STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation and a COVID-19 focused Infection Control survey with an onsite visit on 08/25/20 and a desk review survey on 08/26/20 to 09/01/20 and a telephone exit on 09/01/20.	D 000		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide assistance with meals and promote dignity and respect for 1 of 5 sampled residents (Resident #3), who was dependent on staff for assistance with eating. The findings are: Review of Resident #3's current FL2 dated 8/10/20 revealed: -Diagnoses included unspecified dementia without behavioral disturbance, cognitive communication deficit, and age related physical debility. -The resident required feeding assistance with eating. -There was an order for regular with finger foods diet /regular texture, thin consistency, sippy cup. Review of the Resident Register for Resident #3	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 312	Continued From page 1	D 312		

revealed he was admitted on 8/11/20.

Review of Resident #3's Care Plan dated 8/12/20 revealed:
-There were no documented dietary restrictions.
-There were no devices needed.

Review of Resident #3's physician order dated 08/11/20 revealed regular diet.

Review of Resident #3's progress note dated 08/14/20 revealed the resident required some assistance while eating.

Review of Resident #3's home health services visit dated 08/27/20 revealed finger food diet, sippy cup not necessary.

Review of Resident #3's physician order dated 08/27/20 revealed regular diet with finger foods.

Observation of Resident #3 during the lunch meal service in the Special Care Unit (SCU) in his room on 8/25/20 from 11:14am to 11:27am revealed:
-The resident was seated in his wheelchair with his food in front of him on his bedside table.
-The resident was served meatloaf, mashed potatoes, peas and carrots and a roll, with a glass of tea and a glass of water.
-The resident was eating his mashed potatoes, peas and carrots, and meatloaf unassisted with his hands.
-The resident was very shaky, ate his food with his fingers and dropped food in the floor.
-The resident was served liquids in a regular drinking glass.
-The resident was trembling as he ate with his hands and drank from his glass of tea.
-A personal care aid (PCA) came by and looked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 312	Continued From page 2	D 312		

at Resident #3 from the hallway and saw him eating with his hands and walked away.

Observation of Resident #3 during the dinner meal service in the SCU in his room on 8/25/20 from 4:05pm to 4:12pm revealed:
-The resident was seated in his wheelchair with his food in front of him on his bedside table.
-The resident was having difficulty reaching his food as his wheelchair had rolled back several inches away from his bedside table.
-The resident was attempting to eat his food with his fingers.
-The resident had been served a chicken pattie with gravy, green beans, potatoes, donut holes, water and another beverage, but the glass was empty.
-The resident was served liquids in a regular drinking glass.
-There was a large wet area in the resident's floor in front of his table that appeared to be spilled liquid.
-The resident was attempting to break off a piece of the chicken and gravy with his fingers but was unable to pull apart the chicken.
-A PCA was notified that Resident #3 needed assistance with eating his chicken and gravy.
-The PCA came into the resident's room, rolled his wheelchair closer to his table where he could reach the food and began to cut the chicken and feed the resident.

Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.

Telephone interview with the first shift Supervisor on 8/26/20 at 10:25am revealed:
-The "majority of the time" Resident #3 ate with his hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 312	Continued From page 3	D 312		

-Eating assistance was given when the resident wanted it.
-When Resident #3 pushed his plate away that meant he wanted assistance with eating.
-Resident #3 was "used" to eating with his hands.

Telephone interview with the Special Care Coordinator (SCC) on 8/26/20 at 2:00pm revealed Resident #3's family said he did not need feeding assistance.

Telephone interview with Resident #3's family member on 8/26/20 at 3:07pm revealed:
-The resident had been declining since he broke his back at Christmas and fractured his hip in July.
-He had received eating assistance during a recent hospital stay and at the skilled nursing facility where he had resided before being admitted the current facility.
-He needed help getting started to eat and then was "usually fine."

A second telephone interview with Resident #3's family member on 8/26/20 at 3:35pm revealed:
-The resident needed to be using his cup with a screw-on top and straw.
-It was "not easy" for the resident to drink out of a regular glass because he spilled the contents of the glass "on him and everywhere."

Telephone interview with a Personal Care Aide (PCA) on 8/27/20 at 9:20am revealed:
-She helped to deliver meal trays on 8/25/20, but did not know if anyone assisted Resident #3 with eating.
-She knew Resident #3 needed eating assistance.
-She had seen a cup with a straw in his room before, but he typically drank out of regular cups.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 312	Continued From page 4 Telephone interview with the first shift Supervisor on 8/27/20 at 9:30am revealed: -Staff had been prompting Resident #3 to begin eating and then he would finish the meal on his own. -Staff did not remain in room with the resident. -Staff did not have to be directed to assist with feeding Resident #3, they knew to do it.	D 312		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and directives from the local health department (LHD) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to inappropriate use of disposable gloves by staff to reduce the risk of transmission and infection and screening of visitors and companions. The findings are: 1. Observation on the assisted living hall outside room 302 and room 303 during the lunch meal service on 08/25/20 at 11:40am to 11:45am revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 5	D 338		

