

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL061011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/27/2023
NAME OF PROVIDER OR SUPPLIER MITCHELL HOUSE		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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey and complaint investigation on 09/26/23 to 09/27/23.	D 000	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report. The Plan of Correction is prepared solely as a matter of compliance with State Laws	
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or	D 394	10A NCAC 13F .1008(c & d) Controlled Substance Community has implemented new system regarding disposal and/or destruction of controlled substances. Resident Care Coordinator (RCC) and/or Memory Care Coordinator (MCC) will conduct weekly Medication Cart audits. Community Executive Director (ED), Area Clinical Director (ACD), and/or Regional Director (RDO) will conduct random Medication Cart Audits to assure any expired, discontinued or no longer required medications are pulled from cart. Any expired, discontinued, or no longer required controlled substances will be removed for medication cart and secured in a locked box RCC office. Community ED will assure keys to lock box are maintained in a secure location. Controlled Substances will be disposed of and/or destroyed at the community with two witnesses.	10/17/2023 10/17/2023 10/17/2023 10/17/2023 10/17/2023

Division of Health Service Regulation

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

Megan Burrows

TITLE *Executive Director*

(X6) DATE *10/18/23*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL061011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/27/2023
NAME OF PROVIDER OR SUPPLIER MITCHELL HOUSE		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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 394	<p>Continued From page 2</p> <p>revealed:</p> <ul style="list-style-type: none"> -The destruction form included documentation of destruction of controlled substances for 7 residents. -The form included the residents name, the prescription number, the drug name and strength, the quantity destroyed, the date of the destruction, the method of destruction, the facility administrator or designee to sign as a witness to the destruction, and the consultant pharmacist or pharmacy designee to sign as a witness to the destruction. -Chemical destruction was documented as used for the destruction of all of the controlled substances documented on the form. <p>Interview with the Resident Care Coordinator (RCC) on 09/27/23 at 2:04pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted pharmacy was out-of-state and did not accepted the return of controlled substances. -The facility destroyed controlled substances at the facility using the chemical destruction method. -Destruction of controlled substances was required to be witnessed by two facility administrative staff. <p>Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/27/23 at 3:29pm revealed:</p> <ul style="list-style-type: none"> -The pharmacy did not accept returns of controlled substances. -The facility was responsible for destroying controlled substances utilizing chemical destruction at the facility. -The facility was required to utilize a two person witness of the controlled substance destruction. -He did not know the regulation required a pharmacist, dispensing practioner, or designee of a licensed pharmacist or dispensing practitioner 	D 394		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL061011	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/27/2023
NAME OF PROVIDER OR SUPPLIER MITCHELL HOUSE			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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 394	Continued From page 3 to witness the destruction with the administrator or administrator's designee. A second telephone interview with the same pharmacist at the facility's contracted pharmacy on 09/27/23 at 4:13pm revealed: -The pharmacy's policy was to destroy controlled substances in accordance with state law. -He was going to amend the controlled substance policy to include controlled substance destruction would occur weekly with a licensed nurse as a witness to the destruction. Interview with the Administrator on 09/27/23 at 4:20pm revealed: -The facility's contracted pharmacy would not accept the return of controlled substances. -Destruction of controlled substances occurred at the facility utilizing chemical destruction with a two-staff witness of the destruction. -Administrative staff were supposed to act as witnesses of controlled substance destruction. -They had not been using a licensed pharmacist, dispensing practitioner, or designee of a dispensing practitioner to witness the destruction of controlled substances. -The pharmacy agreement they were in designated their staff as the pharmacy designee for the purposes of controlled substance destruction.	D 394			