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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (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 0605 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 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 [DATE] 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 [DATE] 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 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 [DATE] with diagnoses including a bipolar disorder.The quarterly Minimum Data Assessment (MDS) dated [DATE] 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 [DATE] 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 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.

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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 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE]. Resident #1 was discharged from the facility and admitted to the hospital on [DATE]. 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 [DATE] 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 [DATE]. Resident #10 was discharged from the facility and admitted to the hospital on [DATE]. Resident #10 was readmitted to the facility on [DATE]. 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 [DATE] indicated Resident #10 was severely cognitively impaired. In an interview on 9/19/2025 at 2:35 PM, Nurse #5 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.

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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)

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: 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. Resident #13's significant change Minimum Data Set (MDS) assessment dated [DATE] 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. 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.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses including chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #49 was cognitively intact and was coded as receiving oxygen therapy. Physician orders dated 8/25/2025 included an order for 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. Findings included: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.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. 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 [DATE] 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. 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 [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), altered mental status, chronic systolic heart failure, and wheezing. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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. 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.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 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 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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] with diagnoses including gastro-esophageal reflux disease with esophagitis, anxiety, polyneuropathy, and depression with psychosis. The admission Minimum Data Assessment (MDS) dated [DATE] 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. 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 [DATE] 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). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 [DATE] 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 [DATE] 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 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. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.

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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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	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.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (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 0761 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, 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 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 [ROOM NUMBER] 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 [ROOM NUMBER], she only pushed the lock halfway. Nurse #3 also stated medication cart #1 was not completely locked to allow 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

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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.