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 _____	06/12/2023

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 an annual survey and complaint investigation 06/07/23 - 06/09/23 and 06/12/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) who administered medications had passed the written medication aide exam within 90 days of completing the medication clinical skills competency validation checklist. The findings are: 1. Review of Staff A's personnel record revealed: -Staff A was hired on 06/14/21 as a certified nursing assistant. -There was a certificate of completion dated	D 125		

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 _____	06/12/2023

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 125	Continued From page 1 11/30/22 for the 15-hour state approved medication aide (MA) training for Staff A. -There was documentation of 3 medication clinical skills competency validation checklists completed for Staff A on 10/25/21, 12/06/22, and 04/26/23. -There was no documentation Staff A had successfully passed the state MA exam. Interview with Staff A on 06/12/23 at 7:50am revealed: -She completed all the training to become a MA but she failed the test when she took it about six months ago. -After she failed the test a second time, about a month ago, a Registered Nurse came and reviewed the training with her again. -She was scheduled this week to take the test for a 3rd time. Interview with the Administrator on 06/12/23 at 12:48pm revealed: -He knew Staff A failed the test recently and was scheduled to retake it again this week. -He did not remember Staff A failed the state MA test two times. -He thought Staff A could be retrained and then had another 60 days to pass the test. Interview with the Resident Care Coordinator (RCC) on 06/12/23 at 2:55pm revealed: -The staff who train to be MAs completed a 5-hour and 10-hour course, shadow the MA on the medication cart for 3 days, and get checked off on clinical skills. -Someone from the corporate office was supposed to ensure the medication course, clinical skills and state exam were successfully completed.	D 125		

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 _____	06/12/2023

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 125	Continued From page 2 Interview with the Memory Care Coordinator (MCC) on 06/12/23 at 3:07pm revealed: -Staff interested in becoming a MA had to complete a 5 and 10-hour training, shadow the MA on the medication cart for 3 days, and get checked off on their medication clinical skills before taking their state exam. -The Business Office Manager (BOM) kept track of who was qualified as a MA so she could always ask him if there was any question about it.	D 125		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

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 _____	06/12/2023

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 201	Continued From page 3 (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure required staffing hours were met on night shift based on a census of 31 for 10 of 29 sampled shifts from 05/10/23 to 06/07/23. The findings are: Interview with a resident during the initial facility tour on 06/07/23 at 10:22am revealed sometimes there was only one staff working at night. Interview with a medication aide (MA) on 06/12/23 at 7:50am revealed: -She worked as a night shift MA. -She started working there about two years ago and about four or five months ago she started getting scheduled to work alone. -She thought she needed more help to provide care for the residents because she did not think one person was capable of providing the care the residents needed. -She was afraid if she refused to work alone she would be charged with neglect so she never	D 201		

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 _____	06/12/2023

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 201	Continued From page 4	D 201		

complained about it and just worked by herself.
-In order to accomplish all her duties and answer the call lights timely, she literally had to run up and down the hall during her shift.
-Sometimes she had a personal care aide (PCA) that worked with her but usually she worked by herself.

Telephone interview with a MA on 06/09/23 at 10:34am revealed:
-She worked as a night shift MA in the special care unit (SCU).
-The MA that worked in assisted living frequently worked alone.

Telephone interview with a personal care aide (PCA) on 06/09/23 at 11:05am revealed:
-She worked as a PCA on night shift in the SCU.
-Frequently there was only one MA in assisted living and she worked alone.

Interview with the dietary manager on 06/09/23 at 2:50pm revealed when she came to work in the morning there was frequently one night shift MA working in assisted living.

Review of the facility census from 05/10/23 to 06/07/23 revealed there was a census of 31 residents which required 16 staff hours on night shift.

