PRINTED: 09/29/2025
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 09/18/2025

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

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and complaint investigation on 09/17/25-09/18/25. The complaint investigation was initiated by the Mitchell County Department of Social Services on 08/21/25.	D 000	The responses in the cited statement of deficiencies do not consistute 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 solely as a matter of compliance with state laws.	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (Resident #3) related to notifying the primary care provider (PCP) of fingerstick blood sugars (FSBS) values outside the ordered parameters. The findings are: Review of Resident #3's current FL2 dated 01/28/25 revealed: -Diagnoses included diabetes mellitus type 2, metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic disturbance), and dementia. -There was an order to check FSBS before meals and at bedtime and notify the PCP if the value was less than 80 or greater than 300. Review of a physician's order dated 09/17/25 revealed to check FSBS before meals and at bedtime and notify the PCP if the value was less than 80 or greater than 300.	D 273	Facility RN will in-service Medication Staff to include Executive Director and Care Coordinators on the importance of provider notifications when vitals are outside of their ordered parameter. Executive Director and/or Care Coordinators will review resident vitals no less than weekly for 60 days to ensure proper provider notifications of any residents vitals outside of the ordered parameter.	11/10/25

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 10-21-25

STATE FORM 6899 YT2G11 If continuation sheet 1 of 8

Reviewed and acknowledged Julie Grooms 11/10/25

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D 273	Continued From page 1 Review of Resident #3's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS at 7:00am, 12:00pm, 5:00pm, and 8:00pm and notify the PCP if the value was less than 80 or greater than 300. -There was documentation of 6 occurrences where the FSBS value was less than 80 and there was no documentation the PCP was notified for 3 of 6 opportunities. -There was documentation of 21 occurrences where the FSBS value was greater than 300 and there was no documentation the PCP was notified for 15 of 21 opportunities. Review of Resident #3's August 2025 eMAR revealed: -There was an entry to check FSBS at 7:00am, 12:00pm, 5:00pm, and 8:00pm and notify the PCP if the value was less than 80 or greater than 300. -There was documentation of 6 occurrences where the FSBS value was less than 80 and there was no documentation the PCP was notified for 1 of 6 opportunities. -There was documentation of 12 occurrences where the FSBS value was greater than 300 and there was no documentation the PCP was notified for 6 of 12 opportunities. Review of Resident #3's September 2025 eMAR revealed: -There was an entry to check FSBS at 7:00am, 12:00pm, 5:00pm, and 8:00pm and notify the PCP if the value was less than 80 or greater than 300. -There was documentation of 1 occurrence where the FSBS value was less than 80 and there was	D 273		

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D 273	Continued From page 2 no documentation the PCP was notified for 1 of 1 opportunity. -There was documentation of 9 occurrences where the FSBS value was greater than 300 and there was no documentation the PCP was notified for 9 of 9 opportunities. Review of Resident #3's progress notes from July 2025 through September 2025 revealed: -On 07/09/25 at 11:58am, there was documentation the FSBS was 485, the PCP was notified, and orders were received to administer an additional 2 units (u) of a rapid-acting insulin equaling a total of 4u. -On 07/13/25 at 11:26am, there was documentation the FSBS was 325, the PCP was notified, and orders were received to administer an extra 2u of a rapid-acting insulin. -On 07/17/25 at 5:25pm, there was documentations the FSBS was 57, the PCP was notified, an as needed medication for low glucose levels was administered, and orders were received to recheck a FSBS in 10-15 minutes afterwards. -On 07/25/25 at 5:32pm, there was documentation the FSBS was 429, the PCP was notified, and orders were received to administer an extra 2u of a rapid-acting insulin to equal 4u total. -There was no other documentation the PCP was notified when Resident #3's FSBS value was less 80 or greater than 300. Interview with a medication aide (MA) on 09/18/25 at 9:48am revealed: -Resident #3 had orders to notify the PCP when his FSBS value was less than 80 or greater than 300. -She always sent a text message to Resident #3's PCP when the FSBS value was outside the	D 273		

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D 273	Continued From page 3 ordered parameters. -She documented notifications to the PCP in the eMAR or in the progress notes. -She thought she notified Resident #3's PCP of a FSBS value of 62 on 07/10/25 at 5:00pm but could not remember why she did not document the notification on the eMAR or in the progress notes. Telephone interview with a second MA on 09/18/25 at 12:10pm revealed: -She always documented PCP notifications in the comment section on the eMAR or in the progress notes. -She notified the PCP by text message when she needed to contact him. -She did not notify Resident #3's PCP on 09/10/25 at 7:00am when Resident #3's FSBS value was 580 because the eMAR did not say to notify the PCP. -She thought she notified Resident #3's PCP sometimes when the FSBS values were low or high, but she did not always document notifications because she was always busy administering medications, providing residents' personal care, and sometimes working short staffed. -The PCP never sent any orders back to her when she did notify him of high or low FSBS values and just replied with a "thumbs up" or thanked her for notifying him. Interview with Resident #3's on-call PCP on 09/18/25 at 11:00am revealed: -Resident #3 had orders to check FSBS four times a day and notify the PCP of FSBS values less than 80 or greater than 300. -The office always documented a note in the computer when the facility called and she was not notified of Resident #3's FSBS values of 306 on	D 273		

