

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL059034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/16/2025
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

MCDOWELL HOUSE

**1687 DAIRY ROAD
NEBO, NC 28761**

(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 an annual survey on 04/16/25 through 04/17/25.	D 000	Integrity McDowell House will continue to ensure that we follow good practices to ensure that our residents receive quality of care.	
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: 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). The findings are: Review of Resident #1's current FL2 dated 01/09/25 revealed diagnoses included dementia, depression and generalized anxiety disorder. 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. 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	10A NCAC 13F .0902 (c) (3-4) Health Care The facility will ensure that documentation of the following in the resident's record; (3) written procedures, treatments or orders from a physician or other licensed professional; and (4) implementation of procedures, treatments or orders that are specified in subparagraph (c) (3) of this rule. As observed at the time of the survey , the Resident Care Coordinator acknowledged the one missed laboratory order, contacted the licensed provider of the error and scheduled that order to be completed. The laboratory order was completed on the next lab day scheduled, 4/25/25. To ensure ongoing compliance, the following monitoring process has been put into place. All orders will be documented on a "order log" and will be followed by a two-person check process until completion. The Resident Care Coordinator and/or Designee will review the "order log" daily to ensure the order log process is being followed and completed. The Operational Manager and/or Designee will review all order logs monthly to ensure compliance and the completion of all orders.	completed 4/25/25 5/19/25

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

Janet C. Bush

TITLE Administrator

(X6) DATE

STATE FORM

6899

OY1N11

If continuation sheet 1 of 2

Reviewed and Acknowledged by SSD on 07/11/25

Sharon Dantre RN

Division of Health Service Regulation

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D 276	Continued From page 1 Interview with the Resident Care Coordinator (RCC) on 04/16/25 at 9:55am revealed: -She was responsible to schedule all ordered blood tests with the laboratory. -When she received an order, she filled out a laboratory requisition form and placed it in the laboratory folder. -Staff from the laboratory came to the facility on Fridays for all non-emergent laboratory testing. -She was unsure how she missed the laboratory order for Resident #1 dated 03/20/25. -She thought she possibly got interrupted and missed the order. Interview with the Operations Manager (OM) on 04/16/25 at 10:32am revealed: -The RCC was responsible to ensure all orders were implemented. -There was no follow-up by a second staff member to ensure all orders were implemented. Attempted telephone interviews with Resident #1 PCP on 04/15/25 at 2:53pm and on 04/16/25 at 9:18am were unsuccessful.	D 276		