Review of the staff time records from 05/10/23 to 06/07/23 revealed:
-On 05/10/23, a total of 12 staff hours were provided leaving a shortage of 4 hours.
-On 05/24/23, a total of 12 staff hours were provided leaving a shortage of 4 hours.
-On 05/25/23, a total of 12 staff hours were provided leaving a shortage of 4 hours.
-On 05/29/23, a total of 12 staff hours were

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 _____	06/12/2023

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 201	Continued From page 5 provided leaving a shortage of 4 hours. -On 05/30/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. -On 05/31/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. -On 06/01/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. -On 06/03/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. -On 06/04/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. -On 06/07/23, a total of 12 staff hours were provided leaving a shortage of 4 hours. Interview with the Resident Care Coordinator (RCC) on 06/12/23 at 11:52am revealed: -She was responsible for creating the staff schedule. -She did not realize night shift did not have enough staff hours. Interview with the Administrator on 06/08/23 at 12:01pm revealed: -The RCC was responsible for creating the staff schedule. -The RCC gave him a copy of the monthly schedule, but he did not realize night shift staffing hours were not adequate. -He knew there were a few times the facility was short staffed due to staff calling out at the last minute, but he did not realize it was a significant problem.	D 201		
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	D 270		

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 _____	06/12/2023

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 270	Continued From page 6	D 270		

accordance with each resident's assessed needs, care plan and current symptoms.

This Rule is not met as evidenced by:
A2 VIOLATION

Based on observations, interviews and record reviews the facility failed to provide supervision to 1 of 6 sampled residents (Resident #3) who had a history of wandering behaviors, resulting in four documented falls in three weeks.

The findings are:

Review of Resident #3's current FL2 dated 01/31/23 revealed:
-Diagnoses included Alzheimer's disease, and chronic obstructive pulmonary disease.
-She was documented as constantly disoriented with a history of wandering behaviors.

Review of Resident #3's current care plan dated 05/22/23 revealed:
-The care plan was completed due to a significant change related to a fall on 05/16/23.
-She was documented as having wandering behaviors.
-The was no documentation she needed increased supervision due to having a history of wandering behaviors.
-She was documented as constantly disoriented and needing redirection.
-She independently ambulated and required limited assistance with toileting.

a. Review of Resident #3's incident report dated 05/16/23 revealed:

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 _____	06/12/2023

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 270	Continued From page 7	D 270		

-She had an unwitnessed fall in her bedroom at 12:56am.
-She was found by the medication aide (MA) and sent to the local hospital.
-She was treated for a head laceration and released the same day.

Review of Resident #3's Fall Risk Intervention Care Plan dated 05/16/23 revealed:
-The Special Care Coordinator (SCC) completed the Fall Risk Intervention Care Plan.
-Follow up with the Primary Care Provider (PCP) was the intervention documented.

Review of Resident #3's May 2023 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #3's vital signs were monitored for 72 hours after the fall on 05/16/23.
-There was no documentation she was monitored for changes after the fall.

Review of Resident #3's physician orders dated 05/16/23 revealed a Lidocaine pain patch to be put on her lower back daily.

Review of Resident #3's record revealed:
-There was no hospital discharge summary available for review.
-There was no PCP note available for review.

b. Review of Resident #3's incident report dated 06/04/23 revealed:
-She was found by a personal care aide (PCA) at 4:35pm sitting on the floor in front of a chair in the hall.
-She was treated at the local hospital for a bruise on her left arm and released the same day.

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 _____	06/12/2023

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 270	Continued From page 8	D 270		

Review of Resident #3's Fall Risk Intervention Care Plan dated 06/04/23 revealed:
-The SCC completed the Fall Risk Intervention Care Plan.
-A change to Resident #3's toileting schedule was the intervention documented.

Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #3's vital signs were monitored for 72 hours after the fall on 06/04/23.
-There was no documentation she was monitored for changes after the fall.

Review of Resident #3's record revealed:
-There was no hospital discharge summary available for review.
-There was no change to Resident #3's care plan.
-There was no documentation how Resident #3's toileting schedule was changed.

c. Review of Resident #3's incident report dated 06/07/23 revealed:
-The incident occurred at 5:45am.
-A PCA was providing care to Resident #3's roommate when Resident #3 rolled out of bed onto the floor.
-No injury was documented.
-There was documentation Resident #3 was transported to the local hospital and released that same day.

