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F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite 2/11/25 with additional information obtained remotely on 2/12/25. Therefore, the exit date was changed to 2/12/25. Event ID# M28S11. The following intake was investigated: NC00226985. 1 of the 2 allegations resulted in a deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews the facility failed to ensure cognitively intact residents who were assessed as unsafe smokers were supervised while smoking and did not have smoking materials in their possession for 2 out of 4 residents reviewed for smoking (Residents #1 and #2). Findings included: 1. Resident #1 was admitted to the facility on 3/16/21 with medical diagnoses which included Huntington's disease and ataxia (lack of muscle coordination and control). Resident #1's care plan updated on 8/25/23 revealed that he may smoke while supervised per	F 689	1. Current smoking evaluations were verified and up to date for resident #1 and resident #2 and updated smoking agreements completed on 2/13/2025 by the Director of Nursing/designee to ensure they are both aware of the facility's resident smoking procedures in regards to residents that are assessed as unsafe smokers. Resident #1 and Resident #2 rooms and persons have been inspected to ensure that neither of them have any smoking materials in their possession. None were identified. 2. On 2/13/2025 An audit was conducted by the Director of Nursing/designee on all other residents who smoke to ensure they	3/10/25

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

Electronically Signed | 02/24/2025

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F 689	Continued From page 1 the smoking evaluation due to a history of unsafe smoking habits. Interventions: Ensure that appropriate cigarette/e-cigarette device(s) disposal receptacles are available in smoking areas, lighters/lighter fluid or matches must be maintained by center staff, e-cigarette charging must occur at the nurses station, educate patient/health care decision maker on the facility's smoking policy, inform family and significant others that the patient needs supervision while smoking, inform and remind patient of location of smoking areas and times, monitor patients compliance to smoking policy, maintain patients smoking materials at nurses' station, and provide education/material regarding smoking cessation as needed and as resident will allow. A smoking evaluation dated 10/9/24 revealed that Resident #1 required supervision when smoking due to unsafe smoking habits (has a history of sharing/selling smoking material). Resident #1 was educated on the facility's smoking policy and outcomes of the smoking evaluation. Failure to comply with the smoking rules could result in termination of the smoking privileges and/or initiation of a discharge plan. The 12/16/24 quarterly Minimum Data Set (MDS) assessment revealed Resident #1 had no cognitive impairments and was independent with all activities of daily living (ADL). An incident report dated 12/22/24 at 6:39 PM and completed by the Nurse Supervisor revealed that Resident #1 inappropriately extinguished a cigarette with his shoe, and he had loose frayed jeans. Nurse Aide (NA) #4 observed Resident #1 standing in the smoking area alone. He did not have a cigarette in his hand, but she saw smoke	F 689	have been assessed as independent for safe smoking or if they have been assessed as an unsafe smoker. Smoking agreements were updated on all residents who smoke by the Social Worker to ensure they are educated on the facilities policy and procedure related to smoking to include storage of smoking materials. With permission, residents who smoke have had their room and person inspected to ensure no residents are in possession of any smoking materials. No issues identified as a result of the audit. 3. The Director of Nursing / Designee will provide education to facility staff by 3/10/25 to ensure staff have been educated on the facilities policy related to resident smoking as it relates to ensuring supervision is present for those residents who have been assessed as an unsafe smoker as well as ensuring that no residents have possession of any smoking materials. Any staff not educated in this timeframe will receive education prior to their next scheduled shift. All newly hired staff to include new agency staff will be educated in new hire orientation to ensure they have been educated on the facilities policy related to resident smoking as it relates to ensuring supervision is present for those residents who have been assessed as an unsafe smoker as well as ensuring that no residents have possession of any smoking materials. 4. Quality monitoring will be conducted by the Director of Nursing / Designee 3 times	

