PRINTED: 09/01/2023 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION (X3) D A. BUILDING: CO	
					R
		HAL061011	B. WING		08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE	
MITCHELL	_ HOUSE		VY 226 SOUTH PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
		sure Section conducted a Complaint Investigation on d 08/14/23.			
D 137	10A NCAC 13F .0407 Qualifications	(a)(5) Other Staff	D 137		
	(a) Each staff person shall:(5) have no findings list	Other Staff Qualifications at an adult care home sted on the North Carolina Registry according to G.S.			
	facility failed to ensure E and F) had no subs	as evidenced by: and record reviews, the e 2 of 6 sampled staff (Staff tantiated findings on the Care Personnel Registry			
	The findings are:				
	personnel record reversible. There was a hire date				
		on 08/10/23 at 10:22am as a PCA in the facility.			
		eck for Staff E on 08/11/23 o substantiated findings.			
	Refer to the interview Manager (BOM) on 08	with the Business Office 3/11/23 at 2:40pm.			

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

TITLE (X6) DATE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MITCHELI	L HOUSE		226 SOUTH	_	
			INE, NC 2877		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 137	Continued From page	: 1	D 137		
	Refer to the interview 08/11/23 at 2:48pm.	with the Administrator on			
	2. Review of Staff F's, medication aide (MA), personnel record revealed: -There was a hire date of 01/07/23There was no documentation of a HCPR check upon hire. Interview with Staff F on 08/10/23 at 5:00pm revealed he worked in the facility as a MA.				
	Review of a HCPR check for Staff F on 08/11/23 revealed there were no substantiated findings.				
	Refer to the interview Manager (BOM) on 0	with the Business Office 8/11/23 at 2:40pm.			
	Refer to the interview 08/11/23 at 2:48pm.	with the Administrator on			
	(BOM) on 08/11/23 at -He was responsible to checks on newly hired monthsPrior to that the Adm HCPR checksThe Resident Care C staff and would bring he would complete th -He audited 5 person completed documenta -He was still learning required in the persor -He did not know why completed for Staff D	for completing the HCPR d employees for the last 6 inistrator completed the Coordinator interviewed the him the paperwork and then e HCPR checks. nel records per month for ation. what documentation was nel records. It the HCPR were not and Staff E.			
	Interview with the Adr 2:48pm revealed:	ninistrator on 08/11/23 at			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			_	DUTH C 28777 D PROVIDER'S PLAN OF CORRECTION EFIX (EACH CORRECTIVE ACTION SHOULD BE AG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
		HAL061011	B. WING		08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	L HOUSE		Y 226 SOUTH	•	
	CHMMADVCT		,		N
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
D 137	Continued From page	2	D 137		
	checks were completed. The Administrator comprise to June 2023. The BOM audited 2 to week. The Administrator must be a superscript.	nsible for ensuring HCPR ed on newly hired staff. mpleted the HCPR checks to 4 personnel records per ust have missed or checks for Staff D and Staff			
D 270	Supervision 10A NCAC 13F .0901 Supervision (b) Staff shall provide	e supervision of residents in n resident's assessed needs,	D 270		
	reviews the facility fai for 2 of 5 sampled res wandering behaviors, falls in four weeks (Re documented falls in 3 The findings are:	rype A2 VIOLATION rgs, the previous A2 ted. rs, interviews and record led to provide supervision sidents who had a history of resulting in 6 documented			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL061011	B. WING		R 08/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE		226 SOUTH			
		SPRUCE P	INE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	3	D 270			
	is to check vitals, mor injuries related to the condition for 72 hours	nitor for bruising or other fall and document their				
	atrial fibrillation, and p -Resident #2 was am	dementia, hypertension, peripheral artery disease.				
	-The level of care was documented as special care unit (SCU)There was an order for Eliquis 5mg (used as a blood thinner) twice daily.					
	Review of the Reside revealed an admissio	nt Register for Resident #2 n date of 05/25/23.				
	Review of Resident # was no care plan.	2's record revealed there				
	08/08/23 between 9:2 -Resident #2 was lyin the dining room with a -She had notable faci -Her wheelchair was couch.	ent #2 during initial tour on 20am and 11:00am revealed: g on the couch in front of a blanket over her. al bruising and swelling. beside her to the left of the on the wheelchair but it was				
	Resident #2 dated 07 -On 07/10/23 at 5:00a her room on the floor. -Resident #2 was trar by Emergency Medic 07/10/23 at 6:30am.	am Resident #2 was found in nsported to a local hospital				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		GOWII ELTED
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	L HOUSE		Y 226 SOUTH		
		SPRUCE	PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 4	D 270		
	have been updatedThere was documen	tation the facility would 2 with a follow up with the			
	-Resident #2 was ev contusion of the scalp hitting her head. -A computed tomogra completed for Reside lumbar spine, cervica	s dated 07/10/23 revealed: aluated for a fall with a b after falling backwards and aphy (CT) scan was ent #2's thoracic spine, al spine and her head. tissue hematoma on the			
	Review of Resident 2's Fall Risk Intervention Care Plan dated 07/10/23 revealed: -There was documentation to increase supervisionThere was no documentation describing the increased supervision.				
	medication administrative revealed: -There was document signs were monitored after the fall on 07/10 -There was no document of the sign of	tation Resident #2's vital I every shift for 72 hours			
	Resident #2 dated 07 -Resident experience the hallway, lethargic -There was no fall do -Condition of Resider	ed a change in condition in , not responding per usual. cumentation. nt after Emergency t noted as contusion of			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	, ,	E SURVEY PLETED
		HAL061011	B. WING		08	R 8/ 14/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	•	
MITCHELI	L HOUSE		WY 226 SOUTH PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	schedule Resident #2 Primary Care Provide Review of Resident # Care Plan revealed the Intervention Care Plan Review of Resident # medication administrate revealed there was not taken after 07/15/23 of ED visit. c. Review of an Accide Resident #2 dated 07-Resident #2 was fou of her bedThere was no document to the Emergency-There was document schedule Resident #2 Primary Care Provide Review of Resident #2 Primary Care Provide Review of Resident #2 Care Plan dated 07/2 -The Special Care Cotthe Fall Risk Intervent-Place a safety reminted as safety reminted after the fall on 07/20 -There was no document signs were monitored after the fall on 07/20 -There was no document in the safety for more from the safety for	tation the facility would with a follow up with the er (PCP). 2's Fall Risk Intervention here was no Fall Risk in for this ED visit. 2's July 2023 electronic ation record (eMAR) to documentation of vitals change in condition for this change in condition for this ent/Incident Report for 1/20/23 revealed: and sitting on the floor in front the entation Resident #2 was by Department (ED). Attaiton the facility would with a follow up with the er (PCP). 2's Fall Risk Intervention 0/23 revealed: coordinator (SCC) completed tion Care Plan. der sign where needed. 2's July 2023 electronic ation record (eMAR) that is needed that the every shift for 72 hours 1/23. The every shift for 72 hours 1/23. The every shift for Resident #2 was equent checks after the fall.	D 270			
	a. Review of an Accid	lent/Incident Report for	1			1

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SUR\	
ANDILAN	O CONNECTION	IDEIVIII IOATION NOMBER.	A. BUILDING: _			.0
		HAL061011	B. WING		R 08/14/2	2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE		
MITCHELI	HOUSE		/Y 226 SOUTH PINE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE 0	(X5) COMPLETE DATE
D 270	on the floorResident #2 was trar by EMS on 07/22/23 at 1-there was document schedule Resident #2 Primary Care Provided Review of Emergency discharge instructions 07/22/23 at 4:18pm reverseled to the following of the following thinner and contusions Review of Resident #2 documentation to offer between meals. Review of Resident #2 documentation administrative aled: -There was documentation to offer the fall on 07/22 and the fall of the fa	in the television room lying asported to a local hospital at 3:46pm. Itation the care plan should tation the facility would with a follow up with the ar (PCP). Department (ED) for Resident #2 dated evealed Resident #2 was tnessed fall, on a blood to the right side of the face. 2's Fall Risk Intervention 2/23 revealed there was er snacks to Resident #2 2's July 2023 electronic ation record (eMAR) tation Resident #2's vital every shift for 72 hours /23. mentation Resident #2 was equent checks after the fall. dent/Incident Report for /26/23 revealed: and sitting on the floor in front es documented and sent to the ED. tation the facility would	D 270			
		with a follow up with the				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			_
		HAL061011	B. WING		08	R 8 /14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
MITOLIEL		13681 H	WY 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE	E PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	2 7	D 270			
	Care Plan dated 07/2 -There was documen have been updatedThere was documen schedule Resident #2 Primary Care Provide -There was documen have on appropriate f Review of Resident # medication administrate revealed: -There was documen signs were monitored after the fall on 07/26 -There was no documen monitored for more from the fall of the	tation the care plan should tation the facility would with a follow up with the er (PCP). tation Resident #2 should footwear. 2's July 2023 electronic ation record (eMAR) tation Resident #2's vital every shift for 72 hours /23. hentation Resident #2 was equent checks after the fall. ent/Incident Report for //28/23 revealed: ing on her bedroom floor ead. hsported to a local hospital				
	Primary Care Provide Review of Resident # medication administra	2's July 2023 electronic				
	revealed: -There was documen signs were monitored after the fall on 07/28 -There was no docum	tation Resident #2's vital every shift for 72 hours				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MITCHEL	HOUSE	13681 HW	Y 226 SOUTH		
WILLCHEL	LHOUSE	SPRUCE I	PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	8	D 270		
	07/28/23 revealed: -Resident #2 was evalued: -Resident #2 was evalued: -Resident #2 was evalued: -Review of Resident # Care Plan dated 07/2 - documentation the fact alarm to alert of positions. G. Review of an Accid Resident #2 dated 08 -Resident #2 was four roomResident #2 was transemble on 08/05/23 at 22 -Resident #2 diagnosing -There was document have been updatedThere was document for the property of	luated for a fall with injury to her left shoulder. 2's Fall Risk Intervention 8/23 revealed there was cility would put a bed, chair on changes. ent/Incident Report for //05/23 revealed: hd lying on her floor in her hisferred to the local ED by 1:50am. He with fracture of sacrum. Lation the care plan should with a follow up with the			
	Review of Emergency discharge instructions 08/05/23 revealed the discharge summary a	for Resident #2 dated re was no hospital			
	Care Plan dated 08/0 -There was document supervision.	entation describing the			
	Review of Resident # medication administrative revealed:	2's August 2023 electronic ation record (eMAR)			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
			,		F	
		HAL061011	B. WING		1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	_ HOUSE		226 SOUTH			
			INE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	9	D 270			
	signs were monitored after the fall on 08/05. -There was no docum monitored for more from the fall on 08/05. Interview with a person 08/08/23 at 9:35 am residents were check there vitals each shift. -Other than checking couple of hours she wasked to check on hear she knew Resident would try and check of could. - She was unaware of footwear for Resident.	nentation Resident #2 was equent checks after the fall. onal care aide (PCA) on evealed: eked on and the MA took after a fall. on Resident #2 every was not aware of being r more often. #2 had frequent falls so she on her more often when she				
	10:00am revealed: -She was aware of RefallsShe thought Resider -She had suggested a #2's bed to the SCC b multiple falls but noth -She had observed of mat and thought it wo -She had an alarm on but it is not always us wheelchairShe was not aware of Resident #2.	ther residents using a fall fuld benefit Resident #2. If the back of her wheelchair ed when she is up in her fany safety signs for there was a particular time				

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Interview with a third PCA on 08/08/23 at

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) D 270 Continued From page 10 10:15am revealed: -Resident #2 had frequent falls. -She checked on her every 2 hours like she did for all the residents. -She had a alarm on her chair but the resident could take it off if she wanted. -Resident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.		FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 10 10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.							D	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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) D 270 Continued From page 10 10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.			HAL061011	B. WING		08		
MITCHELL HOUSE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 10 10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.	NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E. ZIP CODE			
SPRUCE PINE, NC 28777 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Deficiency PREFIX TAG Deficiency PREFIX TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Deficiency Def					-,			
CX4 ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETE DATE D 270 Continued From page 10 D 270 10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.	MITCHELI	L HOUSE						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 10 10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.	(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	CORRECTION	(X5)	
10:15am revealed: -Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	COMPLETE	
-Resident #2 had frequent fallsShe checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.	D 270	Continued From page	e 10	D 270				
-She checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.		10:15am revealed:						
-She checked on her every 2 hours like she did for all the residentsShe had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.		-Resident #2 had freq	quent falls.					
-She had a alarm on her chair but the resident could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.			=					
could take it off if she wantedResident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.		for all the residents.						
-Resident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.		-She had a alarm on l	her chair but the resident					
chair to the couch but the staff tried to encourage her not to do so.								
her not to do so.			•					
			t the staff tried to encourage					
Interview with a medication aids (MA) on		her not to do so.						
Interview with a medication aide (IVIA) on		Interview with a medication aide (MA) on 08/08/23 at 3:18pm revealed:						
08/08/23 at 3:18pm revealed:								
-Resident #2 has a alarm on the back of her		-Resident #2 has a al	arm on the back of her					
wheelchair but sometimes staff forget to attach		wheelchair but somet	imes staff forget to attach					
it/turn it on.								
-The electronic medication administration record								
(eMAR) automatically had a place for staff to		, , ,						
check off that staff checked on the resident vitals when staff got the residents vitals.								
-The MA was unaware she was to document a		_						
shift note every shift for 72 hours.								
		,						
Interview with the SCC on 08/10/23 at 9:08am			C on 08/10/23 at 9:08am					
revealed:								
-She was responsible for completing the Fall Risk								
Intervention Care Plan form when a resident had a fall.			n form when a resident had					
-Resident #2 had her vital signs monitored every			vital signs monitored every					
shift for 72 hours after each fall.								
-Monitoring vital signs after a fall was a routine	l							
procedure at the facility.	ĺ	procedure at the facili	ity.					
-She was unaware staff were to document a shift	ĺ							
note every 72 hours after a fall.	ĺ							
-She was not aware of any safety reminder signs	ĺ		of any safety reminder signs					
for Resident #2.	I		la la tamana tina Compi					
-After a fall a Fall Risk Intervention Care Plan	I							
form was always completed in order to determine	I	_						
if a change in care was neededAfter the fall on 07/28/23, Resident #2's had a	ĺ	_						
chair alarm put in place.	ľ							