Review of Resident #3's Fall Risk Intervention Care Plan dated 06/07/23 revealed:
-The SCC completed the Fall Risk Intervention Care Plan.
-Follow up with the PCP was the intervention documented.

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 _____	06/12/2023

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 270	Continued From page 9 Review of Resident #3's June 2023 electronic medication administration record (eMAR) revealed: -There was documentation Resident #3's vital signs were monitored twice a day for 72 hours after the fall on 06/07/23. -There was no documentation she was monitored for any changes in her condition. Review of Resident #3's record revealed: -There was no hospital discharge summary available for review. -There was no documentaion the PCP had evaluated Resident #3 after the fall. Telephone interview with a PCA on 06/08/23 at 1:00pm revealed: -She was working on 06/07/23 when Resident #3 rolled out of bed at 5:45am. -She did not know that Resident #3 had fallen previously on 05/16/23 or 06/04/23. -Resident #3 toileted independently and she was not aware of a toileting schedule. Telephone interview with another PCA on 06/08/23 at 4:07pm revealed: -She worked as a night shift PCA. -She was in the room when Resident #3 rolled out of her bed at 5:45am. -She thought she startled Resident #3 when she started talking to her roommate. -Resident #3 threw her hands up and rolled over onto the floor when she spoke to the roommate. -She yelled for help and PCAs in the hallway heard her and came to help. -Resident #3 toileted independently and she was not aware of a toileting schedule or a change in supervision.	D 270		

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 _____	06/12/2023

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 270	Continued From page 10 Telephone interview with a third PCA on 06/09/23 at 11:05pm revealed: -She was working on 06/07/23 when Resident #3 rolled out of bed at 5:45am. -She and another PCA were in another resident's room when Resident #3 rolled out of bed. -They heard a loud thud and went to investigate and heard the PCA in Resident #3's room calling for help. -Resident #3 was known to frequently wander throughout the night shift. -Resident #3 was not on any toileting schedule because she could toilet independently. d. Review of Resident #3's incident report dated 06/07/23 revealed: -The incident occurred at 8:51pm. -She was found by the MA on the floor in her bedroom, next to her bed. -There was documentation she was sent to the hospital for a left leg injury. Telephone interview with a MA on 06/09/23 at 10:34am revealed: -She found Resident #3 on the floor of her room on 06/07/23 at 8:51pm. -Resident #3 was known to have wandering behaviors and needed frequent redirection. -Resident #3 took evening medications that made her unsteady. -Other than a two-hour toileting schedule she did not know of any increased supervision for Resident #3. -She thought Resident #3 had been on a two-hour toileting schedule for a long time. -There was only one PCA working with her the evening Resident #3 fell. Interview with the SCC on 06/08/23 at 12:13pm and 06/09/23 at 11:30am revealed:	D 270		

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 _____	06/12/2023

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 270	Continued From page 11 -Resident #3 had her vital signs monitored for 72 hours after each fall. -Monitoring vital signs after a fall was a routine procedure at the facility. -After a fall a Fall Risk Intervention Care Plan was always completed in order to determine if a change in care was needed. -After the 06/04/23 fall, Resident #3's toileting schedule was changed . -No other changes were implemented after her falls. -Since Resident #3 had historically been independent with her toileting she was changed to a two-hour toileting schedule to reduce further falls. Interview with the Administrator on 06/08/23 at 8:00am and 06/09/23 at 12:01pm revealed: -Resident #3 had multiple falls in the past few weeks. -Vital signs were monitored for 72 hours after a fall. -A Fall Risk Intervention Care Plan was always completed by the SCC after a fall and a fall intervention was implemented to prevent further falls based on the circumstances of the incident. -No other intervention was put in place other than following up with the PCP after the 05/16/23 and 06/07/23 fall. -A change to the toileting schedule was the intervention implemented after the 06/04/23 fall. -The PCP saw Resident #3 on 06/06/23 and ordered a physical therapy assessment to evaluate and treat lower extremity muscle wasting and atrophy. -He and the SCC met every morning to discuss any changes in resident conditions, needs or care plans. -He expected the SCC to communicate any changes to the MAs and PCAs.	D 270		