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F 689	Continued From page 2 and flames at the bottom of his pants and shoes. The flames were around the bottom 1 inch hem of his pants that were noted to be ragged and frayed. NA #4 stomped out the pants that were dragging on the ground and Resident #1 was trying to assist. NA #4 saw a smoldering cigarette on the ground and extinguished it with her foot and took Resident #1 inside. NA #5 was noted to come up the hall and accompanied Resident #1 back to his room. NA #5 noted some additional smoke and tossed a cup of water from Resident #1's bedside onto the hem area of his pants. NA #5 assisted Resident #1 with removal of his pants, shoes, and socks as NA #4 went to get the nurse. The shoe heels were damaged and the hem of his pants. There were no obvious signs of injury. The Nurse Supervisor entered the room, assessed Resident #1, and did not identify any trauma. As NA #5 was assisting Resident #1 looking for socks, she discovered approximately 30 lighters. NA #5 notified Nurse #3 lighters. The lighters were confiscated and locked up for safekeeping. A skin assessment was completed by (Nurse #3) and there were no injuries noted. (Resident #1) also denied injuries. The Maintenance Assistant entered the building at 6:55 PM to verify safety measures were in place. There was a fire blanket and an updated fire extinguisher available in the smoking area. The ashtrays were emptied, and the red smother can was available. A nursing progress note dated 12/22/24 at 8:58 PM by the previous DON revealed #1 had on frayed, loose jeans and inappropriately extinguished a cigarette using his shoe instead of the designated area. Resident #1 was noted by Nurse Aide (NA) #4 to have a small flame coming from bottom of his right pant leg. When the flame	F 689	a week for 4 weeks, then 2 times a week for 4 weeks then 1 time a week for 4 weeks on 10 residents who smoke to ensure that all residents who have been assessed as an unsafe smoker are supervised during smoking times and that no incidents have occurred while supervised smoking has taken place. Quality monitoring will be conducted by the Director of Nursing / Designee 3 times a week for 4 weeks, then 2 times a week for 4 weeks then 1 time a week for 4 weeks on 10 residents who smoke to ensure that residents do not have smoking materials in their room or in their possession. Quality monitoring will be conducted by the Administrator / Designee weekly x12 weeks by meeting with the smoking residents to go over any issues/concerns. The results of the quality monitoring will be brought to the monthly Quality Assurance meeting to ensure compliance of resident safety x 3 months. The improvement-monitoring schedule will be modified based on the findings of monitoring.	

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was observed, per staff, NA #4 extinguished the flame immediately for safety. Nursing performed a head-to-toe assessment with no noted injuries.

A skin check assessment dated 12/22/24 of Resident #1 revealed that he had no skin issues, and a foot evaluation was completed.

During a phone interview with Nurse #3 on 2/12/25 at 10:46 AM, she revealed that on 12/22/24 NA #4 reported that she had seen Resident #1 out in the smoking area with his pants on fire. He was then accompanied back to his room by the NA #4 and NA #5. Nurse #3 stated that she then notified the Nurse Supervisor, and both went to evaluate him. She was told by NA #5 that Resident #1's pants were still singed when she attempted to take his pants off. There were no injuries, burns, or open skin areas. Resident #1 was then put on 1:1 supervision for the rest of the day without being able to go outside to smoke. He then needed to be evaluated by the previous DON to be cleared for future smoking activity. Nurse #3 stated that there was a "mass number" of lighters in his room, which were collected and put in a secure area for the previous DON to review. Nurse #3 indicated that she had worked at the facility as a short contract agency nurse and could not speak to Resident #1's past. She believed that he was a supervised smoker prior to 12/22/24.

A phone interview attempt was made with NA #4 to discuss the events on 12/22/24, however, the NA was unable to be reached during the investigation.

NA #5 was interviewed via telephone on 2/12/25 at 3:54 PM. She revealed that Resident #1signed

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himself out of the building on 12/22/24. He returned to the facility, went to the smoking area, and NA #4 noticed that his pants were on fire. NA #4 brought him back in the facility, and NA #5 helped escort him to his room. That was when she noticed that his pant leg was still partially on fire. NA #4 went to notify the nurse. She noticed that Resident #1 was not acting right, and with Resident #1's permission, she looked through his drawers for socks and found around 20 lighters. Before the event on 12/22/24, she just assumed Resident #1 was an unsupervised smoker because she saw him in the smoking area on his own many times before. There was a list of smokers located with the smoking materials bin that was updated multiple times, but she could not provide a when the last time it was updated.

A phone interview was conducted with the Nurse Supervisor on 2/12/25 at 4:03 PM. She revealed that on 12/22/24, NA #4 notified her Resident #1 was smoking and he was on fire, which she had to put out. When the Nurse Supervisor asked Resident #1 about the incident, he said that he could not remember he was smoking and on fire. In his room, he had a lot of lighters that were confiscated. She explained that he often left the facility and went to the store. She was also told by NA #4 and NA #5 that his pant leg was still smoking when he was brought inside the facility. His pants were taken off, and she performed a skin check without any injuries noted. Resident #1 was then put on 1:1 supervision.

Resident #1 was interviewed via telephone on 2/12/25 at 11:31 AM. He stated that about a month ago, his pants caught on fire when he was outside in the smoking area and that was when his smoking privileges were reduced to being

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supervised.

