

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNT OLIVE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>228 SMITH CHAPEL ROAD BOX 569</b> <b>MOUNT OLIVE, NC 28365</b>		
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{F 241} SS=H	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, physician, resident and staff interviews, the facility allowed a resident (Resident #168) to disregard 13 of 13 sampled residents' right to be treated with dignity (Resident #39, #43, #68, #71, #78, #79, #81, #105, #129, #131, #143, #172, and #203) as evidenced by vulgar, offensive and disruptive behaviors. The facility also did not maintain dignity for 6 of 6 sampled residents (Resident #44, #79, #83, #105, #122, and #172) who reported facility staff were searching their belongings routinely. Findings included:</p> <p>1.a. Resident #131 was admitted to the facility on 09/06/11. Cumulative diagnoses included unspecified psychosis, depression, aphasia, anxiety and vascular dementia. The most recent Quarterly Minimum Data Set (MDS) of 04/06/15 documented Resident #131 had poor decision making skills with moderately impaired cognition. A grievance/concern form dated 04/10/15 noted Resident #131 ' s family was very upset about an incident with Resident #168. The family reported to the social worker (SW #1) that she did not want Resident #168 anywhere around Resident #131. The family reported being worried about her safety and what Resident #168 was doing when she wasn't sitting with Resident #131. The</p>	{F 241}	<p>¿ 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.¿</p> <p>It appears this 2567 was posted in error. It is one of the 16 citations listed in the 5/9/15 survey identified as KMI511 for the same 5/9/15 survey and contains the same language as the F-241 citation in KMI511. The response to the citation is as follows:</p> <p>F 241 H DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>Residents # 39, # 43, # 71, #78, # 79, #81, #105, # 129, # 131, # 143, and # 172 were informed that resident # 168 was no</p>	6/11/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

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.

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{F 241}	<p>Continued From page 1</p> <p>family reported that Resident #168 had offered a stuffed animal to Resident #131 and the family told him not to give it to her but he gave it to her anyway. When Resident #131 started loving on the stuffed animal, Resident #168 remarked " Hey, I gave you that, why don't you give me some sugar like that? " and leaned into Resident #131. Resident #131 was extremely demented and the family felt that Resident #168 disregarded the family's wishes.</p> <p>A note from SW #1 of 05/04/15 at 4:52 PM noted that a grievance had been received from the call center regarding Resident #131. The grievance concerned resident on resident "tormenting" . According to the care line Resident #131's family was unhappy with the way the facility was handling the situation. SW #1 documented she had been made aware of the issue weeks ago and had been in contact with law enforcement, the Ombudsman and the corporate attorney. She documented she had asked the family of Resident #131 to go to law enforcement themselves. SW #1 telephoned the family and suggested that they go to the Magistrate's office and talk to them about the concern. It was documented that the family stated they understood the restrictions the facility had but she feared for Resident #131's safety. SW #1 also documented she assured the family that she was doing the best she could to keep the two residents from interacting.</p> <p>A late entry note from SW #1 indicated on 05/06/15 at 8:07 AM she had telephoned the magistrate's office. SW #1 was told someone from the facility would need to agree to testify for the resident (Resident #131). SW #1 documented that she could find no one who had witnessed any incidents or had firsthand experience.</p>	{F 241}	<p>longer residing in the center. Resident # 68 was discharged on 5/27/15. Resident # 168 was placed on one-on-one on 5/8/15 until his discharge on 5/21/15.</p> <p>Residents # 172, # 105, # 44, # 79, # 83, # 122 have had their personal items returned or replaced by the Social Services on 5/12/15 . These residents were interviewed on 5/28/15 by Department Managers to ensure that their personal items had been replaced and no further room searches have occurred.</p> <p>Other residents that may potentially be affected were identified by interviewing the residents or families of residents unable to be interviewed. The interviews were conducted by the Social Workers and Recreation Director on 5/11/15 thru 5/20/15.</p> <p>Directed in-service education was provided to the center staff, including Licensed Nurses, nursing assistants, dietary staff, maintenance staff, housekeeping staff, therapy staff and department heads, by Eastern Area Health Education Center (AHEC) on 6/10/15 and 6/11/15 that included Resident Rights, Dignity and Quality Assurance Program. The presentation will be videoed so that it can be presented to newly hired employees and employees that were unable to attend the live presentation. Staff will not be allowed to work until after viewing the video.</p> <p>Education was provided to Licensed</p>		