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D 273	Continued From page 4 09/08/25 at 7:00am, 580 on 09/10/25 at 7:00am, 319 on 09/11/25 at 12:00pm, and 334 on 09/14/25 at 8:00pm. -She expected the facility to call and notify her when Resident #3's FSBS values were outside the ordered parameters so that other orders could be given such as giving additional insulin when the FSBS was too high. -When Resident #3's FSBS values were too high or too low, it placed Resident #3 at risk of being in a medical emergency such as diabetic ketoacidosis (a complication of diabetes where acids build up in the blood to levels that can be life-threatening) for high blood sugars or hospitalization for low and high blood sugars. Interview with the Manager on 09/18/25 at 10:00am revealed: -The MAs were responsible for notifying Resident #3's PCP when the FSBS values were less than 80 or greater than 300. -She was not aware that MAs did not notify Resident #3's PCP regarding some of Resident #3's FSBS values that were less than 80 or greater than 300. -The MAs were supposed to document the notifications to Resident #3's PCP on the eMAR or in the progress notes. -The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) reviewed reports to make sure medications were administered but did not audit the eMARs to make sure the orders were being followed such as notifying the PCP when FSBS values were outside ordered parameters. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable.	D 273		

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D 358	Continued From page 5	D 358		
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 administer medications as ordered for 1 of 5 sampled residents (#1) related to a medication used to relax smooth muscles and reduce secretions. The findings are: Review of Resident #1's current FL2 dated 01/16/25 revealed diagnoses included dysphagia, hypertension, muscle weakness, difficulty walking, anemia, unspecified convulsions, and unspecified symbolic dysfunctions. Review of Resident #1's primary care provider (PCP) order dated 07/10/25 revealed Levsin 0.125mg one tablet twice daily. Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed there was no entry for Levsin. Review of Resident #1's August 2025 eMAR revealed there was no entry for Levsin.	D 358	Facility RN will in-service the Executive Director and Care Coordinators on the importance of initiating and implementing orders written by the residents Physician within the required time frame. Executive Director and/or Care Coordinators will implement and utilize a bucket system for order follow up to ensure compliance with physician orders. Executive Director will monitor/review orders written by the resident's physicians no less than once weekly for 60 days to ensure orders are initiated and implemented timely.	11/10/25

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D 358	Continued From page 6 Review of Resident #1's September eMAR revealed there was no entry for Levsin. Observation of Resident #1's medications on hand on 09/18/25 at 11:00am revealed there was no Levsin available for administration. Interview with Resident #1's Hospice Registered Nurse on 09/18/25 at 9:00am revealed: -She wrote a verbal order for Resident #1 to start taking Levsin and gave the order to a medication aide (MA) on 07/10/25. -Resident #1 had an episode where she had gotten strangled. -Resident #1 was ordered the Levsin to help reduce her secretions. -She did not realize Resident #1 had never received Levsin. Interview with Resident #1's Primary Care Provider (PCP) on 09/18/25 at 12:03pm revealed: -Resident #1 was ordered Levsin on 07/10/25 to help with reducing secretions. -Resident #1 was supposed to use the patch and Levsin together. -She did not realize Resident #1 had not been getting Levsin. -She expected medications to start when orders were written. Interview with the Resident Care Coordinator (RCC) on 09/18/25 at 8:22am revealed: -When orders were written, they were either given to her or the MA, who would then fax the order to the Pharmacy. -She approved the medications when they came back from pharmacy. -She had never seen the order for Levsin for Resident #1. -She was not sure why the order was never	D 358		

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D 358	Continued From page 7 started. Interview with the MA on 09/18/25 at 11:01am revealed: -When she received medication orders, she would make copies of the order and would fax to the pharmacy. -The order approval was completed by the RCC. -She did not remember receiving an order for Levsin for Resident #1. -She thought if she had received the order for Levsin, she had gotten busy and had forgotten about it. Interview with the Manager on 09/18/25 at 8:15am revealed: -Physician orders were given to the RCC, but if the RCC was not available to take the order, they were given to the MA. -Whoever received the orders, faxed the orders to pharmacy. -The pharmacy added orders to the eMAR and the RCC approved the medications once they were sent back from pharmacy. -She expected all orders to be implemented. -She thought it was an oversight and got missed.	D 358		