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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide a safe environment by allowing 3 of 3 staff members to smoke cigarettes near oxygen canisters. Findings included: Review of the Employee Smoking Policy revised 06/01/14 showed, "...employees may smoke only in designated areas ..." Under Purpose, the Policy listed "To provide a safe environment for patients/residents, visitors and employees." In an observation on 09/30/14 at 4:05 PM a staff member was seen sitting on a rolling cart which was a short distance from oxygen canisters. Above the canisters there was a "No Smoking" sign attached to the wall. The staff member was smoking a cigarette. The Maintenance Director was notified and when he arrived there were 3 staff members smoking cigarettes in the same area. The Maintenance Director measured the distance from the end of the cart holding the full oxygen tanks to where the staff members were smoking. The distance was 12 feet. There was a table with an umbrella across the lawn. The table was 28 feet from the oxygen. In an interview on 09/30/14 at 4:15 PM Nurse #4 stated she knew that she was not supposed to	F 323	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Mount Olive Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency. F-323 1. No residents were directly affected by the deficient practice. 2. Current residents had the potential to be affected by the deficient practice. In-service education was provided to staff in all departments on 9/30/14, 10/1/14, and 10/2/14. " A new area has been designated for employee smoking effective 10/1/14. This area is located on the north side of the employee parking several feet beyond the	10/20/14

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

Electronically Signed | 10/16/2014

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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 smoke around oxygen. She indicated she did not know how far away she should be from the oxygen canisters. She stated if someone smoked around oxygen it could cause an explosion. She indicated she was smoking in that area because there was more shade. In an interview on 09/30/14 at 4:18 PM Nurse #5 stated she had been told to smoke in the employee smoking area which was outside. She indicated in orientation the facility provided information on oxygen safety. She stated she knew she should not be close to oxygen when she was smoking but did not know how far away she should be. In an interview on 09/30/14 at 4:22 PM Nurse #6 indicated she knew she should not smoke near oxygen but did not know how far away she should be. She stated smoking around oxygen could cause an explosion. In an interview on 09/30/14 at 4:25 PM the Maintenance Director stated during staff orientation to the facility he pointed out the employee and resident smoking areas. He indicated when he showed the staff the employee smoking area he pointed to the table with the umbrella to designate where the area was. He stated employees were never told they could smoke as close to the oxygen as the staff were smoking. In an interview on 10/02/14 at 4:25 PM the Maintenance Director stated it was his expectation staff smoke only in the areas that were pointed out during orientation as the employee smoking area. In an interview on 10/02/14 at 8:02 PM the Director of Nursing Services (DNS) indicated she expected her staff to not smoke near oxygen canisters.	F 323	required 35 foot limit from hazardous/combustible materials. " A daily audit of the unauthorized smoking areas was initiated on 10/3/14 with a designated staff member checking the areas around oxygen storage and outside the backdoor to the kitchen to identify staff who might be smoking in unauthorized areas. The audit is conducted hourly from 8:30 AM to 8:00 PM Monday Friday and from 8:30 AM to 5:00 PM Saturday and Sunday. Off hour checks between Midnight and 7:00 AM will be made by the maintenance staff at random times 3-4 days per week including weekends. " The areas adjacent to the oxygen storage areas and the kitchen propane tanks located at the backdoor to the kitchen have been measured and maintenance has painted a RED LINE with labeling spaced along the line reading NO SMOKING WITHIN 35 FT OF BUILDING. 3. The facility Safety Committee will provide continuing education to staff on Employee Safe Smoking Practices and the safety officer will provide reports to the QAPI Committee monthly for three months. Maintenance Staff and Housekeeping Staff will visually monitor the previously identified areas as part of their routine duties. Any violators will be directed to the approved employee smoking area and reported to the appropriate department manager for additional training or disciplinary action as indicated. 4. The Daily Audits as previously	

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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2	F 323	described will be conducted by the designated staff members daily for 30 days (11/3/14); then weekly for 8 weeks (1/3/15). Results of the audits/monitoring activity will be presented to the QAPI Committee monthly for 3 months. A Root Cause Analysis and Directed Plan of Correction were initiated for this POC on 10/13/14.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431		10/20/14

