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	HAL061011	A. BUILDING: _____ B. WING _____	01/11/2018

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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 and Mitchell County Department of Social Services conducted an annual survey on January 10 and 11, 2018.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure that staff provided supervision for 2 of 2 sampled residents (#4, #6) who were smoking electronic cigarettes inside the building. The findings are: Observations on 1/10/18 at 9:00am and 1/11/18 at 3:50pm revealed there was a "No Smoking" sign adjacent to the outside front door of the facility and "No Smoking" signs posted inside the facility. A. Review of Resident #6's current FL2 dated 10/6/17 revealed: -Diagnoses included renal artery artherosclerosis, hypertension, lumbosacral spondylosis, peripheral vascular disease, anxiety, depressive disorder, atrial fibrillation, and hyperlipidemia. -There was a physician order for oxygen per	D 270		

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nasal cannula at 2 liters at bedtime and as needed.

Observation on 1/10/18 at 10:10am during the medication pass revealed:
-Resident #6 was sitting in a chair in a resident room adjacent to his room.
-Resident #6 had a white electronic cigarette in his mouth.
-Resident #6 inhaled and exhaled a vapor three times.
-The Medication Aide was in the room and did not speak to Resident #6.

Observation on 1/10/18 at 10:15am of Resident #6's room revealed there was an oxygen concentrator next to the bed with oxygen actively flowing at 2L per minute through a nasal cannula that was on the bed.

Interview on 1/11/18 at 9:00am with Resident #6 revealed:
-He used the electronic cigarette "about once per month".
-"I never use them in my room."
-No staff member had told him not to use the electronic cigarette in the building.
-He used oxygen only at night.

Attempted telephone interview on 1/11/18 at 1:30pm with Resident #6's Power of Attorney was unsuccessful.

Refer to the interview on 1/11/18 at 8:10am with the first shift Medication Aide.

Refer to the interview on 1/11/18 at 8:15am with the facility Nurse.

Refer to the interview on 1/11/18 at 8:32am with

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D 270	Continued From page 2 the first shift Personal Care Aide. Refer to the interview on 1/11/18 at 8:50am with the Resident Care Coordinator. Refer to the interview on 1/11/18 at 8:45am with the Administrator. Refer to the review on 1/11/18 at 8:45am of the facility "Tobacco Use Policy". B. Review of Resident #4's current FL2 dated 4/2/17 revealed diagnoses included dyslipidemia, myocardial infarction, gastroesophageal reflux disease, transient ischemic attack, degenerative joint disease, anxiety, depression, and chronic constipation. Observation on 1/11/18 at 8:55am of Resident #4's room revealed there were three electronic cigarettes on the nightstand next to the bed. Interview on 1/11/18 at 8:55am with Resident #4 revealed: -She did use the electronic cigarette in the building. -No one had told her electronic cigarettes could not be used in the building. -"I only use them once in awhile, like 3 or 4 times a day." -She had not seen other residents using electronic cigarettes in the building. Interview on 1/11/18 at 1:35pm with Resident #4's Power of Attorney revealed: -The POA knew electronic cigarettes were not allowed to be used in the building. -"The facility had a discussion on admission about the electronic cigarettes and they are not allowed in the facility."	D 270		

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D 270	Continued From page 3 -"(Resident #4's name) knows they aren't allowed." Refer to the interview on 1/11/18 at 8:10am with the first shift Medication Aide. Refer to the interview on 1/11/18 at 8:15am with the facility Nurse. Refer to the interview on 1/11/18 at 8:32am with the first shift Personal Care Aide. Refer to the interview on 1/11/18 at 8:50am with the Resident Care Coordinator. Refer to the interview on 1/11/18 at 8:45am with the Administrator. Refer to the review on 1/11/18 at 8:48am of the facility "Tobacco Use Policy". _____ Interview on 1/11/18 at 8;10am with the first shift Medication Aide revealed: -"I have no clue on the policy for e-cigarettes (electronic cigarettes)." -She had seen residents using electronic cigarettes in the building. -She had not told the residents they could not use electronic cigarettes in the building. -"No one has ever gone over an e-cigarette policy." -"I have never seen any signs about e-cigarettes." Interview on 1/11/18 at 8:15am with the facility Nurse revealed: -"I don't know if we have a policy or not about e-cigarettes." -"I think there are some residents that have used	D 270		

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them but I've never seen them."
-"There are no signs in the building about e-cigarettes."

Interview on 1/11/18 at 8:32am with a first shift Personal Care Aide (PCA) revealed:
-"Don't use e-cigarettes in the building. That is the policy."
-She had seen one resident use an e-cigarette in the building.
-"I asked the Med Aide (Medication Aide) if the resident could use it in the building and she said yes."

