

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>HAL059034</b>      | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/16/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MCDOWELL HOUSE</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1687 DAIRY ROAD<br/>NEBO, NC 28761</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                  | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| D 000                                                     | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey on 04/16/25 through 04/17/25.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | D 000                                                                              |                                                                                                                          |                                                        |
| D 276                                                     | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to implement physician's orders for 1 of 3 sampled residents related to orders for laboratory blood tests (Resident #1).<br><br>The findings are:<br><br>Review of Resident #1's current FL2 dated 01/09/25 revealed diagnoses included dementia, depression and generalized anxiety disorder.<br><br>Review of Resident #1's Primary Care Provider's (PCP) order dated 03/20/25 revealed there were laboratory orders for a complete blood cell count (CBC), comprehensive metabolic panel (CMP) (a blood test that measures the body's chemical balance) and magnesium (a mineral) level to be drawn in two weeks.<br><br>Review of Resident #1's record revealed there were no laboratory results for the CBC, CMP and magnesium level ordered on 03/20/25. | D 276                                                                              |                                                                                                                          |                                                        |

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

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| D 276                                                     | <p>Continued From page 1</p> <p>Interview with the Resident Care Coordinator (RCC) on 04/16/25 at 9:55am revealed:</p> <ul style="list-style-type: none"> <li>-She was responsible to schedule all ordered blood tests with the laboratory.</li> <li>-When she received an order, she filled out a laboratory requisition form and placed it in the laboratory folder.</li> <li>-Staff from the laboratory came to the facility on Fridays for all non-emergent laboratory testing.</li> <li>-She was unsure how she missed the laboratory order for Resident #1 dated 03/20/25.</li> <li>-She thought she possibly got interrupted and missed the order.</li> </ul> <p>Interview with the Operations Manager (OM) on 04/16/25 at 10:32am revealed:</p> <ul style="list-style-type: none"> <li>-The RCC was responsible to ensure all orders were implemented.</li> <li>-There was no follow-up by a second staff member to ensure all orders were implemented.</li> </ul> <p>Attempted telephone interviews with Resident #1 PCP on 04/15/25 at 2:53pm and on 04/16/25 at 9:18am were unsuccessful.</p> | D 276                                                                              |                                                                                                                          |                                                        |