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Form Approved OMB
No. 0938-0391

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	01/28/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident, and staff interviews, the facility failed to protect a resident's right to be free from misappropriation of $300.00 after Resident #1 mistakenly transferred funds to Nurse Aide #1 on a money transfer application. This was for 1 of 3 residents reviewed for misappropriation of property (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE].The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 was assessed as cognitively intact.During an interview on 1/22/2026 at 3:05 PM, Resident #1 reported that around Christmas he asked Nurse Aide (NA) #1 to obtain groceries for him from a local store. The resident stated he transferred $120.00 to NA #1 through a money transfer application on his phone to pay for the groceries. Resident #1 confirmed NA #1 did bring him his groceries and provided a reciept. The resident further stated that on the following day, 12/27/2025, he accidentally transferred an additional $300.00 to NA #1 while attempting to send money to a relative for rent. Resident #1 reported that when NA #1 returned to work, he asked her to return the $300.00. According to the resident, NA #1 told him her account had a negative balance, and the money had already been withdrawn. The resident stated NA #1 told him she would repay him when she received her paycheck in two weeks. Resident #1 stated he repeatedly asked NA #1 for the money, but she avoided him and continued to tell him she did not have the funds. The resident reported he attempted to negotiate partial repayment, first requesting $200.00 and later $150.00, but NA #1 still did not return any money. Resident #1 stated he informed the Social Worker on 1/12/2026 that NA #1 was not returning the money, but no action was taken. The resident stated he eventually reported the matter to the Administrator on 1/16/2026, who returned the $300.00 to him. Resident #1 also stated law enforcement interviewed him on 1/16/2026, but he declined to press charges and was satisfied to have his money returned.Review of the transactions on the money transfer application on Resident #1's phone revealed the following information. On 12/26/2025 Resident #1 paid $120.00 to NA #1 for My groceries. On 12/27/2025 Resident #1 transferred $300.00 to NA #1 for Rent. On 1/3/2026 Resident #1 requested $200.00 from NA #1, but the request expired. On 1/4/2026, 1/5/2026, and 1/12/2026 Resident #1 requested $150.00 from NA #1, but the requests expired. All requests were made through the money transfer application.During an interview on 1/22/2026 at 5:06 PM conducted on the telephone, NA #1 stated Resident #1 frequently ordered food deliveries. NA #1 reported that on 12/26/2025 Resident #1 became upset when a grocery delivery was not brought into the facility because it was after 5:00 PM and there was no one at the front desk to let the delivery person into the locked building. NA #1 stated she offered to go to the store to deescalate the situation. NA #1 explained Resident #1 did not have cash, so he sent her funds through the money transfer application for the groceries. Did she bring him the $120 worth of groceries? NA #1 stated she was off work the next day (12/27/2025) and noticed Resident #1 had transferred $300.00 to her account, but she did not know why. NA #1 stated that when she next worked (12/28/2025), she asked the resident about the transfer, and he told her (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was a mistake and requested the money back. NA #1 stated the explanation given by Resident #1 was that he did not have a lot of hand coordination and his shaky hands accidentally sent money to her instead of a family member. NA #1 stated she had over drafted her account and the $300.00 had already been withdrawn automatically by the money transfer application. She stated she told the resident she would repay him when she received her paycheck on 1/16/2026. NA #1 acknowledged the resident continued to ask for the money, but she did not have it to return. NA #1 stated on 1/16/2026 the Administrator called her regarding the matter of the funds, and she came to the facility on her day off to provide $300.00 in cash to the Administrator, who accompanied her to return the money to Resident #1. NA #1 stated she did not intend to take money from Resident #1 and believed the issue would be resolved once she was paid. NA #1 confirmed she had been suspended from her job because she did not come forward to let the Administrator know about the mistaken transfer of money to her by Resident #1 and was suspended until the conclusion of the investigation. NA #1 confirmed she was educated about not taking any money from the residents for any reason.During an interview on 1/22/2026 at 10:49 AM conducted on the telephone, the Social Worker stated Resident #1 informed her on 1/12/2026 that he inadvertently sent $300.00 to NA #1 at Christmas time. Resident #1 told the Social Worker that NA #1's account balance on the money transfer application was negative and she would repay him after receiving her paycheck on 1/16/2026. The Social Worker stated she doubted the truthfulness of the resident's account and decided to wait to see if NA #1 would return the money. On 1/16/2026, NA #1 was not answering phone calls from the Social Worker and was not scheduled to work. At 4:00 PM on 1/16/2026, the Social Worker notified the Administrator of Resident #1's concern that NA #1 was not going to return his funds.The facility Administrator and the Director of Nursing were simultaneously interviewed on 1/22/2026 at 4:46 PM. The Administrator revealed she was notified on 1/16/2026 by the Social Worker that NA #1 owed Resident #1 $300.00. The Administrator stated she interviewed both Resident #1 and NA #1, who provided consistent explanations of the accidental transfer. The Director of Nursing stated NA #1 should not have given Resident #1 her account information for the money transfer application to buy groceries and she should have immediately notified