Division of Health Service Regulation

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DIVISION	or riealin Service Negu	iation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	= IED
					R	,
		1101.004.044	B. WING		1	
		HAL061011			08/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		13681 HV	VY 226 SOUTH			
MITCHEL	L HOUSE		PINE, NC 2877	7		
			FINE, NO 2011			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE
iAO		,	17.0	DEFICIENCY)		
			+			
D 270	Continued From page	e 11	D 270			
	No other changes we	ere implemented after her				
	falls.	ere impiemented after her				
	idiis.					
	Intervious with the Adri	ministrator on 09/00/22 at				
		ministrator on 08/09/23 at				
	4:40pm revealed:					
		tiple falls in the past few				
	weeks.					
		gns were always monitored				
	every shift for 72 hou					
	-	posed to be checked on				
	every 1/2 hour to 1 ho					
		on Care Plan was usually				
		C after a fall and a fall				
	intervention was imple	emented to prevent further				
	falls based on what h	nad happened during the				
	incident.					
	-Interventions were p	ut in place for Resident #2				
	included following up	with the PCP after a fall,				
		snacks between meals, a				
		rsonal alarm but he had not				
		se interventions were in				
	place.					
	•	C to be sure all interventions				
	were in place.					
		t every morning to discuss				
		ent conditions, needs or care				
	plans.	sin containents, neces or care				
	•	C to communicate any				
	changes to the MAs a	•				
	changes to the MAS a	and i OA3.				
	Tolophono intonviow v	with Posidont #2's quardian				
	on 08/09/23 at 3:48pr	with Resident #2's guardian				
	-					
		otified of Resident #2's falls				
	in July and August 20					
		eached out to her to discuss				
		what could be done in an				
	attempt to reduce her					
		as to why Resident #2 was				
	falling so often.					
	-The facility had done	nothing that she was aware				

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 12 of 74

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	O CONNECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		GOWII ELTED
		HAL061011	B. WING		R 08/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE		Y 226 SOUTH	_	
	OLUMBA DV OT		PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 12	D 270		
	of to prevent further fa-The only way she ha was Resident #2's far about one and the ho other one.				
	Based on observation review Resident #2 w	ns, interviews and record as not interviewable.			
		interview with the primary ident #2 on 08/09/23 at at 1:18pm was			
	08/23/22 revealed: -Diagnoses included a hypertension, periphe and type II diabetesResident #7 was intennambulatory.	t #7's current FL2 dated Alzheimer's Disease, eral vascular disease, angina ermittently confused and as documented as special			
	Review of the Reside revealed an admission	nt Register for Resident #7 n date of 03/31/22.			
	Review of the Care P the care plan was las	lan for Resident #7 revealed t completed 04/22/22.			
	on 08/08/23 between revealed: -Resident was lying ir -Resident had facial b	tion aide (MA) on 08/08/23			

Division of Health Service Regulation

STATE FORM 6899 HQ2011 If continuation sheet 13 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELL HOUSE 13681 HW			Y 226 SOUTH		
WILL		SPRUCE F	PINE, NC 2877	7	1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 270	Continued From page	e 13	D 270		
	-Resident #7 had falle been sent to the emel both times.	en a couple of times and had rgency department (ED) pruising was a result of her			
	Report dated 07/24/2 -She had fallen in her of right hip and leg pa -She was transported Department (ED) by E 10:45pmThere was document have been updatedThere was document schedule Resident #2 Primary Care Provide	to the local Emergency EMS on 07/27/23 at tation the care plan should tation the facility would with a follow up with the er (PCP).			
	Resident #7 dated 07 - Resident #7 was evaluip, and leg.	D discharge instructions for //27/23 revealed: aluated for a fall with right nentation of of new orders			
	Care Plan dated 07/2 -There was document supervision.	nentation describing the			
	Resident #7 dated 08 -Resident #7 had falle the day room and was her wheelchairShe was transported	lent/Incident Report for //06/23 at 6:29pm revealed: en out of her wheelchair in s lying on the floor in front of to the local Emergency EMS on 08/06/23 at 6:55pm.			

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 14 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED			
			A. BOILDING.			R
		HAL061011	B. WING		08	R 3/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
			WY 226 SOUTH	,		
MITCHELI	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 14	D 270			
	have been updatedThere was documen schedule Resident #2 Primary Care Provide	tation the care plan should tation the facility would with a follow up with the (PCP). D discharge instructions for				
	Resident #7 dated 08 -Resident #7 was eva	/06/23 revealed: lluated for a fall with bruising				
	Care Plan dated 08/0 -There was documen supervision.	nentation describing the				
	was aware ofShe was not aware of put into place for her	evealed: a couple of falls that she of any interventions being yet. ere was a white board in the d tell about increased				
	08/08/23 at 9:35am re-Residents were obsethere vitals each shift-Other than checking couple of hours she vasked to check on Re-She assumed Reside	erved when the MA took after a fall. on Resident #7 every vas not aware of being esident #7 more often. ent #7 had a fall as she had out she was not working				

Division of Health Service Regulation

STATE FORM 6899 HQ2011 If continuation sheet 15 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL061011	B. WING	·	08	R 3/ 14/2023
	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
MITCHEL	L HOUSE		PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 15	D 270			
	10:00am revealed: -She was aware of Re	nd PCA on 08/08/23 at esident #7 having a fall. w often Resident #7 should PCA on 08/08/23 at				
	-She was only suppos	sident #7 every 2 hours. sed to check on Resident #7 other residents on the				
	revealed: -Resident #7 had her shift for 72 hours afte -Monitoring vital signs procedure at the facil -After a fall a Fall Risl completed in order to care was neededResident #7 had incr her falls with no other	after a fall was a routine				
	4:40pm revealed: -He was not aware of fallsThe residents' vital severy shift for 72 hou-A Fall Risk Interventicompleted by the SC intervention was implifalls based on what hincident.	on Care Plan was usually C after a fall and a fall emented to prevent further ad happened during the us were put in place other				

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 16 of 74

AND DLAN OF CORRECTION IDENTIFICATION NUMBER					JRVEY TED	
		HAL061011	B. WING		08/14	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELL	. HOUSE		226 SOUTH	_		
	OUNDAMEN OF		INE, NC 2877			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	: 16	D 270			
	any changes in reside plans.	every morning to discuss ent conditions, needs or care C to communicate any and PCAs.				
	Based on observation review Resident #7 w	ns, interviews and record as not interviewable.				
		interview with the primary dent #7 on 08/09/23 at at 1:18pm was				
	wandering behaviors redirection, resulting i weeks and 2 falls with in both residents bein for evaluation. This fa	s documented as having and needing frequent n her having 6 falls in 4 n injury in 3 weeks , resulting g sent to the local hospital ailure placed both residents serious physical harm and				
	The facility provided a accordance with G.S.	a plan of protection in 131D-34 on 08/11/23.				
D 273	10A NCAC 13F .0902	(b) Health Care	D 273			
		Prealth Care Assure referral and follow-up And acute health care needs				
	This Rule is not met a TYPE A2 VIOLATION					
		and record reviews, the the primary care provider				

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 17 of 74

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING:		
		HAL061011	B. WING		R 08/14/202	:3
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	L HOUSE		226 SOUTH	_		
			INE, NC 2877			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE CON	(X5) MPLETE DATE
D 273	Continued From page	: 17	D 273			
		oled residents (Resident #8) an alcoholic beverage that nd inability to walk				
	The findings are:					
	revealed: -There was no date of control of the cont	were only allowed in order of a physician. low the physician's order ohol. lowed on the facility, the doto return to the facility in a lent was found to be under ol, the resident's lower physician would be notified. In physician would be notified. In physician administration.				
	09/20/22 revealed: -Diagnoses included disturbance and cogn deficiencyResident #8 was interambulatory.	dementia without behavioral				
	05/22/23 revealed: -Resident #8 was indegrees and -Resident #8 had war -Resident #8 was forgreminders.					

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		EIED
		1141 004044	B. WING		F	
		HAL061011	B. WIIVO		08/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHEL	HOUSE	13681 HWY	226 SOUTH			
		SPRUCE P	INE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 18	D 273			
	05/09/23 revealed: -There was an order of treat high blood glucos 15 units three times of the end o	for Novolog (a medication to use) insulin 100units/ml inject aily. For glucose tablet 4 grams, aded for low blood sugar for Levemir (a medication to use) insulin 100units/ml inject ag for blood sugar greater for units at bedtime for blood to. For metformin (a medication acose) 1000mg twice daily. For atorvastatin (a gh cholesterol) 40mg at at bedtime. For triazadone (a medication to use) 100mg daily. For sertraline (a medication to usercy) 100mg daily. For aspirin (blood thinner) For gabapentin (a medication to usercy) 100mg at bedtime. For hydrochlorothiazide (a usercy) 12.5mg For lisinopril (a medication to usercy) 10mg daily.				

Division of Health Service Regulation

Review of Resident #8's record on 08/10/22

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING: _		
	HAL061011	B. WING		R 08/14/2023
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	13681 HV	/Y 226 SOUTH		
MITCHELL HOUSE	SPRUCE	PINE, NC 28777	7	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
consumptionThere was no doc 06/06/23. Interview with a pe 08/10/23 at 10:22a -She worked on the earlier when another break, took Reside a local restaurantShe could not recative to the facility, he satisfies instructed Remoom for dinner but of the chairThe other PCA assidining room and afthe courtyard and pushesShe was told by the had consumed alcolunch at a local restaurantThe previous Spectowas present when resident consumed informed the Admir. Interview with a set 10:29am revealed: -When Resident #8the outing she notices asked the previous of the courting restaurant.	hysician's order for alcohol umentation of the event on rsonal care aide (PCA) on m revealed: e SCU approximately 2 months er PCA who was on her lunch nt #8 out of the facility to eat at all the date of the incident. bught Resident #8 came back at in a chair in the courtyard. sident #8 to go to the dining the was unable to get up out sisted Resident #8 to the ter dinner he came back out to projectile vomited into the the other PCA that Resident #8 bohol when she took him to taurant that day during her cial Care Coordinator (SCC) the other PCA told her the alcohol during lunch and	D 273		

Division of Health Service Regulation

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
		13681 HW	Y 226 SOUTH		
MITCHEL	L HOUSE	SPRUCE F	PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 273	Continued From page	: 20	D 273		
	dinner when he project bushes.	ng in the courtyard after ctile vomited into the assist Resident #8 into his			
	took Resident #8 out -When Resident #8 re "wobbly", pale skin co vomitedHe took Resident #8' could not recall the blace recalled it was lowThe previous SCC whe informed herHe did not document because the previous Resident #8 in his bed	evealed: the SCU the day the PCA of the facility on her break. eturned to the facility he was elor, smelled of alcohol, and as blood pressure and he cood pressure reading but he as present on the SCU and			
	and 08/11/23 at 9:30a Resident #8 to lunch if She was working in Stook Resident #8 out it restaurant and he was purchasedResident #8's POA at #8 out for lunch some -The last time (06/06/out for lunch she asked and a former SCC for alcohol and they allow -Resident #8 was not the facility for the restone beer.	SCU on 06/06/23 when she of the facility to a local served a beer which she sked her to take Resident etimes. 23) she took Resident #8 and permission from the POA Resident #8 to consume			