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 _____	06/12/2023

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 270	Continued From page 12 Telephone interview with Resident #3's family member/guardian on 06/08/23 at 11:53am revealed: -Resident #3 fell several times in the past three weeks. -The facility had done nothing that she was aware of to prevent further falls. -She started complaining about back pain after she was treated for a urinary tract infection (UTI) at the beginning of May 2023. -She was started on a Lidocaine pain patch to her lower back in mid May 2023 after the first fall because it was thought her back was bothering her after the UTI. -Resident #3 was able to walk and get in and out of bed independently until a week or two ago when she noticed a decline in Resident #3's leg strength and stability. -Resident #3 was admitted to the hosprital after the fall on 06/07/23. Attempted telephone interview with Resident #3's PCP on 06/09/23 at 10:59am was unsuccessful. Based on observation, interview and record review Resident #3 was not interviewable. Refer to Tag D 465, NCAC .13F .1308(a) Special Care Unit Staff _____ The facility failed to provide adequate supervision to Resident #3, who was documented as having wandering behaviors and needing frequent redirection, resulting in her having four falls in three weeks, resulting in her being sent to the local hospital for treatment and admitted to the hospital after the most recent fall, putting her at substantial risk for serious physical harm and constitutes a Type A2 Violation.	D 270		

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 _____	06/12/2023

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 270	Continued From page 13 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/23. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 12, 2023.	D 270		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain a record of menu substitutions indicating what foods were actually served to residents. The findings are: Interviews with 4 residents during initial tour on 06/07/23 from 9:09am-10:11am revealed: -The meals served were frequently different from the menu posted.	D 292		

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 _____	06/12/2023

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 292	Continued From page 14 -Fish was rarely served when it was on the posted menu. -The same food items were frequently repeated. -They rarely served red meat when it was on the menu. Review of the lunch menu for 06/07/23 revealed the menu consisted of lemon pepper fish, mixed vegetable blend, buttered squash, dinner roll and ice cream. Observation of the lunch meal service on 06/07/23 at 12:05pm revealed the meal consisted of Mexican soup, cornbread, nacho chips and an ice cream bar. Review of the breakfast menu for 06/08/23 revealed the menu consisted of breakfast sausage casserole, home fried potatoes, assorted fruit, juice and milk. Observation of the breakfast meal service on 06/08/23 at 7:15am revealed the meal consisted of scrambled eggs, sausage, hash brown potatoes, peaches, dry cereal with milk, juice and yogurt. Review of the lunch menu for 06/08/23 revealed the menu consisted of BBQ chicken thighs, corn, cole slaw, breadsticks and pears. Observation of the lunch meal service on 06/08/23 at 12:15pm revealed the meal consisted of chicken cordon blue, mashed potatoes, broccoli, biscuit and pears. Review of the facility's meal substitution book revealed: -The substitution list was kept in the same book as all the facility's menus.	D 292		

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 _____	06/12/2023

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 292	Continued From page 15 -The list consisted of four columns: date, menu item, substitution and staff initials -There were three entries for every day of the month: one for each meal of the day. -The main entrée for the meal was written in the 2nd column. -If the menu entree was served a dash was written in the 3rd column but a different main entrée was written in the 3rd column if it varied from the menu entrée. -There were no entries to document the substitutions made to the menus for lunch on 06/07/23 or breakfast and lunch on 06/08/23. Interview with the Dietary Manager on 06/08/23 at 8:40am and 11:20am revealed: -She made Mexican soup for lunch on 06/07/23 because she the fish that was on the menu was not available. -She documented in the food substitution book what was served for the main entrée only because that was how she was trained by the previous dietary manager. -She did not know she should document anything that was substituted. -She rarely had to substitute side items because she usually had them. -Meats were difficult to get when she ordered them, so she made substitutions to those frequently. -She did not order the fish on the menu because it was always out of stock, but she never chose a different type of fish because she did not think that was allowed. -She did not serve the menu items for lunch on 06/08/23 because those items were not available until after the food delivery truck came. Interview with the Regional Director of Operations on 06/08/23 at 9:23am revealed:	D 292		

