DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
E0000	Initial Comments The survey team entered the facility on 9/14/25 to conduct a recertification and complaint investigation survey and exited on 9/19/25. Additional information was obtained on 9/22/25 and 10/1/25. Therefore, the exit date was changed to 10/1/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D6477-H1.	E0000		10/13/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 9/14/25 to conduct a recertification and complaint investigation survey and exited on 9/19/25. Additional information was obtained on 9/22/25 and 10/1/25. Therefore, the exit date was changed to 10/1/25. The following intakes were investigated: 3 of the 26 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 09/15/25 and was removed on 9/20/25. An extended survey was conducted.	F0000		10/13/2025
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints	F0605	Resident #75 and Resident #1 receive anti-psychotic medication. The Abnormal Movement Scale (AIMS) scales completed on 9/22/25 by the Director of Nursing to assess potential adverse medication reaction. An audit was conducted on 10/14/25 on current residents to identify residents that receive anti-psychotic medications that would require an Abnormal Involuntary Movement Scale (AIMS) to assess for potential adverse medication reactions by the Nurse Managers to ensure that their AIMS scales were current. Any discrepancies identified were corrected at the conclusion of the	10/23/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0605 SS = E	Continued from page 1 imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or	F0605	Continued from page 1 audit. The Regional Director of Nursing educated the Director of Nursing and the Nurse Managers on 10/14/25 on the importance of completing the Abnormal Involuntary Movement Scales per facility policy to monitor for adverse side effects of medications that can cause abnormal movements. The Director of Nursing and/or a nurse manager will educate all licensed nurses regarding the importance of conducting AIMs assessments per policy by 10/22/25. Newly hired Directors of Nursing, Nurse Managers or Licensed Nurses will have this same education upon hire during their orientation period. Additionally, this education will be provided to agency licensed nurses prior to their working on the floor. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 4 weeks to ensure AIMS assessments are completed and current. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education. COMPLIANCE DATE: 10/23/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0605 SS = E	Continued from page 2 (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by:	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0605 SS = E	Continued from page 3 Based on record reviews and interviews with staff and the facility Consultant Pharmacist, the facility failed to provide ongoing Abnormal Involuntary Movement assessments to assess for potential adverse medication reactions for 2 of 3 residents (Residents #75 and #1) reviewed for receiving antipsychotic medications. The findings included: 1. Resident #75 admitted to the facility on 08/21/24 with diagnoses including depression with psychosis. Resident #75's physician's order dated 10/25/2024 documented a revision of Quetiapine Fumarate (an antipsychotic) to 300 milligrams (MG) at bedtime. The admission Minimum Data Assessment (MDS) dated 8/28/2024 indicated Resident #75 had cognitive impairment with no display of behaviors coded. The MDS was coded for Resident #75 receiving antipsychotic medications on a routine basis. Resident #75's care plan reviewed 9/16/2025 indicated a risk for complications related to the use of psychotropic and psychotic medications. Interventions included AIMS testing per protocol. Resident #75's medical record documented one Abnormal Involuntary Movement Scale (AIMS) assessment on file dated 8/23/24. There were no other abnormal movement assessments found in the medical record. In an interview on 9/19/25 at 1:31 PM, the Director of Nurses (DON) stated the facility used the AIMS assessment for residents on antipsychotics and no other assessments. She stated there were no other AIMS assessments completed for Resident #75 other than the one on 8/23/24. In a phone interview 9/19/2025 4:02 PM, the Pharmacy Consultant explained the AIMS assessments was to be conducted by nursing staff every six months after the initial AIMS assessment for residents receiving antipsychotics. The pharmacy consultant could not recall if she had discussed Resident #1's AIMS assessment with the Director of Nursing. In an interview 9/19/2025 at 5:07 PM, the Director of Nursing (DON) stated she started at the facility in February 2025. She stated the nursing staff were to conduct the AIMS assessments every 6 months unless there was a change in the resident and the electronic	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0605 SS = E	Continued from page 4 medical record would trigger when an AIMS assessment was due if the notification of AIMS assessment was activated. She stated Resident #1's and Resident #75's EMR may not have been activated to identify an AIMS assessment was due for the residents. 2. Resident #1 was admitted to the facility on 8/28/2023 with diagnoses including a bipolar disorder. The quarterly Minimum Data Assessment (MDS) dated 8/29/2025 indicated Resident #1 was cognitive intact with no display of behaviors coded. The MDS was coded for Resident #1 receiving antipsychotic medications on a routine basis and gradual dose reduction was recorded clinical contraindicated as of 8/12/2025. Resident #1's care plan reviewed 9/14/2025 indicated a risk for complications related to the use of psychotropic and psychotic medications. Interventions included AIMS testing per protocol. Physician orders dated 8/26/2024 included Quetiapine Fumarate 100 milligrams three tablets three times a day for bipolar depression. An Abnormal Involuntary Movement Scale (AIMS) assessment dated 12/8/2024 in Resident #1's electronic medical record (EMR) reported Resident #1 was not experiencing involuntary movements, an adverse side effect to antipsychotic medications. There was no documentation of an AIMS assessment since 12/8/2024 for Resident #1 in the EMR. In an interview on 9/19/2025 at 3:00 PM, Unit Manager #2 stated she didn't know why an AIMS assessment had not been completed on Resident #1 and stated she was not aware Resident #1 needed an AIMS assessment. In a phone interview 9/19/2025 4:02 PM, the Pharmacy Consultant explained the AIMS assessments were to be conducted by nursing staff every six months after the initial AIMS assessment for residents receiving antipsychotics. The pharmacy consultant could not recall if she had discussed Resident #1's AIMS assessment with the Director of Nursing. In an interview 9/19/2025 at 5:07 PM, the Director of Nursing (DON) stated she started at the facility in February 2025. She stated the nursing staff were to conduct the AIMS assessments every 6 months unless there was a change in the resident and the electronic medical record would trigger when an AIMS assessment was due if the notification of AIMS assessment was	F0605		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0605 SS = E	Continued from page 5 activated. She stated Resident #1's and Resident #75's EMR may not have been activated to identify an AIMS assessment was due for the residents. In an interview 9/19/2025 at 7:00 PM, the Administrator stated the Director of Nursing was responsible for ensuring AIMS assessments were completed as recommended.	F0605		
F0628 SS = B	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the	F0628	Resident #1 and Resident #10 returned to the facility. No residents were affected by this citation. The Social Services Director or the Social Services assistant notified the ombudsman on 10/14/25. The Social Services Director and Social Services Assistant completed a quality review on 10/14/25 of residents currently transferred/ discharged to the hospital to ensure compliance of the transfer/ discharge notice and notification to the ombudsman. Any noted discrepancies were corrected. The Regional Social Services Director educated the Social Workers on 9/30/25 to provide written notification of transfer/discharge notice to the resident / resident representative of residents transferred to the hospital and provide a copy of the transfer/ discharge notice to the Ombudsman of residents transfer to the hospital. Newly hired Social Services staff members will be educated during orientation to this process. The Director of Nursing and/or Nurse Manager educated all facility and agency licensed nurses by 10/10/2025 to provide written notification of transfer / discharge notice upon transfer to the hospital. All newly hired licensed nurses to include agency nurses will be educated nurses by the Director of Nursing or Nurse Manager during their orientation process. The Administrator and/or the Director of Nursing will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 4 weeks, to ensure residents identified as being transferred to the hospital to ensure resident and or resident representative was provided written notification and the ombudsman was notified. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0628 SS = B	Continued from page 6 reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred	F0628	Continued from page 6 Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0628 SS = B	Continued from page 7 or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0628 SS = B	Continued from page 8 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by:	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0628 SS = B	Continued from page 9 Based on record review, resident interview and staff interviews, the facility failed to provide written notice of transfer/discharge to residents and to the Ombudsman for residents who were transferred from the facility to the hospital for 2 of 5 residents reviewed for hospitalization (Resident #1 and Resident #10). Findings included: 1. Resident #1 was admitted to the facility on 8/28/2023. Resident #1 was discharged from the facility and admitted to the hospital on 5/23/2025. Resident #1 returned to the facility on 5/27/2025. A review of Resident #1's electronic medical record (EMR) revealed no written notice of transfer/discharge was provided to Resident #1 related to the hospitalization on 5/23/2025. Additionally, there was no evidence that the Ombudsman had been notified of the transfer. The quarterly Minimum Data Set (MDS) assessment dated 8/29/2025 indicated Resident #1 was cognitively intact. On 9/18/2025 at 1:20 pm in an interview with Resident #1, he stated he was unable to recall receiving a notice of transfer or a written letter notifying him of the reason he was discharged from the facility to the hospital on 5/23/2025. 2. Resident #10 was admitted to the facility on 4/7/2022. Resident #10 was discharged from the facility and admitted to the hospital on 6/18/2025. Resident #10 was readmitted to the facility on 6/28/2025. A review of Resident #10's EMR revealed no written notice of transfer/discharge was provided to Resident #10 related to the hospitalization on 6/18/2025. Additionally, there was no evidence that the Ombudsman had been notified of the transfer. The significant change MDS assessment dated 7/5/2025 indicated Resident #10 was severely cognitively impaired. In an interview on 9/19/2025 at 2:35 PM, Nurse #5	F0628		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER **Mount Olive Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0628 SS = B	Continued from page 10 explained the following information was sent with the resident when they transferred from the facility to the hospital: face sheet, order summary, medication administration record and the completed transfer form. Nurse #5 stated the nursing staff did not send a notice of transfer with the residents. On 9/19/2025 at 5:07 PM in an interview, the Director of Nursing stated the notice of transfer form was not given to residents transferred to the hospital by the nursing staff. On 9/19/2025 at 2:11pm in an interview, the Social Worker stated she started in April 2025, and she had not completed notice of transfer forms for Resident #1 and Resident #10. She added the Social Worker Assistant was responsible for ensuring residents transferred received a notice of transfer. On 9/19/2025 at 2:02 PM in an interview with the Social Worker Assistant, she explained notice of transfers were given to the residents and/or resident's representative by social services staff when transferred to the hospital. She stated the Ombudsman was emailed at the end of each month the number of transfers/discharge and sent a copy of each residents' notice of transfer. The Social Worker Assistant stated she did not have a notice of transfer for Resident #1 when he transferred to the hospital 5/23/2025 or for Resident #10 when she transferred to the hospital on 6/18/2025. She stated Resident #1 and Resident #10 should have been given a notice of transfer and could not explain why they were not given a notice of transfer. She explained since there was no copy of the notice of transfer for Resident #1 and Resident #10, the Ombudsman would not have received notification of the transfers. On 9/19/2025 at 7:00 PM in an interview, the Administrator stated the social services staff were responsible for sending a notice of transfer to the resident or resident representative when transferred to the hospital. She stated a notice of transfer should have been sent to the hospital with Resident #1 and Resident #10, the social services staff should have followed up with Resident #1 and Resident #10 the following day and notified the Ombudsman of the transfer.	F0628		
F0689 SS = SQC J	Free of Accident Hazards/Supervision/Devices	F0689	Resident #13 was discharged on 9/26/25.	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 11 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 observations, record review, and resident, staff, Nurse Practitioner, (NP) Psychiatric NP and Medical Director interviews, the facility failed to assess a resident for self-administration of her enteral feedings (a method of delivering nutrition directly into the gastrointestinal tract, typically through a feeding tube, for individuals who cannot consume food orally) and to put effective interventions in place after Resident #13 was repeatedly observed by staff putting unidentified liquids in her gastronomy tube (g-tube [provides nutrition via a liquid formula delivered through a flexible tube that is surgically placed through the abdomen into the stomach]); rummaging through the trash for food /liquids; chewing and spitting out food items into the trash can; obtaining food as a prize for bingo; and disconnecting herself from her g-tube pump and removing the tube feeding formula bag during continuous feedings. Resident #13 had a diagnosis of vascular dementia and had an order for NPO (nothing by mouth) status due to dysphagia (difficulty swallowing). She was determined to have impaired insight and judgement by the Psychiatric NP. On 9/15/25 Resident #13 was observed by the surveyor administering to herself via bolus (administration of a limited volume of formula through a feeding tube over brief periods of time) the contents of a bottle labeled Jevity (tube feeding formula) dated 9/12/25 that contained a light tan milk-like liquid. The Medical Director indicated Resident #13 self-administering her tube feedings put Resident #13 at risk of serious injury/harm from aspiration (accidental inhalation of foreign substances, such as food, liquid, or air, into the lung which can lead to aspiration pneumonia), overfeeding, and infection. The deficient practice occurred for 1 of 1 resident reviewed for tube feeding Resident #13).	F0689	Continued from page 11 An audit of current residents who have physician ordered for tube feeding were audited through observation, chart review and staff interviews by the Regional Director of Nursing on 9/18/2025 to determine if they have behaviors of rummaging in the trash, disconnecting their feeding tubes and or self-administering substances in their feeding tube. No other residents were identified as having the above behaviors. An audit of current residents diet was reviewed on 09/18/25 to identify any other residents with a Nothing by Mouth (NPO) order by the Director of Nursing. No other residents have an order for NPO. The Director of Nursing, Nurse Managers or licensed nurse educated all staff members and agency staff regarding adherence to the physician's orders regarding diet to include order for nothing by mouth (NPO),informing the nurse if any resident who has an enteral feeding noted to be placing anything in their enteral feeding tube or in their mouth from 9/17/25 through 9/19/25. This same education will be provided to the following: staff members who did not work during the time of the scheduled education above before returning to work, newly hired staff during their orientation period and any agency staff prior to their working the floor. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, 1x per week for 4 weeks, to ensure physician's orders regarding diet to include order for nothing by mouth (NPO),informing the nurse if any resident who has an enteral feeding noted to be placing anything in their enteral feeding tube or in their mouth. The monitors will be presented to the Quality Assurance Committee each month.. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 12 Immediate Jeopardy began on 9/15/25 when Resident #13 was observed self-administering via her g-tube the contents of a bottle labeled Jevity dated 9/12/25 that contained a light tan milk-like liquid. Immediate Jeopardy was removed on 9/20/25 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: A hospital discharge summary dated 3/8/25 stated Resident #13 had a g-tube placement in 2015 secondary to a stroke. The discharge summary stated Resident #13 was admitted on 2/19/25 due to a swelling in her left hand and upper left extremity. She was diagnosed with left internal jugular vein thrombosis (a medical condition where a blood clot forms in a blood vessel and stops blood flow) and pneumonia. Her g-tube dislodged on 3/6/25 and she was treated for hypoglycemia (a condition where the blood sugar drops below normal) which was resolved after initiation of tube feeds. She was discharged to the facility on 3/8/25. Resident #13 was admitted to the facility on 3/8/25 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (opening of the stomach) for enteral feedings, malnutrition and vascular dementia. Review of Resident #13's face sheet indicated Resident #13 was her own responsible party. A physician's order dated 3/8/25 read Jevity 1.5 Cal administer continuously via pump at 60 milliliters (ml) per hour 24 hours per day or until total nutrient delivered. The manufacturer's instructions for Jevity indicated careful handling was required to prevent potential for microbial contamination. Microbial contamination can lead to serious harm and/or death. All medical foods, regardless of type of administration system, require careful handling because they can support microbial growth. A physician's order dated 3/9/25 read NPO. Resident #13's care plan had a focus of tube feeding	F0689	Continued from page 12 care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 13 dated 3/12/25 which stated, Resident had an enteral feeding tube to meet nutritional needs r/t (related to) an inability to consume sufficient calories and/or nutrients by mouth safely due to NPO status, Gastrostomy, Vascular Dementia, CVA, Hemiplegia Affecting Left Nondominant Side, Dysphagia, Cachexia, Severe Protein-Calorie Malnutrition. Interventions included flush tube with 15 milliliters of water before and after each medication pass, flush tube with 15 milliliters of water with each medication, flush tube with 15 milliliters of water between each medication, check placement of tube daily and before administering feedings and medications, check for clogs in tube daily and before administering feedings and medications, check for gastric residual volume prior to feeding or medication administration, and monitor labs. A physician's order dated 3/14/25 specified to flush tube with 50 ml of water every 4 hours during continuous tube feeding. A Nurse Practitioner (NP) progress note dated 4/4/25 stated it had been reported by nursing that Resident #13 has been taking herself off tube feeding and had a blood sugar of 44 on 4/3/25 due to it not running. She was also observed by the NP taking gauze, tape and supplies off a nursing cart. When asked to return the supplies she did so. Resident was further noted to have a cup of water which she stated was to flush her feeding tube. She did not have a syringe. Resident received education that she cannot swallow properly and so she needs to be more careful and not to attempt to eat or drink. A NP progress note dated 4/7/25 stated Resident #13 had lost weight since admission since she had been disconnecting her tube feeding at times. The note further stated Resident #13's blood sugars were less than 100 when not running her tube feeding continuously. There was no mention of educating the resident within the note. A nursing progress note written by Nurse #9 dated 4/10/25 stated Resident #13 repeatedly stopping tube feeding, turning off pump, disconnecting tube, clamping off tube frequently throughout shift. She was trying to be off continuous feed more than she is allowing it to infuse throughout the course of the shift. Resident #13 was also getting up in wheelchair and going into other residents' rooms. She also was digging through the trash can in the day room more than once. She asked to keep partially used feeding bottles and flush bag when replaced daily. It was explained that once it had been accessed for 24 hours bacterial growth begins. It was	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 14 further explained that only unpunctured bottles are shelf stable. Resident #13 continued to be found getting the bottles out of the trash and trying to store them in her closet. Nurse #9 was not interviewed. A physician's order dated 4/11/25 read Jevity 1.5 Cal. Administer continuous via pump 65 ml per hour 24 hours per day. A progress note written by Nurse #10 dated 4/14/25 revealed Resident #13 continued to pause her continuous feeding. The nurse spoke to Resident #13 about stopping her feeding without informing the nurse. The note also stated Resident #13 had to go to a local emergency department to have her g-tube replaced due to giving herself a bath. When her glucose was checked her range was 58/34. Resident #13 was given sugar water, med pass with sugar and a glucose injection in her right arm. Blood glucose was rechecked and her level increased to 101. The note additionally stated when resident is not on her feeding her glucose level decreases and education was provided. Nurse #10 was not interviewed. A speech therapist note dated 4/22/25 indicated speech therapy services were not indicated at this time. There were no other speech therapy assessments completed. A progress note dated 5/8/25 written by the NP revealed Resident #13 had been hoarding anything she could find in the facility and had developed a large pile of things by her bed. She stated they were her things and did not want them touched. The note further revealed the NP placed an order for a psychiatric consult due to paranoia, hoarding and anxiety. A nursing progress note written by Nurse #11 dated 5/21/25 read that Resident #13 had turned off her tube feeding and unhooked her g-tube to go out of her room for short periods of time. Resident #13 was educated that she is on continuous feedings at this time and is at risk for weight loss. An initial psychiatric evaluation by the Psychiatric NP dated 5/22/25 revealed Resident #13 was diagnosed with hoarding disorder and other specified anxiety disorders. She was referred due to paranoia and signs of hoarding and anxiety. During this evaluation, Resident #13 was noted to have multiple snacks in her wheelchair. She also was noted to have excessive oral secretions and had a cup in her wheelchair to spit in.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 15 Resident #13 was noted to exhibit extreme hoarding tendencies, often collecting medical items and belongings from others in her room. She had no explanation for doing this. Resident #13 was assessed as having limited insight and poor judgement. Her cognition was intact. Resident #13 was ordered fluoxetine (antidepressant that treats depression, anxiety and other disorders) 20 mg (milligrams) each morning for anxiety and hoarding. Follow-up included psychiatric follow-up for management of anxiety, hoarding and adjustment on a regular basis. A physician's order dated 5/23/25 read every day and night shift until 5/25/25 administer continuous Jevity 1.5 Cal via pump at 70 ml per hour. Increase by 20 ml per hour every four hours, until goal rate of 130 ml per hour. On at 8:00 PM and off at 8:00 AM. A physician's order dated 5/24/25 instructed staff to flush tube with 120 milliliters of water before each feeding and flush tube with 120 milliliters of water after each feeding. A medical provider order was written on 5/24/25 for fluoxetine 20 milligrams (mg) via g-tube once a day for anxiety and hoarding behaviors. A physician's order dated 5/25/25 specified Jevity 1.5 Cal administer every day and night shift via pump at 130 ml per hour 12 hours per day. On at 8:00 PM and off at 8:00 AM. Review of Resident #13's medical record revealed no assessments or physician orders for self-administration of her tube feedings. A follow-up psychiatric evaluation by the Psychiatric NP dated 6/5/25 revealed Resident #13 exhibited fair insight and judgement during this session. Resident #13's care plan dated 7/2/25 reflected behaviors such as retrieving items out of trash cans to include food items; self-administering water, soda, and enteral feeding in her g-tube; and putting food items in her mouth, chewing them up, and spitting them out. Interventions included: educate and remind resident that according to her physician's orders she is NPO status and cannot eat or drink by mouth and she can only receive 100% nutrition/medications/water via G-tube via nurses and notify physician/family as indicated. Another focus of the care plan dated 7/2/25 was physical behaviors related to poor impulse control as well as going into other patients' rooms and taking items. Interventions included: remind resident she	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER: Mount Olive Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 16 cannot go in other rooms and take things, psych (psychiatric) consult as needed, seek staff support, and Social Service visits. An additional focus of the care plan dated 7/18/25 stated Resident #13 had a decline in cognitive function or impaired thought processes related to dementia. Interventions included: observe for changes in cognitive status, allow resident to make choices about care and explain all interventions. Resident #13's significant change Minimum Data Set (MDS) assessment dated 7/4/25 revealed she was assessed as having moderate cognitive impairment with no behaviors. Her assessment reflected the use of a feeding tube for 51% or more of her total calories. The assessment reflected Resident #13 needed extensive assistance from one person-assist for eating. Resident #13 utilized a wheelchair for mobility. A follow-up psychiatric evaluation by the Psychiatric NP dated 7/22/25 revealed reports that Resident #13 continued to take items that do not belong to her and store them in her room along with her own belongings that she has piled in her room. Resident #13 was assessed as having limited insight and poor judgement. A progress note dated 7/29/25 written by the NP revealed she was informed by nursing staff Resident #13 continued to roll around the unit taking things and placing them in her room. A physician's order dated 8/9/25 specified Jevity 1.5 Cal to be administered at 120 ml per hour, 12 hours per day. On at 8:00 PM and off at 8:00 AM. A follow-up psychiatric evaluation by the Psychiatric NP dated 8/19/25 revealed Resident #13 continued to take items that did not belong to her and couldn't explain why. Cognitive behavioral strategies were attempted but she was not cognitively able to participate. Evaluation further read, "although she is fairly alert and oriented on basic cognition, screening, her insight and judgement are so impaired that I do not feel that psychotherapy is 'sticking' from visit to visit". During an interview with the Psychiatric Nurse Practitioner on 9/17/25 at 10:07 AM she reported Resident #13 had no insight or judgement about her behaviors and how they may be harmful. She reported when Resident #13 was questioned about going through the trash she stated she was looking for something to use to make crafts for her grandchildren.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 17 A nursing progress note written by Unit Manager #1 dated 9/3/35 stated Resident #13 was found outside engaged in self-feeding with a syringe via g-tube utilizing several bottles of sports drink and juice to flush the tube. Resident #13 was educated about physician orders, the feeding process and safety measures. A review of Resident #13's September 2025 MAR recorded a Jevity 1.5 enteral feeding was started at 8:00 PM on 9/12/2025 by Nurse #6. There was no allotted time and/or space on the MAR to document when the second bottle of Jevity 1.5 enteral feeding bottle was started for Resident #13. Therefore, there was no documentation on the MAR when Nurse #6 started a second bottle of Jevity 1.5 enteral feeding for Resident #13 on 9/12/2025. A phone interview was conducted with Nurse #7 on 9/16/25 at 10:03 AM who stated Resident #13's tube feeding stayed on the pole of the tube feeding pump after it was turned off in the morning on 9/13/2025. She stated either Resident #13 unhooked herself or the night shift nurse did this. Nurse #7 stated on 9/13/25 at 7:00 AM when she assumed care Resident #13 was unhooked from the feeding pump and dressed. She reported she had caught Resident #13 with water in a sports drink bottle approximately one month ago. She stated Resident #13 used the water to flush her tube. Nurse #7 stated she stopped Resident #13 from flushing her tube and disposed of the sports drink bottle. She indicated this occurred only once and she provided education to the resident. During an observation on 9/14/25 at 9:30 AM as the survey team was entering the facility, Resident #13 was observed in a wheelchair to the left of the facility's front entrance on the concrete sidewalk. She was observed holding her gastrostomy tube (g-tube) with her left hand and holding a milk-like substance in a clear bottle in her right hand. Resident #13 was observed on 9/15/25 at 7:10 AM self-propelling herself via wheelchair into the room leading outside into the smoking area. A black bag was observed on the back of the wheelchair with two bottles of clear liquid and a bottle with a milk-like substance with no labels on the bottles observed. A continuous observation occurred on 9/15/25 from 7:20 AM until 7:30 AM of Resident #13 in a wheelchair in the living room that had the door that led out to the smoking area. She was positioned between a drink machine and a table with three clear plastic bottles on	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 18 the table. Two of the bottles were small, unlabeled and filled with a clear liquid and one labeled (could not read the label) medium sized bottle that contained a light tan milk-like liquid. Resident #13 was observed connecting a syringe (60 milliliters) to the g-tube opening and turning the lock on the g-tube. She held her g-tube in her left hand and reached for one of the bottles with clear liquid with her right hand and filled the syringe with the clear liquid substance. Resident #13 then filled the syringe full of the light tan milk-like liquid while holding the g-tube upright and allowed the liquid to infuse by gravity. She followed with another syringe full of light tan milk-like liquid and used the piston of the syringe to push the remainder of the liquid into the g-tube. Resident #13 then filled the syringe with the clear liquid from one of the clear unlabeled plastic bottles to infuse via gravity. She continued and filled the syringe with the light tan colored milk-like liquid to infuse via gravity into the g-tube followed by a second syringe full of light tan milk-like liquid. She was observed using the piston to push the last syringe of the milky liquid into the g-tube. Resident #13 then filled the syringe full of clear liquid to flow via gravity into the g-tube. She then pushed the lock of the g-tube and placed the bottles that had the clear liquid into the black bag on the back of her wheelchair. She returned the syringe and piston into a plastic bag. The syringe and piston was observed in a plastic bag that was not labeled with the date and placed it in the black bag on the back of her wheelchair. The medium sized bottle was observed on the table and was labeled Jevity 1.5 with a label dated 9/12/25 0500 (5:00 AM) 130 ml/hr and there was approximately 100 milliliters left in the bottle. There was no expiration date observed on the bottle of Jevity 1.5. Resident #13 stated it was her bottle, and it came from her house. While the surveyor was addressing Resident #13 about the bottle of milky liquid Unit Manager #3 walked in and asked if there was a problem. Unit Manager #3 was shown the label of the bottle and informed the surveyor was attempting to identify the liquid Resident #13 was observed inserting in her g-tube and the surveyor returned the bottle to the table. In an interview with Unit Manager #3 on 9/15/2025 at 8:07 pm, she stated she had started at the facility a couple weeks ago and Resident #13 was a resident that did her own thing at the facility self-propelling through the hallways. She stated she had never seen Resident #13 self-administer an enteral feeding through the g-tube and on the morning of 9/15/25 she only recalled seeing Resident #13 with the Jevity bottle and	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 19 the milk-like liquid in the Jevity bottle on the table in the living room. An interview was conducted with Resident #13 on 9/16/25 at 11:00 AM. She reported she did not get her tube feeding on 9/14/25 because it was never hooked up. She reported she was hungry and that was the reason she was observed giving herself a tube feeding the previous morning (9/15/25). Resident #13 stated she gave herself 3 tube feedings daily and sometimes she received tube feeding continuously at night. She further stated she disconnected her tube feeding to go to smoke and to use the bathroom at night. She reported the tube feeding solution she was using on 9/15/25 came from her home. Resident #13 indicated she would dig in the trash cans in order to use the items she found to make crafts for her grandchildren. She was not aware of the amount of formula she was ordered and could not articulate dangers of administering more tube feeding than ordered. A telephone interview was conducted with Nurse #6 on 9/15/25 at 6:55 PM who reported she was familiar with Resident #13. She stated Resident #13 had turned her tube feeding off when not asleep. Nurse #6 stated Resident #13 often “does what she wants to do”. She reported that she hung a bottle of tube feeding solution at 5:00 AM on 9/12/25. Nurse #6 stated Resident #13 must have taken the bottle down from the pole for the bottle dated 9/12/25 to be in Resident #13’s possession. She further stated staff had discussed among themselves to not leave trash in Resident #13’s room. Nurse #6 stated some nights Resident #13 had been caught self-administering her tube feeding and she would redirect her. She further stated Resident #13 would steal tube feeding solution from the top of the medication carts. Nurse #6 stated she had witnessed Resident #13 taking another resident’s tube feeding off the medication cart and retrieved it from Resident #13. She stated she had not witnessed Resident #13 going through trash cans. Nurse #6 indicated Resident #13 kept empty bottles in her room and filled the empty bottles with water from the bathroom sink. She stated she had never seen Resident #1 get bottles out of the trash, but suspected Resident #13 was going through the trash to obtain them. Nurse #6 reported she would stop Resident #13 from filling the empty bottles with water. On 9/15/25 at 8:45 am a 1000 milliliter bottle of Jevity 