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{F 241}	<p>Continued From page 2</p> <p>During an interview with Resident #81 on 05/07/15 at 3:45 PM, she stated about a month ago she had witnessed Resident #168 feeling the back of Resident #131's neck and flipping her hair. She stated Resident #131 was not capable of speaking for herself. She didn't report it to anyone.</p> <p>Resident #105 reported during an interview on 05/09/15 at 1:02 PM that he had witnessed Resident #168 twirling Resident #131's wheelchair around until she cried. He stated that Resident #168 was constantly harassing her.</p> <p>During an interview with the social worker #1 (SW #1) on 05/07/15 at 11:20 AM, she stated she had received a grievance from Resident #131's family in regards to Resident #168 harassing Resident #131 in front of the family. She stated the family was concerned about Resident #168 being inappropriate with Resident #131.</p> <p>1.b. Resident #78 was admitted to the facility on 02/14/13. Cumulative diagnoses included depression, neuralgia and quadriplegia. The most recent Quarterly Minimum Data Set (MDS) assessment of 03/31/15 documented Resident #78 was cognitively intact and independent with decision making. This resident was also included in a list provided by the facility as being alert, oriented and reliable.</p> <p>A note from social worker #1 (SW #1) of 03/11/15 at 2:08 PM noted that the nurse staff scheduler had informed her that Resident #168 was speaking in an inappropriate vulgar manner to another female resident (Resident #78). It was noted that this time staff witnessed this behavior. SW #1 documented that Resident #168 was asking inappropriate sexual questions and the resident (Resident #78) felt uncomfortable and voiced she did not like him talking to her like that. Another note from SW #1 of 03/12/15 at 8:16 AM</p>	{F 241}	<p>Nurses and Nursing Assistants on dealing with difficult behaviors on 6/1 and 6/2/15 by the Nurse Practice Educator (NPE).</p> <p>Education was provided to Licensed Nurses, Nursing Assistants, Dietary, Housekeeping, Therapy Staff and Department Heads on 5/20/15, 5/21/15 and 5/22/15 on what constitutes abuse, what to report, who to report abuse to, and types of abuse by the Social Workers. Resident interviews will be conducted on 14 interviewable residents weekly for 6 months, then monthly for 6 months by the Social Services and Activities regarding if they feel if any abuse has occurred or been observed. A resident interview tool will be used for the resident interviews.</p> <p>Center staff was in-serviced on the revised bulletin that lists the items that the residents are requested not to have in their rooms and that the staff is not allowed to search the residents' rooms. The education was provided on 6/1/15 and 6/2/15 by the Admission Director. During the Resident Council meeting of 5/12/14, the revised list was reviewed with the members by the Activity Director and Social Worker. The Administrator and Director of Nursing also attended the meeting to answer questions from the Council.</p> <p>The bulletin that listed the items that resident were not allowed to have in their rooms was revised to include aerosol cans and over the counter medications and ointments by the Administrator and</p>		

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{F 241}	<p>Continued From page 3</p> <p>noted that SW #1 had spoken with Resident #168 about the incident of yesterday with a female resident where he was asking her sexual questions. He denied talking with the female (Resident #78).</p> <p>Resident #78 was interviewed about the incident with Resident #168 on 05/09/15 at 3:00 PM. She was visiting her male friend in his room. Resident #78 stated Resident #168 picked on her and harassed her constantly. She stated she had complained to several staff members including the social workers but no one had done anything because he was still doing it. Resident #78 could not provide any of the staff member's names other than social worker #1 (SW #1). Resident #78 stated Resident #168 would park himself in her doorway and stare at her from the hallway which made her very uncomfortable. She stated she felt that he was invading her rights when he made those horrible sexual comments in front of the other residents. Resident #78 reported there had been one incident with him a few months back where she was so upset she cried from embarrassment about the disrespectful way he treated her. She stated he was making awful vulgar sexual comments that she couldn't repeat about sexual things he thought she and her male friend were doing. Resident #78 stated he yelled it out (the B--- J---) in the hallway in front of the other residents. Her male friend reported that Resident #168 was constantly harassing Resident #78 and staff allowed him to do so. He stated he was present in the hallway that day and he told Resident #168 to stop talking to her like that. He also stated he told Resident #168 if he didn't leave her alone he was calling the police himself since the facility didn't appear to be doing anything to resolve the issue. Resident #78</p>	{F 241}	<p>Director of Nursing on 5/13/15. A mailing to the residents, responsible party, of the revised bulletin was completed on 5/28/15 by the Admission Director. A copy of the bulletin was posted on each resident bulletin board in their rooms by the Admission Director on 5/27/15. An interview will be completed on 14 alert/oriented residents weekly for 6 months and monthly for 6 months if room searching are been conducted and if personal items are being removed b staff. The interviews will be completed by the Social Workers and Activities.</p> <p>The results of the resident interviews regarding abuse and privacy will be presented to the Quality Assurance Committee by the Social Worker monthly for 12 months.</p>		

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{F 241}	Continued From page 4 stated no one had come back to her to ask her any questions about the incident or offer any resolution to the problem she was having with Resident #168. (The male friend did not want to be included in the list of residents but gave permission to share the interview.) 1c. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/21/15 indicated he was cognitively intact and independent with decision making. He was also identified by the facility to be alert, oriented and reliable. Resident #105 was interviewed on 05/06/15 at 10:30 AM. He stated Resident #168 constantly yelled, cursed and would go into other resident's rooms uninvited. He stated he harassed the female residents in the building and had witnessed him going into other residents' rooms to curse them. He commented that this type of behavior had been going on for over a year now. He stated Resident #168 came into his room about 3 weeks ago and demanded a bag of pork skins that he had seen on top of his refrigerator. Resident #105 stated he told Resident #168 that he couldn't have the bag of skins. He stated that Resident #168 responded that if he wanted it he would take it and he couldn't stop him. As he was talking, tears were coming out of both eyes. Resident #105 stated Resident #168 told him there was nothing he could do about it because he was "stuck" in the bed and couldn't get up to stop him. He reported that he had reported that incident and others concerning Resident #168 to SW #1 on many occasions. When questioned about resolution, he stated SW #1 told him Resident #168 had rights and she couldn't do anything about it. He also stated she told him he	{F 241}			