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 _____	06/12/2023

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 292	Continued From page 16 -The dietary manager should document everything that was substituted on the menu, not just the main entrée. -Other facilities in the region used a substitution book that had space to document everything that was substituted and she did not know why they did not use the same substitution form. -She did not know why the dietary manager was trained to only document main entrees. Interview with the Administrator on 06/09/23 at 12:01pm revealed: -The dietary manager could make substitutions but needed to document what was substituted. -He, like the dietary manager, thought only the main entrée item needed to be documented.	D 292		
D 432	10A NCAC 13F .1106 (f) Settlement Of Cost Of Care 10A NCAC 13F .1106 Settlement Of Cost Of Care (f) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the Estate Administrator for 1 of 1 sampled resident (#6) was given his personal funds refund within 30 days after the resident's death.	D 432		

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 _____	06/12/2023

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 432	Continued From page 17 The findings are: Record review revealed Resident #6 was admitted to the facility on 12/29/22 and died at the facility on 03/29/23. Telephone interview with Resident #6's Estate Administrator on 06/08/23 at 3:00pm revealed: -Resident #6 passed away at the facility on 03/29/23. -The Resident Trust Account funds were issued to her on 03/29/23 by the BOM. -The BOM informed her on 03/29/23 that he would request the room and board refund from the corporate business office, and it would be received within 30 days. -She called the BOM and the Administrator during the last week of May 2023 and asked where the refund check was. -The BOM and Administrator both indicated they would contact the corporate business office about the refund check. -As of 06/07/23, no room and board refund check has been received and this was all she was waiting on to close out the estate for Resident #6. Interview with the Business Office Manager (BOM) on 06/08/23 at 12:13pm revealed: -Resident #6 had a Resident Trust Account with the facility. -On 03/29/23 Resident #6 passed away at the facility and the $25.75 in his Resident Trust Account was issued to his Estate Administrator. -On 03/30/23 the BOM requested a room and board refund to the corporate business office for Resident #6 by email. -The home office usually issued a room and board refund by check within 30 days after a resident expired in the facility.	D 432		

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 _____	06/12/2023

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 432	Continued From page 18 -On 05/22/23 he received a phone call from Resident #6's Estate Administrator asking about the room and board refund that she had not received. -He sent a second email to the corporate business office requesting the refund of room and board for Resident #6 on 05/22/23. -He sent a third email to the corporate business office requesting the refund of room and board for Resident #6 on 05/31/23. -He was unsure why the corporate business office had not issued a check for a refund for room and board for Resident #6. Interview with the Administrator on 06/08/23 at 12:32pm revealed: -It was company policy to issue a room and board refund within 30 days after a resident was discharged from the facility. -The corporate business office would issue a refund check to the facility. -When the BOM received the check, he contacted the Estate Administrator for directions to either mail the check or have the Estate Administrator pick up the check at the facility. -There have been several staff changes in the Accounts Payable and Accounts Receivable departments at the corporate business office and he thinks there was miscommunication between the staff that caused this error.	D 432		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this	D 465		

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 _____	06/12/2023

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 465	Continued From page 19	D 465		

Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to ensure required staffing hours were met on night shift in the special care unit (SCU) based on a census of 38-43 for 12 of 29 sampled shifts from 05/10/23 to 06/07/23.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/2023 revealed they had a SCU with a capacity of 48.

Interview with a resident during the initial facility tour on 06/07/23 at 10:22am revealed sometimes there was only one staff working at night.

