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	10/27/2022

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 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19161 Based on record review, observation and staff, family & resident interviews the facility failed to assure two of 2 sampled residents (Resident # 9 and Resident # 7) received their medications. Based on record reviews and staff interviews, the facility failed to consistently follow established procedures for the accounting of controlled substance medications administered to 2 of 2 residents reviewed (Resident #7and Resident #2) who received a controlled substance medication on an as needed (PRN) basis. The findings included. 1. Resident #9 was admitted on [DATE]with diagnoses of pain in limb, multiple sclerosis, major depressive order, pyelonephritis, insomnia, and chronic pain syndrome. Resident #9's Minimum Data Set Assessment coded the resident as cognitively intact. The resident had an order for Xtampza ER 12-hour 9 mg orally every 12 hours for pain. Upon record review it was revealed that the last day the medication was documented as given was on 10/21/2022 at 7:00 pm. On 10/26/2022 at 3:40 pm, Resident #9 was interviewed and stated that he had not received his pain medication (Xtampza) for 5 days. He stated that the nurses told him that he needed a hard script to get any more of the medication. He informed the surveyor that his pain level was an 8 out 10, and he had not slept for the past few nights. In an interview with Nurse #4 on 10/26/2022 at 4:10 pm she revealed that she had called the pharmacy that morning about the availability of this medication. She relayed to the surveyor that the pharmacy stated the medication was held up for prior authorization, but they would send out 3 days' worth of the medication today. The Director of Nursing obtained a stat order for 1 tablet of Lortab to be given, which was procured out of the automated dispensing machine and given at 5:14 pm. Surveyor noted that the resident was angry but took the stat medication. 2. Resident # 7 was admitted to the facility on [DATE] with a diagnosis of anxiety. (continued on next page)

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

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Resident #7's minimum data set assessment, coded the resident as having mild cognitive impairment. Resident # 7 had a current order, which originated on 10/8/2022, for Alprazolam (generic Xanax) to be given every 8 hours as needed. Review of the October 2022 MAR (Medication Administration Record) medications revealed the resident received her last Alprazolam dose on 10/22/2022 at 9:30 am and did not receive the next dose until 10/24/2022 at 3:23 pm. Review of Resident Council Meeting Notes of 9/21/22 revealed that running out of medications was an issue brought up under Nursing Issues. On 10/25/2022 at 11:15 am the Director of Nursing was interviewed and acknowledged there were problems with medication availability. On 10/25/2022 at 12:00 pm Resident # 7 was interviewed. The resident stated that she had not received any of her Xanax for 4 days, until she received a dose yesterday evening. She stated that not being able to obtain her medications was her biggest concern. The resident stated to surveyor she wanted to have her Alprazolam twice per day and would ask for it but the nurses did not have it. On 10/25/2022 at 2:37 PM Resident #7's Responsible Party was interviewed on the phone. He stated that he had been in the facility on Sunday and was made aware by Resident # 7 that she had not receive Alprazolam (Xanax) over the weekend. Interview with Nurse #3 on 10/26/2022 at approximately 11:00 am revealed the nurse was aware Resident # 7 had been requesting the Alprazolam but stated it had not been available. A record review of Resident #7's Medication Administration Record (MAR) and Control Medication Declining Count Sheet found discrepancies in recording of doses given to the resident. Resident #7 had an order for Alprazolam 0.5 mg orally every 8 hours as needed dated 10/8/2022. The MAR indicated that the medication was not given to the resident on 10/13, 10/19, 10/22, 10/23, 10/24, & 10/25. The declining inventory count sheet indicated that the medication was given each of those days, 10/13 at 10 am and 7 pm; 10/19 at 8 am and 7 pm; 10/22 at 9:30 am; 10/23 at 6:23 pm; 10/24 at 10:00 pm and 10/25 at 9:30 am. 32394 3. Resident #2 was admitted to the facility on [DATE]. A review of Resident #2's admission orders revealed a physician's order was written on 7/15/22 for 7.5 milligrams (mg) hydrocodone / 325 mg acetaminophen to be given as one tablet by mouth every 6 hours as needed (PRN) for pain. Hydrocodone / acetaminophen is a combination pain medication which contains an opioid pain reliever (a controlled substance). (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's August 2022 Medication Administration Record (MAR) indicated one dose of the PRN 7.5 mg hydrocodone / 325 mg acetaminophen was administered to Resident #2 on 8/1/22 and on 8/5/22 (for a total of two doses). No other doses of PRN hydrocodone / acetaminophen were documented on the August 2022 MAR as having been administered to Resident #2. However, review of Resident #2's Controlled Medication Utilization Record (a declining inventory record of each controlled substance medication dispensed for a resident) revealed 1 tablet of 7.5 mg hydrocodone / 325 mg acetaminophen was taken from the inventory 6 times during the month of August 2022 on the following dates/times: --On 8/1/22 at 3:50 PM; --On 8/5/22 at 9:16 AM; --On 8/7/22 at 9:00 AM; --On 8/8/22 at 9:00 AM; --On 8/9/22 at 9:00 AM; --On 8/9/22 at 4:43 PM. An interview was conducted on 10/27/22 at 3:13 PM with Nurse #1. Nurse #1 was identified by her signature on Resident #2's Controlled Medication Utilization Record as having removed one tablet of 7.5 mg hydrocodone / 325 mg acetaminophen from the medication (med) cart on 8/7/22 at 9:00 AM without documenting its administration to the resident on the MAR. During the interview, Nurse #1 reported that when she administered a controlled substance medication to a resident she would document taking the med out of the med cart on the Controlled Medication Utilization Record. When asked, the nurse stated she would also document administering this medication on the resident's MAR. She did not know why the medication administration was not documented on Resident #2's MAR. A telephone interview was conducted on 10/27/22 at 3:53 PM with Nurse #2. Nurse #2 was identified by her signature on Resident #2's Controlled Medication Utilization Record as having removed one tablet of 7.5 mg / 325 mg hydrocodone / acetaminophen from the medication cart on 3 occasions (8/8/22 at 9:00 AM, 8/9/22 at 9:00 AM and 8/9/22 at 4:43 PM) without documenting its administration to the resident on the MAR. During the interview, Nurse #2 reported she normally documented the medication was pulled from the med cart on the Controlled Medication Utilization Record and its administration on the resident's MAR. The nurse stated she only worked 4 or 5 shifts at this facility as an agency (temporary) nurse. When asked, Nurse #2 did not know why she had failed to document the hydrocodone / acetaminophen administration on Resident #2's MAR. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	An interview was conducted on 10/26/22 at 1:14 PM with the facility's Director of Nursing (DON). During the interview, the DON was shown both Resident #2's August 2022 MAR and his Controlled Medication Utilization Record for the PRN hydrocodone / acetaminophen. The DON confirmed there were discrepancies between the two documents. When asked, she reported the two documents should match up. During a follow-up interview conducted on 10/26/22 at 2:15 PM, the DON reported education needed to be provided to staff on the importance of documenting on both the Controlled Medication Utilization Record and MAR when a controlled medication was pulled from the cart and administered to a resident. She reported that although the facility had self-identified some medications concerns, this issue was different and had not been addressed in their current plan of correction.