Interview on 1/11/18 at 8:50am with the Resident Care Coordinator (RCC) revealed:
-The residents were not supposed to use the electronic cigarettes in the building.
-"We had a family meeting in December and asked that they (e-cigarettes) not be brought in."
-There were no signs posted about electronic cigarettes in the building.

Interview on 1/11/18 at 8:45am with the Administrator revealed:
-There were no signs posted in the building about electronic cigarettes.
-There was a policy about smoking.
-There were "No Smoking" signs posted in the building.
-"The policy does not state electronic cigarettes but we treat it like a regular cigarette."
-"We don't have any current residents that are using e-cigarettes now; if we did, we would address it."
-She was not aware that Resident #4 and #6 were using electronic cigarettes in the building.

Review on 1/11/18 at 8:48am of the facility Tobacco Use Policy revealed:

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D 270	Continued From page 5 -The "No Smoking" policy was reviewed with residents and the responsible party at admission. -Residents could only smoke in designated smoking areas outside the building. _____ The facility failed to ensure staff provided supervision for 2 of 2 sampled residents (#4, #6) who smoked electronic cigarettes in the facility with oxygen in use. The actions of Resident #4 and #6 was detrimental to the health, safety, and welfare of all the residents residing in the facility which constitutes a Type B Violation. _____ The facility provided a Plan of Protection on 1/11/18 that included: -Facility obtained the electronic cigarettes from the resident. -The electronic cigarettes will be stored in the medication cart for use when the resident requests. -A resident council meeting is planned for 1/24/18 to discuss the dangers of electronic cigarettes and the designated areas outside the facility. -The Administrator will monitor to ensure proper use of devices in the designated areas. -The Administrator will monitor on a daily basis for a week, then twice a week for two weeks, and then at random going forward. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2018.	D 270		
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	D 276		

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D 276	Continued From page 6 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 assure implementation of a physician order for Thrombo-embolic Deterrent Hose (TED) for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL2 dated 6/29/17 revealed diagnoses included atrial fibrillation, hypertension, and Alzheimer's dementia. Review of Resident #3's Resident Register revealed she was admitted to the facility on 6/29/17. Review of Resident #3's subsequent physician orders, dated 11/16/17, revealed an order for "AE hose 18 x 18", on in am off in pm (Thrombo-Embolic Deterrent Hose used for fluid retention and blood clots). Review of Resident #3's Electronic Medication Administration Records for November 2017 through January 2018 revealed no entry for TED hose. Interview with the Resident Care Coordinator on 1/11/18 at 10:15am revealed:	D 276		

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-The TED hose had not been dispensed by the pharmacy and Resident #3 did not have any.
-The order for the TED hose was faxed to the pharmacy when first written.
-The pharmacy sent a response requesting the size of the TED hose and that request was misplaced "in the shuffle."
-She was not sure what happened with the TED hose order.

Interview with the Nurse Practitioner (NP) on 1/11/18 at 10:40am revealed:
-She had just been informed by facility staff that Resident #3's TED hose were not dispensed until 1/10/18 and the hose were too small.
-She would have to decide what to do about ordering another pair of hose since a larger pair would be a "special order."
-When asked about the significance of the delay in obtaining the TED hose, she responded with, "I can't answer that."
-She had ordered the TED hose in an attempt to reduce the swelling in Resident #3's legs and feet.

Telephone interview with the SCU Coordinator on 1/11/18 at 2:45pm revealed:
-She did not have any resident records with her for specific information related to the TED hose and did not know what happened with the delay.
-She was responsible for ordering medications and treatments from the pharmacy but the medication aides were also involved in sending orders to the pharmacy.

Telephone interview with the facility's pharmacy provider on 1/11/18 at 11:47am revealed:
-They received the TED hose order on 11/16/17 and responded requesting the facility to clarify with size required.