During an interview with the Assistant Administrator on 2/12/25 at 2:58 PM, she revealed that a staff member (unknown) contacted her on 12/22/24 about Resident #1's pants were on fire. She came to the facility to assess the situation. The Assistant Administrator stated that she had observed Resident #1 was not injured or harmed. Maintenance came out the same day to evaluate the safety of the smoking area, and Resident #1 was also educated. Resident #1 was a supervised smoker at the time of the 12/22/24 incident. The Assistant Administrator could not say how Resident #1 retrieved a lighter or cigarette. Resident #1 would leave the facility and go to the store, and what he purchased was unknown. Resident #1 was alert and oriented and was considered an unsafe smoker prior to 12/22/24 due to the history of sharing cigarettes.

A phone interview was conducted with the previous DON on 2/12/25 at 11:57 AM, and she revealed that on 12/22/24 Resident #1 was outside in the smoking area, and he put a cigarette out with his foot. She stated that the bottom of his jeans was frayed. A staff member was not outside with him in the smoking area at the time. After that day, Resident #1 was then determined to be a supervised smoker. The previous DON indicated that she was unaware Resident #1 was a supervised smoker since 10/23/23.

The previous interim Administrator was interviewed via telephone on 2/12/25 at 12:21 PM. He revealed that he heard what had happened with Resident #1 on 12/22/24 from the

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Assistant Administrator. She told him that a bag of lighters were found in Resident #1's room during the search. She told him that the fringe on his pants caught fire when he was putting out a cigarette in the outside smoking area. The previous interim Administrator could not recall whether Resident #1 was a supervised or unsupervised smoker prior to 12/22/24. All other details related to this incident; the previous interim Administrator stated that he could not recall. He indicated that he came in "on the tail end" of the situation and nursing performed all necessary research on the issue.

During an interview with the Administrator on 2/12/25 at 5:05 PM, he revealed that Resident #1 was smoking unsupervised and retained smoking materials from an unknown source. Resident #1 should not have received any smoking materials from any source, and he should have been supervised while out in the smoking area during a designated smoking time.

2. Resident #2 was admitted to the facility on 5/7/19 and readmitted to the facility on 11/4/24 with medical diagnoses which included chronic obstructive pulmonary disease (COPD), congestive heart failure, and absence of right and left fingers.

Resident #2's 01/12/23 care plan revealed that he acted in a problematic way by inappropriate smoking related to decreased safety awareness. The smoking interventions included: Nursing staff to assist resident to the designated smoking area during established/predetermined facility smoking times, not to leave resident unattended while smoking, supervise resident while smoking, document episodes of inappropriate smoking or

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potential smoking policy violations and report observations to Administrator and/or administrative staff, place smoking materials at nurses' station for storage, provide resident education on smoking policy, and provide a smoking apron for resident.

The smoking evaluation dated 10/9/24 for Resident #2 revealed that he was an unsafe smoker and required direct supervision while smoking. He was re-educated on the smoking policy and was given a copy of the policy.

The 11/11/24 significant change Minimum Data Set (MDS) assessment revealed Resident #2 had no cognitive impairments, had impairment on both sides of the upper limbs, and used a walker as a mobility device. He was also coded with current tobacco use.

An incident report dated 1/8/25 at 1:45 PM completed by Nurse #1 revealed that Resident #2 came to Nurse #1 to re-wrap the bandage on his left hand. The bandage was visibly burnt. There was no damage to the skin, no burns, redness, or open areas noted. Resident #2 stated that he was outside smoking. He was not smoking during supervised smoking times, and no staff were there monitoring him. Resident #2 stated: "It's no big deal." Resident #2 did not have any fingers on either hand.

Nurse #1 was interviewed via telephone on 2/11/25 at 12:00 PM. She revealed that on 1/8/25 around 1:00 PM, she was walking down the hallway and noticed Resident #2's left hand bandage was burnt. Resident #2 asked Nurse #1 to change his bandages, which were covered by self-adherent wrap. He told her that he was

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outside smoking and dropped ashes on the bandage. He said it was no big deal, and he was reminded that he could not smoke unsupervised. Nurse #1 asked Resident #2 to come back to the unit where she was assigned, so that she could rewrap his hands. Resident #2 then went to Nurse #2 to rewrap the bandages. Only the left hand self-adherent wrap was burnt, and the right bandage looked like it was chewed. There were no injuries noted to either hand. Nurse #1 then notified the previous Director of Nursing (DON) and the previous interim Administrator about Resident #2's bandages and smoking unsupervised. She did not observe who gave or lit Resident #2's cigarette, but he told her that Resident #2 lit the cigarette for him. Nurse #1 indicated that supervised smokers get their cigarettes from a locked bin at nurses' station 3 behind a locked door. The assigned NA at each designated smoking time usually brought the bin outside, and the supervised smokers got one cigarette at a time. She was unsure about the process for unsupervised smokers, but only supervised smokers went out at the designated times.

