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 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted on 3/18/25 through 3/20/25. Event ID# RZIZ11. The following intakes were investigated: NC00228309, NC0027833, NC00227797, NC00226905, NC00226709, NC00226728, NC00226561, NC00226659, NC00226503, NC00225859, NC00225097, NC00224729, NC00224406, NC00224383. 3 of the 25 allegations resulted in a deficiency.	F 000		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, Nurse Practitioner (NP), surgical specialist's staff and Medical Director interviews, the facility failed to administer the bowel preparation (the process of cleaning out the intestines) on two separate occasions. The first was for a scheduled colonoscopy (an exam used to look for changes in the large intestine) on 12/17/24 and the second was for a limited sigmoid colon (part of the large intestine that is close to the rectum) resection (the process of cutting out tissue or part of an organ) for a "suspicious" colon polyp (small growths on the lining of the large intestine)	F 684	1. Resident #4 has been scheduled for a new colonoscopy at Wayne UNC Endoscopic Center on 03/28/25 at 8:15am. Bowel preparation completed on 3/27/25 per physician order for resident # 4 2. On 3/21/25, the Director of Nursing / Designee conducted an audit of all outside appointments for all procedures from the past 90 days to ensure all pre-procedure instructions were followed as outlined per physician□s order. No	4/2/25

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

Electronically Signed | 03/27/2025

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F 684	Continued From page 1 scheduled on 2/24/25. Review of the hospital discharge summary dated 2/24/25 revealed Resident #4 was placed under general anesthesia and the abdominal incisions had been made when the surgeon observed the colon was full of stool and aborted the surgery. The incisions were closed with sutures and a liquid topical skin adhesive and the resident returned to the facility. Resident #4 will require another colonoscopy before the surgery can be rescheduled. This was for 1 of 3 residents reviewed for professional standards in the provision of medical care (Resident # 4). The findings included: Resident #4 was admitted to the facility on 10/17/24 with diagnoses which included gastrointestinal hemorrhage, benign neoplasm of colon, peptic ulcer, and colon polyp. Review of Resident #4's consultation report dated 12/5/24 completed by the Gastroenterologist (a medical doctor who specializes in the treatment of the gastrointestinal tract) revealed a recommendation for a colonoscopy and provided the bowel preparation orders with instructions. Review of Resident #4's quarterly Minimum Data Set (MDS) dated 1/23/25 revealed Resident #4 as cognitively intact. a. Review of Resident #4's physician orders dated 12/10/24 revealed the following: - Colonoscopy scheduled on 12/17/24 - Resident nothing by mouth (NPO) after midnight on 12/16/24 - On 12/16/2024: Add water to the "Fill To" level mark of the prep container. SHAKE until	F 684	additional negative findings as a result of the audit. 3. On 3/21/25, the Nurse Practice Educator / Designee conducted education with nursing staff (FT, PT, PRN and Agency) on the pre-procedure instructions as outlined per physician□s orders in order to ensure accurate transcription of the orders to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person - centered care plan and the residents choices. On 03/21/25, the Transportation Aide / Medical Record Clerk was educated to ensure all post appointment consults and orders are given to the resident□s nurse for follow-up of any pre-procedure and post-procedure instructions to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person - centered care plan and the residents choices. All newly hired nursing staff to include new agency staff will be educated on the pre-procedure instructions as outlined per physician□s orders in order to ensure accurate transcription of the orders to ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person - centered care plan and the residents choices. The completion date of staff education is 4/1/25. 4. Effective 3/21/25, the Director of	