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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 3 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to store medications in a locked cart or medication room that was inaccessible to residents and visitors for 1 of 12 (Resident #16) resident rooms that were observed on the initial tour of the facility. Findings included: Resident #16 was admitted to the facility on 08/12/14 with cumulative diagnoses of asthma, diabetes, and heart failure. Resident #16's Admission Minimum Data Set (MDS) showed Resident #16 was cognitively aware. Review of the medical record did not show any record that Resident #16 had been approved to self- administer medications. In an observation on 09/30/14 at 10:40 AM a medication cup with a white capsule inside was sitting on an over the bed table in Resident #16's room. The capsule was dry and no moisture was noted in the medicine cup. The over the bed table was against the wall in line with the door to the room. Nurse #1 came to the room and observed the medication. She took the capsule back to the medication cart and went through Resident #16's medication cards. The capsule matched the medication in the card labeled omeprazole 20 milligrams. In an interview on 09/30/14 at 10:45 AM Nurse #1	F 431	F 431 1. Resident # 16 is administered and has accepted his medication daily. 2. Residents that have medication ordered by the physicians have the potential to be effected by the said deficient practice. Room rounds were performed throughout the center to identify any resident that may have medication left at the bedside by the administrative nurses on 9/30/14. No medication was observed at residents bedside. 3. Licensed nurses were reeducated by the Staff Development Coordination on 9/30/14 and 10/1/14 regarding medication administration and leaving medication at bedside. Room rounds will be conducted daily on alternating shifts for one month to monitor for medication left at bedside by administrative nurses, then weekly for 2 months. Medication administration observation will be performed on 3 nurses on alternating shifts weekly by administrative nurses for one month, then monthly times 2 months. 4. The Director of nurses will review room rounds and medication administrative	

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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 4 stated the omeprazole was scheduled to be given at 6:00 AM and had been initialed as given by Nurse #2. She indicated there were visitors in the facility and also residents with decreased cognition who wandered through the facility hallways and sometimes entered other resident rooms. In an interview on 10/01/14 at 3:06 PM Nurse #2 indicated she had given Resident #16 the omeprazole at 5:15 AM. She stated she handed Resident #16 the omeprazole in a medication cup and he put the medication in his mouth, took the cup of water and handed back the empty medication cup. Nurse #2 disposed of the medication cup in the medication cart trash bin. She stated she did not leave medication in the resident's rooms for them to take. In an interview on 10/02/14 at 11:55 AM Nurse #1 stated medications should never be left in a resident's room. She indicated the nurse needed to watch the resident take the medication and make sure there were no swallowing problems. Nurse #1 stated if a medication was left out anyone could walk in and remove the medication and take it themselves or give it to a resident. She indicated there were no residents in her assignment, which included Resident #16, that were approved to self-administer their medications. In an interview on 10/02/14 at 12:18 PM Nurse #3 stated when medications were passed the nurse needed to stay in the resident's room until all the medications were taken. She indicated medications should never be left in rooms for residents to take at a later time. She stated residents could wander into the room and take the medication. She indicated unless she saw the resident swallow the medication she would not know if they had taken it.	F 431	observation for any trends and report to the Performance Improvement Committee monthly for 3 months. A Root Cause Analysis and Directed Plan of Correction were initiated for this POC on 10/13/14.	

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 _____	C 10/02/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CENTER	**228 SMITH CHAPEL ROAD BOX 569 MOUNT OLIVE, NC 28365**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 5 In an interview on 10/02/14 at 1:35 PM Resident #16 indicated he did not remember if he took the omeprazole on 09/30/14. In an interview on 10/02/14 at 7:37 PM the Director of Nursing Services (DNS) stated she expected the nurses to provide the correct medications to the residents. She indicated the nurse should stay in the resident's room until the medication was swallowed and to never leave medications at the bedside. She stated it was important not to leave the medication at the bedside because confused residents could take the medication and have an allergic reaction. She indicated it was also important that residents take the medications that were ordered for them.	F 431		