1.5 with 1000 milliliters observed hanging on the pump for continuous feedings in Resident #13’s room. A syringe packet was observed which was dated 9/15/25, the Jevity 1.5 bottle was labeled 9/14/25 2000	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 20 (8:00 PM) and a water bag was dated 9/13/25 0500 (5:00 AM). The tip of the tubing connected to the tube feeding formula and water was observed hanging downward from the pump with no end cover. When the tube feeding pump was turned on the settings were observed cleared. There was no flush or tube feeding infusion rate set on the pump. Resident #13 was not present in the room at the time of the observation. Review of Resident #13's September 2025 Medication Administration Record (MAR) revealed the 9/14/25 feeding was signed off at 8:00 PM by Nurse #1. The order specified for Jevity 1.5 Cal to be administered every day and night shift continuous via pump at 130 milliliters per hour. 12 hours per day (On at 8:00 PM and off at 8:00 AM). A telephone interview was conducted with Nurse #1 on 9/15/25 at 6:36 PM who stated 9/14/25 was her first time working with Resident #13. She reported that she worked from 7:00 PM to 7:00 AM on 9/14/25. She stated she was told in report by Nurse #7 that Resident #13 administered her own tube feeding. When Nurse #1 was asked if Resident #13 self-administered enteral feedings through the g-tube, Nurse #1 stated she was unaware if Resident #13 had an order for self-administration for tube feeding. Nurse #1 stated she was told Resident #13 gets up out of bed and disconnects the tube feeding. She stated she was also told that Resident #13 turned the pump on and off when she got up and at night. Nurse #1 stated Resident #13 was already hooked up to her tube feeding when she entered the room on 9/14/25 at 8:00 PM. Nurse #1 could not explain why there was still 1000 ml in the tube feeding formula bottle on 9/15/25 at 8:45 am. An interview was conducted with Unit Manager #1 on 9/15/25 at 3:03 PM who stated she had removed the Jevity and water bottle from Resident #13's room that morning. She reported the Jevity bottle was dated 9/14/25 at 8:00 PM and the water flush was labeled 9/13/25. Unit Manager #1 stated she removed the items because she observed there was no cover on the tip of the tubing that was inserted into the g-tube. Unit Manager #1 stated she could not recall how much tube feeding formula was in the Jevity bottle when she removed the bottle from the pole on 9/15/2025. An interview and observation were conducted with Resident #13 on 9/15/25 at 8:53 AM who stated sometimes she administered her tube feeding and sometimes the facility did it. She further stated she administered her tube feedings when she lived at home. Resident #13 indicated it was not a continuous feeding. Resident #13	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER: **Mount Olive Center**	STREET ADDRESS, CITY, STATE, ZIP CODE: **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 21 stated she was not able to swallow and spit her saliva into a cup. She was observed with a cup to spit her saliva in during the interview and observation. During an observation on 9/15/25 at 4:30 PM Resident #13 was observed leaning into the trash can at the front entrance of the facility. Unit Manager #2 was observed outside at this time. Resident #13 was not observed taking anything out of the trash can. An interview was conducted with Unit Manager #2 on 9/16/25 at 12:00 PM who stated she was outside on 9/15/25 but did not see Resident #13 take anything out of the trash can. She reported she did not see Resident #13 at the trash can. During an observation of Nurse #4 hanging Resident #13's the tube feeding on 9/15/25 at 8:20 PM, an empty Jevity 1.5 bottle enteral feeding bottle labeled 9/15/2025 2000 (8:00pm) at 50 ml/hr was observed in the trash can, a 12-ounce unopened soda can was observed on the floor and a small 8-ounce apple juice bottle that was ½ full of a cloudy yellow substance was observed on the bedside table. Resident #13 stated the drinks were not hers. Nurse #4 started the tube feeding after the tube feeding solution was hung. At the end of the observation Nurse #4 left the room without emptying the trash which contained an empty Jevity 1.5 bottle or remove the bottle of apple juice and the can of soda. During an interview with Nurse #4 at 9/15/25 at 8:45 pm, she stated she was unaware of Resident #13's behavior of rummaging through the trash; however, she stated she was aware of Resident #13's behaviors concerning turning her enteral feeding pump on and off throughout the night. Nurse #4 reported she turns the pump back on when she hears the pump beeping which means it is not running. During an interview with the Activities Director on 9/15/25 at 8:15 PM she reported she was advised by the Speech Therapist last week that Resident #13 could not swallow. She stated the Speech Therapist asked her to consider other prizes other than food for bingo. The Activities Director stated she was not aware that Resident #13 could not have any nutrition or fluids by mouth. She reported this information was never reported to her. The Activities Director stated Resident #13 had received food prizes for winning bingo beginning 7/15/25. She stated the prizes consisted of oatmeal cakes, toaster pastries, and peanut-butter and cheese crackers. The Activities Director stated she had never seen the resident consume any food or fluids.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 22 A telephone interview was conducted with Speech Therapist on 9/17/25 at 11:20 AM. She reported Resident #13 was unable to swallow. Speech Therapist #1 stated she spoke with the Activities Director the previous week about considering other prizes other than food for bingo. Resident #13 liked to go to bingo and should not be given food prizes. The Speech Therapist stated there is a risk of choking if Resident #13 attempted to eat food and there was a risk of aspiration as she was not able to swallow. The Speech Therapist stated she was not working with Resident #13 and Resident #13 had never been on her caseload because the resident was not able to swallow. She reported Resident #13 had come to her on several occasions and asked to be evaluated to eat again. She reported that she had told Resident #13 when she was able to swallow her saliva they could work on an evaluation to eat again. The Speech Therapist further stated she had given Resident #13 ice chips when Resident #13 would come to her and discuss receiving nutrition by mouth and Resident #13 would have to spit them out because she could not swallow. She stated she had been made aware by staff that Resident #13 had food in her room but didn't take any action. She reported she felt the food couldn't be removed because it was the resident's property. The Speech Therapist stated she did not document when she gave Resident #13 ice chips. A telephone interview was conducted with Registered Dietician (RD) #1 on 9/17/25 at 11:44 PM who stated speech therapy was working with Resident #13 on her ability to eat so she had not addressed changing her feedings. She stated she reviews resident charts from home and does not work within the facility. The ST stated the resident had never been on caseload. She reported she was unaware of any concerns related to Resident #13 eating, self-administration of tube feeding or going through trash cans. She stated she could not address concerns related to swallowing but there was potential for infection due to cross contamination from self-administration of tube feeding and using items from the trash in her tube feeding. A phone interview was conducted with Registered Dietician #2 on 9/17/25 at 12:03 PM. She stated she was not aware that Resident #13 had disconnected her tube feedings and a concern with Resident #13 disconnecting her tube feedings was not knowing how much tube feeding solution she was receiving. Registered Dietician #2 further stated it would be important to monitor Resident #13's blood sugar to ensure it does not drop. Registered Dietician #2 stated another concern would be fluid overload. She stated she was unsure if she had ever met Resident #13 because she is only in the	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 23 facility one or two days a week. She reported Register Dietician #1 was responsible for reviewing charts and she (RD #2) attends care plan meetings and meets with new admissions. During an interview with the DON on 9/15/25 at 8:37 PM, she was informed Nurse #4 was observed exiting Resident #13's room and leaving an empty tube feeding bottle in the trash can, a half of a bottle of cloudy apple juice and a canned drink in Resident #13's room. The DON stated Resident #13 was care planned for retrieving items from the trash and reported Nurse #4 was an agency nurse and was not aware to remove the bottles and trash from Resident #13's room. DON stated she would educate Nurse #4 on Resident #13's care plan for behaviors. The DON stated staff, including agency staff, were educated on Resident #13's behaviors including rummaging through trash but could not provide specifics and did not provide documentation. During an interview with the Director of Nursing (DON) on 9/15/25 at 4:48 PM she reported Resident #13 could not swallow liquids or food. She reported she was aware that the resident would go through the trash, ask other residents for drinks and would disconnect her tube feeding at times. The DON was also aware Resident #13 would chew food items and spit them out. She reported the resident had been educated about the dangers of these behaviors by the staff members when they made the observation. The DON indicated that the resident had not been assessed for self-administration of her tube feeding. The DON stated she was not aware the Activities Director was giving food for bingo prizes to Resident #13. The DON acknowledged the dangers of all these behaviors and stated staff members would redirect Resident #13 when they observed the behaviors. An interview was conducted with the facility Nurse Practitioner (NP) on 9/17/25 at 12:25 PM. She reported it was dangerous for Resident #13 to self-administer her tube feedings. She stated Resident #13 had low blood sugars in the past from not receiving her tube feedings because she disconnected herself from the pump. NP further stated she was aware of Resident #13 self-administering her tube feeding and putting sports drink in her g-tube. She further stated she had seen Resident #13 in the trash and had witnessed her steal items such as gauze, gloves and briefs from the nurse's cart and she convinced Resident #13 to return the items. The NP stated the Registered Dietician needs to be aware of a deviation in the amount of tube feeding solution Resident #13 received in order to adjust tube feeding to ensure Resident #13 receives an adequate number of calories. She stated she was not aware the	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 24 Registered Dietitian had not been informed about Resident #13 disconnecting her tube feedings and she had not discussed this with the physician. The NP stated that Resident #13 was “going to do what she was going to do” and that she did not have time to call the physician every time Resident #13 had behaviors. She stated she had talked with Resident #13 about the dangers of not getting her full amount of tube feeding but Resident #13 voiced compliance but then would continue the behaviors. During an interview with the Medical Director on 9/18/25 at 11:10 AM he stated Resident #13 self-administering her tube feedings put Resident #13 at risk of serious injury/harm from aspiration, overfeeding, and infection. He stated he was not made aware of this behavior or the behaviors such as digging in the trash and chewing/spitting out food. and had he been made aware he would have recommended 100% supervision during Resident #13’s tube feedings. The Administrator was notified of Immediate Jeopardy on 9/18/25 at 4:55 PM. The facility provided the following immediate jeopardy removal plan with a removal date of 9/20/25. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance: Resident #13 has a gastronomy tube (g-tube) and receives nutritional feedings and medication via the g-tube. Resident #13 has a physician order for nothing by mouth (NPO) with continuous feed via tube feed pump 12 hours per day. On 09/15/25, the Surveyor allegedly observed Resident #13 administering a brownish white substance in a bottle labeled Jevity dated 09/12/25 in her gastronomy tube (g-tube). Resident #13 does not have an order to self-administer tube feedings. During an interview with Resident #13 she stated she obtained the bottle labeled Jevity out of the trash can on 09/13/25. The liquid substance in the container labeled Jevity was brown milky in appearance. Resident #13 was placed on 1:1 supervision on 9/15/2025 by facility staff to ensure safety. On 09/15/25, the Interdisciplinary team (Administrator,	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 25 Director of Nursing, Nurse Manager, Social Worker, Social Worker Assistant, Activities, Minimum Data Set (MDS) Nurse) reviewed Resident #13's care plan. The care plan indicated that the resident is retrieving items out of the trash can, food items, etc. She is hoarding items and states she is going to make piggy banks for her grandchildren out of the empty tube feed bottles. It is noted in Resident #13's care plan that the resident self-administered water and soda in her g-tube and that the resident self-administers Jevity. The resident also puts food items in her mouth and chews them up and spits it out. Per the care plan, the interventions included educating the resident as needed regarding self-administration of liquids via her g-tube, notify the physician and family as indicated, observe for signs and symptoms of aspiration and notify the physician as indicated. The carton labeled Jevity dated 09/12/25 had been administered per physicians order and was discarded in the residents room trash can. Unopened nutritional feedings are kept in a secure location until the scheduled administration time per the physician's order. On 09/15/25, Resident #13's orders were for Enteral Feed every day and night shift, Jevity 1.5, administering continuous via pump 130mL per hour 12 hours per day (On: 2000 (8p) OFF: 0800 (8a). On 09/15/25, the Administrator asked Resident #13 why she rummages through the trash and why she self-administers bolus feed. She stated she rummages through the trash to find items to make crafts for her grandkids. She also states that she self-administers bolus feed because she is hungry or thirsty. The care plan was reviewed with the resident and updated to reflect her behaviors listed in this paragraph. On 9/15/2025 Resident #13 was educated by the Director of Nursing on not self-administering liquids via her g-tube and not retrieving items out of the trash can. Resident #13 was educated on the risk of administering unknown liquids in g-tube including contamination, ensuring appropriate liquids/ nutrition, etc. and the risk of obtaining items from the trash that can be contaminated and put the resident at risk for infection.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER **Mount Olive Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 26 On 09/15/25, Resident #13 was educated on not disconnecting the feeding and notifying the nurse when she wants her tube feeding to be disconnected by the Director of Nursing. The education included risk associated with self-administering without safe handling to include contamination, infections, proper feed and amount. On 09/16/25, the Director of Nursing notified the dietitian of resident being thirsty and hungry in between continuous tube feedings and after a thorough review of the chart, the interdisciplinary team including the dietitian and physician / nurse practitioner recommended adding bolus feeding 2 times during the day (12p and 4p) to provide additional calories. An order was received. On 9/17/2025, Resident #13 was seen by the Psychiatric Nurse Practitioner and was deemed capable of making her own decisions. The Psychiatric NP states in her note, although some of her decisions may not be great ones, she has not been deemed incompetent and seems capable of making informed medical decisions. Resident #13 was seen by the Psychiatric Nurse Practitioner on 08/19/25 that indicated that although the resident was fairly alert and oriented on basic cognition screening, her insight and judgement were impaired. A chart review indicated a Brief Interview for Mental Status (BIMS) assessment was completed on 07/07/25 with a score of 12 indicating Resident #13 has moderate impairment. On 09/18/25, a BIMS assessment was completed with a score of 14 indicating an intact cognition. Resident #13 has had overall improvement in her cognition. On 09/17/25, the Administrator was notified by the Speech Therapist that the Activity Director was unaware that Resident #13 has a physician order indicating nothing by mouth (NPO) and provided the resident with prizes for bingo that included food and snacks. These food and snack prizes were provided to Resident #13 two times on 7/15/25 and 8/19/25 by the Activities Director. The Activity Director was educated on 09/17/25 by the Administrator on not providing food or beverages to residents that have a physician's order indicating NPO and/or altered diet. The Activities Director was educated by the Administrator to speak to the Licensed Nurse to identify a resident's ordered diet on 9/17/25.