Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044041	A. BUILDING: ______ B. WING ______	C 07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES WILLOWS	**65 LOVING WAY CLYDE, NC 28721**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 07/21/22 and 07/22/22.	D 000		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) who provided personal care to residents had documentation of successful completion of an	D 150		

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80-hour personal care training and competency evaluation program.

The findings are:

Review of Staff A's, personal care aide's (PCA), personnel record revealed:
-Staff A's hire date was 04/26/21.
-There was no documentation Staff A completed an 80-hour personal care and competency training.

Interview with the Business Office Manager (BOM) on 07/22/22 at 10:11am revealed:
-She was responsible for maintaining all of the records related to staff qualifications.
-Staff A was hired as a PCA on 04/26/21.
-Staff A had not yet completed the 80-hour personal care and competency training.
-PCA's were required to complete the 80-hour personal care and competency training within 6 months of hire.
-Staff A had been registered for the training and was emailed a link to access the training, however Staff A did not complete the training.

Interview with the Administrator on 07/22/22 at 12:45pm revealed:
-He was aware Staff A did not complete the 80-hour personal care and competency training.
-Staff A had been given three prior opportunities to take the training.
-She had been scheduled for the training, but missed the class.
-Staff A would have to complete the training offered 07/27/22 or she would not be allowed to come back to work.

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D 187	10A NCAC 13F .0604 (d) Personal Care And Other Staffing	D 187		

10A NCAC 13F .0604 Personal Care And Other Staffing

(d) Homes with capacity or census of 13-20 shall comply with the following staffing. When the home is staffing to census and the census falls below 13 residents, the staffing requirements for a home with 12 or fewer residents shall apply.
(1) At all times there shall be an administrator or administrator-in-charge in the home or within 500 feet of the home with a means of two-way telecommunication.
(2) When the administrator or administrator-in-charge is not on duty within the home, there shall be at least one staff member on duty on the first, second and third shifts.
(3) When the administrator or administrator-in-charge is on duty within the home, another staff member (i.e. co-administrator, administrator-in-charge or aide) shall be in the building or within 500 feet of the home with a means of two-way telecommunication at all times.
(4) The job responsibility of the staff member on duty within the home is to provide the direct personal assistance and supervision needed by the residents. Any housekeeping duties performed by the staff member between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks. The staff member may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder care of residents or immediate response to resident calls, do not disrupt residents' normal lifestyles and sleeping patterns and do not take the staff member out of view of

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where the residents are. The staff member on duty to attend to the residents shall not be assigned food service duties.
(5) In addition to the staff member(s) on duty to attend to the residents, there shall be staff available daily to perform housekeeping and food service duties.

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

Based on observations, interviews, and record reviews, the facility failed to ensure there was at least one staff member on duty at all times in the facility on night shift to provide personal care and supervision to the residents.

The findings are:

Interview with Transport staff on 07/21/22 at 8:40am revealed:
-The current census was 19 residents.
-Currently, there was one personal care aide (PCA) assigned to remain in the facility and provide personal care and supervision to the residents, and one medication aide (MA) assigned to administer medications on day shift (6:30am to 3:00pm).

Observation in the facility on 07/21/22 at 8:45am revealed there was one PCA in the facility to provide personal care and supervision to the residents.

Interview with the PCA on 07/21/22 at 8:46am revealed:
-The MA assigned to the facility was currently

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next door at a sister facility administering medications.
-The MA would return to the facility.
-The MA was responsible for administering medications in two facilities.

Observation outside the facility on 07/22/22 at 8:10am revealed the entrance doors to the sister facility were within approximately 20 yards of the facility exit.

Interview with one resident on 07/21/22 at 9:14am revealed:
-Staff did not always respond timely to answer call lights.
-She needed assistance from staff to go to the bathroom, to transfer, and to shower.
-"Sometimes" it took staff "awhile" to respond to her call light.
-One night "about a month and a half ago" she had put her call light on at 3:30am to 4:00am and night shift staff did not respond to the call light.
-The call light was responded to by day shift staff.
-The staff person that responded told her they were short staffed.

Review of the facility's June and July 2022 staffing schedule revealed:
-The schedule was for staffing to cover three separate facilities located on the property.
-The schedule did not specify who had been assigned to work in each of the three separate facilities.
-The schedule did not specify who had worked in each of the three separate facilities on each day.
-There was no way to distinguish which specific staff had provided coverage for the facility in June and July 2022.