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F 684	Continued From page 2 everything is completely dissolved. Okay to add Crystal Light flavoring to the solution. When reconstituted, the solution should be used within 48 hours. Starting at 5:00pm, rapidly drink 8 ounces every 20 minutes UNTIL ALL THE SOLUTION IS GONE. Continue drinking clear liquids until bedtime - At 6:00 pm on 12/15/24 mix 2 capfuls of Polyethylene Glycol in 16 ounces of liquid and drink every 5 to 10 minutes. Take 2 Bisacodyl tablets. - At 7:00 pm on 12/15/24, mix 2 capfuls of Polyethylene Glycol in 16 ounces of liquid and drink over 5 to 10 minutes. Take 2 Bisacodyl tablets. - Clear liquid diet the day before procedure (No solid foods) Review of Resident #4's Medication Administration Record (MAR) for December 2024 revealed the follow: - bowel preparation to be given on 12/16/24 at 5:00 was not initialed as administered - bowel preparation to be given at 6:00 pm on 12/15/24 had an "X" in the signature block was not administered. - bowel preparation to be given at 7:00 pm on 12/15/24 was not entered on the MAR for administration - nothing by mouth (NPO) order showed a start date of 12/17/24 on December MAR A progress noted dated 12/17/24 completed by the previous Director of Nursing (DON) revealed Resident #4 was unable to attend the colonoscopy appointment scheduled for 12/17/24 because he drank a ½ can of soda and had not completed the bowel preparations. The previous DON called the provider's office to get the	F 684	Nursing / Designee will utilize the whiteboard in the morning clinical meeting to discuss and review all upcoming appointments as well as to review previous appointments to ensure that no orders / follow up appointments are missed being transcribed to the MAR and to ensure accuracy. Quality monitoring will be conducted 5x a week for 12 weeks On 3/21/25, the Administrator conducted an ADHOC QAPI meeting in collaboration with the Medical Director to review the deficient practice and to review the plan of correction. The Administrator / designee will review the quality monitoring reports in the monthly quality assurance meeting x 3 months. Subsequent plans of corrections and increased monitoring to ensure compliance with the plan of correction will be conducted as required.	

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F 684	Continued From page 3	F 684		

procedure rescheduled. The procedure was rescheduled for 1/7/25. It was noted the provider would send new prescriptions for the bowel preparations needed for the colonoscopy procedure.

During a phone interview with the previous DON on 3/20/25 at 9:33 am, she stated she was made aware this incident on 12/17/24 by Nurse #1. Nurse #1 first reported to the previous DON that Resident #4 did not have orders for bowel preparations but later admitted that she did not give the bowel preparations to Resident #4. The previous DON further explained she called the provider's office and rescheduled the colonoscopy and notified Resident #4's family of the situation.

Attempts were made to interview Nurse #1 via phone but were unsuccessful. Nurse #1 no longer worked at the facility.

During an interview with the Nurse Practitioner (NP) on 3/19/25 at 10:36 am, she stated she reviewed and approved Resident #4's 12/5/24 gastroenterology consultation report on 12/6/25. The NP further stated the consultation report included the bowel preparation orders for the scheduled colonoscopy on 12/17/24 and expected the nursing staff to administer the bowel preparation for Resident #4 prior to his colonoscopy scheduled on 12/17/24.

b. Review of Resident #4's consultation note dated 1/16/25 completed by the Gastroenterologist revealed a colon polyp that was eating into the colon lining and a referral to a surgeon for a partial colectomy (surgical procedure where part of the large intestine is

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	345126	A. BUILDING _____ B. WING _____	C 03/20/2025

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F 684	Continued From page 4	F 684		

removed) was recommended.

Review of Resident #4's surgical consultation note dated 1/29/25 completed by the surgeon revealed the colonoscopy was completed on 1/7/25 and revealed a 20 cm (centimeter) x 15 cm polypoid lesion (small, raised growth that protrudes from the lining of an organ or cavity such as the intestines) that was very suspicious for adenocarcinoma (a type of cancer that starts in the glands that line the organs). The surgeon's assessment and plan was Resident #4 required a limited sigmoid colon (part of the large intestine that is close to the rectum) resection (the process of cutting out tissue or part of an organ). The date for the surgery and the bowel preparation instructions were not included on the consultation report dated 1/29/25.

Review of Resident #4's physician order dated 2/5/25 revealed an order for nothing by mouth (NPO) after midnight on 2/23/25 for surgery scheduled on 2/24/25.