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{F 241}	<p>Continued From page 5</p> <p>didn't have any rights. Resident #105 stated Resident #168 had told him and the other residents as well as staff that he could do whatever he wanted. Resident #105 stated no one would say anything to him. He commented that Resident #168's behaviors were very upsetting for him. He also commented that he couldn't continue to "live like this" going without sleep every single night because of Resident #168's yelling, cursing and playing his television full volume.</p> <p>During another interview with Resident #105, on 05/08/15 at 11:28 AM, he stated he didn't feel that the facility was doing anything to change the way Resident #168 behaved. He stated he had been up every night this week yelling, cursing and playing his television at full volume. He appeared to be angry and frustrated based on his tone stating something had to be done. Resident #105 reported he had complained to SW #1 several times and she always responded that she had spoken with Resident #168 about the issue. Resident #105 commented it was obvious that talking with Resident #168 was not doing anything. He also stated he knew first hand that Resident #168 had been warned by staff to behave when visitors were in the building. He also stated if he capable of behaving when visitors were in the building why couldn't he behave all of the time.</p> <p>1.d. Resident #203 was admitted to the facility on 04/30/15. Cumulative diagnoses included hypertension, gastroesophageal reflux disease (GERD) and cerebrovascular accident (CVA). There was no minimum data set (MDS) assessment available for this resident. Resident #203 was identified by the facility as being alert, oriented and reliable.</p>	{F 241}			

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{F 241}	<p>Continued From page 6</p> <p>A nurse's note of 05/05/15 at 11:11 AM indicated Resident #203 was alert and oriented x 4. During an interview with Resident #203, on 05/06/15 at 6:00 PM, he stated this was his second admission to the facility. He reported during his last admission there were problems with Resident #168 talking ugly to the other residents in the facility and it was still happening. Resident #203 stated Resident #168 disturbed the residents at night preventing them from sleeping. He reported this past Sunday his family was visiting him. He stated his grandchildren were here and Resident #168 was using M----- F----- along with other "awful" words in front of them. He stated he did not like that type of language to begin with but it was even worse when it was in front of his grandchildren. Resident #203 stated he didn't like that type of language in front of the other residents either. He reported it to be disgusting. When questioned if he had reported it, he responded he had not and that was why he was complaining in hopes someone could do something since the administration at the facility had not.</p> <p>1.e. Resident #39 was admitted to the facility on 11/27/12. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA) and abnormality of gait. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/07/15 noted Resident #39 to be independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #39, on 05/09/15 at 11:45 AM, she stated one night recently she was going to the bathroom and Resident #168 was in the hallway. She stated he started yelling at her from the hallway calling her</p>	{F 241}			

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{F 241}	<p>Continued From page 7</p> <p>"d--- f-a-- ". Resident #39 stated she told him to stop calling her names. She stated he continued to roll down the hallway yelling out "d--- f-a- ". She stated she had not reported it to anyone but if he continued to talk to her in that manner or came into her room she would hit him with her reacher. Resident #39 commented that she felt his language was offensive.</p> <p>1.f. Resident #43 was admitted to the facility 04/30/13. Cumulative diagnoses included neurogenic bladder and hypertension. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/02/15 documented Resident #43 as independent with decision making and cognitively intact. He was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #43, on 05/06/15 at 10:50 AM, he stated Resident #168 would go into other resident's rooms uninvited and would take sodas. He stated the management of the facility was well aware of his behaviors. He reported that Resident #168 constantly "picked on" one of the female residents. Resident #43 stated SW #1 had reported to him that the facility was actively seeking placement elsewhere. He stated staff and other residents had complained to him about Resident #168 being loud and disruptive.</p> <p>1.g. Resident #68 was admitted to the facility on 03/02/15. Cumulative diagnoses included thyroid disorder, depression and seizure disorder. The most recent Admission Minimum Data Set (MDS) assessment of 03/05/15 documented that Resident #68 was cognitively intact with independent decision making skills. He was also identified by the facility as being alert, oriented and reliable.</p>	{F 241}			



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{F 241}	Continued From page 8  During an interview with Resident #68, on 05/07/15 at 9:50 AM, he stated that Resident #168 was the rudest and most disrespectful person he had ever encountered. He stated Resident #168 terrorized the other residents and treated the elderly badly. Resident #68 stated he sits behind the residents and mocks them and makes fun of them. He stated he talked ugly to them calling them names. Resident #68 stated Resident #168 was up all night every night disturbing all of the residents with his television on full volume preventing anyone from getting any sleep. He stated Resident #168 was constantly yelling and cursing and disturbing everyone. Resident #68 stated he had asked the staff to ask Resident #168 to please turn his television down and they responded that it wouldn't do any good to ask him to turn it down because he turned it back up after they left the room. He stated the whole issue with Resident #168 had become a "big joke" with the staff. He was expressing anger with the issue and stated he was fed up. Resident #68 stated he complained to social worker #1 (SW #1) about Resident #168 and was told Resident #168 had rights and was told there was nothing they could do. He commented "what about my rights?" and stated he had rights just as well as Resident #168 did. He reported complaining to the Administrator about 3 weeks ago concerning issues with Resident #168. He stated he had complained again this past Monday about Resident #168 and was told by the Administrator that his "hands were tied." Resident #68 reported that he had complained to the nurses and they did nothing either. He stated that a few weeks ago he had been involved in a grievance with 3 other residents about Resident #168. He stated they wrote down about 15	{F 241}			

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{F 241}	<p>Continued From page 9</p> <p>different issues concerning Resident #168 and took them to SW #1. Resident #68 reported nothing had changed and expressed that it was not "right" that Resident #168 would be allowed to mistreat the other residents and act like he was. He added that the "old folks" in this facility should not have to put up with Resident #168 constantly abusing then and staff doing nothing to stop it.</p> <p>1.h. Resident #71 was admitted to the facility on 10/28/09. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA) and osteoarthritis. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/06/15 documented Resident #71 to be independent with decision making and was cognitively intact. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #71, on 05/07/15 at 9:35 AM, she stated Resident #168 was loud. She stated his room was at the other end of the hall and she could hear him in her room. She stated he felt that his constant cursing was offensive. She stated she was afraid of him because of his anger management problems. She had not reported her feelings to anyone.</p> <p>1.i. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident #79 was cognitively intact with independent decision making skills. Resident #79 was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #79, 05/07/15 at 2:30 PM, she stated Resident #168 "picked</p>	{F 241}			