Telephone interview with a medication aide (MA) on 06/09/23 at 10:34am revealed:
-She worked as a MA on night shift (7:00pm - 7:00am).
-One or two personal care aides (PCAs) worked with her, but it was usually just one.
-Occasionally she had a PCA that worked for a few hours to cover during high need times.
-Sometimes when there were two PCAs working one would go to the assisted living side and work because that side frequently had a MA working by herself.

Telephone interview with a PCA on 06/08/23 at

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 _____	06/12/2023

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 465	Continued From page 20	D 465		

11:05am revealed:
-She worked as a PCA on night shift.
-When three or four staff worked, one of them would frequently go to the assisted living side and help.
-When only two people were working it was rough; a 3rd staff would be very helpful.
-She was usually able to accomplish all her duties, but it was only because she started getting residents up at 5:00am.

Telephone interview with another PCA on 06/09/23 at 4:48pm revealed:
-She worked as a PCA on day shift.
-There were usually two or three staff working night shift when she came to relieve them on day shift.

Review of the staff time records from 05/10/23 to 06/07/23 revealed:
-On 05/10/23, the census was 43 requiring 34.4 staff hours; a total of 24 staff hours were provided leaving a shortage of 10.4 hours.
-On 05/11/23, the census was 43 requiring 34.4 staff hours; a total of 29 staff hours were provided leaving a shortage of 5.4 hours.
-On 05/12/23, the census was 43 requiring 34.4 staff hours; a total of 24 staff hours were provided leaving a shortage of 10.4 hours.
-On 05/16/23, the census was 43 requiring 34.4 staff hours; a total of 32 staff hours were provided leaving a shortage of 2.4 hours.
-On 05/19/23, the census was 43 requiring 34.4 staff hours; a total of 32 staff hours were provided leaving a shortage of 2.4 hours.
-On 05/20/23, the census was 43 requiring 34.4 staff hours; a total of 24 staff hours were provided leaving a shortage of 10.4 hours.
-On 05/24/23, the census was 41 requiring 32.8 staff hours; a total of 24 staff hours were provided

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 _____	06/12/2023

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 465	Continued From page 21	D 465		

leaving a shortage of 8.8 hours.
-On 05/25/23, the census was 42 requiring 33.6 staff hours; a total of 24 staff hours were provided leaving a shortage of 9.6 hours.
-On 05/29/23, the census was 42 requiring 33.6 staff hours; a total of 24 staff hours were provided leaving a shortage of 9.6 hours.
-On 06/02/23, the census was 43 requiring 34.4 staff hours; a total of 24 staff hours were provided leaving a shortage of 10.4 hours.
-On 06/03/23, the census was 43 requiring 34.4 staff hours; a total of 12 staff hours were provided leaving a shortage of 22.4 hours.
-On 06/07/23, the census was 38 requiring 30.2 staff hours; a total of 24 staff hours were provided leaving a shortage of 6.2 hours.

Interview with the Special Care Coordinator (SCC) on 06/08/23 at 11:30am revealed:
-She and the Resident Care Coordinator (RCC) from assisted living were responsible for creating the staff schedule.
-She did not know how many staff were required to work on night shift based on the census.
-She knew there were nights only two staff worked, and she thought there should be more, but the schedule had been that way prior to her becoming the SCC two months ago.

Interview with the Administrator on 06/08/23 at 12:01pm revealed:
-The RCC and SCC were responsible for creating the staff schedule.
-The RCC and the SCC gave him a copy of the monthly schedule, but he did not realize night shift staffing hours were not adequate.
-He knew there were a few times the facility was short staffed due to staff calling out at the last minute, but he did not realize it was a significant problem.

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 _____	06/12/2023

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 465	Continued From page 22 Refer to Tag D 0270, NCAC .13F .0901(b) Personal Care and Supervision. _____ The facility failed to ensure there was adequate staff working on night shift for 19 out of 29 shifts in the SCU, where 38-43 residents resided in the past month, including one who needed increased supervision. This failure was detrimental to the health and safety of the residents and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/23. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 27, 2023.	D 465		