During an interview with the Scheduler on 3/18/25 at 3:20 pm, she stated she did not remember when Resident #4 returned from his surgical consultation appointment on 1/29/25. She further stated she did not receive any paperwork from the surgeon's office from Resident #4. The Scheduler indicated she reviewed the consultation report and the consultation report did not note any bowel preparation orders. She further indicated she did not recall receiving any telephone orders from the surgeon's office. The Scheduler did not follow up with the surgeon's office to inquire if any paperwork had been given to Resident #4.

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F 684	Continued From page 5	F 684		

An interview was conducted with Medication Aide #1 on 3/18/25 at 1:30 pm. Medication Aide #1 explained she worked on 1/29/25 and remembered Resident #4 going to his appointment. Medication Aide #1 did recall if Resident #4 returned from his appointment with any paperwork. She further stated if Resident #4 had returned with any paperwork she would have given the paperwork to Unit Manager #1.

A phone interview with Unit Manager (UM) #1 was conducted on 3/18/25 at 6:38 pm. UM #1 stated she was not employed at the facility during January 2025.

During an interview with Resident #4 on 3/19/25 at 9:05 am, he stated he did not remember his appointment on 1/29/25 and does not remember if he was given any instructions at that appointment. Resident #4 further stated he did not have any fears of returning to the hospital for the surgical procedure.

Review of the Nurse Practitioner's (NP) note dated 2/4/25 revealed Resident #4's surgery was scheduled for 2/14/25 but was rescheduled to 2/24/25 for a robotic (surgical technique that uses a computer-controlled system of robotic arms to assist surgeons) sigmoid colon resection. The NP's note documented Resident #4's current orders were reviewed.

During an interview with the Nurse Practitioner (NP) on 3/19/25 at 10:36 am, she stated she did not know why the surgery date changed from 2/14/25 to 2/24/25. The NP indicated she did not remember receiving or seeing any bowel preparation orders for Resident # 4's surgery scheduled on 2/24/25. The NP further stated the

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F 684	Continued From page 6	F 684		

Scheduler emailed her on 2/5/25 and requested an order for NPO for Resident #4 after midnight on 2/23/25 and she entered the order in the computer. When asked why she did not question if Resident #4 needed bowel preparations prior to the surgery scheduled on 2/24/25, the NP explained she felt it was the surgeon's office responsibility to follow up with the facility about bowel preparations needed prior to the surgery.

Review of Resident #4's February 2025 Medication Administration Record (MAR) revealed no order for nothing by mouth (NPO) for 2/23/25.

A progress note dated 2/21/25 completed by the Scheduler documented the family was made aware of Resident #4's surgery was scheduled for 2/24/25 for a colon polyp removal and Resident #4 would be held overnight for observation.

During a phone interview with UM #2 on 3/19/25 at 7:42 pm, she stated she was not employed at the facility in January 2025. UM #2 further stated she started working at the facility in February 2025. The UM #2 indicated she never received any bowel preparation instructions for Resident #4 for his scheduled surgery on 2/24/25. She does not know for sure if UM #1 was given the paperwork from this appointment or if Resident #4 received any paperwork. The UM #2 indicated she did not follow up with the surgeon's office.

A progress note dated 2/24/25 at 9:11 am completed by UM #1 documented she received call from the general surgeon who inquired if Resident #4 had received bowel preparation prior to the procedure this morning. She notified provider that an order was not received from his

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F 684	Continued From page 7	F 684		

office to give bowel preparation and Resident #4 did not receive a bowel prep.

A phone interview with Unit Manager (UM) #1 was conducted on 3/18/25 at 6:38 pm, she stated Resident #4 did not have an order for bowel preparation for scheduled surgery on 2/24/25. She did not follow up with surgeon's office to inquire about any bowel preparation instructions.

A progress noted dated 2/24/25 at 3:44 pm completed by UM #1 documented Resident #4 returned from hospital from having laparoscopy procedure on the right side of abdomen; noted with 5 surgical wounds closure with glue. The areas were noted with mild redness, no discharge, no swelling. Resident #4 denied nausea and rated his pain a 5 out of 10. UM #1 called the surgical center to receive surgical discharge orders due to no paperwork received on return. Resident #4's vitals signs were within normal limits.