herself (the Director of Nursing) or the Administrator when she became aware the $300.00 was accidentally put into her account. The Administrator confirmed that she educated NA #1 that she should not take money from the residents for any reason. The Administrator stated she would have immediately refunded Resident #1 his $300.00 if she had been made aware.The facility provided a corrective action plan that was not acceptable to the State Agency. When addressing how the facility identified other residents as having potential to be affected by the same deficient practice, they did not address all cognitively impaired residents. The facility's monitoring plan did not address how the facility would monitor to ensure the deficient practice would not recur for all cognitively impaired residents. Additionally, as of 1/23/2026 the State Agency had not received an initial report for the allegation of misappropriation involving Resident #1 as the victim and NA #1 as the perpetrator.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to implement the abuse policy and procedures when the Administrator was not immediately notified of an allegation of misappropriation of funds resulting in delayed protection, reporting, and investigation for 1 of 3 residents reviewed for misappropriation of property (Resident #1). Findings included:Review of the facility's abuse policy and procedures, last reviewed on 11/14/2025, revealed: Anyone who witnesses an incident of suspected abuse, neglect, involuntary seclusion, injuries of unknown origin, or misappropriation of patient property is to tell the abuser to stop immediately and report the incident to his/her supervisor immediately, regardless of the shift worked. The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. The abuse policy and procedure additionally stated: Immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect, the Administrator or designee will perform the following. initiate an investigation within 24 hours of the allegation of abuse that focuses on causative factors and interventions to prevent further injury, and the center will protect patients from further harm during an investigation. The policy further indicated the Administrator, or designee would report allegations to the appropriate stated and local authority(s) involving misappropriation of property within 24 hours if the event did not result in serious bodily injury.Resident #1 was admitted to the facility on [DATE].The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #1 was assessed as cognitively intact.During an interview on 1/22/2026 at 10:49 AM conducted on the telephone, the Social Worker stated Resident #1 informed her on 1/12/2026 that he inadvertently sent $300.00 to Nurse Aide (NA) #1 at Christmas time. Resident #1 told the Social Worker that NA #1's account on the money transfer application was negative and she would repay him after receiving her paycheck on 1/16/2026. The Social Worker stated she doubted the truthfulness of the resident's account and decided to wait to see if NA #1 would return the money. The Social Worker elaborated to say the information provided by Resident #1 did not make sense to her. On 1/16/2026, NA #1 was not answering phone calls from the Social Worker and was not scheduled to work. At 4:00 PM on 1/16/2026, the Social Worker notified the Administrator of Resident #1's concern that NA #1 was not going to return his funds. The Social Worker stated she should have notified the Administrator immediately on 1/12/2026.The facility Administrator and the Director of Nursing were simultaneously interviewed on 1/22/2026 at 4:46 PM. The Administrator confirmed she was notified on 1/16/2026 by the Social Worker that NA #1 owed Resident #1 $300.00. The Administrator stated that the Social Worker should have notified her immediately on 1/12/2026 of the funds that needed to be returned to Resident #1 by NA #1. The Administrator confirmed that NA #1 was on the schedule and had nurse aide assignments from 1/12/2026 to 1/16/2026, after which she was put on administrative leave to protect the residents. The Director of Nursing stated NA #1 should have immediately notified herself (Director of Nursing) or the Administrator when she (NA #1) became aware the $300.00 was accidentally put into her account. The Administrator revealed the local police department and adult protective services were notified on 1/16/2026 but did not make a formal report because the funds were returned to Resident #1. During a phone interview on 1/28/2026 at 8:59 AM, the Administrator stated that on 1/16/2026 she was rushing to submit the initial allegation report concerning the alleged misappropriation of funds from Resident #1. She explained she inadvertently transposed letters in the State Agency's email address, causing the report to fail to transmit. The Administrator further stated she did not receive any notification from her email service indicating the message had failed. She reported she was unaware the initial allegation (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report had not been received until 1/27/2026, when the surveyor informed her that the State Agency had not received the initial report as of 1/23/2026. The Administrator confirmed she sent the initial allegation report on 1/27/2026 to the correct email address for the State Agency. The Administrator confirmed NA #1's employment was terminated with the facility. The Administrator stated that NA #1 took advantage of Resident #1 and that if she had come forward immediately on 12/27/2025 when the $300 was transferred to her money transfer application account by Resident #1, she would have been disciplined with a suspension, but likely not terminated from her employment. The facility provided a corrective action plan that was not acceptable to the State Agency. As of 1/23/26 the State Agency had not received an initial allegation report for the allegation of misappropriation involving Resident #1 as the victim and NA #1 as the perpetrator. The facility's corrective action plan incorrectly stated that the initial allegation report was sent to the State Agency on 1/16/2026.