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{F 241}	<p>Continued From page 10</p> <p>on" one of the female residents constantly and she couldn't defend herself. She also stated that he talked very "ugly" to her. She also commented that Resident #168 usually bothered the residents who weren't capable of defending themselves. She stated she had complained to various staff members in the past about Resident #168's behaviors but nothing was ever done so she stopped complaining.</p> <p>1.j. Resident #81 was admitted to the facility on 03/13/14. Cumulative diagnoses included hypertension, diabetes mellitus and anemia. The most recent quarterly Minimum Data Set (MDS) assessment of 04/23/15 documented Resident #81 has being independent with decision making. There were no behaviors noted in this assessment. She was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #81, on 05/07/15 at 3:45 PM, she stated that Resident #168 would come into her room uninvited when she was wearing her night gown. She stated that it bothered her and felt he was mistreating her. She stated she had witnessed Resident #168 bothering a female resident about a month ago. She commented that about a month ago she and some of the other residents had complained to SW #1 about him and SW #1 told her that the facility couldn't do anything about Resident #168. Resident #81 stated if Resident #168 continued to come into her room uninvited she would use her walking stick on him. She also commented she did not like being mistreated.</p> <p>1.k. Resident #129 was admitted to the facility on 11/11/11. Cumulative diagnoses included hypertension, cerebrovascular accident (CVA) with hemiplegia and difficulty walking. The most recent Quarterly Minimum Data Set (MDS)</p>	{F 241}			

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{F 241}	<p>Continued From page 11</p> <p>assessment of 03/11/15 documented Resident #129 as being independent with decision making and cognitively intact. She was also identified as being alert, oriented and reliable by the facility. During an interview with Resident #129, on 05/07/15 at 9:35 AM, she stated Resident #168 played his television so loud at night that it kept her awake and she couldn't sleep. She stated she had reported the issue to 2 different nurses but couldn't remember who. She stated Resident #168 would get so angry over things and she was afraid of him. Resident #129 also stated " he cares" her.</p> <p>1.I. Resident #143 was admitted to the facility on 11/18/13. Cumulative diagnoses included cerebral palsy, anxiety and difficulty walking. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/15/15 documented Resident #143 as being independent with decision making and cognitively intact. He was also identified by the facility as being alert, oriented and reliable. During an interview with Resident #143, on 05/07/15 at 10:55 AM, he stated because of cerebral palsy he ambulated with 2 hand held walking canes and was very slow. He stated Resident #168 had a habit of "riding" on his heels with his wheelchair. Resident #143 stated about a couple of months ago he was walking in the hall with his canes and Resident #168 came up behind him. He stated Resident #168 used very loud foul language and threatened to "run him over." Resident #143 reported that he was afraid that Resident #168 was going to hurt him. He commented that he had completed a grievance and gave it to the social services department.</p> <p>During another interview with Resident #143, on 05/09/15 at 3:15 PM, he stated there was an</p>	{F 241}			

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{F 241}	<p>Continued From page 12</p> <p>on-going problem with Resident #168 telling him he was going to "run him over." He stated that he had been to the social worker to report the issue.</p> <p>During another interview with SW #1, on 05/09/15 at 5:00 PM, she stated as of last evening Resident #168 had been placed on one on one supervision in an attempt to control his behaviors. She was not aware of any issue regarding Resident #143 and denied ever receiving any grievance or complaint from Resident #143. She stated no one had reported anything about Resident #168 trying to "run over" Resident #143.</p> <p>1.m. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/01/15 documented Resident #172 was independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable.</p> <p>During an initial interview with Resident #172, on 05/04/15 at 5:41 PM, she stated staff were nice to her but there was one resident (Resident #168) who was disruptive and harassed some of the other residents constantly. She stated one of the female residents was "scared to death" of him. She reported Resident #168 being up at night yelling and cursing in the halls. Resident #172 stated he had his volume too high on his television making it difficult for her to sleep. She also stated a lot of the residents would not go to activities programs because Resident #168 was so disruptive.</p> <p>During the follow-up interview with Resident #172, on 05/07/15 at 2:40 PM, she stated</p>	{F 241}			

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{F 241}	<p>Continued From page 13</p> <p>Resident #168 constantly bothered and harassed the other residents. She stated Resident #168 kept everyone up all night using "awful" language, shouting and yelling down the halls. Resident #172 stated she had complained to numerous staff members about his behaviors but no one did anything about it. She commented she was tired of not getting any sleep because of Resident #168's yelling and cursing. Resident #172 stated she and 2 of the other residents had gone to SW #1 to report concerns regarding Resident #168 ' s behaviors and the way he treated the other residents. She stated SW #1 told her she would speak with Resident #168. She stated SW #1 told her Resident #168 had his rights. She commented so did she and she felt that no one cared about her rights because nothing had changed. Resident #172 stated no one listened to her complaints and Resident #168 was allowed to do whatever he wanted. She stated staff didn't say anything to him when he was acting out. She reported that Resident #168 "bothered" and "tormented" one of the confused female residents and was constantly calling her names. She stated she shouldn't have to "be shut up in her room" because of him and his behaviors. Resident #172 commented she was tired and frustrated with not being allowed to get a good night's sleep because of Resident #168.</p> <p>Resident #168 was admitted to the facility on 05/22/14 and re-admitted on 10/13/14. Cumulative diagnoses included hypertension, quadriplegia and delusional disorder. A "contract to enhance POSITIVE behaviors" , signed by Resident #168 on 12/17/14, noted that the goal was that Resident #168 would treat all residents and staff members with kindness. The</p>	{F 241}			