-There were two metal rolling carts.
-On the first cart, there was a tall metal beverage dispenser on the top shelf which contained ice water .
-On the second shelf of the first cart there was a plastic bin which held a bottle of antibacterial hand sanitizer and held a second plastic bin of silverware packets which included a knife, fork, and spoon wrapped in a paper napkin.
-On the second cart, there were prepoured cups of tea, additional empty beverage cups, empty coffee cups, and a carafe of coffee, and a pitcher of tea.
-Three staff prepared beverages for the lunch meal to serve to residents in their rooms.
-The three staff were observed to be wearing face masks and vinyl gloves.
-At 11:42am, a personal care aide (PCA) wearing a pair of vinyl gloves, retrieved a silverware packet and placed it in her right front scrub pocket.
-The PCA then got a cup of tea, water, and coffee and delivered the beverages to a resident in room 300 (the door to room 300 was open and did not require the PCA to touch the surface of the door).
-The PCA came out of room 300 and, without removing her gloves, pushed the door to resident room 302 open and delivered the silverware packet to a resident inside.
-The PCA exited room 302 and touched the surface of the door when pulling the door closed.
-The PCA then went to the metal cart and applied hand sanitizer to the vinyl gloves.

Observation of meal delivery on the Special Care Unit (SCU) on 08/25/20 from 11:10am to 11:16am revealed:
-Facility staff were observed delivering the lunch meal to residents in their rooms.
-The lunch meal was on a metal cart with a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 6	D 338		

plastic bottle of antibacterial hand sanitizer sitting on the top shelf.
-Facility staff were observed to be wearing a face mask and vinyl gloves.
-Three different facility staff were not removing their gloves between each in room meal delivery to residents.
-These facility staff were observed using hand sanitizer on gloves between meal delivery to each resident.

Interview with the Administrator on 08/25/20 at 11:46am revealed:
-It was the facility policy for staff to use hand sanitizer on vinyl gloves between residents when delivering beverages and food to the residents in their rooms.
-Using hand sanitizer on vinyl gloves was what the staff had been trained to do.

Interview with a PCA who delivered trays on the assisted living hall on 08/25/20 at 2:55pm revealed:
-She had placed the wrapped silverware packet in her scrub pocket because she had her hands "full."
-Placing wrapped silverware in her scrub pocket was not something she would routinely do.
-It was the facility's policy to use hand sanitizer on vinyl gloves when serving residents in their rooms for all meals.
-It was policy to use one pair of vinyl gloves per hall to pass out beverages to residents in their rooms.
-She routinely changed her vinyl gloves and put new ones on when she started on the "next hall."

Telephone interview with a PCA who routinely worked on the SCU on 08/27/20 at 9:00am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 7	D 338		

-She delivered meal trays to residents on the SCU for the lunch meal on 08/25/20.
-She was instructed by her coworkers that she could use hand sanitizer on her gloves between residents when delivering meal trays room to room.
-The facility staff only started wearing gloves and using hand sanitizer when delivering in room meal trays since COVID-19 started.
-She used hand sanitizer on her gloves between each meal tray delivery.
-She changed her gloves once when she dropped a plastic dome lid covering a plate on the floor, reached down to pick it up, then removed her gloves, used hand sanitizer and put on a new pair of gloves.

Interview with the Divisional Director of Clinical Services on 08/25/20 at 3:20pm revealed:
-The facility's policy of using antibacterial hand sanitizer on vinyl gloves to allow reuse of the gloves to pass beverages and plated food to residents in their rooms was obtained from CDC guidelines.
-The policy was implemented due to the nationwide shortage of gloves and other personal protective equipment (PPE).
-The policy was "more about conservation."
-The facility had stopped communal dining at the end of March 2020 and thus had been delivering meals to residents in their rooms since that time.
-On 06/16/20, the Division Vice President of Operations had instructed her to send out an email to all the communities in her Division to sanitize gloves when giving meals to residents.
-Sanitizing gloves was just used for meal delivery.
-"This was just an added layer of protection."