Division of Health Service Regulation

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				DATE SURVEY COMPLETED		
			B. WING			R
		HAL061011	B. WING		08	3/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MITCHEL	I HOUSE		IWY 226 SOUTH			
WIITOTILL	LIIOOOL	SPRUC	E PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 21	D 273			
	became sick and he -She was never give about what Resident consumeShe was only told at #8 should not have b	n guidance or expectations #8 should or should not fter the event that Resident been served alcohol. with the former SCC on				
	-She worked as the SPCA took Resident # served alcoholThe PCA asked her #8 out for lunch and who gave permission-After the PCA and Facility several PCAs Resident #8 as he was resident #8 was sittle smelled alcohol on heresident vomited in the Two staff walked Rehe slept the rest of the She informed the Accondition.	SCC on 06/06/23 when the 8 out to lunch and he was if she could take Resident she asked the Administrator in. Resident #8 returned to the asked her to check on as not "acting right". Iting in the courtyard and she is breath and then the he bushes. It is is bed where the night. It is a sident #8 to his bed where the night. It is a sident #8's P of Resident #8's condition				
	08/10/23 at 2:58pm r -She gave permissio Resident #8 out to lu -She did not give the Resident #8 to consu a "recovering alcoho itThe PCA texted her	n for the PCA to take nch. PCA permission for ume alcohol because he was lic" and she advised against after the lunch on 06/06/23 sident #8 consumed a beer				

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 22 of 74

DIVISION	n Health Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					_	_
			D WING		F	
		HAL061011	B. WING		08/1	4/2023
NAME OF DE	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZIR CODE		
NAME OF T	TOVIDER OR SOLT LIER			KIE, ZII GODE		
MITCHELL	HOUSE		/Y 226 SOUTH			
		SPRUCE	PINE, NC 2877	7		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				BEHOLEKOT		
D 273	Continued From page	e 22	D 273			
		a DCA that also mayon said				
	•	e PCA that she never said				
		cohol and that she had				
	advised against it.					
		vith the facility's contracted				
	PCP on 08/10/23 at 3	•				
		ny notification from the				
	facility that Resident #					
		ysician's order for Resident				
	#8 to consume alcoho					
		e let Resident #8, who had a				
	_	a, consume alcohol because				
	of the medications he	•				
		vhile taking prescription				
	medications could car	use an alcohol/drug				
	interaction (nausea ar	nd vomiting, drowsiness,				
	changes in blood pres	ssure, loss of coordination,				
	fainting, and headach	ies).				
	-Had he been notified	I he would have instructed				
	staff to telephone Em	ergency Medical Services				
		esident #8 to the local				
		ent (ED) for evaluation.				
	0 , 1	,				
	Interview with the Adr	ministrator on 08/10/23 at				
	2:50pm revealed:					
	-The PCA came in on	her day off work to take				
	Resident #8 to lunch.	•				
		eturned to the facility he				
	wasn't "acting like him					
		Resident #8, he stated he				
	had a shot of whiskey					
	-When he questioned					
		ot of whiskey which she paid				
	for.	ot of Willows Willow Sile paid				
		evious SCC to notify the				
	PCP.	wood ooo to notily tile				
	FU F .					
	Interview with the Adr	ministrator on 08/11/23 at				
	9:15am revealed:	imiliation on 00/11/23 at				
	J. IJaili IEVEAIEU.		1			

Division of Health Service Regulation

-The facility policy on resident alcohol

STATE FORM 6899 HQ2O11 If continuation sheet 23 of 74

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL061011	B. WING		08/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	_ HOUSE		WY 226 SOUTH EPINE, NC 28777	7	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTE
D 273	the amount of alcohol medications reviewed interactions. -He never gave any gwhat should not occur. -He telephoned the loconfirmed that Reside. -He never spoke to the consuming alcohol beformer SCC to do so ther. The facility failed to new the resident arriconsuming alcohol and vomited, was unable and required a medical placed Resident #8 at physical harm and conviolation. The facility provided a accordance with G.S. 08/11/23. CORRECTION DATE VIOLATION SHALL N	ust be a physician's order, must be specified, and for alcohol/drug uidelines to Staff D about at at lunch. cal restaurant and they ent #8 was served whiskey. e PCP about Resident #8 ecause he instructed the end did not follow up with a bound of the facility after and was physically ill, to ambulate independently, all evaluation. This failure it substantial risk for serious institutes a Type A2	D 273		
D 338	all residents guarante Declaration of Reside	Resident Rights hall assure that the rights of ed under G.S. 131D-21, nts' Rights, are maintained	D 338		
	This Rule is not met				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74101 2741	or Contraction	IBENTIN IO/MITON NOMBER	A. BUILDING: _		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE	13681 HW	Y 226 SOUTH		
WILL		SPRUCE	PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 338	Continued From page	24	D 338		
	TYPE A1 VIOLATION				
	Based on interviews a facility failed to protect and verbal abuse and personal care aide (Pallowed a resident (#8 dementia and who resunit (SCU), to consurt the resident becoming medical evaluation (Roursed a resident, did resident alone while in refused to administer distress (Resident #6 assist another resident yelled at the resident	and record reviews, the st all residents from physical I neglect related to Staff D, CA), who purchased and B), who had a diagnosis of sided in the Special Care me the alcohol resulting in g physically ill and required a tesident #8), staff who not assist and left the n respiratory distress, and a medication for respiratory), and staff who refused to not to the bathroom and			
	09/20/22 revealed: -Diagnoses included of disturbance and cognideficiencyResident #8 was integambulatory.	t #8's current FL2 dated dementia without behavioral itive communication ermittently disoriented and pecial Care Unit (SCU).			
	05/22/23 revealed: -Resident #8 was indeResident #8 had warResident #8 was forgoreminders. Review of Resident #8 revealed:				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		HAL061011	B. WING		R 08/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE		Y 226 SOUTH		
		SPRUCE I	PINE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	338 Continued From page 25		D 338		
	-There was no documentation of the event on 06/06/23. Interview with a personal care aide (PCA) on 08/10/23 at 10:22am revealed: -She worked on the SCU approximately 2 months earlier when Staff D who was on her lunch break, took Resident #8 out of the facility to eat at a local restaurantShe could not recall the date of the incidentWhen Staff D brought Resident #8 came back to the facility, he sat in a chair in the courtyard.				
		lent #8 to go to the dining e was unable to get up out			
	of the chair.	e was unable to get up out			
		ident #8 to the dining room			
	and after dinner he ca	ame back out to the ille vomited into the bushes.			
	-She was told by the	Staff D that Resident #8 had nen she took him to lunch at			
		t day during her break.			
	· · · · · · · · · · · · · · · · · · ·	I Care Coordinator (SCC) aff D told her the resident			
	•	ring lunch and informed the			
	Interview with a second PCA on 08/10/23 at 10:29am revealed:				
		eturned to the facility after			
	_	d he was acting strange and us SCC where Resident #8			
	went on the outing an				
	restaurant.	Posidont #0 to lunch that day			
	told staff Resident #8	Resident #8 to lunch that day consumed a beer.			
	-Resident #8 was sitti	ing in the courtyard after			
	dinner when he project	ctile vomited into the			
	bushesIt took 3 or 4 staff to	assist Resident #8 into his			
	bed.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLE	:150
		HAL061011	B. WING		R	4/2023
					1 00/14	4/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE		/ 226 SOUTH INE, NC 2877	7		
()(1) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	D 338 Continued From page 26		D 338			
	took Resident #8 out -When Resident #8 re "wobbly", pale skin co vomitedHe did not document because the previous Resident #8 in his bec Administrator and let Telephone interviews and 08/11/23 at 9:30a Resident #8 to lunch -She was working in Stook Resident #8 out restaurant and he wa purchasedResident #8's POA a #8 out for lunch some -The last time (06/06/ out for lunch she aske and a former SCC for alcohol and they allov -Resident #8 was not the facility for the rest one beerShe and Resident #8 when they returned to became sick and he v -She was never given about what Resident so consumeShe was only told aff #8 should not have be	evealed: the SCU the day Staff D of the facility on her break. eturned to the facility he was olor, smelled of alcohol, and if the event or notify the PCP SCC told him to put d and she would inform the the Administrator "handle" it. on 08/10/23 at 12:20pm am with the PCA who took revealed: SCU on 06/06/23 when she of the facility to a local as served a beer which she sked her to take Resident etimes. 23) she took Resident #8 ed permission from the POA Resident #8 to consume wed it. feeling well when they left reaurant and he consumed be were gone one hour and of the facility the resident fromited. In guidance or expectations if the event that Resident iter the event that Resident				
	08/10/23 at 5:00pm re					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER MITCHELL HOUSE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL061011	B. WING		08/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	•	
			/Y 226 SOUTH	,		
MITCHEL	L HOUSE		PINE, NC 2877	7		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page 27		D 338			
	-She had been working Staff D took Resident served alcoholStaff D asked her if so out for lunch and she who gave permission -After they arrived bar PCAs asked her to chwas not "acting right". Resident #8 was sitting smelled alcohol on his resident vomited in the Two staff walked Reshe slept the rest of the She informed the Ad condition and she informed the Ad condition and she informed (PCP). Telephone interview wow 108/10/23 at 2:58pm reshe gave permission #8 out to lunchShe did not give permonsume alcohol becalcoholic" and she ad Staff D texted her aftinform her that Reside the POA said he could the POA responded said he could consume advised against itShe did not receive a Administrator or the Shecoming ill once he Telephone interview wo PCP on 08/10/23 at 3	#8 out to lunch and he was the could take Resident #8 asked the Administrator ck to the facility several heck on Resident #8 as he ing in the courtyard and she is breath and then the le bushes. Isident #8 to his bed where le night. Iministrator of Resident #8's formed the Primary Care with Resident #8's POA on levealed: In for Staff D to take Resident mission for Resident #8 to leause he was a "recovering livised against it. ler the lunch on 06/06/23 to lent #8 consumed a beer like d. It to Staff D that she never he alcohol and that she had leany communication from the leany communicat				

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-Staff should not have let Resident #8, who had a

