Not Received Until 11/07/25

PRINTED: 09/13/2024
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	R-C 09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and complaint investigation from 09/04/24 - 09/05/24.	D 000	Responses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with state laws.	
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A and Staff B) were competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration for assistance with transfers and	D 161	10A NCAC 13F .0504 a & b Executive Director and/or designee will audit all employee files to ensure all required have appropriate LHPS documented training completed by Clinical Nurse Consultant, RN. Clinical Nurse Consultant, RN will validate all staff on LHPS tasks that have incomplete documentation. Community Business Office Coordinator and/or Executive Director will audit no less than 5 employee files monthly including new hires for 60 days then quarterly thereafter. Executive Director, Business Office Coordinator and Care Coordinators were in-serviced on the importance of staff competency check offs for all employees upon hire. In-service conducted by Clinical Nurse Consultant, RN .	9/30/2024 9/30/2024 9/30/24 9/30/2024

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

Executive Director 10-1-25

Reviewed and Acknowled LMJ 11/13/25

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D 161	Continued From page 1 ambulation. The findings are: 1. Review of Staff A's (personal care aide) personnel record revealed: -Staff A was hired 08/19/24. -Staff A was hired as a personal care aide (PCA). -There was no documentation Staff A completed a LHPS competency validation. Observation of the dining room on 09/04/24 at 3:26pm revealed: -A resident was sitting in a chair in the dining room and was incontinent of urine. -Staff A and another personal care aide (PCA) assisted the resident out of the chair and both PCAs held onto each of the resident's arms and walked with the resident down the hallway to his room. Attempted telephone interview with Staff A on 09/05/24 at 9:44am was unsuccessful. Refer to the interview with the LHPS nurse on 09/05/24 at 10:13am. Refer to the interview with the Administrator on 09/05/24 at 10:30am. 2. Review of Staff B's (personal care aide) personnel record revealed: -Staff B was hired 08/22/24. -Staff B was hired as a PCA. -There was no documentation Staff B completed a LHPS competency validation. Interview with Staff B on 09/05/24 at 9:46am revealed: -She had started working at the facility about two	D 161		

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D 161	Continued From page 2 weeks ago. -She assisted residents with transfers from the bed to the wheelchair and with ambulation. -She had worked several shifts assisting residents with transfers and ambulation since she started working. -She was not competency validated for these tasks. Refer to the interview with the LHPS nurse on 09/05/24 at 10:13am. Refer to the interview with the Administrator on 09/05/24 at 10:30am. Interview with the LHPS nurse on 09/05/24 at 10:13am revealed: -The Administrator was responsible to inform her when new staff had been hired. -She would schedule a time to check off the new staff on required tasks. -She was notified when Staff A or Staff B were ready to be competency validated for the tasks by the Administrator. -She was responsible for ensuring the staff was competency validated. Interview with the Administrator on 09/05/24 at 10:30am revealed: -Newly hired PCA's were not to perform hands-on-care until they had been competency validated by the LHPS nurse. -The Administrator, Resident Care Coordinator or Special Care Coordinator would be responsible to let the new PCA know they could not perform hands-on-care until they were competency validated. -She thought she had informed Staff A and Staff B to "shadow" the other PCA's only, but she was not sure.	D 161		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#3) related to a medicated topical cream. The findings are: Review of Resident #3's current FL2 dated 12/26/23 revealed diagnoses included dementia and difficulty walking. Review of Resident #3's Physician's orders dated 06/18/24 revealed: -An order for Venelex ointment, (used to protect the skin from urine) apply a thin layer to buttocks three times daily. -An order for Baza cream 12%, (a barrier cream) mix with Venelex and apply to buttocks three times daily. Review of Resident #3's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Venelex ointment, apply a thin layer to buttocks three times daily. -There was documentation Venelex ointment was	D 358	10A NCAC 13F .1004(a) Executive Director, Care Coordinators and/or designee to complete medication cart audits to ensure all prescribed medications are available for use. Clinical Nurse Consultant, RN to in-service all medication aide staff, to include, Executive Director and Care Coordinators on resupply of medication within an appropriate time frame to ensure no lapse in administration. Executive Director, Care Coordinator and/or designee will conduct weekly medication cart audits.	9/30/2024