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D 276	Continued From page 8 -They had no documentation the facility communicated with them about the TED hose until 1/10/18 (day of survey), when the facility called and requested an extra large, extra long pair of TED hose. Review of a fax message from the pharmacy to the facility dated 1/9/18 revealed, "We cannot dispense Ted hose without appropriate measurements. Please send TED measurements." Telephone interview with Resident #3's responsible person on 1/10/18 at 8:45am revealed: -Resident #3 had swollen legs and feet ever since she was admitted to the facility. -Resident #3 only had 1 kidney and had kidney disease which resulted in fluid retention. -She was not aware that Resident #3's physician had ordered any measures to address the edema except for the resident to keep feet up and an order for furosemide medication (a medication used to treat fluid build up). Based on observations, interviews, and record reviews, Resident #3 was not interviewable due to diagnoses of dementia.	D 276		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 310	Continued From page 9 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure for 1 of 3 sampled residents (#7) with a physician order a a Mechanical Soft Diet order was served as ordered. The findings are: Review of Resident #7's current FL2 dated 4/15/17 revealed: -Diagnoses included senile dementia, muscle weakness, and esophageal reflux. -A physician order for a Mechanical Soft diet. Review of Resident #7's Licensed Health Professional Support (LHPS) review dated 12/29/17 revealed the LHPS Nurse checked the task for "feeding techniques of residents with swallowing problems" and "Mech Soft" was handwritten in the space. Review of the Therapeutic diet list in the kitchen revealed Resident #7 was on a "Mechanical Soft, Entire Meal" diet. Interview with a Personal Care Aide (PCA) on 1/11/17 at 7:30am revealed: -She was working in the kitchen and on the floor "today" because a dietary staff was out. -She served whole grapes and strawberries for breakfast because the menu said to serve "fresh fruit." -They served grapes "all the time" to all residents. -She was not aware if grapes should have been cut up for residents on a mechanical soft diet but she and other staff would go around the dining room and assist residents with cutting up the grapes.	D 310		

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D 310	Continued From page 10 Observation of the breakfast meal on 1/11/17 at 7:30am through 8:30am revealed: -Two of three residents sampled with a Mechanical Soft diet order did not come to the breakfast meal. -Resident #7 was served whole grapes with no mechanical alteration with strawberry halves, ground sausage, scrambled eggs, pancakes, and beverages. -A PCA cut up the grapes after surveyor questioned her. -Resident #7 ate all the food items including the fruit with no difficulty. Review of the breakfast Therapeutic Mechanical Soft menus revealed: -Fresh fruit was listed to be served under the "Regular" diet column with "M. S." listed in the column for fruit under the Mechanical Soft column. -There was no definition at the bottom of the menu for "M.S." -There was a definition at the bottom of the menu for "X" which stated the food was to be served for that diet. Interview with the Dietary Manager on 1/11/18 at 7:50am revealed: -They had a contract with a company which provided therapeutic menus on a website. -The Business Office Manager printed off the regular and therapeutic menus for him because he did not have a computer in dietary. -He thought the initials "M.S." in the Mechanical Soft column beside the fresh fruit entry meant that food was to be served. -He did not have any printed guidance or definition for the term M.S. -He had worked there a year and three months.	D 310		

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-The facility was using these same menus when he began working there.
-The Regional Purchasing Director Assistant was the only one who had trained him on the use of the facility menus.
-He was not aware recipes were available with the menus.
-He had taken the State Food Service Orientation Training.

Telephone interview with the Registered Dietitian's Assistant who managed the therapeutic menu website on 1/11/18 at 8:50am revealed:
-Recipes for the therapeutic menus were available for all menu items with guidance documented on the recipes how to serve residents with therapeutic diets a particular food.
-Each recipe was available by clicking on a box beside each food on the menu.
-She would be glad to have a telephone tutorial with the facility staff and teach them how to use the menus.
-The Registered Dietitian was not currently available.

Observation of the Dietary Manager on 1/11/18 at 9:10am revealed:
-He pulled up the menu website and found the therapeutic menus the facility uses.
-He clicked on the small box beside where fresh fruit was listed on the breakfast menu for 1/11/18.
-Directions for serving fresh fruit to residents on a Mechanical Soft diet popped up on the computer screen.

Review of the directions for serving fresh fruit to residents on a Mechanical Soft diet revealed, "Serve canned fruit, peeled fresh fruit, or ripe berries without seeds (or with small seeds). No fresh apples, grapes, mango, papaya, pears or

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D 310	Continued From page 12 pineapple. Fruit should be cut in small bite size pieces." Interview with the Nurse Practitioner on 1/11/18 at 11:45am revealed, Resident #7 could have swallowed the grapes and "choked." Interview with the Administrator on 1/11/18 at 9:20am revealed: -She was not aware there were no directions on the therapeutic extension menus how to serve each food. -She had worked there as the Administrator for 7 weeks. -She would assure the menus and recipes for the week were printed every Monday and shared with all the dietary staff. -The Dietary Manager was scheduled for a telephone tutorial with the facility menu's Registered Dietitian Assistant on 1/12/18. -The Dietary Manager will print all recipes every Monday morning during the morning meeting to assure modified diets are being followed. Attempted telephone interview with Resident #7's responsible person on 1/11/18 at 11:41 was not successful. Based on observations, interviews, and record reviews, Resident #7 was not interviewable due to diagnoses of dementia. .	D 310		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

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D912	Continued From page 13 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to supervision while smoking. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure that staff provided supervision for 2 of 2 sampled residents (#4, #6) who were smoking electronic cigarettes inside the building. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).]	D912		