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{F 241}	<p>Continued From page 14</p> <p>objective for this goal was that Resident #168 would use nice words when speaking to residents. Another goal indicated that Resident #168 was to stay in his room and his space. The objective for this goal was that Resident #168 would learn to respect the privacy of the other residents by not going into their rooms. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/16/15 noted Resident #168 to be cognitively intact with independent decision making skills. He had verbal behavior symptoms exhibited 1 to 3 days during the assessment period. Resident #168's care plan of 02/23/15 identified problems with:</p> <ul style="list-style-type: none"> <li>. Exhibits behaviors of verbal aggression as evidenced by calling residents names. Interventions included approach him in a calm friendly manner, develop a behavior plan if needed. Another intervention was to identify triggers and reduce exposure to them. Maintain a consistent routine as possible was also included as an intervention.</li> <li>. Exhibits disruptive/demanding behaviors as evidenced by cursing at staff and picking arguments with his roommate. Interventions included to approach in a calm friendly manner, document interventions and responses, identify behavior triggers and reduce exposure to them, maintain consistent routine and work with resident to develop a behavior contract if necessary.</li> </ul> <p>Information provided by the facility of 04/10/15 indicated that the corporate Regulatory Affairs Specialist had provided recommendations for dealing with Resident #168. The recommendations included:</p> <ul style="list-style-type: none"> <li>.Reach out to the ombudsman for assistance with placement</li> </ul>	{F 241}			

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{F 241}	<p>Continued From page 15</p> <p>.Contact local police to have them talk with Resident #168 regarding behaviors</p> <p>.Continue search for alterative placement</p> <p>.If able to locate safe discharge to let the specialist know</p> <p>A note from SW #1 of 04/14/15 at 4:00 PM noted that a meeting had been held with Resident #168, 2 police officers and the social worker. It was documented that the police spoke with Resident #168 about his behaviors and how his behaviors were unacceptable. The police officers also told Resident #168 that these behaviors could be punishable by law if anyone felt the need to press charges. The police officers also explained to Resident #168</p> <p>The physician's orders for May of 2015 indicated Resident #168 was receiving Ambien 2.5 milligrams (a sleep aid) at bedtime as needed, Celexa 30 milligrams daily (an antidepressant), Depakote 250 milligrams at bedtime (a mood stabilizer) and Valium 5 mg every 8 hours as needed (an antianxiety medication).</p> <p>An interview was conducted with Nurse #6 on 05/07/15 at 9:30 AM. She stated she worked on Resident #168's hall and was familiar with him and his behaviors. She stated he was angry, aggressive and disrespectful to the other residents. Nurse #6 stated she had been in his room on several occasions and asked him to turn his television volume down and he would get very angry with her but he would turn it down. She stated but as soon as she left out of the room he would turn it back up. Nurse #6 stated she had told him to not go into other resident's rooms and to respect their privacy as well as respect them as individuals. She stated some of the residents had complained to her about Resident #168 and she advised them to talk with the social workers.</p>	{F 241}			



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{F 241}	Continued From page 16 Resident #168 was interviewed on 05/07/15 at 10:45 AM. Resident #168 reported that some of the residents had complained about the volume of his television and he would turn it down. Resident #168 stated the staff employed at the facility was too young to work with elderly residents including himself. He stated he was - years old and wasn't going to have any young staff member telling him what to do with his television because the television was his. He denied being disruptive and disrespectful to the other residents in the facility. It was apparent that he was beginning to get agitated as he was taking his gloves off and putting them back on during the interview and was not maintaining eye contact. He was also becoming argumentative. Resident #168 also stated no one was going to tell him what to do. He denied going into other resident's rooms uninvited. He reported that at times he wasn't able to sleep at night and would go to the break room for a while but he would go back to his room. When questioned about being loud and keeping the other residents awake, he responded "you could hear a pin drop" on night shift. Resident #168 reported the facility staff had telephoned the police about him and they came out to the facility. He reported that he was not afraid of the police officers. Resident #168 stated that routinely when he was self-propelling his wheelchair down the hallways there were several residents who parked their wheelchairs in the hallways. He reported that he expected them to move out of his way because they could see him coming and he shouldn't have to say anything to pass through. When questioned about being considerate of others when he needed to pass them, he responded "why should I have to say excuse me?" Resident #168 stated he did not know what his rights were here at the facility and	{F 241}			

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{F 241}	<p>Continued From page 17</p> <p>ended the conversation saying it was time for a smoke break. A follow-up interview was not conducted due to the apparent agitation and defensiveness displayed during this interview. During an interview with the social worker #1 (SW #1) on 05/07/15 at 11:20 AM, she stated she had spoken with Resident #168 on multiple occasions about the rights of the residents. She stated talking with him was nonproductive and he continued with the unacceptable behaviors. SW #1 stated she had lots of incidents too numerous to go over individually regarding Resident #168. She reported that she had spoken with him on almost a daily basis in regards to the huge list of unacceptable behaviors that he exhibited. SW #1 reported that she had contacted the Ombudsman for advice. When questioned about the safety of the residents in the facility she responded that the police had been out to the facility to speak with Resident #168 and gave him a verbal warning. She commented the behaviors were unchanged. SW #1 stated he had a signed behavior contract but there were no consequences if he broke the contract. She reported the only consequence was a 30 day notice for discharge but thus far she had not been able to find suitable placement for Resident #168. She commented that no one at the facility could do anything with him or his behaviors. SW #1 stated she could not provide a safe and orderly discharge so he would continue to be there until she found an appropriate placement.</p> <p>A telephone interview was conducted with the Ombudsman on 05/07/15 at 3:03 PM. She stated the facility telephoned her about a month ago asking if she could come out and brainstorm with them on some issues at the facility. She stated they expressed no urgency with the request. The Ombudsman stated she came out last week and</p>	{F 241}			