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER **Mount Olive Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 27 On 09/18/25, the physician was notified to request an order to provide Resident #13 education on self-administration of bolus tube feeding. An order was obtained and the resident was notified. She verbalized understanding. Teaching to begin on 09/18/25 with return demonstration upon completion of education. Prior to her admission in March 2025, Resident #13 administered bolus feeding and cared for her g-tube at home. Resident #13 has had the g-tube for approximately 10 years. The Director of Nursing met with the resident on 09/18/25 and discussed the new treatment plan. The resident was happy and satisfied with the plan and having the opportunity to demonstrate self-administration of bolus feeding to give her back her independence. On 09/18/25, a new order was received for Resident #13 for Jevity 1.5 five times a day, administer bolus via gravity 240ml until two cal HN comes in. Continuous feed was revised / discontinued per physicians order. On 9/19/25, a self-administration assessment was completed by the Licensed Nurse. The assessment indicated Resident #13 is able to administer bolus feeding without any difficulty. On 09/19/25, an order was received for Jevity 1.5 five times a day to administer bolus via gravity 240ml until two cal HN comes in. Resident #13 may self-administer with nurse supervision. The Care Plan was reviewed by the interdisciplinary team and updated by the Minimum Data Set Nurse (MDS) for self-administration for bolus feedings with nurse supervision. The resident's Medication Administration (MAR) was updated by the Market Clinical Lead on 09/19/25 to reflect the change in orders and communicated to the Licensed Nurses through the Medication Administration Record (MAR). Current residents' diets were reviewed on 9/18/2025 by the Director of Nursing to identify any other residents with a Nothing by Mouth (NPO) order. No other residents have an order to be NPO. Current residents who have physician ordered tube feeding were audited through observation, chart review and staff interviews by the Director of Nursing on 9/18/2025 to determine if they have behaviors of	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER **Mount Olive Center**	STREET ADDRESS, CITY, STATE, ZIP CODE **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 28 rummaging in the trash, disconnecting their feeding tubes or self-administering substances in their feeding tube. No other residents were identified as having the above behaviors. Specify the action the entity will take to alter the process or system failure prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: All facility staff to include agency staff were educated via regroup (a written electronic messaging system) by the Social Worker Assistant with received receipts on 9-18-2025 on the expectation to verify a resident's diet order with the nurse or reading the physician order in the electronic medical record prior to providing or administering any food or liquid orally to a resident to ensure the resident does not have a physician order indicating NPO. Newly hired staff, including agency staff will be educated upon hire in orientation. In person education to be conducted by the Market Clinical Lead, Director of Nursing or Nurse Managers on or before their next scheduled shift to ensure validation and understanding of the regroup education received. Receiving a receipt through a regroup electronic messaging system means the education was delivered to the staff member. On 09/16/25, the Administrator, Regulatory Compliance Advisor, Market Resource Operator, Market Clinical Lead, Director of Nursing and Nurse Managers educated all the facility staff to include agency staff via written electronic messaging by the Social Worker assistant with received receipt on 09/17/25 on not leaving food and or drink items unattended to ensure resident safety in any environment or area within the facility that is frequented by or accessible to residents in order to prevent a resident with a physician order indicating NPO not to be able to obtain food or liquids. Newly hired staff, including agency staff will be educated upon hire in orientation. In person education will also be provided to validate understanding of education. Licensed Nurses including agency nurses were educated by the Market Lead or the Director of Nursing on discarding tube feed containers, bags and or remaining feed in a secure location not accessible by residents	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 29 by 09/19/25. New hired nurses including agency nurses will be educated upon hire in orientation. On 09/16/25, the Regulatory Compliance Advisor conducted an audit of the nourishment (kitchenette) rooms on Station 1, Station 2, and Station 3 to ensure doors had a functioning locking system that is not accessible to residents. No issues were identified. On 09/18/25, the Market Clinical Lead, Director of Nursing or Nurse Managers educated all facility staff to include agency staff in person on diet restrictions and or consistency to ensure the safety of the residents for consuming the appropriate food or liquids as indicated per physician's order and the risks. Newly hired staff to include new hired agency staff will receive this education during orientation before providing direct resident care. On 9/18/25 all facility staff including agency staff were educated in person by Market Clinical Lead, Director of Nursing or Nurse Managers on the importance of alerting nursing staff if a resident is observed placing anything in their tube feeding and the risk associated with this. Licensed nursing staff were educated in person by the Market Clinical Lead, Director of Nursing or Nurse Managers on notifying the physician if a resident is observed placing anything in their tube feed or in their mouth if they have a physician order for NPO. Newly hired staff to include new hired agency staff will receive this education during orientation before providing direct resident care. The Administrator and Director of Nursing is tracking all education noted above to ensure that no staff works after 09/19/25 prior to receiving education. Alleged date of immediate jeopardy removal: 9/20/25 Onsite validation of the immediate jeopardy removal plan was completed on 9/19/25. Resident #13 was observed on 1:1 supervision from 9/15/25 through 9/19/25. An interview was conducted with the Activities Director that prior to any activity she is to pull a dietary report on all residents. During an interview with the Social Services Assistant, she explained the regroup e-mail system and how she can track the emails	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0689 SS = SQC-J	Continued from page 30 received by staff to ensure all staff received the update to not leave any food or drink items unattended. Interviews with staff revealed they were educated to stop a resident who had an order for nothing by mouth if they were found placing anything in their mouths and notify the Nursing Supervisor. Nursing staff interviewed stated they had received education on tube feeding, diet orders and diet consistency. An interview with the Marketing Clinical Lead revealed the Director of Nursing would be responsible for tracking that education is received prior to providing direct care. Review of the care plan revealed the change to allow Resident #13 to administer her tube feeding. A self-assessment for tube feeding was completed 9/18/25. The immediate jeopardy removal date of 9/20/25 was validated.	F0689		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to administer enteral feeding formula at the correct rate as ordered by the physician for 1 of 1 resident (Resident #13) reviewed for enteral feedings (Resident #13). Findings included:	F0693	Resident #13 was discharged from the facility on 9/26/25. On 9/25/25 an audit was conducted by the Regional Director of Nursing to ensure residents requiring enteral feedings are being administered enteral feeding formulas at the correct rate as ordered by the physician. No issues identified. The Director of Nursing and or Nurse managers educated all facility licensed nurses and agency licensed nurses on ensuring residents receive enteral feeding formula at the correct rate as ordered by the physician by 10/22/25. All newly hired licensed nurses and newly scheduled agency nurses will receive the same education by the Director of Nursing or Nurse Manager during their orientation process. The Director of Nursing and/or Nurse Manager will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 4 weeks to ensure residents identified as requiring tube feeding are being administered enteral feeding formula at the correct rate as ordered by the physician. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER: **Mount Olive Center**	STREET ADDRESS, CITY, STATE, ZIP CODE: **228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0693 SS = D	Continued from page 31 Resident #13 was admitted to the facility on 3/8/2025 with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (opening of the stomach) for enteral feedings, malnutrition and vascular dementia. Resident #13's significant change Minimum Data Set (MDS) assessment dated 7/4/2025 revealed she was assessed as having moderate cognitive impairment with no behaviors. The MDS assessment reflected the use of a feeding tube for 51% or more of Resident #13's total calories. Physician's orders dated 8/9/2025 included continuous eternal feeding via a pump at 130 milliliters (ml) per hour for 12 hours a day. The continuous eternal feeding (a way of providing nutrition right to the stomach or small intestine) was to start at 8:00 PM and stop at 8:00 AM. An order to flush the gastrostomy tube with 50 ml of water every 4 hours during continuous eternal feedings was written on 3/13/2025. On 9/15/2025 at 8:20 PM, Nurse #4 was observed hanging Resident #13's enteral feeding scheduled for 8:00 PM. Resident #13's enteral feeding set up consisted of two plastic bags: one bag contained 1000 liters of water used for water flushes and the second bag contained 1000 liters of the enteral feeding formula. Nurse #4 was observed programming the eternal feeding pump to infuse the eternal feeding at 50 milliliters per hour and the water flushes at 130 milliliter every 4 hours. Nurse #4 was then observed connecting the eternal feeding tubing to Resident #13 gastrostomy tube and turning on the eternal feeding pump to continuously administer the eternal feeding. Nurse #4 was observed exiting the room at 8:30 PM who reported she had completed the task of starting Resident #13's eternal feeding. On 9/15/2025 at 8:33PM, Nurse #4 was asked to verify with the surveyor the physician's order of the eternal feeding. Nurse #4 stated the physician's order for Resident #13's to receive the continuous eternal feeding at 130 milliliters per hour and to receive 50 milliliters of water flushes every 4 hours. She stated she had entered the settings of the eternal feeding incorrectly and needed to reset the eternal feeding pump for Resident #13's continuous eternal feeding.	F0693	Continued from page 31 Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0693 SS = D	Continued from page 32 On 9/15/2025 at 8:34 PM in an observation and interview, Nurse #4 was observed re-entering Resident #13's room. The eternal feeding pump was observed infusing Resident #13's eternal feeding at 50 ml/hour and the water flush was set to infuse 130 ml every 4 hours. Nurse #4 was observed changing the setting on the eternal feedings pump to 130 ml/hour for the eternal feeding and water flushes were set at 50 ml every 4 hours. Nurse #4 stated the eternal feeding was not set on the eternal feeding pump as ordered by the physician and she had read the physician's orders wrong and had to reset the eternal feeding pump. The Director of Nursing (DON) was interviewed on 9/15/25 at 8:57 PM. The DON stated Resident #13 enteral feeding pump should have been set at the correct rates for the eternal feeding and water flushes as ordered by the physician.	F0693		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, staff interviews and Nurse Practitioner interview, the facility failed to administer supplemental oxygen as prescribed by the physician and failed to post cautionary signage indicating the use of oxygen for 3 of 9 residents reviewed for respiratory services (Resident #39, #91 and #49). 4. Resident #49 was admitted to the facility on 1/3/2020 with diagnoses including chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated 8/25/2025 indicated Resident #49 was cognitively intact and was coded as receiving oxygen therapy. Physician orders dated 8/25/2025 included an order for	F0695	On 9/14/25, resident #91 and resident #39, oxygen concentrator setting was corrected to match the liters per minute as prescribed by the physician's order by a nurse manager.. On 9/14/25, the correct signage was placed on the door of resident #49, by the respiratory therapist. An audit was conducted on 10/3/25 by the Director of Nursing to ensure that residents receiving supplemental oxygen was being administered per physician orders to include the number of liters per minute and the Oxygen signage was in place. The Director of Nursing or a Nurse Manager provided education by 10/22/25 to all licensed nurses and medication aides working in the facility on ensuring that there was an oxygen sign outside of any resident room that has oxygen in the room, on how to correctly read the liters per minute on the oxygen concentrators and to monitor to ensure that only 1 order for oxygen liters per minute was ordered at any given time for any given resident. Additionally, the medication aides were taught that when reading the oxygen concentrator, if the liters per minute did not match the order, that they were to get a licensed nurse to read the orders and adjust the liters per minute to make it correct on the oxygen concentrator. The education also included checking the door frame of those residents requiring oxygen to ensure that the proper signage is in place. Any Licensed Nurses and medication aides who were unavailable during the education period will have the	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0695 SS = E	Continued from page 33 oxygen at three liters per minute via nasal cannula every shift. Resident #49's care plan last updated on 8/26/2025 documented Resident #49 was at risk for respiratory complications and was receiving oxygen at 3 liters per min. via nasal cannula every shift. On 9/14/2025 at 1:25 PM, Resident #49 was observed lying in bed receiving oxygen at 3 liters per minute via nasal cannula. However, there was no signage posted outside Resident #49's door indicating "No Smoking - Oxygen in Use." During an interview on 9/14/2025 at 4:23 PM, Nurse #3, stated that signage indicating "No Smoking - Oxygen in Use" should have been posted outside Resident #49's door. She explained that it was the responsibility of the respiratory therapist to place the signage. In a phone interview on 9/16/2025 at 9:58 AM, Nurse #5 stated that Resident #49 should have had the appropriate signage posted. She was unaware that the signage was missing and said she did not check Resident #49's door on 9/14/25. As the weekend supervisor, she stated she had never been instructed by the Administration team to conduct resident rounds to verify oxygen signage on the weekend. On 9/14/2025 at 4:40 PM in an interview with Respiratory Therapist (RT) #2 confirmed that Resident #49 should have had a magnetic "No Smoking - Oxygen in Use" sign outside the door. RT #2 explained respiratory therapy staff are responsible for placing signage for new admissions and residents on their case load. However, nurses were expected to apply the signage when initiating oxygen therapy for residents not on the respiratory caseload. RT #2 acknowledged that respiratory therapy staff were expected to check weekly for proper signage but could not explain why the signage was missing in this case. In an interview on 9/15/2025 at 2:04 PM, the Director of Nursing (DON) stated that the facility uses magnetic signage to indicate oxygen use and no smoking. She explained that both nursing and respiratory staff were responsible for ensuring the signage was posted when oxygen was initiated. Since not all residents on oxygen were on the respiratory caseload, nursing staff were expected to ensure signage was in place. The DON also stated that during daily rounds conducted by Administration during the week and by the weekend supervisor on the weekends, staff should verify that appropriate signage is posted.	F0695	Continued from page 33 education prior to their next shift. This same education packet will be placed into the licensed nurse and medication assistant in-service education book to be included during orientation for licensed nurses and certified medication assistants. Any newly scheduled agency nurse will have the same education prior to working on the floor. The Director of Nursing and/or Nurse Manager will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 8 weeks to ensure receiving supplemental oxygen is being administered per physician orders to include the number of liters per minute and oxygen signage in place. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0695 SS = E	Continued from page 34 Findings included: 1.Resident #39 was admitted to the facility on 7/23/25 with diagnoses which included acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), severe persistent asthma with acute exacerbation, acute bronchitis and hypoxemia. Physician order dated 7/24/25 included an order for oxygen at 3 liters per minute to maintain 90% and above oxygen saturation via nasal cannula. Review of Resident #39's admission Minimum Data Set (MDS) dated 7/30/25 revealed he was cognitively intact and coded for oxygen therapy. Resident #39's care plan dated 7/31/25 included a focus for respiratory complications related to recent hospitalization, acute respiratory distress with hypoxia and acute exacerbation of severe persistent asthma. Interventions included oxygen via nasal cannula at 3 liters per minute as needed for hypoxia and to keep oxygen saturations (a measurement of how much oxygen present in the blood) greater than 90 percent (%). Observation on 9/15/25 at 8:44 am Resident #39 was in his room lying in bed wearing a nasal cannula and his oxygen concentrator on 4 liters per minute. A review of Resident #39's September 2025 Medication Administration Record (MAR) recorded Resident #39 received 3 liters of oxygen via nasal cannula on 9/15/25 and recorded oxygen saturation was 97 percent (%). In an interview with the Unit Manager #1 on 9/15/25 at 1:15 pm, she stated the oxygen concentrator level for Resident #39 should be at 3 liters per minute. During an interview with Medication Aide #1 on 9/15/25 at 1:15 pm, she stated she was the medication aide for Resident #39 on day shift (7:00 am until 3:00 pm) for 9/15/25. Medication Aide #1 further stated the oxygen concentrator read 4 liters per minute and documented at 4 liters per minute. Medication Aide #1 indicated the oxygen concentrator should have been set a 3 liters per minute and she could not change the levels on the oxygen concentrators. Medication Aide #1 stated Resident #39 was capable of adjusting the settings on his oxygen concentrator.	