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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mount Olive Center	228 Smith Chapel Road Mount Olive, NC 28365

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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). 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 [DATE] stated Resident #13 had a g-tube placement in 2015 secondary to a stroke. The discharge summary stated Resident #13 was admitted on [DATE] 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 [DATE] 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 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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 [DATE] indicated Resident #113 was cognitively intact and was coded for hypertension. Resident #113's quarterly MDS dated [DATE] 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. 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). 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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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). 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 [DATE] 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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. 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.