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{F 241}	Continued From page 18 met with SW #1. She stated she advised them to call the police each time incidents occurred. She stated SW #1 told her she had not been able to find a suitable place for him to be discharged to. The Ombudsman commented that the facility had not imposed any consequences for his unacceptable behaviors and he was doing whatever he wanted whenever he wanted and no one had done anything to stop him. During an interview with the nurse staff scheduler, on 05/07/15 at 4:00 PM, she stated Resident #168 had been a problem for the facility for a while. She stated he was constantly making inappropriate comments to the other residents. She stated she had witnessed incidents and had reported them to the social services department. During an interview with Nurse #4, on 05/07/15 at 4:40 PM, she stated she worked third shift and there was one resident who disrupted the entire hall. She stated Resident #168 made inappropriate verbal sexual comments to the residents. She stated she had overheard some of the other residents talking about his behaviors and constant verbal abusive manners. When questioned if she reported it or talked with them about it, she responded she had not. She did state she passed it on to the oncoming nurses. Nurse #4 stated she had spoken with him numerous times about his inappropriate behaviors toward the other residents but he paid no attention to what she was saying and continued doing the same things. She commented that when she spoke with him about his behaviors he told her no one could kick him out of the building. Nurse #1 was interviewed on 05/07/15 at 5:15 PM. She was identified as working third shift on Resident #168's hall. Nurse #1 reported that she was very familiar with Resident #168 and his	{F 241}			

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{F 241}	Continued From page 19 behaviors. She reported that he frequently told staff that he could do whatever he wanted and no one could stop him. Nurse #1 stated it didn't do any good to say anything to him because there were no consequences for his unacceptable behaviors. She stated there was chaos wherever he would go in the building. Nurse #1 reported him as being belligerent with the other residents and harassed the residents who weren't capable of defending themselves. She commented that just the other day she overheard Resident #168 call a very confused female resident an awful name (f---- b----). She stated she intervened and told him how inappropriate that it was to talk like that and he needed to stop. Nurse #1 reported it was fruitless to complain to management about his behaviors because it "falls on deaf ears" so staff had stopped complaining. She reported that Resident #168 had been acting this way since the day he was admitted and he was fully aware of what he was doing. Nurse #1 added that because there were no consequences for his unacceptable behaviors he did whatever he wanted. A telephone interview was conducted with a third shift nurse (Nurse #5) who had been identified as working regularly with Resident #168 on 05/07/15 at 11:16 PM. He stated he was very familiar with Resident #168. When questioned about Resident #168's behaviors, Nurse #5 laughed and responded Resident #168 was usually up all night and would go to bed about 4:00 AM. He reported that some of the residents on his hall did complain about not being able to sleep because of him playing his television loudly. Nurse #5 stated he would go into Resident #168's room and ask him to turn the volume down on his television. He stated he would turn it down but as soon as he left the room Resident #168 would	{F 241}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345126</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>05/09/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>MOUNT OLIVE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>228 SMITH CHAPEL ROAD BOX 569</b> <b>MOUNT OLIVE, NC 28365</b>		
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{F 241}	Continued From page 20 turn it back up. Nurse #5 stated Resident #168 had been "acting out" for a long time and thought the rules at the facility did not apply to him. Nurse #5 stated he had documented his behaviors and passed it on to the oncoming shift. Nurse #5 reported that Resident #168 was fully aware of what he was doing. During a telephone interview with a third shift nurse aide (NA #1) on 05/07/15 at 11:30 PM, NA#1 stated Resident #168 was disrespectful of everyone including staff and residents. She stated he cursed "something awful" at the residents. NA #1 stated she was a Christian and couldn't repeat the words he used. She stated residents on the hall where he resided complained about him being disrespectful to them and about the loud volume of his television. She stated it did no good to try to correct his behaviors because he did what he wanted. NA #1 also stated he was taking pictures of some of the female residents with his cellular phone and she told him he couldn't do that. She reported Resident #168 did not respect the other resident's rights. NA #1 stated staff were very aware of his behaviors and she had reported it. During an interview with Resident #168's physician, on 05/08/15 at 10:00 AM, he stated he was new at this facility and had been Medical Director for about a month. He reported he had not been able to review all of the resident's charts as yet. He stated no one had specifically made him aware of any issues with Resident #168. The physician stated staff communicated with him through a communication book. He stated he was looking through it last week to see what issues were there that he needed to address. He stated he ran across an entry about Resident #168 but couldn't remember what the issue was or who had written it in the book. He stated when	{F 241}			

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{F 241}	<p>Continued From page 21</p> <p>he inquired he was told by staff that Resident #168's behaviors were inappropriate. He remarked that his first reaction was "Why is he still here?" The physician stated there was no medication that he could prescribe that would change or correct his behaviors without over medicating him which he couldn't do. He stated Resident #168 was completely aware of his behaviors and was a "mean" individual who enjoyed bullying others. He commented that he had spoken with staff and was told that they were not able to provide a safe discharge but were working on it. The physician stated that if his behaviors were threatening to the other residents or to the staff he needed to be discharged.</p> <p>The Administrator was interviewed about Resident #168 on 05/08/15 at 12:00 PM. He reported being aware of Resident #168's behaviors since February 2015. He stated social services had been dealing with the issues regarding Resident #168 and was actively seeking alternate placement for him. He stated the previous social worker had been dealing with the behavior issues but was not as pro-active as SW #1. He stated SW # was actively dealing with the issues associated with Resident #168. He reported that they were unable to control him or his behaviors because Resident #168 felt he was above the law so he did whatever he pleased. The Administrator also reported that Resident #168 was a master manipulator and knew exactly what he was doing. The Administrator reported they had telephoned the police to come to the facility and talk with Resident #168 about his behaviors. He stated the police told him he couldn't touch any of the residents here. He reported the corporate attorney had been consulted as well. The Administrator stated they</p>	{F 241}			