Review of the surgical discharge summary dated 2/24/25 revealed the information was faxed to the facility at 1:27 pm which included the instructions for medication changes and post operative instructions for general anesthesia care and laparoscopy care instructions. The NP initialed she received and reviewed this discharge summary at 3:00 pm on 2/24/25.

During an interview with the Surgical Specialist's nurse on 3/19/25 at 8:15 am, she stated she remembered Resident #4 and indicated the standardized list of instructions which included bowel preparation instructions was given to Resident #4 at this consultation appointment scheduled on 1/29/25. The Surgical Specialist's

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F 684	Continued From page 8	F 684		

nurse further explained that these standardized instructions were given to Resident #4 even though the surgery had not been scheduled on the day of his appointment.

During an interview with the Surgical Specialist's scheduler on 3/19/25 at 11:33 am, she stated Resident #4 was given the standardized surgical instructions which included bowel preparation instructions on 1/29/25 at his surgical consultation visit. She further stated the surgical procedure could not be completed on 2/24/25 because the tattoo ink markings (temporary or permanent ink marks placed in the colon to help surgeons locate specific areas or lesions during procedures) were not visible, and Resident #4 had not completed the bowel preparation prior to the surgery. The surgery had not been rescheduled according to the surgeon's office and Resident #4 would need another colonoscopy prior to scheduling the second surgery.

Review of the hospital discharge summary dated 2/24/25 completed by the general surgeon revealed Resident #4 was placed under general anesthesia, urinary catheter placed, arterial line in left arm placed, abdominal incisions made for placement of robotic arms. The summary further revealed no evidence of any tattoo ink markings visible and noted the colon was full of stool. The general surgeon called the facility and inquired if Resident #4 had received bowel preparations over the weekend as had been ordered by surgeon's office and was informed Resident #4 did not have bowel preparations. The procedure was aborted at that time. The instruments were removed from the abdomen. The abdomen was cleaned and dried and incisions were closed with suture and Dermabond. Resident #4 returned to

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F 684	Continued From page 9	F 684		

the facility.

An attempt to interview the general surgeon on 3/19/25 was unsuccessful as he was out of the office on vacation.

During an interview with the Director of Nursing (DON) on 3/20/25 at 11:45 am, she stated she has been employed at the facility since 2/13/25. The DON stated she was aware of the surgery scheduled for Resident #4 and offered the explanation of a communication breakdown as to why Resident #4 did not receive the bowel preparation prior to the surgery. The DON further stated going forward that any resident going out for an appointment, the facility will look at the cognitive level of the resident and make a decision if the resident needs a staff member to accompany them to the appointment. The DON indicated that she would meet with the Scheduler after the outside appointments and discuss any information and/or orders received. She stated her expectations of the nursing staff were to follow the provider's orders and follow up or ask questions with the provider's offices in regard to any paperwork and/or instructions given to the residents. The DON further indicated discussions with the nursing staff pertaining to the importance of documentation would be done.

During an interview with the Assistant Administrator on 3/20/15 at 12:15 pm, she stated the consultation paperwork was sent with Resident #4 with preoperative instructions but did not have the bowel preparation instructions. The Assistant Administrator further stated the general surgeon's office called the facility and gave the bowel preparation instructions to the Scheduler but was unsure what happened with those bowel

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F 684	Continued From page 10	F 684		

preparation instructions. The Assistant Administrator explained her expectations of the nursing staff were to follow up with the provider's offices to ensure instructions were given and followed.

In a phone interview with the Medical Director on 3/20/25 at 1:41 pm, he stated he was aware that Resident #4 needed to have a colon polyp removed and was scheduled for surgery. The Medical Director was unaware the surgical procedure could not be completed due to Resident #4 not having his bowel preparations prior to the surgery. The Medical Director further explained that he expected the nursing staff to follow up with provider's offices on any instructions given to the residents but especially with any colonoscopy or procedures which involved the colon a bowel preparation would need to be completed and the nursing staff should have followed up with the general surgeon's office.