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL061011	B. WING		R 08/14/2023	
NAME OF B			DESC CITY STA	TE 710 CODE	1 00/14/2023	\neg
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
MITCHEL	L HOUSE		' 226 SOUTH INE, NC 2877	7		
0/0.15	STIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J 0/5	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	:
D 338	Continued From page	28	D 338			
	diagnosis of dementia taking prescription me -Consuming alcohol v medications could cal interaction (nausea al changes in blood pres	a, consume alcohol while edications. while taking prescription use an alcohol/drug nd vomiting, drowsiness, essure, loss of coordination, les) and the resident should				
	2:50pm revealed: -Staff D took Residen returned to the facility himselfWhen he questioned had a shot of whiskey -When he questioned Resident #8 had a sh for.	Resident #8, he stated he				
	9:15am revealed: -The facility policy on consumption was that order, the amount of a and medications revieinteractionsHe never gave any gwhat should not occur with Resident #8Staff D was working (06/06/23), clocked or took Resident #8 to a gone for about 45 mir -He telephoned the loconfirmed that Resides	t there must be a physician's alcohol must be specified, ewed for alcohol/drug nuidelines to Staff D about r when on a lunch outing the day of the event ut for her lunch break, and local restaurant and was				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NO 28777 (X4) ID PREFIX TAG (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG TAG CROSS-REFERENCE TO THE APROPRIATE D 338 Continued From page 29 Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. -He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. -He had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol. -If a resident used alcohol outside the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE MITCHELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES SPRUCE PINE, NC 28777 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 Continued From page 29 Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. -I-te contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. -I-he had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol. -If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's				7.1. 50.25		D D
MITCHELL HOUSE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 (X4] ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 338 Continued From page 29 Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. -He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. -He had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol. -If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's			HAL061011	B. WING		
SPRUCE PINE, NC 28777 SUMMARY STATEMENT OF DEFICIENCIES CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 338 Continued From page 29 D 338 Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. He had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol -If a resident was expected to return to the facility, the resident was expected to return to the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	FE, ZIP CODE	
CALL DEFICIENCY SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH OPERICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE D 338 Continued From page 29 D 338 Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. -He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. -He had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol. -If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's	MITOLIEL		13681 HW	Y 226 SOUTH		
CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	MIICHEL	L HOUSE	SPRUCE P	INE, NC 28777	•	
Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her. -He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again. -He had written notes about the event but could not locate them. Review of the facility's Alcoholic Beverage Policy revealed: -There was no date on it. -Alcoholic beverages are only allowed in accordance with the order of a physician. -The facility would follow the physician's order regarding serving alcohol. -If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state. -In the event the resident was found to be under the influence of alcohol, the resident's	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
responsible party and physician would be notifiedGuidance would be obtained from the resident's physician relevant to medication administration. Interview with Resident #8 on 08/10/23 at 11:10am revealed sometimes his POA or Staff D took him out of the facility to a local restaurant for lunch. 2. Review of Resident #6's current FL2 dated 09/16/22 revealed: -Diagnoses included stage 4 chronic obstructive pulmonary disease (COPD) (this is the final stage of lung disease which causes frequent flare ups of respiratory distress which can be fatal),	D 338	Resident #8 consumit instructed the former follow up with her. -He contacted the fact Department for guidat was instructed to inform Resident #8 out of the He had written notes not locate them. Review of the facility's revealed: -There was no date of contact the Alcoholic beverages accordance with the contact the resident was expected sober state. -In the event the resident influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party and Guidance would be contact to the influence of alcohoresponsible party	ng alcohol because he SCC to do so and did not sility's Human Resources nee regarding Staff D and rm Staff D not to take e facility again. about the event but could so Alcoholic Beverage Policy in it. are only allowed in order of a physician. How the physician's order ohol. Schol outside the facility, the did to return to the facility in a selent was found to be under ol, the resident's in physician would be notified. Sobtained from the resident's medication administration. Int #8 on 08/10/23 at metimes his POA or Staff Dicility to a local restaurant for it #6's current FL2 dated stage 4 chronic obstructive coPD) (this is the final stage in causes frequent flare ups	D 338	DEFICIENCY)	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELL	HOUSE	13681 HW	Y 226 SOUTH		
MITCHELI	L HOUSE	SPRUCE F	PINE, NC 28777	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 338	and assisted living. Review of Resident # 12/06/22 revealed: -He was admitted to to the care of a local hose COPDHe was ambulatory wellHe required oxygen at rest and 4L when and the was sometimes of needing reminders. Review of Resident # 04/04/23 revealed the 3L continuous and many with a wheelchair. Interview with Reside revealed: -He had a lung disease breath but sometimes he had trouble breath continuous positive aid mask up to his foreher room, he told her her Staff A said "expletive breathe, put your mass walked out of his roomStaff A did not come the rest of the nightStaff B griped or yelle assistance and he oftitalking with other staff.	atory in a wheelchair. cumented as domiciliary 6's Care Plan dated the facility on 06/28/21 under spice provider for severe with a wheelchair. at 3 liters (L) nasal cannula imbulating in a wheelchair. lisoriented and forgetful 6's physician orders dated for was an order for oxygen ay use 4L when ambulating at #6 on 08/08/23 at 4:25pm the and was always short of the had trouble breathing. assistance one night when ing and moved his rway pressure (CPAP) ad when Staff A entered his had trouble breathing, and to wonder you can't sk on" and turned and	D 338		
	a medication used for -Staff C velled and are	respiratory distress.			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			7. 501251110.			R
		HAL061011	B. WING		08	3/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		13681 H\	WY 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 338	that he had already be medication for respiral Staff C did not give hit. He has given up call from the facility staff a refused to help him with breathing. He told a couple of the A, B, and C but Staff mean to him. He reported Staff C on Nurse (RN) for refusion medication to him that breathe better. Interview with the Refunction (RCC) on 08/08/23 at 3:50 pm refusion with a day so 08/08/23 at 3:50 pm refusi	een administered his atory distress when he knew im the medication. ing for help or assistance at night because they when he had trouble he day shift MAs about Staff A, B, and C continued to be to the hospice Registered at he required to help him sident Care Coordinator to 3:45pm revealed: any complaints from staff being "rude". complain to her about 2 of Staff A and B) being verbally shift medication aide (MA) on evealed: ere always "grumpy" and ther staff and residents. that 3 of the night shift MAs buld not help him when he when he experienced ge 4 COPD and often had a sometimes turned blue. Fused to administer Resident ation for respiratory distress her a text message on told Resident #6 the atory distress was in his	D 338			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			SURVEY PLETED	
			A. BOILDING			_
		HAL061011	B. WING		08	R / 14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		13681 HV	WY 226 SOUTH			
MITCHELI	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETE DATE
D 338	Continued From page	÷ 32	D 338			
		t administer the medication . , B, and C to the RCC.				
	8:18pm from Staff C t Staff A told Resident	sage dated 08/03/23 at o the day shift MA revealed #6 she put his medication for ith his other medications "fine since".				
	3:52pm revealed: -She did not rememb medication for respira she only administered night medicationsResident #6 did roll of wheelchair on 08/03/2 nose turned blue and oxygen tank was emp -She took Resident # him from the portable	er Resident #6 asking for his atory distress on 08/03/23 so d Resident #6's scheduled down the hallway in his 23 when she noticed his Resident #6's portable by. 6 to his room and changed oxygen tank (which was 6's oxygen concentrator.				
	RN on 08/10/23 at 11 -She or another hosp twice weekly for stage -Resident #6 experier rest and worsened wi -Resident #6 required staff with most tasks of breathThe hospice provide administered as need distress and "air hung -Resident #6 reported several staff refused in	ice RN saw Resident #6 e 4 COPD. heed shortness of breath at th any exertion. It assistance from the facility due to his shortness of the ordered a medication to be led for any respiratory ger". It to her several times that to administer the medication				
		s to him. Dispice RN provided staff and Dispice RN provided staff and Dispication weekly about not				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		HAL061011	B. WING		0.6	R 8/ 14/2023
NAME OF D	ROVIDER OR SUPPLIER	•	ADDRESS, CITY, STATE	ZIR CODE	1 3	
NAME OF T	NOVIDEN ON 3011 EIEN		WY 226 SOUTH	, ZII CODE		
MITCHEL	L HOUSE		E PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page refusing to administer medication for respirative with the RC revealed she and the by Resident #6's hos administer a medicate Resident #6 on multing in respiratory distress. Interview with the Add 4:40pm revealed: -He did not know that and walked out of the on Resident #6 was in respiratory distress. He saw Resident #6 was alwed - Staff A should not have with the Add - Staff A should not have assist Resident #6 was in respiration or dered for the did not know State assist Resident #6 was alwed - He did not know State assist Resident #6He did not know a for administer the medication ordered for Resident #6He expected the fact when needed, treat respect, and administer the medication of the staff o	e 33 If Resident #6's ordered atory distress. If C on 08/10/23 at 3:55pm e Administrator were notified spice RN that staff refused to sion for respiratory distress to ple occasions when he was section of the spiratory distress to ple occasions when he was section of the spiratory distress to ple occasions when he was section of the spiratory of the night when sespiratory distress. It's face turn blue before as having trouble breathing, ways short of breath. The save left Resident #6 alone irratory distress. If B yelled or refused to hen he called for assistance. If C refused to administer a for respiratory distress to the spiratory distress the spiratory distress the spiratory distress and the spiratory distress t	D 338			
		Parkinson's disease. atory with a walker.				

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STATEMENT	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ΞΤΕD
					F	{
		HAL061011	B. WING		08/1	4/2023
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MITCHELL	L HOUSE	13681 HW	Y 226 SOUTH			
		SPRUCE	PINE, NC 2877	7		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 34	D 338			
	-He was intermittently	confused.				
		ocumented as domicilary.				
	Review of Resident #1's Care Plan dated					
	12/13/22 revealed:	i s Care Plan dated				
	1	e assistance from staff with				
	bathing, dressing, and	0				
	 -He required physical toileting and transfers 	l assistance from staff with				
	-He had limited strength of his bilateral upper					
	extremities.	y 9 2				
	Interview with Reside 11:17am revealed:	nt #1 on 08/08/23 at				
		disease and required the				
		aff members with transferring				
	-He was sitting on a p	oillow in the recliner chair				
		rd time repositioning himself				
	_	edsore on his tailbone. scream" at him when he				
	called for assistance					
	because he could not	•				
		ould tell him to just sit back				
		he bathroom because he				
		to the bathroom by himself. alp him to the bathroom on				
		and Staff B to the Resident				
	· ·	CC) many times but Staff A				
		to scream and refuse to help				
	him to the bathroom.					
	Interview with the RC revealed:	C on 08/08/23 at 3:45pm				
	-Resident #1 reported	d to her on multiple				
	-	A and Staff B were rude to				
	Resident #1.	-# A I Ot-# D				

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"mean" to him but then Resident #1 would "laugh"