Review of the email sent out by the Divisional Director of Clinical Services on 06/16/20 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 338	Continued From page 8 4:26pm revealed: -"As referenced below, we need to implement the following protocols for Meal Distribution/Infection Control Practices immediately." -All employees distributing meals to residents must wear gloves while distributing the meals. -They must use hand sanitizer to their gloved hands between each resident. -They may wear the same pair of gloves between residents, up to 15 residents, at which time they must change their gloves, unless the gloves become compromised (torn/holes) or are visibly soiled, which would require a new pair of gloves. -In the event that during the meal distribution, if a resident requires any assistance with toileting, or other care involving contact with bodily fluids, they must change their gloves after this assistance, prior to distributing the meal to the next resident. Telephone interview with the Senior Vice President of Clinical Services on 08/25/20 at 4:25pm revealed: -The policy of using antibacterial hand sanitizer on vinyl gloves came from the CDC guidelines entitled "Strategies for Optimizing the Supply of Disposable Medical Gloves" updated April 30, 2020. -Use of antibacterial hand sanitizer was to be used when there were "anticipated shortages." -They had some challenges getting some supplies. -They wanted to be responsible in the use of those supplies. -During normal meal service in a dining room, gloves were not required to be worn by staff to serve meals to residents. -"Out of an abundance of caution" they implemented glove use and antibacterial hand sanitizer use to deliver meals to residents in their rooms.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 9 -The corporation was involved in the NC State Coalition who managed the State's supply of PPE. -There was only a 93 day supply of gloves left in the State. -They were being "respectful" and not "wasteful" of the State's supplies. -The policy of apply antibacterial hand sanitizer to the vinyl gloves was only for serving meals to residents in their rooms. -The vinyl gloves and antibacterial hand sanitizer to those gloves were not used for direct care. -Staff were instructed to change the gloves used for direct care and perform appropriate hand hygiene when personal care was performed. Review of the CDC guidelines entitled "Strategies for Optimizing the Supply of Disposable Medical Gloves" updated April 30, 2020 revealed: -The document offered a series of options to optimize supplies of disposable medical gloves in healthcare settings when there was a limited supply. -In instances of severely limited or no available disposable medical gloves, non-healthcare disposable gloves (e.g., food service gloves) may be considered for situations where health care personnel were not exposed to pathogens. -Non-healthcare disposable gloves were available in many different materials, including polyvinyl chloride, nitrile, and latex. -The extended glove use guidance applied only to disposable medical gloves and did not apply to non-healthcare glove alternatives. Observation of the box label of the gloves facility staff used to perform meal service activities on 08/25/20 at 3:22pm revealed: -The gloves were "vinyl exam gloves." -The gloves were "safe for food contact."	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 10 Review of the facility's Know What To Do Guide: Proper Use of Personal Protective Equipment Medical Gloves revealed: -The CDC had provided guidance for performing hand hygiene of gloved hands for extended use of medical gloves. -The following extended use guidance applied only to disposable medical gloves and did not apply to non-healthcare glove alternatives. -Antibacterial hand sanitizer was not recommended for vinyl gloves as it may degrade the gloves. Telephone interview with a local health department nurse on 08/25/20 at 3:50pm revealed: -Using antibacterial hand sanitizer on gloves and reusing them was not standard practice. -Typically antibacterial hand sanitizer was used on bare hands. -Standard practice was to change gloves after each patient interaction. Telephone interview with the Administrator on 08/27/20 at 2:52pm revealed: -Staff had been instructed to wear vinyl food service gloves and apply antibacterial hand sanitizer to the gloves between each resident meal pass. -The policy was implemented due to a nationwide PPE shortage. -The policy was based on CDC guidelines for glove conservation in times of glove shortages. -The gloves were an "extra layer of protection" for staff. 2. Review of the CDC guidelines for Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities revealed:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 11	D 338		

-Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms consistent with COVID-19 (fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) before starting each shift/when they enter the building.

Review of the North Carolina Department of Health and Human Services Updated Guidance on Visitation, Communal Dining and Indoor Activities for Larger Residential Settings (Adult Care Homes, Behavioral Health/Individuals with Developmental Disability, Intermediate Care Facilities, Psychiatric Residential Treatment Facilities dated 07/16/20 revealed:
-Visitor's must be screened for fever and other symptoms associated with COVID-19 (fever equal to or greater than 100.0 F, cough, shortness of breath, sore throat, muscle aches, chills or onset of loss of taste or smell).

Review of the resident roster dated 08/25/20 revealed there were 70 residents on the roster with 31 residents residing on the assisted living (AL) and 39 residents residing in Special Care Unit (SCU) of the facility.

Observation of the signage on the front entrance to the facility on 08/25/20 at 9:02am revealed no visitors were permitted, to guard against the spread of COVID-19.

Observation of the front lobby upon entrance to the facility on 08/25/20 between 9:05am and 9:10am revealed:
-A staff member wearing a mask opened the door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 12	D 338		

for surveyors to enter the front lobby.
-Surveyors entered the facility with masks on.
-Surveyors were not asked any screening questions.
-Surveyors were not asked to have their temperatures checked.

