near During an interview an kitchen with the Direc 12/5/18 at 2:57pm rev complaints from resid insects in their rooms observed she indicate that the maintenance maintenance contact agency. Upon observe 2-compartment sink/p interview, the DON stan many insects to count aware the resident ha room, but she was un the kitchen. Interview with Housek	nd observation with the nt on 12/5/18 at 2:45pm ware of the insects npartment sink/preparation had appeared to be at least 2-compartment at 2:50pm revealed insects n morning meetings. She sects underneath the preparation table. She stated east a couple dozen insects She was unaware of where m but Indicted it could be arby floor drain. Ind observation of the facility tor of Nursing (DON) on vealed she did get ents in regard to seeing . When insects were ed it was her expectation be notified, and that the outside pest control vation underneath the preparation table during the ated that there were too t. She indicated she was ad seen insects in their naware of insect activity in	F	925					
	in the facility when sh	e performed cleaning he would step on them and							

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	-	D HUMAN SERVICES				FORM	0: 01/09/2019 APPROVED		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		345126	B. WING		_		C 06/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE				
				228 SMITH CHAPEL ROAD					
MOUNT OLIVE CENTER			MOUNT OLIVE, NC 28365						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 925	insects were coming f An observation and in was conducted on 12, revealed the facility di activity. He indicated director would supply in-between pest contr the insect activity. He the extend of the inse provided picture of the 12/5/18 underneath th sink/preparation table observation was mad two packages of chee preparation side of the sink/preparation table was observed in the 2 dietary manager state was preparing lasagn Observation undernea revealed a large num and some actively mo observed to be crawlii the 2 pans of spaghet open shredded chees Manager indicated it to foods be prepared un During an interview w at 1:00am revealed he by the Maintenance A insects located under sink/preparation table activity would come a the kitchen area during	1 revealed she though the from the walls. therview with Dietary Director /6/18 at 10:40am. He d have issues with insect the previous maintenance with him insecticide to use ol visit to aid in controlling e indicated he was unware of ct activity until he was e insects by the facility on he 2-compartment . During the interview an e of two pans of sauce and ese were observed on the e 2-compartment . A bowl of lasagna noodles 2-compartment sink. The ed the unnamed staff person a. ath the 2-compartment sink ber or insects. Some still oving. An insect was ing on the wall directly over ti sauce and 2 packages of i.e. The Dietary was his expectation that der sanitary conditions. ith pest control on 12/6/18 e received a call on 12/5/18 issistant in regard to the the 2-compartment he indicated that the insect ind go. He sated serviced ig the night when the kitchen	F 92		JEFICIENCY)				
	insects located under sink/preparation table activity would come a the kitchen area durin was not in service. H	the 2-compartment he indicated that the insect nd go. He sated serviced							

Facility ID: 923344

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		ID HUMAN SERVICES				FORM	APPROVED		
							0.0938-0391		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION JILDING			SURVEY LETED		
			A BOILDI			с			
		345126	B. WING						
NAME OF PI	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE						
	LIVE CENTER			228 \$	SMITH CHAPEL ROAD				
				MOUNT OLIVE, NC 28365					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF				PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION		
PREFIX TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE		
					DEFICIENCY)				
F 925	Continued From page		F 9	925					
	when food is delivere	d by vendors.							

Event ID: GYG411

Facility ID: 923344

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