Interview with the RCC on 07/22/22 at 10:21am

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revealed:
-MAs and PCAs were not assigned to work in specific facilities on the schedule.
-At 6:30am, when the PCAs arrived to work they would come to the MA on duty and ask which facility they needed to cover for that day.
-The MA would assign each PCA to cover a facility.
-At night (11:00pm to 7:00am), they always tried to have at least one MA and two PCAs to cover three facilities.
-This schedule provided at least one staff person in each facility.
-There were times when the staff would have to leave the facility and go help in another building or staff from a sister facility would have to come over to help in their facility in emergency situations.
-This left the residents in the facility or the sister facility without staff for brief periods of time (10-15 minutes).
-There was not an Administrator or Administrator-In-Charge who lived within 500 ft. of the facility.
-If staff did not come to work, he had to come in to replace them.
-Staff typically were assigned to work from 2:15pm to 3:00am or 3:00am to 3:00pm to ensure coverage on all shifts.
-The modified shift schedules had been in place for two months or longer due to being short staffed.

Telephone interview with the Regional RCC on 07/22/22 at 12:12pm revealed:
-They tried to schedule at least three or four staff on nights.
-They were short staffed at times.
-On nights (11:00pm to 7:00am) they typically had one staff to cover each facility, but sometimes

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they might only have two staff to provide coverage for three facilities.
-The Administrator did not live within 500 ft. of the facility.
-The RCC provided backup staffing coverage.
-The RCC lived 5 minutes away from the facility.
-The previous RCC had recently retired, but still worked some hours occasionally.
-The previous RCC was still willing to cover the facility if needed and lived only 3 minutes from the facility.
-She also could provide backup staffing coverage and she lived 15 minutes away from the facility.
-They tried to schedule at least four or five staff on evenings (3:00pm to 11:00pm).
-The numbers did not include dietary staff or housekeeping staff.
-They had done everything they could to hire more staff and retain staff.
-The Administrator had raised pay and offered bonuses.
-They had job fairs to try to attract new applicants.
-They had tried to use staffing agencies to assist with coverage, but many times the agency staff would not show up to work.

Interview with the Administrator on 07/22/22 at 12:45pm revealed:
-It was primarily night shift when the facility might have to share staff with a sister facility.
-There had been occasions when the one staff in the facility had to go to a sister facility to help, because the staff who was supposed to work in the other facility called out 5 minutes before the start of their shift.
-He had occasions when he had staff to leave in the middle of a shift without alerting anyone in advance.
-He did not live within 500 ft. of the facility.
-The RCC lived only 5 minutes away from the

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facility and was always available if needed.
-The previous RCC lived within 5 minutes of the facility and would respond if needed.
-The transportation staff lived 10 minutes away from the facility and would respond if needed.
-He was doing everything he could to hire new staff and retain existing staff including offering bonuses and paying PCAs $15 to $20 plus per hour.

Interview with the Transport staff on 07/22/22 at 2:05pm revealed:
-She was also trained and worked as a PCA in the facility.
-She had worked on night shift "a couple times" in the past year when the facility was short staffed.
-There was usually only one staff in the facility on night shift.
-They usually had two MAs and one PCA to cover three buildings at night.
-There had been one night three weeks ago when there had been only two staff to cover three buildings.
-She never left the residents in the facility unattended when she worked.

Interview with an MA on 07/22/22 at 2:20pm revealed:
-She routinely worked 6:30am to 10:30pm.
-A couple of weeks ago, a resident fell at in a sister facility and a PCA called her for help.
-She had to leave the residents in the facility unattended for 10 to 15 minutes to respond to assist the PCA with the fall at the sister facility.

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The facility's failure to ensure residents were not left unattended when staff left the building to assist staff in a sister facility with resident care or in an emergency left the residents' in the facility unsupervised and without personal care

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D 187	Continued From page 8 assistance for brief periods of time. This was detrimental the health, safety, and welfare of the residents and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/22/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 5, 2022.	D 187		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to serve a therapeutic diet as ordered by the Primary Care Provider (PCP) for 1 of 2 residents (Resident #4) with a mechanically altered regular diet with ground meats. The findings are: Review of Resident #4's current FL2 dated 06/07/22 revealed: -Diagnoses included Alzheimer's disease and	D 310		

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Parkinson's disease.
-There was a mechanically altered diet order for regular with ground meats.

Review of the undated resident's diet orders provided by the Dietary Manager (DM) on 07/21/22 revealed Resident #4's diet order was regular with ground meats.

Observation of Resident #4's lunch meal on 07/21/22 served at 12:05pm revealed:
-Resident #4's meal consisted of roast beef that was uncut, mashed potatoes, a carrot and celery mixture, dinner roll and chocolate pie.
-Resident #4 had water and milk to drink.