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0695 SS = E	Continued from page 35 During an interview on 9/15/25 at 2:02 pm with the Director of Nursing (DON), she stated the nursing staff should be reading the physician orders and checking the oxygen concentrators for the correct liters per minute setting every shift. In an interview on 9/17/25 at 12:41 pm with the Nurse Practitioner (NP), stated the nursing staff should be following the physician orders and checking the oxygen concentrators for the correct setting of liters per minute every shift. During an interview with the Administrator on 9/19/25 at 6:01 pm, she stated her expectations were that the nursing staff followed the physician orders and verifying the oxygen concentrators are set at the correct liters per minute. 2.Resident #91 was admitted to the facility on 6/29/24 with diagnoses which included chronic obstructive pulmonary disease (COPD), altered mental status, chronic systolic heart failure, and wheezing. Resident #91's Physician order dated 7/5/24 for oxygen at 2 liters per minute via nasal cannula for hypoxia. Review of Resident #91's quarterly Minimum Data Set dated 8/26/25 revealed he was cognitively intact, coded for oxygen therapy and hospice. Resident #91's care plan dated 9/5/25 included a focus for respiratory complications related to recent hospitalization. Interventions included oxygen via nasal cannula at 2 liters per minute for hypoxia and to observe for signs/symptoms of respiratory distress. Observations on 9/14/25 at 9:22 am and 9/14/25 at 1:45 pm revealed Resident #91 was in his room lying in bed wearing a nasal cannula and his oxygen concentrator on 6 liters per minute. A review of Resident #91's September 2025 Medication Administration Record (MAR) recorded Resident #91 received 2 liters of oxygen via nasal cannula each shift on 9/14/25 and recorded oxygen saturations of 97 percent (%). In an interview with the Unit Manager #2 on 9/15/25 at 1:45 pm, she stated the nursing staff should be reading the physician orders and checking the oxygen concentrators levels every shift.	F0695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0695 SS = E	Continued from page 36 In a phone interview with Nurse #2 on 9/17/25 at 4:15 pm, she stated she was the nurse for Resident #91 during the night shift (7:00 pm to 7:00 am). Nurse #2 indicated she knew Resident #91 had an order 2 liters per minute of oxygen. Nurse #2 further stated she did not check the level on the oxygen concentrator for Resident #91 during her shift. During an interview on 9/15/25 at 2:02 pm with the Director of Nursing (DON), she stated the nursing staff should be reading the physician orders and checking the oxygen concentrators for the correct liters per minute setting every shift. In an interview on 9/17/25 at 12:41 pm with the Nurse Practitioner (NP), stated the nursing staff should be following the physician orders and checking the oxygen concentrators for the correct setting of liters per minute every shift. During an interview with the Administrator on 9/19/25 at 6:01 pm, she stated her expectations were that the nursing staff followed the physician orders and verifying the oxygen concentrators are set at the correct liters per minute.	F0695		
F0732 SS = B	Posted Nurse Staffing Information CFR(s): 483.35(i)(1)-(4) §483.35(i) Nurse Staffing Information. §483.35(i)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.	F0732	The staffing sheet was corrected to reflect the correct nursing hours and census on 9/19/25 by the Regional Director of Nursing. A quality review was completed by the staffing scheduler and the Executive Director of the last 30 days of staffing sheets and staffing hours corrected to reflect hours of nursing staff worked by 10/20/25 The Administrator educated the Director of Nursing and nurse managers on 10/17/25 on ensuring the accuracy and completeness of the nurse staffing daily posting. The scheduler and licensed nurses currently working in the facility were educated by the Director of Nursing and/or nurse manager on how to complete the nursing staff posting by 10/21/25. This same education will be provided to any newly hired Director of Nursing, Nurse Managers, Schedulers and Licensed Nurses during their orientation period. Any agency licensed nurse will be educated to this process prior to working on the floor. The Director of Nursing and/or Nurse Manager will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 4 weeks to ensure that the staff posting is being thoroughly completed and updated daily with changes in staff or census occurring during each shift.	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0732 SS = B	Continued from page 37 §483.35(i)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (i)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(i)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(i)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff interviews, the facility failed to post accurate daily nurse staffing information for 3 of 6 days reviewed (9/12/25, 9/13/25, 9/14/25). The findings included: A review of the daily nurse staff posting by front office on 9/14/25 at 9:51 AM revealed a posting dated Friday, 9/12/25. There was a staff posting dated Saturday, 9/13/25 behind the posting for 9/12/25, and there was no staff posting for Sunday, 9/14/25. The daily nurse staff posting dated 9/12/25 included the Nurse Aide (NA) staffing numbers for the day shift (7:00 AM-3:00 PM) but did not include information about the staffing for the other shifts (3:00 PM-11:00PM and 11:00 PM-7:00 AM). The daily nurse staff posting dated 9/13/25 was blank except for prefilled NA numbers and hours. There was no other information on the posting, including the census, the staffing for the licensed nurses, or the total number of hours worked. In an interview on 9/19/25 at 6:06 PM, the Director of	F0732	Continued from page 37 The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0732 SS = B	Continued from page 38 Nurses (DON) said she had started as the DON in the facility in July 2025 and had to check who was responsible for the daily posting on the weekends. She stated the weekend Nurse Supervisor was supposed to be responsible for maintaining the daily staffing posting on the weekends but had not been assigned or trained to do that so it had not been done. In an interview on 9/19/25 at 6:57 PM, the Administrator stated she was not sure who was responsible for maintaining the daily nurse staffing posting on the weekends but expected that it should have been part of the weekend Nurse Supervisor's duties. The weekend Nurse Supervisor was unable to be interviewed.	F0732		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician	F0756	Resident #1 AIMS was completed by the Director of Nursing on 09/22/25 per pharmacy recommendation. Resident #2 had behavior monitoring added to the MAR for the morning dose of clonazepam and divalproex sodium by Regional Director of Nursing on 10/17/25 and anticoagulant monitoring was added to the MAR on 10/17/25 per pharmacy recommendation. Resident #75 AIMS was completed by the Director of Nursing on 09/22/25 per pharmacy recommendations and psyllium was discontinued on 10/01/25.Resident #113 no longer resides in the facility. The Licensed Pharmacist completed a comprehensive review of current residents providing recommendations on 9/29/25. The pharmacy recommendations were reviewed by the Physician, Nurse Practitioner or the Director of Nursing as indicated and addressed irregularities on 10/02/25. A meeting was held on 10/15/25 with the Administrator, the Regional Nurse Consultant and the Director of Nursing to review the policy and procedure for the Monthly Drug Regimen Review. This same education will be provided to any newly appointed Licensed Pharmacist and any newly hired Director of Nursing by the Administrator. The Administrator educated the Director of Nursing and the Nurse Managers on the facility policy and procedure for Monthly Drug Regimen Review on 10/15/25. This same education was placed in an in-service binder to be provided to any newly hired Director of Nursing or Nurse Managers during their orientation period.	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 39 should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Consultant Pharmacist, and the Nurse Practitioner, the facility failed to address irregularities identified by the Consultant Pharmacist during monthly drug regimen reviews (Residents #75, #113, #1, and #2) and to maintain documentation of the monthly drug regimen reviews within the facility and readily available for review (Resident #75). This deficient practice affected 4 of 5 residents reviewed for unnecessary medications. The findings included: 1.Resident #75 admitted to the facility on 10/25/24 with diagnoses including gastro-esophageal reflux disease with esophagitis, anxiety, polyneuropathy, and depression with psychosis. The admission Minimum Data Assessment (MDS) dated 8/28/2024 indicated Resident #75 had moderate cognitive impairment with no display of behaviors coded. The MDS was coded for Resident #75 receiving antipsychotic medications on a routine basis. Resident #75's physician's orders revealed the following: Order dated 10/25/2024 documented a revision of Quetiapine Fumarate (an antipsychotic) to 300 milligrams (MG) at bedtime. Order dated 10/26/24 read Sucralfate Oral Tablet 1 gram (GM) 1 tablet by mouth three times a day for gastric protection and Metoprolol (blood pressure) 25 mg one-half tablet two times a day and to hold the dose if his systolic blood pressure (SBP) was less than 100 or his heart rate was less than 60. Order dated 4/30/2025 for Pregabalin (for pain) Oral Capsule 50 MG 1 tablet by mouth three times a day.	F0756	Continued from page 39 A tracking tool was implemented on 10/17/25 to monitor the completion of the pharmacy recommendations in a timely manner, to be completed monthly by the Director of Nursing to ensure compliance. The medical providers were educated by the Administrator by 10/14/25 on the importance of completing the pharmacy recommendations in a timely manner and returning them to the Director of Nursing for review and to ensure implementation of the recommendations. This same education will be placed in an inservice binder and any new medical providers will be provided the same education upon hire by the Administrator. The Administrator or Director of Nursing will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 8 weeks to ensure pharmacy recommendations are reviewed and irregularities are addressed as indicated. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 40 Order dated 6/03/2025 for Hydroxyzine HCl (for itching and anxiety) tablet 25 milligrams (mg) 1 tablet by mouth three times a day. Order dated 7/24/2025 for Pantoprazole Sodium Oral Tablet Delayed Release 40 MG (for gastroesophageal reflux) 1 tablet by mouth one time a day. Order dated 8/29/2025 for Quetiapine Fumarate (an antipsychotic) 200 MG tablet at bedtime. Order dated 9/08/2025 for Psyllium Oral Packet (a fiber supplement) every 12 hours. 1a. Resident #75's medical record only had one an Abnormal Involuntary Movement Scale (AIMS) assessment on file dated 8/23/24. There were no other abnormal movement assessments found in the medical record. On 2/21/25, 3/30/25, 5/30/25, 6/29/25, 7/28/25, and 8/29/25, the facility Consultant Pharmacist drug regimen review noted for Resident #75 to have an AIMS, used to assess for adverse reactions to psychoactive medications) assessment done due to Resident #75 receiving an antipsychotic medication. The pharmacist noted on 6/29/25 that antipsychotic medications have the capacity to cause tardive dyskinesia and other movement disorders. She recommended a movement test, such as the AIMS assessment, be performed initially (within 30 days) and then at least every 6 months while Resident #75 continued the medication. A handwritten undated and unsigned comment documented "noted." The reviews dated 2/21/25, 3/30/25, 5/30/25, 7/28/25, and 8/29/25 were unsigned and had no evidence of staff acknowledgement. In an interview on 9/19/25 at 1:31 PM, the Director of Nursing (DON) stated she was unaware the Consultant Pharmacist had recommended an AIMS assessment for Resident #75. She stated the facility used the AIMS assessment for residents on antipsychotics and no other assessments. She stated there were no other AIMS assessments completed for Resident #75 other than the one on 8/23/24. 1b. The pharmacist drug regimen review dated 2/21/25, 7/28/25, 8/29/25 for Resident #75 included recommendations for psyllium, a fiber supplement, to be given at least 2 hours apart from any other medication. The reviews dated 2/21/25, 7/28/25, and 8/29/25 were unsigned or had no evidence of staff acknowledgement. Review of the Medication Administration Records (MAR) from January 2025-September 2025 documented that psyllium was scheduled for administration at 6:00 AM and 5:00 PM. An entry on the MAR dated 9/8/25 noted the	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 41 times for psyllium were changed to 5:00 AM and 5:00 PM within an hour of other medications. The Hydroxyzine, Pantoprazole, Pregabalin were scheduled to be administered at 6:00 AM, and Sucralfate was scheduled to be administered at 4:00 PM. Review of the September 2025 MAR documented that he was scheduled to receive psyllium at 5:00 AM, hydroxyzine (for anxiety and itching), pantoprazole (for gastroesophageal reflux), and pregabalin (for nerve pain and anxiety) at 6:00 AM. Resident #75 was scheduled to receive sucralfate at 4:00 PM and psyllium at 5:00 PM. In an interview on 9/19/25 at 11:37 AM, Nurse #6 stated she had administered Resident #75's medications on 9/18/25. She stated she provided him with his psyllium and sucralfate at the same time, though he refused to take the medications that day. She stated that because the medications were an hour apart, she administered them together and said there was no order or indication that she could not administer them together. In an interview on 09/19/25 at 10:42 AM, the Nurse Practitioner stated she had not seen the recommendations to separate the time of psyllium administration. She stated the psyllium could affect the absorption of the other medications taken with the psyllium and said it was good practice to separate them. In an interview on 9/19/25 at 12:07 PM, the Consultant Pharmacist stated she recommended separating psyllium from other medication administration times by 2 hours because it could affect how well the other medications were absorbed into his system. In an interview on 9/19/25 at 6:06 PM, the Director of Nurses (DON) stated she was not aware of the recommended administration time changes and confirmed that after reviewing the administration times of Resident #75's medications, he was receiving psyllium with other medications scheduled within the next hour regularly. She stated she had become the DON in February 2025 and had not worked on any of the Consultant Pharmacist recommendations. She stated the Nurse Practitioner received all of the recommendations and would make adjustments to orders and administration times on the MAR. She stated she had tried to make corrections in a resident's clinical record (no resident specified) and the Nurse Practitioner would adjust the DON's documentation after, so it was more efficient to allow the NP to receive them all directly.	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 42 In an interview on 9/19/25 at 10:24 AM, the Nurse Practitioner stated she did not directly receive the Consultant Pharmacist's recommendations, but they were given to her by the facility to address. She stated she did not change information in the electronic medical record herself but reviewed them and return them to a nurse manager. She stated she would sign or initial the recommendations she reviewed. 1c. Resident #75's progress notes dated 8/22/24, 8/30/24, and 4/27/25 completed by the Consultant Pharmacist all documented that Medication Regimen Reviews were performed and a Comments/Recommendations were made. The progress notes indicated to see the reports. The facility was unable to provide the referenced Medication Regimen Review reports that were mentioned in the Consultant Pharmacist's progress notes for Resident #75 dated 8/22/24, 8/30/24, and 4/27/25. In an interview on 9/19/25 at 6:06 PM, the DON stated she could not find any additional documentation of the Consultant Pharmacist's monthly Medication Regimen Review reports. She stated she wasn't aware of where any additional Medication Regimen Review reports were stored. She further stated that she had asked other nurse managers to check to see if they had any recommendations filed in their office, but there were no additional Medication Regimen Review reports found. In an interview on 9/19/25 at 10:24 AM, the Nurse Practitioner stated she did not directly receive the Consultant Pharmacist's recommendations, but they were given to her by a nurse manager to address. She explained that she reviewed the recommendations, signed or initialed them, and then returned them to a nurse manager. In an interview on 9/19/25 at 6:57 PM, the Administrator stated she expected the facility Consultant Pharmacist's recommendations to be addressed. 2. Resident #113 was admitted to the facility on 6/5/2025 with diagnoses of hypertension (high blood pressure) and heart failure. Physician's orders dated 7/25/2025 included carvedilol (a blood pressure reducing medication) 12.5 milligrams (mg) twice a day for blood pressure; hold for systolic (top number of a blood pressure) blood pressure less than 150 milliliters of mercury (mmHg).	