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101 2741	or contraction	IDEITH IO/HIGH HOMBER	A. BUILDING: _			
		HAL061011	B. WING		R 08/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MITCHELI	L HOUSE		Y 226 SOUTH PINE, NC 2877	7		
()(1)	OUR MADY OTATEMENT OF DESIGNATION			PROVIDER'S PLAN OF CORRECTIO	N (VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
D 338	338 Continued From page 35		D 338			
	about itShe did not tell the Administrator that Resident #1 said Staff A and Staff B were mean to Resident #1 because she did not think Resident #1 "meant it". Telephone interview with Resident #1's hospice registered nurse (RN) on 08/09/23 at 8:28am revealed: -She saw Resident #1 weeklyResident #1 could ambulate with a walker but required total assistance from staff with his activities of daily living (ADL) such as getting dressed, bathing, and toileting. Interview with the Administrator on 08/09/23 at					
	4:40pm revealed: -The RCC did not repverbal abuse or negle Resident #1 to the ba -The Activities Director complained to her aborefusing to assist Resabout 3 weeks ago by and Staff B about the the allegation and sai would have to wait to they were assisting all	ort Staff A or Staff B for ect by refusing to assist throom. or reported Resident #1 out Staff A and Staff B sident #1 to the bathroom at when he asked Staff A incident, the staff denied d they told Resident #1 he go to the bathroom because nother resident. #1 complained about the y Staff A and Staff B				
	responsible person or unsuccessful.	interview with Resident #1's n 08/09/23 at 8:39am was interview with Staff A on vas unsuccessful.				
	·	nsure all residents were				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL061011	B. WING		R 08/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE	13681 HWY	226 SOUTH			
WIITCHELL		SPRUCE P	INE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMP	LETE
D 338	Continued From page	e 36	D 338			
	protected from neglect to staff purchasing an resided on a SCU, to caused the resident to vomit, need assistance required a medical evidid not receive, Resided by staff and left alone respiratory distress an refusing to administer distress, and Resider by 2 staff members for to go to the bathroom was told to use the batharm and neglect of the a Type A1 Violation. The facility provided a accordance with G.S.	ct and verbal abuse related ad allowing Resident #8, who consume alcohol which become physically ill, be with ambulation, and valuation which the resident dent #6 who was cursed at in his room while in and another staff member a medication for respiratory at #1 who was screamed at or calling out for assistance and multiple occasions and athroom in his brief. This estantial physical and mental the residents and constitutes				
D 358	10A NCAC 13F .1004 Administration	l(a) Medication	D 358			
	(a) An adult care horn preparation and admit prescription and non-by staff are in accorda(1) orders by a licens which are maintained	sed prescribing practitioner in the resident's record; and on and the facility's policies				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED		
			A. BOILDING			
		HAL061011	B. WING		R 08/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
			Y 226 SOUTH	,		
MITCHELI	L HOUSE	SPRUCE	PINE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
D 358	Continued From page	e 37	D 358			
	TYPE A2 VIOLATION					
	review, the facility fail medication as ordered	d for 1 of 1 sampled resident to a medication used to				
	The findings are:					
	medication administrative revealed: -Medications were adwith written orders of -All medications administration record -If there were any que or directions of a medication administration of a medication administration record -If there were any que or directions of a medication administration record -If there were any que or directions of a medication administration reverse and record -If there were any que or directions of a medication administration ad	nistered would be lectronic medication				
	09/16/22 revealed dia chronic obstructive pu (this is the final stage	#6's current FL2 dated agnoses included stage 4 almonary disease (COPD) of lung disease which ups of respiratory distress				
	the care of a local hose COPDHe required oxygen a rest and 4 liters when					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED		
					R	
		HAL061011	B. WING		08/14/2023	}
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MITOLIEL		13681 HV	WY 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMP	PLETE
D 358	Continued From page	: 38	D 358			
	04/04/23 revealed an medication used to tre	eat pain and respiratory ery 4 hours as needed for				
	4 hours as needed for -There was document	or morphine take 5mg every r shortness of breath. tation of 15 out of 180 hine 5mg administered from				
	4 hours as needed for -There was document opportunities of morp 07/01/23 through 07/3	or morphine take 5mg every r shortness of breath. tation of 38 out of 186 hine 5mg administered from 81/23. tation morphine 5mg was				
	4 hours as needed for There was document opportunities of morp 08/01/23 through 08/01/23 through 08/01/23 through 08/01/23 through 08/01/23 through 08/01/23 through 08/01/24 through 08/01/25 th	aled: or morphine take 5mg every r shortness of breath. tation of 21 out of 48 hine 5mg administered from				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		1 -	
		HAL061011	B. WING		R 08/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		13681 HWY	226 SOUTH			
MITCHELI	_ HOUSE	SPRUCE P	INE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	ΓE
D 358	Continued From page	÷ 39	D 358			
	shift MA on 08/03/23.					
	revealed: -He had liquid morphi when he experienced -There were several in refused to administer had trouble breathing -He knew he could as every 4 hours if he ne -Sometimes he would aide (MA) for his orde trouble breathing and administer the morph a different, unknown in was his morphine mix -He knew the medical applesauce was not in crushed-up pill, and he that came in a syringe -The night shift MA was administer his morphit time for the medication administered the mor -The last time the MA morphine to him was linterview with a day so 3:50pm revealed: -Resident #6 had more hours when needed for COPD.	MAs at the facility who him his morphine when he was staff for his morphine when he weded it. It ask a night shift medication when he had the MA would either not intered morphine when he had the MA would either not intered in applesauce. It was a wis morphine because it was a wis morphine was a liquid because ould often refused to me telling him it was not on or that she already phine to him. In refused to administer the on 08/03/23. Shift MA on 08/08/23 at rephine ordered every 4 or shortness of breath for				
	•	ift MA refused to administer red morphine because the				
	night shift MA would s saying Resident #6 w "he's being a pain" ar the night shift MA refu	send her a text message anted his morphine like nd Resident #6 also told her				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
					F	₹
		HAL061011	B. WING		l l	14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
MITCHELL	LUQUEE	13681 HW	Y 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE I	PINE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 358	hours and he request looked at the eMAR a administered the more. She reported the nigit Care Coordinator (RC she would talk to the situation. Telephone interview vollogologologologologologologologologol	#6 if it had been at least 4 ed the medication, but she and the night shift MA never phine. ht shift MA to the Resident CC) and the RCC told her night shift MA about the with a day shift MA on revealed: ent her a text message to n 08/03/23 at 8:18pm saying wanted more morphine. iff MA she documented the ident #6's morphine on morphine was due and to ster the morphine to MAR when she worked her ht shift MA never phine to Resident #6 on essage from the night shift A dated 08/03/23 revealed: essaged saying Resident #6 vanting another morphine". ponded with "I clicked it off aid, "When did you give it". d, "I gave it at 4:30pm". aid she put the morphine in her medications and "he's visible on the picture of the	D 358	DEFICIENCY)		
	been fine since"There were no times text message provide	visible on the picture of the d. vith a night shift MA on				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		R	
		HAL061011	B. WING		1	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE	13681 HWY	226 SOUTH			
		SPRUCE PI	NE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	: 41	D 358			
	-She worked night shi -She could not remen morphine on 08/03/23 -Resident #6 rolled do wheelchair on 08/03/2 and he was short of b oxygen tank was emp to his room, applied h concentrator, and adr slow-release pain me -She was never told b message to administe #6. -She administered the pain medication to Re not tell her he was ha though Resident #6 w nose was blue). -She never refused to Resident #6, but she	aft on 08/03/23. The Resident #6 asking for 8. The Samuer Resident #6 asking for 8. The Samuer Resident #6 asking for 8. The Samuer Resident #6 asking in his 23 and his nose was "blue", areath because his portable by, so she took Resident #6 is oxygen from his oxygen ministered his scheduled dication. The Samuer Resident MA in a text for the morphine to Resident #6 because he did for ving trouble breathing (even was short of breath and his 15 administer morphine to knew other MAs refused to 15 cause Resident #6 used to 15 cause the last time she				
		nt #6 on 08/10/23 at hing on 08/09/23 and the g administered morphine to				
	-The morphine helped -He did not know why not want to administe needed it. -The other night shift	d him to breathe easier. The other night shift MA did The morphine to him when he MA told him that he did not The and he knew morphine				
	morphine to him man	MA refused to administer y times before, but he did cause "it was a battle I				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		LETED
						₹
		HAL061011	B. WING		08/	14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13681 HW	/Y 226 SOUTH			
MITCHELI	LHOUSE		PINE, NC 2877	7		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE DATE
D 358	Continued From page	e 42	D 358			
	wasn't going to win".	d to administer his marphine				
		d to administer his morphine eathe, he became anxious				
	and scared.	eattle, tie became anxious				
	anu scareu.					
	Telephone interview v	vith Resident #6's hospice				
) on 08/10/23 at 11:37am				
	revealed:	,				
	-She or another hosp	ice RN saw Resident #6				
	twice weekly for stage					
	-Resident #6 experier	nced shortness of breath at				
	rest and worsened wi	th any exertion.				
		r ordered morphine to be				
		led for any respiratory				
	distress and "air hung					
		to her several times that				
		nister morphine to him.				
		ospice RN provided staff and				
		ucation weekly about not morphine to Resident #6.				
	_	#6 on 08/02/23 and he				
		taff refused to administer				
	•	hine and when she looked				
		not administered morphine				
	to Resident #6.	·				
	-She told the RCC tha	at Resident #6 needed his				
	morphine and the RC	C administered it to him.				
		ine was necessary for him				
	-	ood vessels in his lungs and				
		tions so that he could take				
	deeper breaths.					
		at administering morphine				
		ot up to the staff's judgment				
	Resident #6 needed i	morphine as ordered when				
		เ. n respiratory distress and it				
		her dose of morphine, the				
		hospice to get orders				
		vailable 24 hours a day.				
		oke to the RCC about staff				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL061011	B. WING		08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE	13681 HW	Y 226 SOUTH		
WIITCHELI	L HOUSE	SPRUCE F	PINE, NC 28777	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	÷ 43	D 358		
D 358	refusing to administer was about 2 weeks ag the situation had reso-Resident #6 previous helpless when he was staff refused to admin-Resident #6 not rece was in respiratory distinget enough oxygen, in respiratory distress, cout, or death. Telephone interview wourse practitioner (NF revealed: -She ordered morphinas needed for respirations and respiratory distinguished with the compain, but it would not was in respiratory distinguished would open Resident #6's lungs a oxygen and would slorespirations to allow hord administering Resmorphine and said the education to staff regard Resident #6's morphin-She did not know that were still refusing to a Resident #6.	r morphine to Resident #6 go and the RCC assured her lived. sly told her that he felt is in respiratory distress and lister his morphine. living the morphine when he tress could cause him to not herease the severity of the ause heart problems, pass with Resident #6's hospice by on 08/10/23 at 12:35pm the take 5mg every 4 hours tory distress for Resident I stage COPD. If a slow-release pain redered for chronic back help Resident #6 when he tress. In up the blood vessels in Illowing him to take in more low down Resident #6's him to take deeper breaths. Eviously reported staff were lident #6's ordered ley provided weekly larding administering	D 358		
	Resident #6's morphil distressBy not administering	morphine to Resident #6 he			

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DIVISION	n Health Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					R	2
		HAL061011	B. WING		08/1	4/2023
			•			
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITOLIELI	HOUGE	13681 HW	/ 226 SOUTH			
MITCHELL	- HOUSE	SPRUCE P	INE, NC 2877	7		
	OLIMANA DV OT		1			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(X5) COMPLETE
TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
IAG		,	IAG	DEFICIENCY)		
D 358	Continued From page	e 44	D 358			
		ot get enough oxygen into				
	his bloodstream, and	could lead to death.				
	Interview with the RC	C on 08/10/23 at 3:55pm				
	revealed:	·				
	-She worked on 08/01	1/23 and saw Resident #6				
		by the medication cart				
	•	ift and night shift MAs to				
	-	rcotics for the change of				
	shift.	1 1.6 344 6 1 1				
		ne day shift MA for his				
	morphine.					
	-She heard the day sh	hift MA tell Resident #6 he				
	had to wait 2 more ho	ours for the morphine				
	because he had taker	n it 2 hours prior.				
	-The hospice RN cam	ne to her and told her				
		peen administered morphine				
		eported the facility staff				
	refused to administer					
		MAR and Resident #6's				
	morphine had not bee	en administered since				
	07/31/23 at 1:23pm.					
		ident she became aware of				
		ng to administer morphine to				
	Resident #6.					
	-She reported the MA	for not administering the				
	morphine to Resident	#6 on 08/01/23 to the				
	Administrator.					
	-She told the night sh	ift MA to administer				
		ne on 08/03/23 since the				
		nted the administration of				
	the morphine at the in					
		y the night shift MA did not				
	administer the morphi	ine to Resident #6 on				
	08/03/23.					
	-She knew she had in	structed 6 MAs to				
	administer medication	ns as ordered including as				
	needed medications.	-				

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Interview with the Administrator on 08/09/23 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL061011	B. WING		R 08/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE	13681 HWY	226 SOUTH			
WILLOHELL	- HOUSE	SPRUCE P	INE, NC 2877	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 45	D 358			
D 358	4:40pm revealed: -He knew Resident #6 sometimes because if face turn blue beforeResident #6 was see had stage 4 COPDHe was not aware Rebreath and his nose to 08/03/23He was not aware of administer morphine in the did not know why administer morphine when Resident #6 was nose turned blueThe RCC told him the refusing to administer #6He expected the MA to residents as ordered interview with the Are 08/11/23 at 11:11am in the she was the RN for the visited the facility weedshe did not know so refused to administer she did not know Reprovided weekly and/facility staff regarding to administer morphing to administer morphing. The facility failed to a ordered for Resident in the some interview with any	6 had trouble breathing he saw Resident #6's whole en by hospice because he esident #6 was short of urned blue on the evening of fany MAs refusing to to Resident #6. In the night shift MA did not to Resident #6 on 08/03/23 Its short of breath and his to Resident #6 on Resident to Resident #6 on Resident to Resident #6 on OR/03/23 Its short of breath and his to administer medications and by the physician. The Clinical Director (ACD) on revealed: the facility and normally the facility and normally the facility staff morphine to Resident #6. The sident #6's hospice RN or bi-weekly education to the why staff should not refuse the to Resident #6. The total Resi	D 358			
	due to a lack of oxyge to feel scared and an	en and causing Resident #6 xious placing Resident #6 at				
	risk of an increase in	severity of respiratory				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL061011	B. WING		R 08/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	
MITCHELI	_ HOUSE		WY 226 SOUTH E PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	death. This failure pla substantial risk of his and constitutes a Type The facility provided a accordance with G.S. this violation.	ms, passing out, and/or ced Resident #6 in health, safety, and welfare e A2 Violation.	D 358		
D 399	10A NCAC 13F .1008 (h) The facility shall ediversions are reported enforcement agency at Registry as required by suspected drug diversions.	controlled Substance Controlled Substance Ensure that all known drug and to the pharmacy, local law and Health Care Personnel by state law, and that all sions are reported to the all be documentation of the sten.	D 399		
	facility failed to report drug diversion of resid medications to the ph	and record reviews, the allegations of suspected dents' controlled substance armacy and local law staff (previous Special			

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 47 of 74

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
			_		R
		HAL061011	B. WING		08/14/2023
					1 00/1 1/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
MITCHEL	L HOUSE		VY 226 SOUTH		
			PINE, NC 28777		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 399	Continued From page	e 47	D 399		
	The findings are:				
	-	s Medication Diversion			
	policy dated Septemb	sure that all Federal and			
	State regulations rele				
	narcotic medications				
		not found or accounted for,			
		dinator or the Administrator			
	to local law enforcem	otify and report the situation			
		HCPR), the Department of			
		s), the dispensing pharmacy,			
	and the resident's phy				
	-Staff implicated in div until completion of an	version would be suspended investigation.			
	Interview with a perso 08/08/23 at 10:15am	onal care aide (PCA)on revealed:			
		ember who had refused to			
		on the medication cart on			
		e suspected the previous nts oxycodone and possible			
	methadone.	its oxycodorie and possible			
		e administrator and there			
	was an investigation.				
		ee Notes written by a MA			
	dated 06/30/23 revea				
		I her to change a resident's			
		r order as the pharmacy had ontinued another order.			
		e MA the keyboard she typed			
		password and then she slid			
	the keyboard back to	the SCC.			
	Review of the Employ	yee Notes written by a			
	second MA dated 06/	30/23 revealed:			
	-On 06/05/23 at 7:06p	om the MA was counting the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R
		HAL061011	B. WING		08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		13681 HW	Y 226 SOUTH		
MITCHELL	_ HOUSE		PINE, NC 2877	7	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 399	Continued From page	2 48	D 399		
	modication cart and th	ne count was wrong for			
	oxycodone for a resid				
	•	ous SCC who told her the			
	count would be off by				
	-	got rid of the oxycodone.			
		he previous SCC putting			
		in her purse, but she did not			
	know what the medici	•			
	-On 06/21/23 the MA	said the previous			
	approached her and a	asked for the methadone			
	and oxycodone bottle	s for a resident because the			
	orders on the bottles	were different from that on			
	the computer.				
		eturned the methadone			
		codone bottle, when she			
		CC to explain, the previous			
	_	odone was not allowed on			
		ut the methadone was.			
	-Another MA docume				
		oxycodone because since d the oxycodone and the			
		ot answering her text, she			
	marked refused for th				
		SCC came in the next day,			
	•	previous SCC the resident			
		s of her oxycodone the			
		r the resident didn't have			
	anymore.				
	-When she gave her t	the previous SCC the bottle			
	yesterday there were	6 pills in the bottle.			
	-Another MA stated "t	hen we need to drug test			
	everyone".				
	-The previous SCC pr				
	-	sident and stated there was			
		ot know where the other pills			
	were.				
	-On 06/26/23 as she				
	•	ch the previous SCC told			
		esident an as needed (PRN)			
	oxycodone and did no	ot waste it off the count, and	1		

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STATE FORM 6899 HQ2O11 If continuation sheet 49 of 74