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D 358	Continued From page 4 not administered on 09/02/24 through 09/05/24, with "on hold until pharmacy provides" as the reason why it was not administered. -There was an entry for Baza 12% cream, mix with Venelex ointment and apply to buttocks three times daily. -There was documentation Baza 12% cream was administered three times daily from 09/02/24 through 09/05/24. Observation of Resident #3's medications on hand on 09/05/24 at 9:50am revealed Venelex ointment was not available to administer. Interview with a medication aide (MA) on 09/05/24 at 9:50am revealed: -The Venelex ointment ran out on 09/01/24. -They had a hold order until it was delivered from the pharmacy. -She "guessed" the MA that obtained the verbal order on 09/02/24 sent the request to the pharmacy. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 09/05/24 at 10:16am revealed: -A 56.7 gram tube of Venelex was dispensed from the pharmacy on 08/12/24 and was technically supposed to last about 7 days but it usually lasted much longer because only a small amount was used. -It was ordered to be mixed with the Baza 12% cream. -A refill request for the Venelex had not been received from the facility. Interview with Resident #3's primary care provider (PCP) on 09/05/24 at 11:16am revealed: -Resident #3 was ordered Baza 12% cream as a skin protectant because she was incontinent.	D 358		

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D 358	Continued From page 5 -Baza 12% cream was thick, so Venelex ointment, which protected the skin from urine, was ordered to be mixed with it to make the Baza cream thinner. Interview with the Administrator on 09/05/24 at 11:04am revealed: -Resident #3 was prone to skin breakdown and had creams available to protect her skin, which was currently clear. -The MA who discovered the Venelex needed to be refilled on 09/02/24 should have immediately requested a refill from the pharmacy. -If a MA received a verbal order from the PCP the order should be sent to the pharmacy immediately and not wait for the PCP to sign the order before sending it. Attempted telephone interview with a MA on 09/05/24 at 11:12am was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of	D 367		

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D 367	Continued From page 6 medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the electronic medication administration record (eMAR) was accurate for 1 of 5 sampled residents (#3) related to the application of a ankle stabilizer. The findings are: Review of Resident #3's current FL2 dated 12/26/23 revealed diagnoses included dementia, difficulty walking and parkinsons disease. Review of Resident #3 physician's orders dated 06/18/24 revealed an order for an ankle stabilizer to be applied to the right ankle every morning and removed at bedtime. Interview with Resident #3 upon initial tour on 09/04/24 at 10:04am revealed: -She was supposed to be wearing a brace on her right ankle that was ordered after a previous fall. -She did not know where the brace was located. Observation of Resident #3's room on 09/04/24 at 10:04am revealed: -Resident #3 was sitting in a reclining wheelchair with both legs elevated and there was no ankle stabilizer on Resident #3's right ankle. -There was no ankle stabilizer observed in the room.	D 367	10A NCAC 13F. 1004 (j) Community Medication Staff will ensure that medication and/or braces, stabilizer, etc. are not pre-charted to be administered at a later time. Community Exectuive Director, Clinical Nurse Consultant and /or care coordinators will conduct no less than weekly medication pass observation with different medication staff for 30 days and no less than monthly thereafter. Clinical Nurse Consultant will in-service on rule area .1004 (j) to include precharting and ensuring observation of resident receiving medications and treatments.	9/30/2024

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D 367	Continued From page 7 Observation of Resident #3 on 09/05/24 at 9:05am revealed: -She was seated in a wheelchair in the activity room. -An ankle stabilizer was not on her right ankle. Observation of Resident #3's room on 09/05/24 at 9:10am revealed: -Resident #3 was not in the room. -An ankle stabilizer was in a chair near the bed. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for an ankle stabilzer- put on right ankle every morning (8am) and remove at bedtime (8pm). -There was documentation the ankle stabilizer was applied at 8am on 09/04/24 and at 8am on 09/05/24. Interview with the medication aide (MA) on 09/05/24 at 9:13am and 10:03am revealed: -She "never" applied Resident #3's ankle stabilizer before breakfast because her feet did not fit well under the dining room table if she had the stabilizer on her ankle. -She "generally" documented she applied the ankle stabilizer when she administered Resident #3's medications before breakfast but did not put in on Resident #3 until later. -She was getting ready to put the ankle stabilizer on Resident #3. -She was not sure why she documented she applied it before she actually did; "that is a good question that I don't have an answer for". -She was trained to document on the eMAR at the actual time she administered medications or completed something like applying a ankle stabilizer, not prior to doing it.	D 367		

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D 367	Continued From page 8 Interview with the Administrator on 09/05/24 at 11:04am revealed: -The MA should only document on the eMAR at the time she actually applied the ankle stabilizer; not earlier when she was administering the medications. -The MA was trained in proper documentation and she expected her to document properly.	D 367		