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 43 A review of Resident #113's monthly Medication Regimen Reviews (MRR) conducted by the Pharmacy Consultant reported on 7/31/2025 the medication, carvedilol, was administered to Resident #113 and should have been held for a systolic blood pressure less than 150 mmHg on 7/26/2025. The MRR dated 8/30/2025 for Resident #113 reported carvedilol was given and should have been held for systolic blood pressure less than 150 mmHg on 8/2/2025, 8/3/2025, 8/4/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, 8/9/2025, 8/10/2025, 8/11/2025, 8/12/2025, 8/13/2025, 8/14/2025, 8/15/2025, 8/16/2025, 8/17/2025, 8/18/2025, 8/20/2025, 8/21/2025, 8/22/2025, 8/24/2025 and 8/26/2025. There was no documentation on or for the MRR dated 7/31/2025 or 8/30/2025 that the recommendation for Carvedilol had been addressed by the Director of Nursing or the Nurse Practitioner. There were no signatures, initials or dates recorded on the MRRs. The words, fixed and noted, were written near other medications with recommendations to clarify strength, frequency and diagnoses on 7/31/2025 MRR that were repeated recommendations on the 8/30/2025. There was no documentation beside the carvedilol recommendation to record the nursing recommendation had been addressed. In an interview on 9/19/2025 at 4:02 PM, the Pharmacy Consultant stated the monthly MRR recommendations were sent via email to the Director of Nursing and Administrator at the end of each month within a couple days after completion of the MRR. She explained the MRR dated 7/31/2025 recorded the nursing staff had not followed the parameter protocol as ordered by the physician to hold the medication, carvedilol on 7/26/2025. She explained on the MRR dated 8/30/2025 there was a trend identified of Resident #113 receiving carvedilol when the systolic blood pressure readings were less than 150 mmHg. The Pharmacy Consultant stated she could not recall discussing with the Director of Nursing or the Nurse Practitioner that Resident #113 was receiving carvedilol when the systolic blood pressure was recorded below the parameter of 150 mmHg. In an interview on 9/17/2025 at 5:50 PM, the Director of Nursing (DON) stated she started at the facility in February 2025. She explained that since February 2025 the process was the pharmacy consultant emailed the pharmacy recommendations to the DON, the DON provided the pharmacy recommendations to the Nurse Practitioner (NP) and the NP addressed the physician and nursing pharmacy recommendations. The DON stated the NP was responsible for communicating nursing recommendations to the nursing staff and did not recall the NP communicating concerns that Resident #113 was receiving carvedilol when systolic blood pressure was less than	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 44 150 mmHg to the DON. The DON also stated she had experienced problems with receiving emails and her email address had been changed multiple times since starting at the facility. In an interview on 9/17/2025 at12:42 PM, the Nurse Practitioner explained Resident #113 was on carvedilol to conserve her heart function to alleviate the possibility of heart surgery. Resident #113 was experiencing some orthostatic hypertension, and the cardiologist ordered the carvedilol to be held when systolic blood pressure was less than 150mmHg. She stated she was not aware or notified that Resident #113 had been administered carvedilol when Resident#113's systolic blood pressure was recorded less than 150mmHg. In a follow up phone interview on 10/1/2025 at 11:54 AM, she stated since March 2025 she had been addressing only the physician pharmacy recommendations, and the DON was responsible for addressing the nursing pharmacy recommendations. In an interview conducted on 9/19/2025 at 7:00 PM, the Administrator stated she did not think she was receiving pharmacy recommendations from the pharmacy consultant. She stated the Director of Nursing was responsible for receiving the pharmacy recommendations monthly and addressing the nursing recommendations and ensuring the physician/nurse practitioner addressed and returned the physician recommendations. She explained she was not aware who was maintaining copies of the addressed pharmacy recommendations at the facility. 3. Resident #1 was admitted to the facility on 8/28/2023 with diagnoses including a bipolar disorder. Physician orders dated 8/26/2024 increase quetiapine (an antipsychotic medication) to 300 milligrams (mg) three times a day for bipolar depression. An Abnormal Involuntary Movement Scale (AIMS) assessment dated 12/8/2024 in Resident #1's electronic medical record (EMR) reported Resident #1 was not experiencing involuntary movements, which could potentially be an adverse side effect to psychotropic medications. There was no documentation of an AIMS assessment since 12/8/2024 for Resident #1 in the EMR. A review of the monthly Medication Regimen Reviews (MRR) recorded on the electronic medical record EMR) recorded there were irregularities in the medication regimen noted and there were pharmacy recommendations for Resident #1 from January 2025 to August 2025. The facility was unable to provide copies of the	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 45 pharmacy recommendations for Resident #1 for the period of 1/1/2025 through 8/31/2025. Resident #1's monthly Medication Regimen Review (MRR) dated 7/31/2025 conducted by the Pharmacist Consultant requested verification that an updated AIMS assessment had been completed and filed in the EMR for Resident #1. A review of Resident #1's August and September 2025 Medication Administration Record (MAR) recorded Quetiapine was administered three times a day as ordered with no behaviors documented for Resident #1. The facility was unable to provide a copy of the pharmacy recommendations for Resident #1 for the period of 8/1/2025 through 8/31/2025. In a phone interview 9/19/2025 at 4:02 PM, the Pharmacy Consultant explained the AIMS assessments was to be conducted by nursing staff every six months after the initial AIMS assessment for residents receiving antipsychotics. She explained when recommendations were not addressed, the recommendation was repeated the following month to be addressed and/or discussed with the Director of Nursing. The pharmacy consultant could not recall if she had discussed Resident #1's need for an updated AIMS assessment with the Director of Nursing. She stated she had been conducting a monthly MRR for Resident #1 and had emailed the physician and nursing recommendations to the Director of Nursing and Administrator at the end of each month from January 2025 to August 2025. The pharmacy consultant stated pharmacy recommendations were to remain with Resident #1 for the lifetime of his stay at the facility. The pharmacy consultant did not know who was responsible in maintaining storage of the pharmacy recommendations documenting that the pharmacy recommendations had been addressed. In an interview 9/19/2025 at 5:07 PM, the Director of Nursing (DON) stated she started at the facility in February 2025. She explained that since February 2025 the process was the pharmacy consultant emailed pharmacy recommendations to the DON and the DON provided the pharmacy recommendations to the Nurse Practitioner (NP) and the NP addressed the physician and nursing pharmacy recommendations. She stated the NP had access to the MAR to make changes as needed and referenced that the NP was a nurse. The DON stated the NP was responsible for signing the pharmacy recommendations and maintaining storage of the hard paper copy pharmacy recommendations addressed. The DON did not know where the NP stored the pharmacy	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 46 recommendations. She stated she was not able to locate the pharmacy recommendations for Resident #1 for the period of 1/1/2025 through 5/31/2025 and 8/1/2025 through 8/31/2025. She stated the nursing staff were to conduct the AIMS assessments every 6 months unless a change in the resident and the electronic medical record would trigger when Resident #1's AIMS assessment was due if the notification of AIMS assessment was activated. She stated Resident #1's EMR may not have been activated by the nursing staff to identify an AIMS assessment was due for Resident #1. The DON further stated the NP was responsible to communication nursing recommendations to the nursing staff and did not recall the NP communicating Resident #1 needed an AIMS assessment and did not think the NP was communicating Resident #1 needing an AIMS assessment to the nursing staff. In a phone interview on 10/1/2025 at 11:54 AM, the Nurse Practitioner stated up until March 2025 she would address physician and nursing pharmacy recommendations monthly. She explained she would correct medication orders for the nursing staff on the MAR. She stated nursing recommendations like AIMS assessments were highlighted on the hard paper copy of the pharmacy recommendations and returned to the Director of Nursing to address. She stated since March 2025, she had only been addressing the physician recommendations, and the Director of Nursing was responsible for addressing all the nursing recommendations. She stated the hard paper copy pharmacy physician recommendations that had been addressed were returned to the Director of Nursing to maintain in the DON office. The DON stated her email had been changed multiple times since starting at the facility because she realized she was not receiving emails. In an interview conducted on 9/19/2025 at 7:00 PM, the Administrator stated she did not think she was receiving pharmacy recommendations from the pharmacy consultant. She stated the Director of Nursing was responsible for receiving the pharmacy recommendations monthly and addressing the nursing recommendations and ensuring the physician/nurse practitioner addressed and returned the physician recommendations. She explained she was not aware who was maintaining copies of the addressed pharmacy recommendations at the facility. 4. Resident #2 was admitted to the facility 11/30/2022 with diagnoses including anxiety disorder, bipolar disorder, depression, and peripheral vascular disease. A review of the monthly Medication Regimen Reviews (MRR) on the electronic medical record EMR) recorded	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 47 there were irregularities in the medication regimen noted and there were pharmacy recommendations recorded for Resident #2 from January 2025 to August 2025. The facility was unable to provide copies of the pharmacy recommendations for Resident #2 for the period of 1/1/2025 through 5/31/2025 and 7/1/2025 through 7/31/2025. Resident #2's monthly Medication Regimen Reviews (MRR) dated 8/31/2025 conducted by the Pharmacist Consultant requested behavior monitoring be added to the morning dose of the clonazepam (an anti-anxiety/anti-seizure medication) order and to the divalproex sodium (an anti-seizure medication) order on the Medication Administration Record (MAR) and to add anticoagulant monitoring to the MAR. Physician orders as of 9/2/2025 included clonazepam 0.5 milligrams(mg) three times a day for anxiety, divalproex sodium delayed release 250 mg three times a day for bipolar depression, apixaban (anticoagulant) 5 mg two time a day for peripheral vascular disease, sertraline hydrochloride (HCL), an antidepressant 150 mg a day for bipolar depression. A review of Resident #2's September 2025 Medication Administration Record (MAR) revealed Resident #2 was administered medications as ordered. The MAR indicated when clonazepam (originally order on 5/2/2025) was changed to three times a day on 9/2/2025, behavior monitoring was not included on the MAR for the medication. There was no behavior monitoring attached to the divalproex sodium order on the MAR and sertraline HCL had been increased on from 100 mg (8/14/2025) to 150 mg on 9/11/2025. There was no behavior monitoring or anticoagulant monitoring included on the September MAR for documentation as requested in the 8/31/2025 MRR pharmacy recommendation. In a phone interview on 9/19/2025 at 4:02 PM, the Pharmacy Consultant explained when recommendations were not addressed, the recommendation was repeated the following month to be addressed and/or discussed with the Director of Nursing. The pharmacy consultant could not recall if she had discussed the monitoring behaviors and anticoagulants for Resident #2 with the Director of Nursing. She stated she had been conducting a monthly MRR for Resident #2 and had emailed the physician and nursing recommendations to the Director of Nursing and Administrator at the end of each month from January 2025 to August 2025. The pharmacy consultant stated pharmacy recommendations were to remain with Resident #2 for the lifetime of his stay at	F0756		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0756 SS = E	Continued from page 48 the facility. The pharmacy consultant did not know who was responsible in maintaining storage of the pharmacy recommendations documenting that the pharmacy recommendations had been addressed. In an interview 9/19/2025 at 5:07 PM, the Director of Nursing (DON) stated she started at the facility in February 2025. She explained that since February 2025 the process was that the pharmacy consultant emailed pharmacy recommendations to the DON, the DON provided the pharmacy recommendations to the Nurse Practitioner (NP) and the NP addressed the physician and nursing pharmacy recommendations. She stated the NP had access to the MAR to make changes as needed and referenced that the NP was a nurse. The DON stated that the NP was responsible for signing the hard paper copy pharmacy recommendations and maintaining storage of the pharmacy recommendations addressed and she did not know where the NP stored the pharmacy recommendations. She stated she was not able to locate the pharmacy recommendations for Resident #2 for the period of 1/1/2025 through to 5/31/2025 and 7/1/2025 through 7/31/2025. In a phone interview on 10/1/2025 at 11:54 AM, the Nurse Practitioner stated up until March 2025 she would address physician and nursing pharmacy recommendations monthly. She explained she would correct medication orders for the nursing staff on the MAR. She stated non-medications nursing recommendations were highlighted and returned to the Director of Nursing to address. She stated since March 2025, she had only been addressing the physician recommendations, and the Director of Nursing was responsible for addressing all the nursing recommendations. She stated the hard paper copy pharmacy physician recommendations that had been addressed were returned to the Director of Nursing to maintain in the DON office. In an interview conducted on 9/19/2025 at 7:00 PM, the Administrator stated she did not think she was receiving pharmacy recommendations from the pharmacy consultant. She stated the Director of Nursing was responsible for receiving the pharmacy recommendations monthly and addressing the nursing recommendations and ensuring the physician/nurse practitioner addressed and returned the physician recommendations. She explained she was not aware who was maintaining copies of the addressed pharmacy recommendations at the facility.	F0756		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	Resident #113 no longer resides in the facility. An audit was completed by the Director of Nursing by 10/20/25 on residents currently prescribed blood	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 49 §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, Pharmacy Consultant #1 and Nurse Practitioner and Cardiologist interviews, the facility failed to prevent a significant medication error when a resident was administered blood pressure medication with a blood pressure recorded below the parameters ordered by the physician for 1 of 6 residents whose medication regimens were reviewed (Resident #113). Finding included: Resident #113 was admitted to the facility on 6/5/2025 with diagnoses including hypertension (high blood pressure) and heart failure. Resident #113 was discharged from the facility on 9/2/2025. A review of Resident #113's blood pressure recorded in the electronic medical record from 6/6/2025 to 7/31/2025 ranged from 101/50 mmHg to 164/43 mmHg. The admission Minimum Data Set (MDS) assessment dated 6/12/2025 indicated Resident #113 was cognitively intact and was coded for hypertension. Resident #113's quarterly MDS dated 8/14/2025 was coded for orthostatic hypotension (sudden drop in blood pressure when a person stands up after sitting or lying down that can cause dizziness). Resident #113's care plan dated reviewed last on 6/18/2025 included a focus for a risk for cardiovascular symptoms or complications. Interventions included administering medications as ordered, assessing for effectiveness and reporting abnormalities to the physician and assessing and monitoring vital signs as ordered and reporting abnormalities to the physician. Nursing documentation dated 7/15/2025 by Unit Manager #2 recorded Resident #113 blood pressure was 86/50 and the Nurse Practitioner was notified.	F0760	Continued from page 49 pressure medications to ensure medications with parameters were being administered per physician's order. Any discrepancies identified were addressed. The Director of Nursing and/or a Nurse Manager educated Licensed Nurses and Medication Assistants currently working the facility by 10/22/25 on following physicians orders with emphasis on medications with parameters. Any Licensed Nurses who were unavailable during the education period will have the education prior to their next shift. This same education packet will be placed into the staff in-service education book and will be required during new hire orientation for Licensed Nurses and Medication Assistants. Any newly scheduled agency licensed nurses will also be provided the same education prior to working on the floor. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 8 weeks to ensure medications with parameters are being administered per physician's order. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 50	F0760		

Nurse Practitioner (NP) progress notes dated 7/15/2025 recorded while Resident #113 was having a therapy session, Resident #113 became lightheaded, dizzy and a drop in blood pressure. The NP recorded with Resident #113 positioned in bed with feet elevated, Resident #113 vital signs improved. NP rechecked on Resident #113 also later in the evening of 7/15/2025 with Resident #113 reporting she was feeling better and discussing with therapy Resident #113 needs and monitoring in therapy. NP progress notes further recorded Resident #113 had discussed with the NP that the cardiologist had recommended changing her medications and Resident #113 was scheduled to follow up with the cardiologist the following week.