Interview with the Administrator on 08/25/20 at 11:46am revealed:
-All the members of the survey team would need to go to the front reception area of the facility to be screened for symptoms of COVID-19 and have their temperatures checked.
-It was the facility's policy to check temperatures and screen all visitors upon entering the facility.
-The staff had "failed" to screen the surveyors and check their temperatures upon entry to the building that morning due to "everybody being nervous."
-She "respectfully" asked if all the members of the survey team would go up front "now" to have their temperatures checked and answer all of the required screening questions.

Observations in the front lobby of the facility on 08/25/20 from 11:54am to 12:15pm revealed:
-A staff member in the reception area was wearing a mask.
-The staff member used a non-contact thermometer to check the survey team members temperatures.
-The staff member then asked each survey team member COVID-19 screening questions and documented the responses and temperature on an electronic tablet.
-Each surveyor being screened was required to sign the entry to verify the screening questions had been answered.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 13	D 338		

08/27/20 at 2:52pm revealed:
-The facility's policy was to check temperatures and screen for symptoms of COVID-19 immediately upon entry to the facility.
-She did not know why staff did not do that other than "State was in the building."
-Until the evening of 08/25/20, companions were told to come in through the employee entrance, change their clothes in the employee break room bathroom, and then come to the front reception area for COVID-19 screening.
-After 08/25/20, the companions were now coming to the front entrance reception area and being screened, then going to change their clothes in the break room bathroom, and then proceed to the sitting area with resident.
-The companions knew if they left the building they had to be rescreened and have their temperatures checked upon return.

Observation at the end of the assisted living hallway between rooms 300 and 301 on 08/25/20 at 9:30am revealed:
-There was a door at the end of the hallway to allow for entry and exiting the facility.
-There was signage on the outside of the door that read "No Visitors Permitted."
-A resident companion entered the facility through the door at the end of the hallway wearing a mask.
-The resident companion entered room 301 without being screened for COVID-19.
-There was no staff in the hallway when the companion entered the facility.

Interview with the resident companion on 08/25/20 at 9:33am and at 3:25pm revealed:
-"Corporate" gave him a waiver that allowed him to visit his family member when he wanted to.
-He visited his family member daily and provided

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 14	D 338		

care for her.
-He had to follow the same guidelines as the staff when he entered the facility.
-He had to wear a mask, change his clothes, get his temperature checked, and fill out a questionnaire every time he entered the facility.
-He would go to a medication aide or to the front desk and have his temperature checked when he entered the facility.
-He had entered the facility earlier this morning (08/25/20) and was screened but had to leave to pick up some supplies for his family member.

Telephone interview with a second resident companion on 08/27/20 at 3:51pm revealed:
-She routinely worked 2:00pm to 7:00pm.
-She put on a mask before she entered the facility.
-She would enter the facility through the "back door."
-She would then go directly to the bathroom and wash her hands and change her clothing.
-She then walked to the front entrance reception desk where facility staff checked her temperature and screened her for symptoms of COVID-19.
-There were no staff "at the back" or a bell to ring.
-The staff had companions come in the back door because there were less residents in that location and staff felt it was safer for the residents.
-She ran errands for the resident before she came to work, so she did not have to leave once she was there.

Telephone interview with a third resident companion on 08/31/20 at 11:11am revealed:
-She called facility staff to notify them of her arrival and facility staff would come and let her into the facility through the "back door."
-She put on a mask before she entered the facility.

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	HAL061011	A. BUILDING: _____ B. WING _____	C 09/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MITCHELL HOUSE	13681 HWY 226 SOUTH SPRUCE PINE, NC 28777

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D 338	Continued From page 15	D 338		

-She then would go to the bathroom to wash her hands and change her clothing.
-She then would go to the front reception desk where facility staff checked her temperature and screened her for symptoms of COVID-19.

Telephone interview with a resident's Nurse Practitioner (NP) on 08/28/20 at 4:25pm revealed:
-It was important for every visitor and staff that entered the facility to be screened.
-If all visitors and staff were not screened before they entered the facility, someone might enter the building that was sick and spread COVID-19 to the residents.
-The visitors and staff should be screened to reduce the risk of spreading COVID-19.

Interview with the Special Care Coordinator (SCC) on 08/25/20 at 11:05am revealed:
-The staff entered the facility through a designated entrance in the back of the facility.
-Each staff member must change their clothes and be screened before entering the facility.
-The screening included a temperature check and completing a questionnaire.
-A staff member was usually sitting at the desk inside the front door to screen all visitors entering the building.
-She did not know why someone was not sitting at the front door to complete screenings this morning (08/25/20).
-The staff get scared when state workers enter the facility and probably "just forgot to screen" the surveyors.

Interview with the Administrator on 08/25/20 at 12:12pm revealed:
-The resident companions should not be using the side door to enter the facility.
-All "sitters" had been instructed to use the staff

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D 338	Continued From page 16 entrance when entering the facility. -Each "sitter" was instructed to change their clothes, get their temperature checked, fill out a questionnaire, and put on a mask before entering the facility.	D 338		