Division	of Health Service Regu	liation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					
					R
		HAL061011	B. WING		08/14/2023
		0.775.7.1	DD500 0171/ 074	TE 710 000E	
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	IE, ZIP CODE	
MITCHELL	HOUSE	13681 H\	VY 226 SOUTH		
MITCHELI	L HOUSE	SPRUCE	PINE, NC 28777	7	
0(1) 15	CLIMMADV CT	ATEMENT OF DEFICIENCIES	15	PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
		,		DEFICIENCY)	
					
D 399	Continued From page	e 49	D 399		
	_	or the day, the MA would			
	have to document the	e waste herself.			
	-On 6/30/23 a MA we	nt to lunch and the previous			
	SCC took the kevs to	the medication cart, going			
		oom and came back out later			
		noodie, then took a pill bottle			
		-			
		noved the pills from the			
		to the bottle in her purse.			
	-On 06/30/23 these in	ncidents were reported to the			
	Administrator.				
	Interview with the Re	gional Director of Operations			
	(RDO) on 08/10/23 at	-			
	, ,	•			
	-Her role was to provi	ide guidance for the			
	Administrator.				
	-When she was notific	ed by the Administrator of			
	the suspected drug d	iversion with the previous			
	SCC, she had informed	ed the Administrator to notify			
	the pharmacy and loc	-			
		sponsible for notifying the			
	pharmacy and local la	· ·			
	-She was unaware he				
		aw enforcement regarding			
	the suspected drug d	iversion by the previous			
	SCC.				
	Interview with the Adr	ministrator on 08/11/23 at			
	8:50am revealed:				
		f the allegation of diversion			
		i the anegation of diversion			
	on 06/30/23.				
		ons had been brought to his			
		esidents prior to 06/30/23.			
	-There were only two	resident's narcotic			
	,	with the suspected drug			
	diversion that he was				
		and Human Resources on			
	_	inu muman kesources on			
	06/30/23.				
	I	ailed the drug test and he			
	terminated her emplo	yment after he received the			

results.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	A. BUILDING:		
		HAL061011	B. WING		R 08/14/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE	13681 HWY	226 SOUTH			
		SPRUCE P	INE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	E
D 399	Continued From page	2 50	D 399			
	-He had two medicatic Care Coordinator (RC medication cart on the the medications to enwere missingHe did not report suseither the pharmacy of following the allegation and the thought it was enemploymentHe thought the RDO drug diversion to the enforcement, so he hold was ultimately resulted.	on aides and the Resident CC) go through the e special care unit and count sure no other medications spected drug diversion to or the local law enforcement ons. ough to terminate her had reported the suspected pharmacy and local law ad not. sponsible for reporting sion to the pharmacy and				
	Telephone interview with the local Sheriff at the county sheriff's department on 08/11/23 at 10:30am revealed: -They had not been notified of any drug diversion at the facility. -The facility would need to call and notify the local police department related to where the facility was located. Telephone interview with the police chief at the local police department on 08/11/23 at 10:38am revealed: -The facility had not notified them of any diversion at the facility in June, July or August. -The facility was responsible for notifying them per North Carolina law regarding diversion as soon as they are aware of the incident. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/11/23 at 10:48am revealed: -The facility had not reported any known or suspected drug diversion to the pharmacy to her					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
					R	
		HAL061011	B. WING		08/14/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MITCHELI	_ HOUSE		VY 226 SOUTH	,		
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	PINE, NC 28777	PROVIDER'S PLAN OF CORRECTIO	N (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 399	Continued From page	÷ 51	D 399			
	diversion unless it wa custody.	ot typically document drug s diverted in their chain of port diversion issues to their				
	substance medication law enforcement. The a lack of oversight an facility's controlled su which was detrimenta	eport allegations of of residents' controlled as to the pharmacy and local e facility's failure resulted in d examination into the bstances management al to the health, safety and as and constitutes a Type B				
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 08/11/23 for				
		DATE FOR THE TYPE B IOT EXCEED SEPTEMBER				
D 438	10A NCAC 13F .1205 Registry	i Health Care Personnel	D 438			
	Registry The facility shall comp	Health Care Personnel oly with G.S. 131E-256 and NCAC 13O .0101 and				
	This Rule is not met a TYPE A2 VIOLATION					
	Based on interviews a	and record reviews, the				

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILDING.			
		HAL061011	B. WING		R 08/14	/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHEL	HOUSE	13681 HWY	Y 226 SOUTH			
WIIIOIILL		SPRUCE P	PINE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 52	D 438			
	facility failed to submit physical harm by Staf (PCA), who purchase who resided on a Spethealth Care Personnehours and complete a becoming aware that alcohol for the resider consumed, not report Coordinator (SCC), for diversion, not reportin (MA), for neglect and and leaving a residen respiratory distress (Fat another resident for to go to the bathroom Staff C, MA, for refusion medication for respiratesident he was admit (Resident #6), and no screaming at a reside	t a report of neglect and if D, personal care aide d alcohol for a resident (#8) ecial Care Unit (SCU) to the el Registry (HCPR) within 24 is 5 day report after Staff D had purchased int which the resident ting Staff G, Special Care or suspected narcotic drug ing Staff A, medication aide verbal abuse for cursing t alone in his room while in Resident #6) and screaming r calling out for assistance (Resident #1), not reporting ing to administer a story distress and telling the inistered the medication of reporting Staff B, MA, for ent for calling for assistance and told the resident to go				
	The findings are:					
	Neglect Policy and Pr -It was not datedIn the event of physic neglect of a resident a verbal abuse or negle will complete the HCF -The facility will docur 5 day report and subri -Complete and submi either substantiated of	cal abuse,verbal abuse or allegation of physical abuse, ect of a resident the facility PR 24 hour report. ment findings on the HCPR mit to HCPR. t the 5 day working report				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			71. BOILBING	A. BOILDING.		R
		HAL061011	B. WING		08	3/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
			WY 226 SOUTH	,		
MITCHEL	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 438	Continued From page	e 53	D 438			
	disturbance and cognideficiencyResident #8 was interambulatoryLevel of care was Sp. Review of Resident # 05/22/23 revealed:	ermittently disoriented and pecial Care Unit (SCU). 8 current Care Plan dated ependent with ambulation. Indering behaviors.				
	revealed: -There was not a phy consumption.	8's record on 08/10/22 sician's order for alcohol nentation of the event on				
	-There was no documentation of the event on 06/06/23. Interview with a personal care aide (PCA) on 08/10/23 at 10:22am revealed: -She was working in the SCU 06/06/23 when Staff D, PCA, took Resident #8 off the SCU on her lunch break and took him to lunch at a local restaurantDuring the lunch meal, Staff D purchased for and allowed Resident #8 to consume an alcoholic beverageAfter Resident #8 was assisted to dinner later in the evening, he became sick and projectile vomited into the bushesShe was told by Staff D that Resident #8 had consumed alcohol during her break at a restaurantThe previous Special Care Coordinator (SCC) was present and informed the Administrator.					
		nd PCA on 08/10/23 at				

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L'S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE
₹

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:	
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE	13681 HWY	226 SOUTH		
WILLCHELI	LHOUSE	SPRUCE P	INE, NC 2877	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 438	Continued From page	55	D 438		
	became sick and he	omited.			
	9:30am revealed: -She took Resident ## restaurant and he was purchasedShe knew it was 06/0 family member that de -She was never given about what Resident if	guidance or expectations			
	Telephone interview with the former SCC on 08/10/23 at 5:00pm revealed: -She had been working as the SCC on 06/06/23 when Staff D took Resident #8 out to lunch and he was served alcoholStaff D asked her if she could take Resident #8 out for lunch and she asked the Administrator who gave permissionResident #8 was sitting in the courtyard and she smelled alcohol on his breath and then the resident vomited in the bushesShe informed the Administrator of Resident #8's condition and that Staff D purchased alchohol for the resident which he consumed.				
	08/10/23 at 2:58pm re -She gave permission #8 out to lunchShe did not give perr consume alcohol becalcoholic" and she ad -Staff D texted her aft	n for Staff D to take Resident mission for Resident #8 to ause he was a "recovering vised against it. er the lunch on 06/06/23 to ent #8 consumed a beer like			

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DIVISION	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	TED
					R	
		HAL061011	B. WING		08/14	1/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ALE, ZIP CODE		
MITCHELL	HOUSE	13681 HV	/Y 226 SOUTH			
MITCHELL	- HOUSE	SPRUCE	PINE, NC 2877	7		
0(1) 15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	T	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TREID.		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
			1			
D 438	Continued From page	2 56	D 438			
	TI DOA					
		to Staff D that she never				
	said he could consum	ne alcohol and that she had				
	advised against it.					
	Telephone interview v	with the facility's contracted				
	-	er (PCP) on 08/10/23 at				
	3:35pm revealed:	(. 0.) 00/10/20 0.1				
	•	order for Resident #8 to				
		rider for itesident #0 to				
	consume alcohol.	- I-4 D:-I #0				
		e let Resident #8 consume				
	alcohol while taking p	rescription medications.				
	Interview with the Adr	ministrator on 08/11/23 at				
	9:15am revealed:					
	-The facility policy on	resident alcohol				
		re must be a physician's				
	•	alcohol must be specified,				
	and medications revie					
	interactions.	ewed for alcorlor/drug				
		for Stoff D to take Decident				
		for Staff D to take Resident				
		he thought it had been				
	approved by the POA					
		juidelines to Staff D about				
	what should not occur	r when on a lunch outing				
	with Resident #8.					
	-He reported the ever	nt to the Regional Director of				
	Operations (RDO) wh	no instructed him to contact				
	. ,	s Department for guidance				
	regarding Staff D.					
		cility's Human Resources				
		guidance regarding Staff D.				
	` ' .					
		ed suspending Staff D for 3				
		estigation and instruct her				
		#8 to consume alcohol				
	again.					
	-He did not report Sta	aff D to the HCPR because				
		r" on her lunch break when				
	she took Resident #8					
	100.00					

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Interview with the RDO on 08/10/23 at 3:20pm

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
,			A. BUILDING: _	A. BUILDING:	
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MITCHELI	L HOUSE		Y 226 SOUTH	_	
			PINE, NC 2877		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 438	Resident #8 was serve with Staff D. -She was asked by the regarding disciplinary. She instructed the Action guidance. Interview with the HR 12:13pm revealed: -She had been inform Staff D had taken Resersaurant and he corestaurant and he corestaurant and he corestaurant was informed the inthe facility that day. Staff D was "like a vin Resident #8 to lunch. She directed the Admitten warning and to againIt was not necessary because Staff D was -It was just "bad judges."	the Administrator that yed a beer when out to lunch are Administrator for guidance actions for Staff D. Administrator to contact HR Director on 08/11/23 at a led by the Administrator that sident #8 to a local assumed alcohol. at Staff D was not working at Staff D was not working as ensure it did not happen at to report Staff D to HCPR and working that day. Staff D to HCPR and working that day.	D 438		
	clocked out at 2:34pn -Staff D clocked back clocked out at 5:06pn	n. in for work at 3:40pm and			
	regulations relevant to medications are follow- lf a medication is not	e that all Federal and State o the control of narcotic			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL061011	B. WING		08	R 8/ 14/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
MITCHEL	LUQUEE	13681 HV	WY 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 438	will direct staff to notilocal law enforcemer Registry (HCPR), the Services (DSS), the the resident's physici-Staff implicated in diuntil completion of ar Interview with a med 08/08/23 at 10:15am-There was a MA wh medication cart on 00 suspected Staff G of and possible methad-It was reported to the was an investigation. Review of the Emplodated 06/30/23 reveasing G asked her to methadone to another reprofiled it and disconstant of the lin her username and the keyboard back to Review of the Emplosecond MA dated 06-On 06/05/23 at 7:06 medication cart and to oxycodone for a residence of the Staff would be off by 4 beas he had got rid of the She had witnessed a bottle in her purse, the medicines were. -On 06/21/23 the MA and asked for the medicines were.	ify and report the situation to nt, the Health Care Personnel e Department of Social dispensing pharmacy, and ian. iversion will be suspended in investigation. ication aide (MA) on revealed: o had refused to take the 6/30/23 because she taking residents oxycodone lone. e Administrator and there yee Notes written by a MA aled: o move a resident's er order as the pharmacy had continued another order. MA the keyboard she typed password and then she slid o Staff G. yee Notes written by a /30/23 revealed: pm the MA was counting the the count was wrong for dent. G who told her the count cause they had expired, and	D 438			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BUILDING:		
		HAL061011	B. WING		08/1	4/2023
NAME OF PRO	OVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		13681 HW	Y 226 SOUTH			
MITCHELL	HOUSE	SPRUCE	PINE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	: 59	D 438			
	bottles were different -Staff G returned the inthe oxycodone bottle, explain Staff G stated allowed on the medicamethadone was. -Another MA documer resident refused her chad the oxycodone are answering her text, the #7 refused the oxycodowhen Staff G came explained to Staff G to doses of her oxycodowhen Staff G to doses of her oxycodowhen she gave her soxycodone on 06/29/2/2 bottle available to addron back from lungiven a resident a as and did not waste it obleaving for the day the document the waste from 06/30/23 Staff G were reported to the Allower reported to the Allower she was notified the suspected drug did had informed the Administrator. -When she was notified the Administrator was the Administrator was notified the Administrator was the Administrator	from that on the computer. methadone bottle but not when she asked Staff G to d the oxycodone was not ation cart but the nted on 06/21/23 the oxycodone because Staff G and Staff G was not e MA documented Resident done. in the next day, she the resident had missed two ne and Staff G told her the we anymore. Staff G the bottle of 23, there were 6 pills in the ninister. and another MA were ch Staff G told her she had needed (PRN) oxycodone ff the count, and as she was e MA would have to nerself. s incidents of drug diversion Administrator. O on 08/10/23 at 5:10pm				