A review of the occupational therapy notes recorded on 7/15/2025 Resident #113 complained of feeling lightheaded during the therapy session and nursing was notified. On 7/17/2025 occupation therapy notes recorded Resident #113 decline sitting on the edge of the bed or getting out of the bed due to concerns of her blood pressure dropping when upright and nursing staff were notified.

A review of the physical therapy notes on 7/15/2025 and 7/22/2025 recorded Resident #113 experienced dizziness and a drop in her blood pressure. On 7/15/2025, Resident #113's blood pressure was recorded as 84/69 mmHg after standing for therapy and on 7/22/2025 the blood pressure was recorded as 84/54 mmHg. Resident #113 was transferred back to bed and nursing staff notified. The physical therapy notes recorded no other complaints of dizziness or reports of drops in Resident #113's blood pressure during therapy session that were discontinued on 8/14/2025.

The Cardiology Provider progress notes dated 7/24/2025 recorded Resident #113 had recent episodes of dizziness upon standing/positioning that were likely due to reduced heart function, inactivity and possible autonomic neuropathy from diabetes. Treatment plan included Midodrine (a medication used to treat low blood pressure that cases severe dizziness) 5 milligrams (mg) 30 minutes before therapy to stabilize blood pressure and prevent drops in Resident #113's blood pressure, monitor Resident #113's blood pressure twice daily and record blood pressure readings and hold Coreg if systolic (first number in blood pressure reading) blood pressure was less than 150 millimeters of mercury (mmHg).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 51 Physician's orders dated 7/25/2025 included Coreg 12.5mg twice a day for blood pressure; hold for systolic blood pressure (top reading of a blood pressure) less than 150 mmHg and Midodrine HCL 5mg once a day for orthostatic hypotension. The Medication Administration Record (MAR) for July 2025, August 2025 and September 2025 for Resident # 113 were reviewed. Midodrine 5mg was administered daily as ordered. Coreg 12.5mg was scheduled on the MAR twice a day at 9:00 AM and 9:00 PM for blood pressure with a parameter recorded to hold for systolic blood pressure less than 150 mmHg. In July 2025 from 7/25/2025 to 7/31/2025, 3 out of the 14 scheduled doses of Coreg 12.5mg were recorded on the MAR as administered to Resident #113 when the blood pressure was recorded less than 150 systolic. On 7/26/2025 with a blood pressure reading recorded as 132/75 mmHg. On 7/27/2025 with a blood pressure reading recorded as 144/69 mmHg. On 7/28/2025 with a blood pressure reading recorded as 142/78mmHg. Review of the occupational therapy note recorded on 7/28/2025 Resident #113 reported feeling dizzy with transfer to the bathroom. Nurse was notified and blood pressure was within the normal range. In the month of August 2025, 37 out of the 62 scheduled doses of Coreg 12.5mg were recorded on the MAR as administered to Resident #113 when the blood pressure was recorded less than 150 mmHg systolic: On 8/2/2025 with a blood pressure reading recorded as 142/63 mmHg. On 8/3/2025 with a blood pressure reading recorded as 146/66 mmHg. On 8/4/2025 with a blood pressure reading recorded as136/78 mmHg and140/76 mmHg. On 8/5/2025 with a blood pressure reading recorded as	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 52 128/62 mmHg. On 8/6/2025 with a blood pressure reading recorded as 146/70 mmHg. On 8/7/2025 with a blood pressure reading recorded as 126/76 mmHg. On 8/8/2025 with a blood pressure reading recorded as 125/80 mmHg and 142/78 mmHg. On 8/9/2025 with a blood pressure reading recorded as 144/75 mmHg and 144/75 mmHg. On 8/10/2025 with a blood pressure reading recorded as 123/67 mmHg and 135/79 mmHg. On 8/11/2025 with a blood pressure reading recorded as 135/79 mmHg. On 8/12/2025 with a blood pressure reading recorded as 128/64 mmHg. On 8/13/2025 with a blood pressure reading recorded as 117/61 mmHg. On 8/14/2025 with a blood pressure reading recorded as 104/60 mmHg and 129/76 mmHg. On 8/15/2025 with a blood pressure reading recorded as 128/61 mmHg and 133/63 mmHg. On 8/16/2025 with a blood pressure reading recorded as 143/70 mmHg. On 8/17/2025 with a blood pressure reading recorded as 143/70 mmHg and 135/69 mmHg. On 8/18/2025 with a blood pressure reading recorded as 120/68 mmHg. On 8/21/2025 with a blood pressure reading recorded as 121/76 mmHg. On 8/22/2025 with a blood pressure reading recorded as 100/71 mmHg and 135/59 mmHg. On 8/24/2025 with a blood pressure reading recorded as 138/58 mmHg. On 8/26/2025 with a blood pressure reading recorded as 122/74 mmHg and 131/75 mmHg. On 8/27/2025 with a blood pressure reading recorded as	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 53 133/72 mmHg. On 8/28/2025 with a blood pressure reading recorded as 127/70 mmHg and 129/74 mmHg. On 8/29/2025 with a blood pressure reading recorded as 129/74 mmHg and 130/72 mmHg. On 8/30/2025 with a blood pressure reading recorded as 122/79 mmHg and 117/65 mmHg. Review of the occupational therapy note recorded on 8/1/2025, Resident #113 was able to tolerate the therapy session but complained of dizziness during the therapy session with Resident #113's blood pressure recorded as 110/53. There were no other reports of Resident #113 experiencing dizziness or drops in blood pressure during therapy sessions. In September 2025 from 9/1/2025 to 9/3/2025, 1 out of the 3 scheduled doses of Coreg 12.5mg were recorded on the MAR as administered to Resident #113 when the blood pressure was recorded less than 150 systolic. On 9/2/2025 with a blood pressure reading recorded as 132/77 mmHg. The monthly Pharmacy Consultant's Medication Regimen Reviews dated 7/31/2025 and 8/30/2025 recorded Coreg was given and should have been held for systolic blood pressure less than 150 mmHg on 7/26/2025, 8/2/2025, 8/3/2025, 8/4/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, 8/9/2025, 8/10/2025, 8/11/2025, 8/12/2025, 8/13/2025, 8/14/2025, 8/15/2025, 8/16/2025, 8/17/2025, 8/18/2025, 8/20/2025, 8/21/2025, 8/22/2025, 8/24/2025 and 8/26/2025. There was no documentation that the recommendations on MRRs dated 7/31/2025 and 8/30/2025 for Coreg were addressed by a medical provider or nursing staff. In an interview on 9/19/2025 at12:16 PM, the Certified Occupational Therapy Assistant stated Resident #113's had experienced some episodes of dizziness with a drop in her blood pressure during therapy. She explained Resident #113 was started on a medication to treat orthostatic hypotension that was administered to Resident #113 before therapy sessions and Resident #113 was able to participate more in therapy with decrease complaints of dizziness.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 54 In an interview on 9/17/2025 at 5:09 PM. Nurse #7 reviewed Resident #113's August 2025 and September 2025 MAR and stated based on her documentation on the MARs she administered Coreg to Resident #113 on 8/26/2025, 8/14/2025 and 9/2/2025. Nurse #7 stated based on the physician order on the August 2025 and September 2025 MARs to hold for systolic blood pressure less than 150 mmHg, the medication Coreg should not have been administered to Resident #113 when the blood pressure was recorded less than 150 mmHg. Nurse #7 explained she checked Resident #113 blood pressure before giving the medication and did not read the order completing before administering the mediation. In an interview on 9/17/2025 at 5:33 PM, when Medication Aide #1 read Resident #113 order for Coreg on the August 2025 MAR, she stated Resident #113's systolic blood pressure was less than 150 mmHg and asked what was wrong in administering Resident #113 the medication. When Medication Aide #1 re-read the physician order for Coreg administration, she stated based on the physician order on the August 2025 MAR, she shouldn't have administered the medication on 8/8/2025, 8/9/2025, 8/10/2025 and 8/22/2025 to Resident #113 based on the blood pressure recordings were less than 150 mmHg. Medication Aide #1 stated she did not know why she administered Resident #113 the medication with the order to hold the medication for blood pressure less than 150 mmHg. In a phone interview on 9/19/2025 at 9:41 AM, Nurse #8, who recorded administering 12 doses of Coreg to Resident #113 when the systolic blood pressure was recorded less than 150 mmHg, stated the documentation on the July 2025 and August 2025 MAR was incorrect. Nurse #8 could not explain why she had recorded on the MAR that the medication Coreg was administered on 7/27/2025, 8/2/2025, 8/3/2025, 8/8/2025, 8/9/2025, 8/10/2025, 8/15/2025, 8/16/2025, 8/17/2025, 8/22/2025, 8/24/2025 and 8/30/2025 but insisted Resident #113 knew what medications were administered and Resident #113 would not have allowed her to administer the medication. In an interview on 9/17/2025 at 5:50 PM, the Director of Nursing recalled Resident #113 experiencing some orthostatic hypotension with therapy sessions that was treated with medication. After reviewing the August 2025 MAR for Coreg administration, she explained if the nurses did not scroll down the MAR to view the entire	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 55 medication order, the nurses may have not seen the hold order for the medication Coreg. She stated she did not know why the nurses did not hold the medication when the systolic blood pressure was recorded less than 150 mmHg and stated the medication; Coreg should have been held per the physician's order when Resident #113 systolic blood pressure was recorded less than 150 mmHg. The DON further stated she did not recall any negative side effects due to Resident #113 receiving the medication when the systolic blood pressure was recorded less than 150 mmHg. In an interview on 9/19/2025 at 4:02 PM, the Pharmacy Consultant stated receiving Midodrine HCL daily prevented Resident #113 from becoming hypotensive (less than 90/60 mmHg). In an interview on 9/17/2025 at12:42 PM, the Nurse Practitioner explained Resident #113 was on Coreg to conserve her heart function to alleviate the possibility of heart surgery. Resident #113 was experiencing some orthostatic hypertension, and the Cardiologist ordered the Coreg to be held when systolic blood pressure was less than 150. She stated she was not aware or notified that Resident #113 had been administered Coreg when Resident#113's systolic blood pressure was recorded less than 150. She explained that the Cardiologist had ordered Midodrine HCL that would have worked opposite of the Coreg medication and Resident #113's symptoms of orthostatic hypotension improved. In a phone interview with the Cardiologist on 9/19/2025 at12:20 PM, she stated Resident #113 was seen in July 2025 for orthostatic hypotension. She explained Resident #113 reported she was not able to stand up and participate in therapy because of feeling dizzy when standing. She stated she ordered parameters to hold Resident #113's blood pressure medication if systolic blood pressure was less than 150 and started Resident #113 on Midodrine HCL 5mg a day for the orthostatic hypotension. She explained she had not seen Resident #113's July 2025, August 2025 or September 2025 Medication Administration Records that indicated the blood pressure medication was given when a blood pressure was recorded less than 150. She explained Midodrine HCL was medication that Resident #113 received daily to elevate Resident #113's blood pressure and therefore, when Coreg was administered when Resident #113's systolic blood pressure was less than 150mmHg, Resident #113's blood pressure was able	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025
NAME OF PROVIDER OR SUPPLIER: Mount Olive Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0760 SS = E	Continued from page 56 to remain in the normal range for blood pressures.	F0760		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to secure medications in an unlocked medication cart for 1 of 4 medications carts (medication cart #1) and to discard an unlabeled open vial of insulin from a refrigerator in a medication room (Nursing Station #2 medication room) and secure the locked refrigerated controlled medication black box to a permanent structure in 2 of the 3 medication rooms (Nursing Station #1 medication room and Nursing Station #3 medication room) reviewed for medication storage. Findings include: 1. On 8/14/25 at 10:55 AM, a continuous observation began of an unlocked medication cart #1 located at Nursing Station #3. There was no nursing staff observed	F0761	Medication cart #1 was locked on 9/14/2025 by Nurse #3. Nurse #3 was educated by the Regional Director of Nursing on securing medication carts on 9/14/2025 On 9/19/2025, the Licensed Nurse discarded the unlabeled open vial of insulin from the refrigerator in Nursing Station #2 medication room. The maintenance assistant will secure the locked refrigerated controlled medication black box to a permanent structure in Nursing Station medication room. A quality review was completed by the Regional Director of Nursing and/or Nurse Manager on current prescribed medications to ensure all medications have been dated and labeled upon opening and per the manufactures recommendations storage and / or expiration on 9/30/25 on all medication carts and in the medication storage room. No issues identified. A quality review was completed by the Regional Director of Nursing on 9/30/25, through observation, to ensure 4 of 4 medication carts were locked. No issues were identified. A quality review was conducted by the Regional Director of Nursing through observation to ensure the locked refrigerated controlled medication black box in 3 medication storage rooms is secured to a permanent structure by 10/21/2025. No issues identified. The Regional Clinical Lead educated the Director of Nursing on 10/17/25 to ensure locked refrigerated controlled medication black box in the medication rooms are secured to a permanent structure. The Director of Nursing educated all licensed nurses by 10/22/25 working at the facility and medication aides regarding medication storage to include dating upon opening and returning medications after manufacturers recommended storage time has expired and securing the medication carts. Any licensed nurses working at the facility or medication aides who were unavailable during the education period will have the same education prior to their next shift. The same education packet will be placed into the licensed nurse and Medication Aide in-service education book for new hires and will be	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0761 SS = E	Continued from page 57 at medication cart #1 or at Nursing Station #3 and the lock on medication cart #1 was observed extending outward. Resident #80 was observed walking past the unlocked medication cart #1 and Resident #73 self-propelling his wheelchair past the unlocked medication cart #1. At 10:57 AM, Resident #60 was observed walking past the unlocked medication cart #1. At 11:00 AM, Resident #69 was observed self-propelling his wheelchair past the unlocked medication cart #1. At 11:03 AM, Nurse Aide #6 was observed walking past the unlocked medication cart #1 and Nurse #3 was observed exiting room 404 located across from Nursing Station #3 and walking past the unlocked medication cart #1 to enter the dirty utility room. At 11:04, Nurse #3 was observed addressing Resident #80 who was observed standing in front of the unlocked medicating cart #1 and assisting Resident #80 back to his room down the hall with medication cart #1 remaining unlocked. The continuous observation stopped at 11:06 AM when Nurse #3 returned to the unlocked medication cart #1. On 9/14/2025 at 11:06 AM in an observation and interview with Nurse #3, the locked-on medication cart #1 was observed extending outward. With the lock on medication cart #1 extending outward, the top drawer on the left side of medication cart #1 was opened and observed filled with multiple bottles of over-the-counter medications. Additionally, all four of the drawers on the right side of medication cart #1 were able to be opened and respiratory inhalers, ear and eye medications, a locked narcotic box, diabetic supplies and blood pressure cuffs were observed in the drawers. The three remaining drawers on the left side of medication cart #1 that contained residents' medications from the pharmacy would not open. Nurse #3 explained the lock on medication cart #1 was only halfway extended outward and the lock to medication cart #1 had to be extended completing out for the drawers with residents' medications to open. Nurse #3 stated to lock all drawers on medication cart #1 the lock had to be pushed in completely and stated medication cart #1 was not locked. Nurse #3 was observed using her hand to pull on the halfway extended outward lock to extend the lock outward completely that allowed the drawers with residents' medications to open. Nurse #3 stated that anyone including residents could have extended the lock on medication cart #1 to access residents' medications and also had access to other medications stored on the medication cart. She stated all drawers on medication cart #1 were to be locked when the nurse was not at medication cart #1 and explained when she went to help resident in room 404, she only pushed the lock halfway. Nurse #3 also stated medication cart #1 was not completely locked to allow	F0761	Continued from page 57 included in new hire orientation for licensed nurses and medication aides to be given by the Director of Nursing and/ or the Nurse Managers. The same education will be provided to any newly scheduled agency licensed nurses prior to them working on the floor. