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	12/18/2025

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff, Pharmacy Consultant, Medical Director, and Corporate Medical Director interviews, the facility did not ensure a resident was free of a significant medication error when Resident #1 received 60 milligrams (mg) of oxycodone (a short-acting opioid which is a class of drug used to reduce moderate to severe pain). Oxycodone 60 mg was not prescribed to Resident #1. On 11/28/25 Resident #1 was given oxycodone 60mg medication prescribed to another resident. This deficient practice affected 1 of 5 residents reviewed for significant medication error.Findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included Parkinson's disease (a brain disorder that primarily affects movement) with dyskinesia (involuntary, erratic movements), dementia, and palliative (specialized medical support for people with serious illnesses) care.Resident #1's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively impaired and did not receive opioid medications.Review of Resident #1's active and discontinued orders revealed she did not have an order to receive oxycodone.Review of a medication related incident report dated 11/28/25 indicated that Resident #1 was administered 60 mg of oxycodone that was intended for another resident. The incident report revealed Resident #1 was assessed, the Nurse Practitioner (NP) and Director of Nursing (DON) were notified, an intravenous (IV: within a vein) fluid bolus (a single, large amount of intravenous (IV) fluids administered quickly to a patient) and naloxone (a medication used to reverse opioid overdoses) were ordered, neurological checks (a quick, simple assessment of your nervous system (brain, spinal cord, nerves) by a healthcare provider, checking things like alertness, reflexes, balance, strength, and senses to spot problems like weakness, numbness, or confusion, often using questions, and lights) remained stable, and no distress was observed.Review of the facility's investigation report revealed on 11/28/25 during a medication pass, Nurse #1 administered 60 mg of oxycodone to Resident #1 that was intended for another resident. The DON and the Unit Manager were immediately notified and assessed Resident #1. The Nurse Practitioner was notified by the Unit Manager, and naloxone and 1 liter (L) of IV fluid were ordered. Resident #1 remained alert and her vital signs remained stable. Resident #1's resident representative was notified of the incident. Resident #1 was monitored after the administration of 60 mg of oxycodone per the facility's neurological (neuro) check protocol (every 15 minutes (min) x 2 hours, then every 30 min x 2 hours, then every 60 min x 4 hours, then every 8 hours until at least 72 hours had elapsed).Review of Resident #1's Neuro (neurological) Check Flow Sheet revealed her neuro checks and vital signs were performed per the facility's neuro check protocol and Resident #1 remained stable.Resident #1's medical orders were reviewed. She had an order dated 11/28/25 for naloxone HCL (hydrochloric acid) liquid 4 mg/0.1milliliters (ml) one (1) spray alternating nostrils every 2 minutes as needed for signs of opioid overdose; may be repeated every 2 to 3 minutes for unresponsiveness or difficulty breathing, until individual is breathing (respiratory rate greater than 10 per minute). Resident #1 also had an order dated 11/28/25 for sodium chloride solution 0.9 % (a sterile mixture of 0.9 grams of salt (sodium chloride) dissolved in 100 milliliters of water; a salt concentration like that of human blood and bodily fluids) one (1) liter intravenously one time only for hydration for a 1-day bolus.An interview was conducted on 12/18/25 at 11:29 AM with Nurse #1. Nurse #1 stated she was in training and Nurse #2 handed her medication (oxycodone) intended for Resident #1's roommate. Nurse #1 stated she thought they were for Resident #1 and gave the medication (oxycodone) accidentally to her. Nurse #1 stated she recalled she verified Resident #1's name. Nurse #2 informed her she gave the medication to the wrong resident. Nurse #1 stated she notified the Unit Manager, who called the NP, and received orders. She stated Resident #1 was closely monitored and a few hours after receiving the medication she became sleepy and received one dose of naloxone. Nurse #1 continued to monitor Resident #1, and she was acting like her normal self. Nurse #1 stated the incident was reported to the next oncoming shift.Review of Resident #1's medication administration record (MAR) revealed she received one dose of naloxone at 2:15 PM on 11/28/25.An interview was conducted on 12/17/25 at 6:15 PM with Nurse #2 who was training Nurse #1 on 11/28/25. Nurse #2 stated Nurse #1 asked if she could take the medications into the resident room. Nurse #2 stated she told Nurse #1 the medication was for Resident #1's roommate. Nurse #2 stated she was still at the medication cart preparing Resident #1's medications at that time. Nurse #2 stated she went into the room and saw Nurse #1 standing in front of Resident #1, and she immediately knew Nurse #1 gave Resident #1 the wrong medication. Nurse #2 stated she did not hear or see Nurse #1 confirm Resident #1's name. Nurse

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and staff interviews, the facility did not maintain accurate records related to documentation of medication administration for 1 of 7 residents reviewed for accurate medical records (Resident #2). The findings included:Resident #2 was admitted to the facility on [DATE] with diagnoses which included chronic pain syndrome and fibromyalgia (a chronic condition causing widespread body pain, fatigue, sleep problems, and cognitive difficulties).A review of Resident #2's physician orders revealed an order dated 12/12/25 for oxycodone-acetaminophen 5-325 milligrams (mg) give one (1) tablet by mouth every 6 hours as needed for pain.Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg was reviewed. The narcotic record revealed Resident #2 received one (1) oxycodone-acetaminophen 5-325 mg tablet on 12/12/25 at 4:30 PM and at 10:00 PM.A review of Resident #2's December 2025 Medication Administration Record (MAR) indicated oxycodone-acetaminophen 5-325 mg was not documented as administered on 12/12/25 at 4:30 PM or at 10:00 PM.During a phone interview with Nurse #3 on 12/18/25 at 11:03 AM she confirmed she signed Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg on 12/12/25 at 4:30 PM. Nurse #3 stated she thought she had signed the oxycodone-acetaminophen 5-325 mg tablet off in Resident #2's MAR, and if her initials were not there it was an error on her part. She stated when administering narcotics to any resident she would typically hit (highlight) the medication on the MAR as soon as she pulled the narcotic from the locked box, sign the medication out in the narcotic count book, administer the medication to the resident, and return to the MAR and sign the MAR record.Attempts to reach Nurse #4 who signed Resident #2's individual narcotic record sheet for oxycodone-acetaminophen 5-325 mg on 12/12/25 at 10:00 PM were unsuccessful. Nurse #4 was no longer employed at the facility.An interview was conducted with the Director of Nursing (DON) on 12/18/25 at 1:34 PM. She stated medications were supposed to be documented on both the MAR and narcotic sheet when they were administered to a resident. During an interview with the Administrator on 12/18/25 at 1:54 PM she stated narcotics should be documented on both the narcotic sheet and the MAR.