Division of Health Service Regulation

regarding the suspected drug diversion by Staff

STATE FORM 6899 HQ2O11 If continuation sheet 60 of 74

DIVISION	n Health Service Negu	iauon				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
		1141 004044	B. WING		R	
		HAL061011	D. WING		08/14/2	023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		13681 H\	WY 226 SOUTH			
MITCHELL	_ HOUSE		PINE, NC 2877	7		
			TINE, NC 2011			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
		•	,,,,,	DEFICIENCY)		
D 438	Continued From page	e 60	D 438			
	G.					
	0.					
	Interview with the Adr	ministrator on 08/11/23 at				
	8:50am revealed:	111110trator 011 00/11/20 at				
		f the allegation of diversion				
	on 06/30/23.	the anegation of diversion				
		ns had been brought to his				
		esidents prior to 06/30/23.				
	-There were only two	•				
		vith the suspected drug				
	diversion that he was					
		notes regarding the incident				
		e other than staff writing				
	· · · · · · · · · · · · · · · · · · ·	atements of what they had				
	observed.	15: ((0 (:				
		nal Director of Operations				
	(RDO) and Human Re					
	regarding the alleged					
	•	o report Staff G to the				
	HCPR as he had term					
	•	had reported the suspected				
	•	HCPR, so he had not.				
		sponsible for reporting				
	suspected drug divers	sion to the HCPR.				
	•	vith the representative from				
		14/23 at 10:03am revealed:				
		ion of any report by the				
	facility on Staff G for a	alleged drug diversion.				
	-	t #6's current FL2 dated				
	09/16/22 revealed:					
	_	stage 4 chronic obstructive				
	pulmonary disease (C	COPD) (this is the final stage				
	of lung disease which	causes frequent flare ups				
	of respiratory distress	which can be fatal),				
	congestive heart failu	· · · · · · · · · · · · · · · · · · ·				
		nal heart rhythm with a rapid				

Division of Health Service Regulation

and irregular heartbeat), chronic pain and anxiety.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL061011	B. WING		08	R 3/ 14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
MITCHELL	LUQUEE	13681 H	WY 226 SOUTH			
MITCHEL	L HOUSE	SPRUCE	PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 61	D 438			
	-He was semi-ambula	atory in a wheelchair				
	Tro was som ambais	itely in a micelenant				
	04/04/23 revealed the	6's physician orders dated ere was an order for oxygen ay use 4L when ambulating				
	(RCC) on 08/08/23 at	any complaints from staff taff B being "rude".				
	08/08/23 at 3:50pm re- -Staff A and Staff B w had "attitudes" with or- -Resident #6 told her (Staff A, B, and C) wo called for assistance respiratory distress.	ere always "grumpy" and ther staff and residents. that 3 of the night shift MAs ould not help him when he				
	revealed: -He called Staff A one breathing and moved airway pressure (CPA when Staff A entered trouble breathing, and wonder you can't breaturned and walked our -Staff A did not come the rest of the nightStaff B griped or yello assistance.	back to check on him for ed if you called out for ple times to administer him				
		gued with him on 08/03/23				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL061011	B. WING		R 08/14/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MITCHELL	HOUSE	13681 HW	/Y 226 SOUTH		
MITCHELL HOUSE SPRUCE I		PINE, NC 28777	7		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 62	D 438		
	Staff C did not give hit -He has given up call from the facility staff a refused to help him with breathingHe told a couple of the A, B, and C but Staff mean to himHe reported Staff C to Nurse (RN) for refusion	atory distress when he knew im the medication. ing for help or assistance at night because they when he had trouble the day shift MAs about Staff A, B, and C continued to be so the hospice Registered			
	Interview with the RCC on 08/10/23 at 3:55pm revealed: -She and the Administrator were notified by Resident #6's hospice RN on 08/01/23 that Staff C refused to administer a medication for respiratory distress to Resident #6 when he was in respiratory distressShe did not know Staff C refused to administer a medication for respiratory distress to Resident #6 on 08/03/23She did not know if the Administrator reported any staff to the HCPR.				
	4:40pm revealed: -He did not know that and walked out of the on Resident #6 for the Resident #6 was in re-He did not know Statassist Resident #6 whele He did not know Statamedication ordered for Resident #6.	staff A cursed Resident #6 room not returning to check e rest of the night when espiratory distress. If B yelled or refused to nen he called for assistance. If C refused to administer a por respiratory distress to			

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 63 of 74

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
					1 _	
			B WING		R	
		HAL061011	B. WING		08/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
			Y 226 SOUTH			
MITCHELL HOUSE		PINE, NC 2877	7			
			TINE, NC 2011	T		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		DATE
IAG		,	IAG	DEFICIENCY)		1
D 438	Continued From page	e 63	D 438			
	the Health Care Doro	annal Bagiatry				
	the Health Care Person	offiler Registry.				
	Attempted telephone	interview with Staff A on				
	08/10/23 at 1:43pm w					
	00/10/23 at 1.43piii w	/as unsuccessiui.				
	1 Paviou of Pasidon	t #1's current FL2 dated				
	04/04/23 revealed:	t #13 Current 1 L2 dated				
	-Diagnoses included l	Parkinson's disease				
	-He was semi-ambula					
		•				
	-He was intermittently	Comusea.				
	Interview with Reside	nt #1 on 09/09/23 at				
	11:17am revealed:	111 #1 011 00/00/23 at				
		disease and required the				
		ff members with transferring				
	and toileting.					
		scream" at him when he				
	called for assistance t	•				
	because he could not					
		ould tell him to just sit back				
		ne bathroom because he				
	_	o the bathroom by himself.				
		lp him to the bathroom on				
	08/05/23.					
	-He reported Staff A a	and Staff B to the Resident				
	Care Coordinator (RC	CC) many times but Staff A				
	and Staff B continue t	to scream and refuse to help				
	him to the bathroom.					
	Interview with the RC	C on 08/08/23 at 3:45pm				,
	revealed:					,
	-Resident #1 reported	d to her on multiple				
	occasions that Staff A	and Staff B were rude to				
	Resident #1.					
	-Resident #1 said Sta	aff A and Staff B were				,
	"mean" to him but the	n Resident #1 would "laugh"				,
	about it.	5				,
		dministrator that Resident				
	#1 said Staff A and St					

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Resident #1 because she did not think Resident

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PRINTED: 09/01/2023 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					В	
	HAL061011	B. WING		08	R 8/ 14/2023	
DOVIDED OD SLIDDLIED	etpeet /	ADDRESS CITY STATE	ZIR CODE			
ROVIDER OR SUPPLIER			, ZIP CODE			
L HOUSE						
SLIMMARY S			PROVIDER'S PLAN OF	CORRECTION	(VE)	
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Continued From pag	e 64	D 438				
#1 "meant it".						
4:40pm revealed: -The Activities Direct complained to her al refusing to assist Re about 3 weeks ago be and Staff B about the the allegation and sa would have to wait to they were assisting a -He thought Resider way he was treated because Resident # -He did not report St Attempted telephone	for reported Resident #1 cout Staff A and Staff B sident #1 to the bathroom out when he asked Staff A e incident, the staff denied aid they told Resident #1 he o go to the bathroom because another resident. at #1 complained about the by Staff A and Staff B 1 was depressed. aff A or Staff B to the HCPR.					
neglect by Staff D will allowed a resident the consume the alcoholophysical illness whice evaluation, not report narcotic drug diversit neglect and verbal at a resident alone in high distress (Resident #1 resident for calling of bathroom (Resident refusing to administed distress and telling the administered the menot reporting Staff B for calling for assistation and told the resident to physical processing to a side of the	no purchased alcohol and part resided on a SCU to all which caused the resident the required a medical string Staff G for suspected on, not reporting Staff A for buse for cursing and leaving its room while in respiratory and screaming at another surfor assistance to go to the staff C for the resident he was dication (Resident #6), and for screaming at a resident surfor so to go to the bathroom in his					
	ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENCE REGULATORY OR REGULATORY OR REGULATORY OR REGULATORY) Continued From page #1 "meant it". Interview with the Act 4:40pm revealed: -The Activities Direct complained to her at refusing to assist Re about 3 weeks ago be and Staff B about the the allegation and sawould have to wait to they were assisting a -He thought Resident way he was treated because Resident #-He did not report St. Attempted telephone 08/10/23 at 1:43pm or 1:43pm o	HAL061011 ROVIDER OR SUPPLIER STREET A L HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 #1 "meant it". Interview with the Administrator on 08/09/23 at	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE 13881 HWY 226 SOUTH SPRUCE PINE, NC 28777 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 #1 "meant it". Interview with the Administrator on 08/09/23 at 4:40pm revealed: -The Activities Director reported Resident #1 complained to her about Staff A and Staff B refusing to assist Resident #1 to the bathroom about 3 weeks ago but when he asked Staff A and Staff B about the incident, the staff denied the allegation and said they told Resident #1 he would have to wait to go to the bathroom because they were assisting another residentHe thought Resident #1 complained about the way he was treated by Staff A and Staff B because Resident #1 was depressedHe did not report Staff A or Staff B to the HCPR. Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful. The facility failed to report physical harm and neglect by Staff D who purchased alcohol and allowed a resident that resided on a SCU to consume the alcohol which caused the resident physical illness which required a medical evaluation, not reporting Staff A for neglect and verbal abuse for cursing and leaving a resident alone in his room while in respiratory distress (Resident #6) and screaming at another resident for calling out for assistance to go to the bathroom (Resident #1), not reporting Staff C for refusing to administer a medication for respiratory distress (Resident #6) and screaming at a resident for calling for assistance to go to the bathroom (Resident #1) not reporting Staff C for refusing to administer a medication (Resident #6), and not reporting Staff B for screaming at a resident for calling for assistance to go to the bathroom and told the resident to go to the bathroom in his	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPENT TAG COntinued From page 64 #1 "meant it". Interview with the Administrator on 08/09/23 at 4:40pm revealed: -The Activities Director reported Resident #1 complained to her about Staff A and Staff B refusing to assist Resident #1 to the bathroom about 3 weeks ago but when he asked Staff A and Staff B about the incident, the staff denied the allegation and said they told Resident #1 he would have to wait to go to the bathroom because they were assisting another residentHe thought Resident #1 complained about the way he was treated by Staff A and Staff B because Resident #1 to complained about the way he was treated by Staff A and Staff B because Resident #1 was depressedHe did not report Staff A or Staff B to the HCPR. Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful. The facility failed to report physical harm and neglect by Staff D who purchased alcohol and allowed a resident that resided on a SCU to consume the alcohol which caused the resident physical illness which required a medical evaluation, not reporting Staff G for suspected narcotic drug diversion, not reporting Staff A for neglect and verbal abuse for cursing and leaving a resident alone in his room while in respiratory distress (Resident #6) and screaming at another resident for calling out for assistance to go to the bathroom (Resident #6), and not reporting Staff B for screaming at a resident for calling the resident to go to the bathroom and told the resident to go to the bathroom and told the resident to go to the bathroom and told the resident to go to the bathroom in his	The CORRECTION IDENTIFICATION NUMBER HALO61011 S. WING STREET ADDRESS, CITY, STATE, ZIP CODE 13861 HWY 226 SOUTH SPRUCE PINE, NC 28777 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY NUST BE PRECEDED BY FULL REGULATORY ON LSC DENTIFYING MYCHARION) (EACH CORRECTIVE ACTION SHOWDONE) (EACH CORRECTION SHOWDONE) (