Resident #2 was interviewed on 2/11/25 at 1:05 PM, and he revealed that he did not smoke outside without being supervised on 1/8/25. He was outside with staff and when he ashed his cigarette, it singed his bandage and he could not feel it due to neuropathy. He said he did not get the cigarette from a resident, and he received it from staff during a designated smoking time.

Attempts to interview by phone Nurse #2 were made, but he was unable to be reached during the investigation.

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NA #1, who was assigned to the smoking area at 7:30 AM on 1/8/25, was interviewed via telephone on 2/11/25 at 1:45 PM. She heard about the incident on 1/8/25 when Resident #2 was outside, someone caught him, and his bandage was singed. She had no idea how he got the cigarette or who lit it for him.

NA #2, who was assigned to the smoking area at 10:30 AM on 1/8/25, was interviewed via telephone on 2/11/25 at 1:10 PM. He stated he was unaware that Resident #2 was smoking unsupervised on 1/8/25. There was a list of smokers on the smoking bin that held the cigarettes. Cigarettes were dispersed 1 at a time during designated smoking times, so that residents did not have any smoking materials in their possession. NA #2 stated he assisted the supervised smokers as needed, but he had never seen Resident #2 smoke on his own.

NA #3, who was assigned to the smoking area on 1/8/25 at 2:30 PM, was contacted via telephone during the investigation, but she did not return the call.

An interview with the Assistant Administrator was conducted on 2/11/25 at 11:18 AM. She revealed that she was called to the facility by a staff member (unknown) on 1/8/25 around 1:00 PM and reported that Resident #2 was outside smoking unsupervised. His hands were wrapped with bandages, he had no fingers, and he held the cigarette in between his palms. Resident #2 was supposed to use a special apparatus to assist him with smoking. After she arrived at the facility, she met with Resident #2. It looked like there was a small, singed area on one of his dressings (left), but she did not observe any open

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areas or exposure of any skin. The Assistant Administrator asked Resident #2 about the smoking incident earlier that day, but he could not remember who gave him the cigarette or who lit it for him. When she asked him why he went out on his own, he did not give any explanation and shrugged his shoulders and said: "I won't do it again." The Assistant Administrator stated that she spoke to other residents outside, including Resident #1, and they stated they did not give Resident #2 a cigarette nor did they light it for him. It was explained to Resident #2 that due to his willful neglect of the smoking policy, his smoking privileges would be revoked, or he would be given a 30-day discharge notice if he were caught smoking unsupervised again. The Assistant Administrator stated that she, the previous interim Administrator, and previous DON spoke with Resident #2 and his family member on a conference call about his failure to abide by the smoking rules. The family member urged Resident #2 to follow the rules. The Assistant Administrator further stated, to her knowledge, that Resident #2 did not previously smoke unsupervised. However, in the past, he handed out cigarettes to other residents and refused to wear the smoking apron.

The previous DON was interviewed via telephone on 2/11/25 at 12:37 PM. She revealed that she was out of the building on 1/8/25. She stated that Nurse #1 notified her about what happened on 1/8/25 when Resident #2 was allegedly caught smoking unsupervised without the required adaptive smoking device. She was involved on the phone during the conference call with Resident #2's family member after he was found smoking unsupervised on 1/8/24. The Assistant Administrator warned Resident #2 about the

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30-day discharge notice because Resident #2 was caught smoking unsupervised. She could not recall how Resident #2 got the cigarette or lighter, but stated it was probably from one of the unsupervised smokers. The previous DON indicated that the smoking materials were kept locked up at nurses' station 3. There were bins that held smoking materials for all smokers, including unsupervised smokers, and were labeled with the residents' names. She believed Resident #2's unsafe smoking habits were related to him not having any fingers, otherwise, she was not aware of any other unsafe smoking habits.

During a follow-up phone interview with the previous DON on 2/12/25 at 10:23 AM, she recalled that when Resident #2 was asked how he got the cigarette and lighter on 1/8/25, he said he found them on the ground. Often the smokers said "I don't remember" to any incriminating question related to smoking because they chose not to "snitch" on each other. Cameras were installed at the smoking area a week before she left the facility, which was 2/6/25.

The previous interim Administrator was interviewed via telephone on 2/11/25 at 12:53 PM. He revealed that he could not recall the incident involving Resident #2 on 1/8/25. He stated that Resident #2 could smoke, but he needed an apparatus to assist that could fit in his hand. The previous interim Administrator indicated that the Assistant Administrator handled all situations with the smokers.

During an interview with the Administrator on 2/12/25 at 5:02 PM, he revealed that Resident #2 was smoking unsupervised on 1/8/25 and retained smoking materials from an unknown

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	C 02/12/2025

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	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 689	Continued From page 12 source. He stated that Resident #2 should not have held smoking materials from any source, and he should have been supervised while out in the smoking area during a designated smoking time.	F 689		