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{F 241}	<p>Continued From page 22</p> <p>investigated any resident to resident altercation that was brought to their attention. He stated as soon as an alternate facility could be located Resident #168 would be discharged.</p> <p>The Director of Nurses (DON) was interviewed on 05/08/15 at 4:45 PM. She stated SW #1 was the person responsible for dealing with all of the behaviors exhibited by Resident #168 on a regular basis. She stated Resident #168 had been an issue for the facility for a while and SW #1 was actively seeking alternative placement for him. The DON also stated thus far SW #1 had not been successful.</p> <p>On 05/09/15 at 10:00 AM, the Administrator stated that one on one supervision had been implemented yesterday evening for Resident #168.</p> <p>During another interview with SW #1, on 05/09/15 at 5:00 PM, she stated as of last evening Resident #168 had been placed on one on one supervision in an effort to control his behaviors. She stated his behaviors were discussed every morning during their morning meetings. She stated she had been actively seeking placement and had a tentative placement set for next week. SW #1 stated that she did not know what the previous social worker had done to control his behaviors because the previous social worker didn ' t make a lot of notes in his record. She also stated that the nurses were apparently afraid of him and were not documenting any of his behaviors in his record.</p> <p>2. The undated "A CONDENSATION OF NORTH CAROLINA'S BILL OF RIGHTS FOR NURSING HOME RESIDENTS" that was</p>	{F 241}			

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{F 241}	<p>Continued From page 23</p> <p>included in the admission packet for all residents noted that the resident had the right to be treated with consideration, respect and full recognition of personal dignity and individuality. Information provided by the facility included an undated bulletin entitled "IMPORTANT INFORMATION" which noted that "due to regulatory restrictions and for the safety of all of our patients, the following items are not allowed in patient rooms." The list included aerosol can products, baby powder, petroleum jelly, medicated ointments, medicated creams, eye drops, over the counter medications, alcohol, hydrogen peroxide, hand sanitizer, air fresheners and any product that was labeled "keep out of reach of children." It also indicated that "We reserve the right to remove and dispose of any products deemed potentially harmful (in accordance with NC and Federal regulations)." The facility's policy regarding Patient's Bill of Rights and Responsibilities, with an effective date of 06/01/96 and revision date of 08/04/14, noted that residents have the "fundamental right to considerate care that safeguards their personal dignity along with respecting cultural, social and spiritual values." It further noted that the purpose was to assure that the personal dignity, well-being and self- determination was maintained and to make sure the residents were knowledgeable of their responsibilities in this regard. It noted that the "Patient's Bill of Rights and Responsibilities" would be posted throughout the center at all times.</p> <p>2a. Resident #44 was re-admitted to the facility on 11/07/14. Cumulative diagnoses included congestive heart failure, hypertension, peripheral vascular disease and diabetes mellitus. The most recent quarterly Minimum Data Set</p>	{F 241}			



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{F 241}	<p>Continued From page 24</p> <p>(MDS) assessment of 04/24/15 noted he was cognitively intact and was independent with decision making. Resident #44 was included in a list provided by facility of alert, oriented and reliable residents.</p> <p>On 05/05/15 at 10:26 AM, Resident #44 was interviewed. He stated a while back he had been given a list of items that he was not allowed to have in his room. He stated he couldn ' t remember all of the items on the list. He reported not having the list. Resident #44 stated activities staff #1 (AS #1) would come into his room on a daily basis and search through all of his personal belongings in all of his drawers and his closet. He reported that AS #1 would take Vaseline, baby powder, spray deodorant, shampoo and any item that was aerosol if he had it. He reported this to be most upsetting as he felt that it was an invasion of his right to privacy. Resident #44 reported this was his home and did not think it was right for anyone to come and search through his belongings. He also reported that at times he would refuse to allow them to go through his belongings because it made him so mad that they felt they could do this. He added that he paid monthly to live in this building and felt that taking his belongings was wrong. He also commented that he does not leave the room with any of those items and no one visits who would bring in anything unsafe.</p> <p>2b. Resident #79 was admitted to the facility on 11/18/14. Cumulative diagnoses included diabetes mellitus, anemia, arthritis and depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 04/14/15 noted Resident #79 was cognitively intact and independent in decision making. Resident #79 was also identified by the facility as being alert,</p>	{F 241}			

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{F 241}	<p>Continued From page 25</p> <p>oriented and reliable.</p> <p>During an interview with Resident #79, on 05/07/15 at 2:30 PM, she stated staff come into her room on a regular basis and search her personal belongings. When questioned which staff members, she responded that it depended upon who worked. Resident #79 stated it was upsetting that staff go through her belongings. She stated her family brought in baby wipes and the facility staff person told her she was not allowed to have them so they took them. She stated they took her mouth wash, her air freshener and baby powder. Resident #79 remarked that sometimes odors were overwhelming and she didn't want visitors to have to endure the odors. Resident #79 added that she didn't have much but what she had she wanted to keep. She stated she felt like she had no rights at all and was in prison.</p> <p>2c. Resident #83 was admitted to the facility on 01/06/11. Cumulative diagnoses included congestive heart failure, hypertension and depression.</p> <p>The most recent Quarterly MDS of 04/24/15 noted the resident was cognitively intact. Resident #83 was included in a list provided by the facility of alert, oriented and reliable residents. During an interview with Resident #83, on 05/05/15 at 10:26 AM, she stated that staff (AS #1) would come into her room on a daily basis and go through all of her belongings. She stated this was an invasion of her privacy and her home. She stated she did not like them going through her things but the staff had told her they had to do it so she would allow them to search. Resident #83 commented that the facility staff should not be allowed to go through all of her personal belongings looking for powders or spray</p>	{F 241}			