Division of Health Service Regulation

STATE FORM 6899 HQ2O11 If continuation sheet 65 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL061011	B. WING		08/14/202	23
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
MITCHELL	_ HOUSE		VY 226 SOUTH PINE, NC 28777	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD BE COM		(X5) MPLETE DATE
D 438	Continued From page	: 65	D 438			
	abuse, and drug diver Staff A, B, C, and D confacility which placed the risk for serious physical Type A2 Violation. Refer to tag 0273, 10. Health Care, tag 0338 Resident Rights, tag 0.1004(a) Medication And NCAC 13F.1008 The facility provided a accordance with G.S. this violation.	rsion to HCPR resulted in continuing to work in the he residents at substantial harm and constitutes a A NCAC 13F .0902(b) 8, 10A NCAC 13F .0909 0358, 10A NCAC 13F .dministration, and tag 0399, s(h) Controlled Substance.				
D 452	And Incidents (b) Notification as recthis Rule shall be by a completed according Subchapter or a writte the following informat (1) resident's name; (2) name of staff who incident; (3) name of the pers (4) how, when and woccurred; (5) nature of the injuries.	Reporting Of Accidents quired in Paragraph (a) of a copy of the death report to Rule .1208 of this en report that shall provide ion: o discovered the accident or on preparing the report; where the accident or incident	D 452			
	occurred; (5) nature of the inju					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
74121 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _			
		HAL061011	B. WING		08/14	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MITCHELI	L HOUSE		Y 226 SOUTH PINE, NC 2877	7		
240.15	CLIMMADV CT	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N	0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 452	Continued From page	e 66	D 452			
	of the resident's responsive person as required in and (8) signature of the administrator-in-charg (c) The report as required this Rule shall be subdepartment of social stelefacsimile, electronsiders.	ge. uired in Paragraph (b) of mitted to the county services by mail, nic mail, or in person within discovery or knowledge by				
	facility failed to notify of Social Services (Dincidents involving 2 of (Resident #2 and #7) required emergency refirst aide. The findings are: 1. Review of Resident 05/17/23 revealed: -Diagnoses included atrial fibrillation, and persident #2 was amintermittent confusion behaviors.	and record reviews, the the local county Department SS) within 48 hours for of 3 sampled residents who received injuries that medical treatment other than the theorem of t				
	blood thinner) twice d	for Eliquis 5mg (used as a laily. ss notes for Resident #2				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TIDI E	CONSTRUCTION	(X3) DATE SU	IRV/EV	
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
			A. BUILDING: _				
					R		
		HAL061011	B. WING		08/14	/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
		13681 HV	YY 226 SOUTH				
MITCHELL HOUSE SPRUCE F		PINE, NC 2877	7				
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N	(VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE	
				DEFICIENCY)			
D 452	Continued From page	e 67	D 452				
	dated 07/10/23-08/08	//23 revealed there was no					
		ne local county DSS had					
	been notified of any ir						
	-						
		lent/Incident Report for					
	Resident #2 dated 07						
		am Resident #2 was found in					
	her room on the floor.						
	-Resident #2 was transported to a local hospital						
	by Emergency Medical Services (EMS) on 07/10/23 at 6:30am.						
		nentation the local county					
		Services (DSS) had been					
	notified.	Corvices (200) riad 20011					
	b. Review of an Accid	lent/Incident Report for					
	Resident #2 dated 07	//22/23 revealed:					
		in the television room lying					
	on the floor.						
		nsported to a local hospital					
	by EMS on 07/22/23	at 3:46pm. nentation the local county					
	DSS had been notifie						
	DOO HAG DEEN HOUNE	u.					
	c. Review of an Accid	ent/Incident Report for					
	Resident #2 dated 07	!					
		ing on her bedroom floor					
	with a bump on her h						
		nsported to a local hospital					
	by EMS on 07/28/23						
		nentation the local county					
	DSS had been notifie	a.					
	Interview with the loca	al county DSS Adult Home					
		on 08/08/23 at 9:45am					
	revealed:	5.1 30/00/20 at 3.40am					
		otified Resident #2 had					
		mergency medical treatment					
		8/23, at the local hospital					
		requiring x-rays 07/21/23.					

Division of Health Service Regulation

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SI COMPLE	
			A. BOILDING.		R	
		HAL061011	B. WING		1	4/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE		226 SOUTH			
		SPRUCE P	INE, NC 28777	7	T.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 452	Continued From page	2 68	D 452			
	requiring emergency received notification u-She was also notified					
	the Emergency Departhe residents family a on-call providerShe did not notify the					
	(SCC) on 08/10/23 at -She was responsible Accident/Incident Rep special care unit (SCU the local DSSShe had not faxed th local county DSSShe sent her first Acc the local County DSS for an incident that ha -She was unaware sh	e for faxing the port for all residents in the J) including Resident #2 to the e incident reports to the cident & Incident Report to on 08/08/23 for Resident #2 appened on 08/05/23. The had 48 hours to notify the sthat required emergency				
	08/10/23 at 5:00pm. 2. Review of Residen	n the Administrator on t #7's current FL2 dated				
	08/23/22 revealed: -Diagnoses included / hypertension, periphe and type II diabetes.	Alzheimer's Disease, ral vascular disease, angina				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (A. BUILDING:			
		HAL061011	B. WING		ns	R 3/ 14/2023
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZID CODE	1 00	14/2023
NAME OF F	ROVIDER OR SUFFLIER		WY 226 SOUTH	, ZIF CODE		
MITCHEL	L HOUSE		PINE, NC 28777			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 452	Continued From page	÷ 69	D 452			
		ermittently confused and				
	Review of the progress notes for Resident #7 dated 07/01/23-08/08/23 revealed there was no documentation that the local county DSS had been notified of any incidents/accidents. a. Review of an Accident/Incident Report for Resident #7 dated 07/24/23 at 10:00pm revealed: -She had fallen in her room and was complaining of right hip and leg painShe was transported to the local Emergency Department (ED) by EMS on 07/27/23 at 10:45pmThere was no documentation the local county					
	notified. b. Review of an Accid Resident #7 dated 08 -Resident #7 had falle wheelchair and was ly her wheelchairShe was transported Department (ED) by E	Services (DSS) had been dent/Incident Report for /06/23 at 6:29pm revealed: en in the day room out of her ying in the floor in front of to the local Emergency EMS on 08/06/23 at 6:55pm. mentation the local county				
	Department of Social notified. Interview with the Spe (SCC) on 08/10/23 at -She was responsible Accident/Incident Rep SCU including Reside -She had not faxed the local county DSSShe had started arou	services (DSS) had been ecial Care Coordinator 9:08am revealed: for faxing the port for all residents in the ent #7 to the local DSS. e incident reports to the and the first of July but was supposed to notify the local				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL061011	B. WING		R 08/14/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MITCHELI	HOUSE	13681 HWY	226 SOUTH		
WIITOTILL		SPRUCE P	INE, NC 2877	7	<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 452	Continued From page	2 70	D 452		
	-She was unaware sh local DSS of accident treatment at the local	ne had 48 hours to notify the s that required emergency hospital.			
	Specialist Supervisor	. •			
	Refer to interview with 08/10/23 at 5:00pm.	n the Administrator on			
	5:00pm revealed: -He was not aware th local DSS regarding I requiring more than fi -It was the responsibi local DSS regarding I requiring more than fi	e SCC had not notified the notident and Accident reports rst aide. lity of the SCC to notify the notident and Accident reports rst aide and He expected DSS when there was an			
D 454	10A NCAC 13F .1212 and Incidents	2(e) Reporting of Accidents	D 454		
	And Incidents (e) The facility shall a resident's responsible as indicated on the R following, unless the aperson or contact pernotification: (1) any injury to or illumedical treatment or medical evaluation, we	Reporting Of Accidents assure the notification of a person or contact person, esident Register, of the resident or his responsible son objects to such less of the resident requiring referral for emergency with notification to be as soon er than 24 hours from the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL061011	B. WING		08/1	4/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MITCHELI	HOUSE	13681 HWY	226 SOUTH			
MITCHELI	L HOUSE	SPRUCE P	NE, NC 28777	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 454	injury or illness by staresident's file; and (2) any incident of the elopement which doe requiring medical treatemergency medical ele as soon as possib hours from the time of knowledge of the incidocumented in the reflected elopement requiring in according to Rule .09 This Rule is not met Based on record revisifacility failed to notify within 48 hours of any being sent out to the for evaluation for 1 of (Resident #2). The findings are: Review of Resident #06/01/23 revealed: -Recommended level special care unitDiagnoses included a pain syndrome, type if anxiety disorder and opulmonary diseaseResident # was inter semi-ambulatory with	e resident falling or sonot result in injury atment or referral for evaluation, with notification to le but not later than 48 finitial discovery or dent by staff and sident's file, except for mmediate notification 06(f)(4) of this Subchapter. as evidenced by: ew and interviews, the a resident's legal guardian of incident and 24 hours of local emergency department to sampled residents 2's current FL2 dated of care was domiciliary, severe dementia, chronic li diabetes with neuropathy,	D 454			
	Resident #2 from 07/	10/23- 08/08/23 revealed: her room with injury to her				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED						
			A. BUILDING: _									
			B. WING			R						
		HAL061011	B. WING		08	08/14/2023						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
13681 HWY 226 SOUTH												
MITCHELL HOUSE SPRUCE PINE, NC 28777												
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR		(X5)						
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)		COMPLETE DATE						
D 454	Continued From page	272	D 454									
	emergency departme	nt (FD) for treatment.										
		the hallway change in										
		Resident #2 being sent to										
	the local ED for treatr	•										
	-A fall on 07/20/23 in	her room without injury.										
		the television room with										
	injuries to her head, a	and arm resulted in Resident										
	#9 being sent to the local ED for treatment.											
	-A fall on 07/26/23 in her room without injury.											
		her room with an injury to										
		Resident #2 being sent out										
	to the local ED for tre											
		her room with an injury to										
		in Resident #2 being sent to										
	the local ED for treatment.											
	-There was no documentation the residents											
	guardian was notified.											
	Interview with Resident #2's guardian on											
	08/09/23 at 3:48pm revealed:											
	-She had provided the Administrator the											
		ent #2's guardianship on										
	06/07/23 and explaine											
		Services needed to be										
		nanges in medical conditions										
	or medical decisions to Resident #2.	to be made regarding										
		omeone on call the facility										
	could reach and notify	•										
		nad been notified of any of										
		0/23, 07/15/23,07/20/23,										
	07/22/23, 07/26/23, 0											
		nt the Administrator an email										
		lity had not let her know										
		n sent to the ED on 07/10/23										
	Resident #2's daught											
		at she had provided him										
		cumentation on 06/07/23										
		e be called regarding any										
	changes with Resider											

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NC. 28777 [(24)] (24) III PREFEX (EACH DEFICIENCY MUST SE PRECEDED BY FILL (EACH DEFICIENCY) D 454 Continued From page 73 D 454 Continued From page 73 The hospital notified her that Resident #9 was at the hospital notified her that Resident #9 was at the hospital on 07/15/23. The facility had not reached out to her about any of Resident #2's guardian had not been notified of her falls. Interview with the SCC on 08/10/23 at 9:08am revealed: -She was not aware Resident #2's guardian had not been notified of her falls. -It was the responsibility of the medication aides (MA) to notify the family/legal guardian at the time of the incident. -The MA should have communicated the information to the oncoming shift if the MA could not get in touch with the family/guardian and documented the communication in a progress note or the Accident/Incident Report. Interview with the Administrator on 08/09/23 at 4:40pm revealed: -He was not aware Resident #2's legal guardian was not notified of her falls in July or August 2023. -The MA could have contacted a supervisor or coworker or made a second attempt to call the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 13681 HWY 226 SOUTH SPRUCE PINE, NC 28777 (X4) ID PREPLY TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC LICENTIFYING INFORMATION) D 454 Continued From page 73 -The hospital notified her that Resident #9 was at the hospital notified her that Resident #9 was at the hospital on 07/15/23. -The facility had not reached out to her about any of Resident #2's falls. Interview with the SCC on 08/10/23 at 9:08am revealed: -She was not aware Resident #2's guardian had not been notified of her falls. -It was the responsibility of the medication aides (MA) to notify the family/legal guardian at the time of the incident. -The MA should have communicated the information to the oncoming shift if the MA could not get in touch with the family/guardian and documented the communication in a progress note or the Accident/Incident Report. Interview with the Administrator on 08/09/23 at 4:40pm revealed: -He was not aware Resident #2's legal guardian was not notified of her falls in July or August 2023. -The MA could have contacted a supervisor or coworker or made a second attempt to call the				A. BOILDING.		R	
MITCHELL HOUSE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCE DEFICIENCE DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCY DEFICIENCE DEFICIENCE DEFICIENCE DEFICIENCY DEFICIENCE DEF			HAL061011	B. WING		08/1	4/2023
(24) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PILL PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PILL PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PILL PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 454 Continued From page 73 -The hospital notified her that Resident #9 was at the hospital on 07/15/23The facility had not reached out to her about any of Resident #2's falls. Interview with the SCC on 08/10/23 at 9:08am revealed: -She was not aware Resident #2's guardian had not been notified of her fallsIt was the responsibility of the medication aides (MA) to notify the family/legal guardian at the time of the incidentThe MA should have communicated the information to the oncoming shift if the MA could not get in touch with the family/guardian and documented the communication in a progress note or the Accident/incident Report. Interview with the Administrator on 08/09/23 at 4:40pm revealed: -He was not aware Resident #2's legal guardian was not notified of her falls in July or August 2023The MA could have contacted a supervisor or coworker or made a second attempt to call the	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	MITCHELL	L HOUSE			7		
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-He expected the responsible person to be notified that an incident had occurredThe MA should have documented the attempt to contact the guardian and relay the information to the oncoming shift if notification could not be							

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