Observation of a Personal Care Aide (PCA) on 07/21/22 beginning at 12:13pm revealed:
-She used a fork to cut up pieces of the roast beef to feed Resident #4.
-The pieces of roast beef were not ground.

Interview attempt with Resident #4 on 07/21/22 at 12:49pm was unsuccessful.

Interview with a PCA on 07/21/22 at 12:51pm and 2:05pm revealed:
-She assisted Resident #4 with his lunch on 07/21/22.
-Resident #4's roast beef was a solid piece of meat, so she used a fork to cut it up into bite sized pieces.
-She served Resident #4 whatever the Dietary Aide (DA) brought to the dining room table for his meal.
-She did not know what Resident #4's diet was supposed to be.

Interview with a DA on 07/21/22 at 2:15pm revealed:

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D 310	Continued From page 10 -She thought she gave Resident #4 a chopped diet for lunch because the roast was in long stringy pieces. -She realized after she gave the lunch plate for Resident #4 to the PCA that the food was the wrong diet consistency. -She should have taken Resident #4's lunch plate back to the kitchen to have it "chopped" up better. Interview with the Dietary Manager (DM) on 07/21/22 at 2:20pm revealed: -She changed the routine for the DA's today by putting all special diets on the upper shelves of the food cart. -She thought this would make it easier for the DA's. -She was not aware Resident #4 was served a regular diet. -Resident #4 should have been served a regular diet with ground meats as the PCP order indicated. Interview with the Administrator on 07/22/22 at 2:36pm revealed: -The DM should not have changed the system of handing out plated foods. -He expected all residents to receive therapeutic diets as ordered by the PCP.	D 310		
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	D 312		

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dignity and respect.

This Rule is not met as evidenced by:
Based on observations, record review and interviews, the facility failed to ensure 1 of 4 sampled residents (Resident #4) was treated with dignity and respect as evidenced by staff standing while providing feeding assistance to Resident #4.

The findings are:

Review of Resident #4's current FL2 dated 06/07/22 revealed:
-Diagnoses included Alzheimer's disease and Parkinson's disease.
-There was a mechanically altered diet order for regular with ground meats.

Review of a nurse's note dated 06/09/22 revealed "Resident is not able to feed self needs to be assisted."

Observation of Resident #4's lunch meal on 07/21/22 served at 12:05pm revealed:
-Resident #4's meal consisted of roast beef, mashed potatoes, a carrot and celery mixture, dinner roll and chocolate pie.
-Resident #4 had water and milk to drink.

Observation of a Personal Care Aide (PCA) on 07/21/22 from 12:13pm to 12:45pm revealed she was standing beside Resident #4 while providing feeding assistance to him.

Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.

Interviews with the PCA on 07/21/22 at 12:51pm

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D 312	Continued From page 12 and 2:05pm revealed: -She fed Resident #4 his lunch on 07/21/22. -Resident #4 was unable to cut up his meat by himself. -Resident #4 was unable to use utensils to feed himself. -She did not want the other residents at the same table with Resident #4 to feel crowded so she was standing while providing him feeding assistance. -There was not enough room to pull up another chair and sit at the table with Resident #4. -She was unaware she was not supposed to stand up while she provided Resident #4 feeding assistance. Interview with the Dietary Manager (DM) on 07/21/22 at 2:20pm revealed: -She was not aware until 2 weeks ago that staff was not supposed to stand while providing feeding assistance to a resident. -She did not recall any dietary training she had that addressed standing while providing feeding assistance to residents. -She was not aware the PCA was standing while providing feeding assistance to Resident #4 at the lunch meal on 07/21/22. Interview with the Administrator on 07/22/22 at 12:45pm revealed: -The facility's policy was for staff to provide eating assistance to residents in a seated position. -All staff received training on how to properly provide eating assistance to residents. -He was not sure why staff provided eating assistance from a standing position.	D 312		
D912	G.S. 131D-21(2) Declaration of Residents' Rights	D912		

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G.S. 131D-21 Declaration of Residents' Rights
Every resident shall have the following rights:
2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, and in compliance with relevant federal and state laws and rules and regulations related to staffing.

The findings are:

Based on observations, interviews, and record reviews, the facility failed to ensure there was at least one staff member on duty at all times in the facility on night shift to provide personal care and supervision to the residents. [Refer to Tag 0187, 10A NCAC 13F .0604(d) Personal Care and Other Staffing (Type B Violation)].