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, 1x per week for 4 weeks, to ensure medication carts are secured, medications are dated and labeled upon opening and to ensure locked refrigerated controlled medication black box in the medication rooms are secured to a permanent structureThe monitors will be presented to the Quality Assurance Committee each month. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0761 SS = E	Continued from page 58 nurse aides access to blood pressure supplies on medication cart #1. In an interview on 9/15/2025 at 2:37 PM, Regional Nurse Consultant stated medication cart #1 should been locked at all times when Nurse #3 was not present at medication cart #1. In an interview with the Director of Nursing on 9/15/2025 at 2:16 PM, she stated medication cart #1 should have been completely locked when Nurse #3 was not present at medication cart #1. 2. On 9/19/25 at 11:22 AM, there was a vial of opened Lispro Insulin 100 units per milliliter observed in an illegible labeled medication bottle stored in the medication refrigerator in Nursing Station #2 medication room. The vial of Lispro insulin with an expiration date of 10/5/2027 was not labeled with an open date or a discard date. The manufacturer guide for Lispro insulin stated the vial of Lispro insulin should be discarded 28 days after opening and could be stored unrefrigerated for the duration of the 28 days. On 9/19/2025 at 11:25 AM, Unit Manager #2 stated she checked Nursing Station #2 medication room for medication expirations on 9/18/2025 and all nurses were responsible for checking medication rooms periodically throughout the week. Unit Manager #2 stated when checking the refrigerator temperature in Nursing Station #2 medication room on the morning of 9/19/2025, she did not see the medication bottle with the vial of Lispro insulin because she was pulled out of the medication room to conduct another task before checking the medications. Unit Manager #2 stated the vial of Lispro insulin should have been labeled with an open date and discard date on the vial of insulin. She also stated the medication container should have legible resident information recorded on the label. Unit Manager #2 explained she would ask her supervisor what to do with the vial of insulin and stated she would not use the vial of Lispro insulin for a resident due to no opened date and/or discard date on the vial of insulin. In an interview on 9/19/2025 at 6:04 PM, Director of Nursing stated the unlabeled vial of Lispro insulin with no open and/or discard date and legible resident information on medication container should not have been in the refrigerator in Nursing Station #2 medication room. The Director of Nursing explained insulin expires in 30 days after opening and the vial of Lispro insulin should have been labeled with a date	F0761		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0761 SS = E	Continued from page 59 it was open, and a legible resident label should have been on the medication bottle. The Director of Nursing stated that the vial of Lispro insulin was discarded. 3. On 9/19/2025 at 11:35 AM, an unsecured (not secured to a structure that was not moveable) locked black box that was used to store refrigerated controlled medications was observed in an unlocked refrigerator in the locked Nursing Station #1 medication room. There was no lock observed outside the refrigerator. Unit Manager #1 stated she did not have the key to unlock the black box. On 9/19/2025 at 11:40 AM, Nurse #5 explained there was only one key to the locked black box in the unlocked refrigerator. Nurse #5 was observed removing the locked black box from the unlocked refrigerator and placing on the counter of the medication room. When Nurse #5 unlocked the black box, three unopened vials of Lorazepam (a controlled medication) 20 milligrams per 10 milliliters with an expiration date of March 2026 were observed in a medication bottle that had been filled by the pharmacy on 9/8/2025 for a resident. Nurse #5 stated that although Nursing Station #1 medication room was locked and the black box that stored controlled medications was locked, the locked black box was not secured to a permanent structure to prevent a person to remove the locked black box out of the locked medication room. On 9/9/2025 at 11:50 AM, in Nursing Station #3 medication room, the locked black box that was used to store refrigerated controlled medications was observed in a unlocked refrigerator and unsecured to a permanent structure. There was no lock observed outside the refrigerator. When Unit Manager #3 unlocked the black box, there were no controlled medications observed in the black box. In an interview on 9/9/2025 at 6:04 PM. Director of Nursing stated the black boxes that store refrigerated controlled medications in Nursing Station #1 medication room and Nursing station #3 medication room was not secured to a permanent structure to prevent removal of the locked black box from the medication rooms. She also stated the refrigerators in the medication rooms did not have a lock on the outside of the refrigerator. She explained that the refrigerated controlled medications that were stored in locked black boxes in the refrigerators were behind two locking mechanisms: the locked medication room doors and the locked black boxes and she considered the refrigerated controlled medications securely stored.	F0761		
F0842 SS = E	Resident Records - Identifiable Information	F0842	Resident #113 no longer resides in the facility. On	10/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0842 SS = E	Continued from page 60 CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F0842	Continued from page 60 9/14/25, resident #91's and resident #39 oxygen concentrator settings were corrected to match the liters per minute as prescribed by the physician's order by a nurse manager.. An audit was completed by the Director of Nursing by 10/20/25 on residents currently prescribed blood pressure medications to ensure medications with parameters were being administered per physician's order. Any discrepancies identified were addressed An audit was completed by the Director of Nursing by 10/20/25 on residents currently prescribed supplemental oxygen to ensure administration of oxygen was accurately documented. The Director of Nursing and/or a Nurse Manager provided education to the Licensed Nurses and Certified Medication Assistants currently working the facility by 10/10/25 on maintaining accurate medical record in documenting the administration of oxygen and medications with emphasis on medication with parameters as indicated per physicians orders. Any Licensed Nurses and Certified Medication Assistants who were unavailable during the education period will have the education prior to their next shift. This same education packet will be placed into the staff in-service education book and will be required during new hire orientation for Licensed Nurses and Medication Assistants. Any newly scheduled agency licensed nurses will also be provided the same education prior to working on the floor. The Director of Nursing and/or Nurse Manager will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 8 weeks to ensure receiving supplemental oxygen is being administered per physician orders to include the number of liters per minute. The Director of Nursing or Nurse Managers will conduct quality improvement monitoring 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 8 weeks to ensure medications with parameters are being administered per physician's order. The results of the quality monitoring will be reported by the Director of Nursing or Nurse Managers to the Quality Assurance Performance Improvement Committee Meeting monthly for 3 months. Quality Monitoring schedules may be modified based on quality monitoring findings. The Quality Assurance Performance Improvement Committee members consist of but not limited to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0842 SS = E	Continued from page 61 §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and staff interviews, the facility failed to maintain an accurate medical record in documenting the administration of oxygen reviewed (Resident #39, and Resident #91) and medications (Resident #113) for 3 of 15 residents whose medical records were reviewed. 1. Resident #113 was admitted to the facility on 6/5/2025 with diagnoses including hypertension (high blood pressure) and heart failure. Physician's orders dated 7/25/2025 included Coreg 12.5 milligrams (mg) twice a day for blood pressure; hold for systolic less than 150 millimeters of mercury (mmHg).	F0842	Continued from page 61 Executive Director, Director of Clinical Services, Nursing Supervisor, Medical Director, Social Services Director, Activities Director, Maintenance Director and Minimum Data Assessment Nurse and at least one direct care staff.. The facility will audit to ensure compliance of the deficient practice through audits and education.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345126**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **10/01/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0842 SS = E	Continued from page 62 A review of Resident #113's July and August 2025 Medication Administration Record recorded Nurse #8 administered Coreg 12.5 mg with a blood pressure recording less than 150 mmHg: on 7/27/2025 with a blood pressure reading of 144/69 mmHg, 8/2/2025 with a blood pressure reading of142/63 mmHg, 8/3/2025 with a blood pressure reading of 146/66 mmHg, 8/8/2025 with a blood pressure reading of 142/78 mmHg, 8/9/2025 with a blood pressure reading of 144/75 mmHg, 8/10/2025 with a blood pressure reading of 135/79 mmHg, 8/15/2025 with a blood pressure reading of 133/63 mmHg, 8/16/2025 with a blood pressure reading of143/70 mmHg, 8/17/2025 with a blood pressure reading of 135/69 mmHg, 8/22/2025 with a blood pressure reading of135/59 mmHg, 8/24/2025 with a blood pressure reading of138/58 mmHg and 8/30/2025 with a blood pressure reading of 117/65 mmHg. In a phone interview on 9/19/2025 at 9:41 AM, Nurse #8, stated the documentation on the July 2025 MAR and August 2025 MAR was incorrect. Nurse #8 could not explain why she had recorded that the medication Coreg was administered on 7/27/2025, 8/2/2025, 8/3/2025, 8/8/2025, 8/9/2025, 8/10/2025, 8/15/2025, 8/16/2025, 8/17/2025, 8/22/2025, 8/24/2025 and 8/30/2025 and stated she did not document administration of the medication correctly. She explained Resident #113 would not have allowed her to administer the medication if her blood pressure was less than 150 mmHg. Nurse #8 stated the Resident's July MAR and August MAR reflected an inadequate record. In an interview on 9/19/2025 at 5:07 PM, the Director of Nursing stated Nurse #8 should not have documented the medication, Coreg, was administered to Resident #113 if not administered when the blood pressure was less than 150 mmHg. Therefore, Resident #113's July and August 2025 Medication Administration Records did not reflect an accurate record of Resident #113's medication administration. In an interview on 9/19/2025 at 7:00 PM, the Administrator stated Nurse #8 should have documented the administration accurately to ensure Resident #113's record was an adequate record. Findings included: 2. Resident #39 was admitted to the facility on 7/23/25	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0842 SS = E	Continued from page 63 with diagnoses which included acute respiratory failure with hypoxia (a medical condition where the lungs are unable to adequately provide oxygen to the body, resulting in a dangerously low level of oxygen in the blood), severe persistent asthma with acute exacerbation, acute bronchitis and hypoxemia. Resident #39's Physician order dated 7/24/25 included an order for oxygen at 3 liters per minute to maintain 90% and above oxygen saturation via nasal cannula. A review of Resident #39's September 2025 Medication Administration Record (MAR) recorded Resident #39 received 3 liters of oxygen via nasal cannula on 9/15/25 and recorded oxygen saturation was 97 percent (%) documented by Medication Aide #1 Observation on 9/15/25 at 8:44 am Resident #39 was in his room lying in bed wearing a nasal cannula and his oxygen concentrator on 4 liters per minute. During an interview with Medication Aide #1 on 9/15/25 at 1:15 pm, she stated she was the medication aide for Resident #39 on day shift (7:00 am until 3:00 pm) for 9/15/25. Medication Aide #1 further stated the oxygen concentrator read 4 liters per minute and she documented at 4 liters per minute. During an interview on 9/15/25 at 2:02 pm with the Director of Nursing (DON), she stated the nursing staff should be reading the physician orders and checking the oxygen concentrators for the correct liters per minute setting every shift for accurate documentation. 3. Resident #91 was admitted to the facility on 6/29/24 with diagnoses which included chronic obstructive pulmonary disease (COPD), altered mental status, chronic systolic heart failure, and wheezing. Resident #91's Physician order dated 7/5/24 for oxygen at 2 liters per minute via nasal cannula for hypoxia. A review of Resident #91's September 2025 Medication Administration Record (MAR) recorded Resident #91 received 2 liters of oxygen via nasal cannula each shift on 9/14/25 and recorded oxygen saturations of 97 percent (%) documented by Nurse #2. Observations on 9/14/25 at 9:22 am and 9/14/25 at 1:45 pm revealed Resident #91 was in his room lying in bed wearing a nasal cannula and his oxygen concentrator on 6 liters per minute.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345126	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	**228 Smith Chapel Road , Mount Olive, North Carolina, 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
F0842 SS = E	Continued from page 64 In a phone interview with Nurse #2 on 9/17/25 at 4:15 pm, she stated she was the nurse for Resident #91 during the night shift (7:00 pm to 7:00 am). Nurse #2 further stated she documented Resident #91 was on 2 liters per minute in the MAR. During an interview on 9/15/25 at 2:02 pm with the Director of Nursing (DON), she stated the nursing staff should be reading the physician orders and checking the oxygen concentrators for the correct liters per minute setting every shift for accurate documentation.	F0842		