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{F 241}	<p>Continued From page 26</p> <p>deodorants. She commented that she didn't have much but it was hers and she didn't want people going through it. She stated she used those items when she lived at home before coming here.</p> <p>2d. Resident #105 was admitted to the facility on 08/01/14. Cumulative diagnoses included depression. The most recent Quarterly Minimum Data Set (MDS) assessment of 02/21/15 indicated he was cognitively intact and independent in decision making. Resident #105 was also identified as being alert, oriented and reliable by the facility.</p> <p>During an interview with Resident #105, on 05/06/15 at 10:30 AM, he stated staff routinely search through all of his belongings. He stated it bothered him that they were allowed to do that since this was his home. He stated he was told by staff that he couldn't do anything about it so he would just leave his room and let them go through whatever they wanted. Resident #105 stated they took his shaving cream. He also stated they would take anything that was aerosol as well as any type of powder. Resident #105 stated if he was living in a private home he could have those items and didn't understand why he couldn't have them here.</p> <p>2e. Resident #122 was admitted to the facility on 11/21/14. Cumulative diagnoses included hypertension, diabetes mellitus and quadriplegia. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/12/15 documented Resident #122 to be independent with decision making and cognitively intact. He was identified by the facility as being alert, oriented and reliable.</p> <p>An interview was conducted with Resident #122</p>	{F 241}			

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{F 241}	<p>Continued From page 27</p> <p>on 05/06/15 at 11:40 AM per request. He stated staff would come into his room regularly and search through his personal belongings and his closet. He stated they search through all of his drawers and closet even if he wasn't in his room. Resident #122 stated activities staff #1 had been in and gone through his belongings. He commented "it ain't right" that facility staff did this. Resident #122 stated it made him mad and it was very upsetting that they thought it was okay to search his belongings. He stated when he questioned staff about the issue, he was told it was their job. Resident #122 commented that he felt like he was in prison here and had no privacy at all. He also commented that this was his home. He remarked staff would take his Vaseline. Resident #122 stated he didn't have anything dangerous unless Vaseline was.</p> <p>2f. Resident #172 was admitted to the facility on 01/02/15. Cumulative diagnoses included hypertension and diabetes mellitus. The most recent Significant Change Minimum Data Set (MDS) assessment of 04/01/15 documented Resident #172 was independent with decision making and cognitively intact. She was also identified by the facility as being alert, oriented and reliable.</p> <p>During an interview with Resident #172, on 05/07/15 at 2:40 PM, she stated she felt she was in a prison here and that she had no rights at all. She stated she did not appreciate staff coming into her room to search through all of her belongings. She could not say which staff members. She stated this was her home and they had no right to take anything from her and it was an invasion of her privacy. Resident #172 stated when she questioned staff about searching her belongings she was told they needed to make sure no one had any aerosols because confused</p>	{F 241}			

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{F 241}	Continued From page 28 residents might get them. She stated no one came into her room and if she had aerosols she would keep them in a drawer. Resident #172 stated she had a bag of salt packets and staff took it. She commented that she was not on a salt restricted diet. AS #1 was interviewed on 05/08/15 at 4:10 PM. She stated she did Partner Rounds on a daily basis as did other staff members. AS #1 stated each staff person was assigned a certain set of rooms for Partner Rounds. She stated when she went into the resident's room she was looking for several things. She stated she was looking to see if they were hoarding linens. She stated she looked to see if their personal belongings were in plastic bags. AS #1 stated she looked for any open food items or meal trays that had been left in the rooms. She stated she looked to see if there were any ants and for any clutter on top of the closets. She stated if there were any pests in the room she would complete a work order. When asked what items she was removing from their rooms, she responded that she took Vaseline, baby powder, air fresheners, alcohol rubs, over the counter medications, and any aerosol spray can product. AS #1 stated that was all that she could think of at the moment. She stated the items taken from the rooms were usually sent home with the family or kept in the social work office. AS #1 stated some of the residents disagreed with this and would refuse to allow her in the room to search their belongings. She stated the admissions office had sent out the list (undated bulletin "IMPORTANT INFORMATION) to all of the families advising them of items the residents were not allowed to have in this building but was not sure of when it was sent. She was unable to name all of the items on that list. When questioned if she felt	{F 241}			

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{F 241}	Continued From page 29 that this was an invasion of the resident ' s privacy, she responded that it probably was but it was part of her responsibility during rounds to take items that were not allowed. She stated it was part of the Partner rounds that all administrative staff performed. The Administrator was interviewed on 05/08/15 at 12:00 PM. He stated he had seen the list of items (the undated bulletin entitled "IMPORTANT INFORMATION") yesterday and had looked over it. He stated he was a bit surprised at some of the items on the list as they were personal use items. He stated staff should not be searching resident's belongings. The Administrator stated that administrative staff were assigned a set of rooms for their Partner program. He stated they visit new residents daily for a few days after admission to see how things were going for them. He stated they also visit the longer term resident on a monthly basis to see how things were going for them as well. The Administrator stated the facility strived to maintain a homelike environment. He stated he would be revising the list. The Administrator commented that some of the residents were very protective of their "junk" and maybe staff weren't using the right approach. He stated if the items were still in the facility they would be given back to the residents and if not the items taken would be replaced.	{F 241}			