STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY 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 completed a follow-up survey from 11/29/22 through 11/30/22.	D 000		
D 187	10A NCAC 13F .0604 (d) Personal Care And Other Staffing 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	D 187		

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response to resident calls, do not disrupt residents' normal lifestyles and sleeping patterns and do not take the staff member out of view of 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:
FOLLOW-UP TO TYPE B VIOLATION

Based on these findings, the previous Type B Violation was not abated.

Based on interviews and record reviews, the facility failed to ensure when the Administrator or Supervisor-in-Charge was not on duty within the facility, there was at least one staff member on duty at all times on second and third shifts to provide personal care and supervision.

The findings are:

Interview with the Resident Care Coordinator (RCC) on 11/29/22 at 8:45am revealed there were 16 residents who resided at the facility.

Review of the facility's November 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.

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-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 on the November 2022 staffing schedule.

Interview with a resident on 11/29/22 at 9:35am revealed:
-There was medication aide (MA) who worked at night from 10:30pm until day shift arrived.
-"A month ago," she had gotten up during the night and had been unable to find any staff in the facility.
-The assigned night shift staff (10:30pm until 3:00am) in the facility had to go over to a sister facility to assist residents during the night shift.

Interview with a MA on 11/29/22 at 3:20pm revealed:
-She worked at the facility full-time as a MA from 2:30pm to 3:00am and "sometimes" she stayed until 6:30am.
-She was the only staff in the facility and a sister facility "most of the time" from 10:30pm to until 2:00am or 3:00am when the day-shift MA or the RCC came to work to start day-shift.
-One of the facilities would be without a staff person from 10:30pm to 2:00am or 3:00am unless another staff volunteered to work over.
-From 2:30pm to 10:30pm, there was one MA in the facility and one MA and PCA in the sister facility.
-There was one PCA who covered the other sister facility from 2:30pm to 10:30pm.
-One of the MA's had to go to the other sister facility to administer medications during the 2:30pm to 10:30pm shift.
-There was one resident in the facility who required two person assistance with repositioning in the bed.

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-A staff member from another building would have to leave their building unattended and come to help assist the resident requiring two person assistance.

Interview with a second MA on 11/29/22 at 11:35am revealed:
-She worked full-time primarily as a MA from 3:00am to 3:30am to 2:30pm to 3:00pm.
-For the past couple of months, she had also worked some nights.
-The MA who primarily worked 2:30pm to 3:00am was by herself to staff the facility and a sister facility from 2:30pm to 3:00am until day shift arrived at 3:00am.
-Then she and the night shift MA would cover two facility's "unless" there was a resident who required two person assistance.
-When a resident required two person assistance, one of the staff would leave one facility unattended and go to the other facility to assist the staff provide resident care.
-There was only one resident currently who resided in the facilty who required two person assistance.
-There were 4 incontinent residents who resided in the facility.
-A toileting and incontinent round took two staff approximately 30-45 minutes to complete, which meant residents in one facility were left unattended during the round.

Interview with a third MA on 11/29/22 at 12:05pm revealed:
-She worked as a MA and PCA full-time in the facility since the start of November 2022.
-She worked both day and night shifts.
-From 10:30pm to 3:00am, the night time MA was assigned to staff the facility and a sister facility by herself.

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-Residents in the facility or sister facility were being left alone from 10:30pm to 3:00am because staff was also assigned to a sister facility on the same campus.
-The night MA was responsible for administering medications to residents in all three facility on campus from 10:30pm to 2:30am-3:00am when a day-shift MA arrived.
-On the 2:30pm to 10:30pm shift she and another MA did rounds together for about an hour which left the residents in the sister facility without staff for an hour during that shift.
-It took 10 to 15 minutes for her and another MA to do rounds in the sister facility which left the resident in the facility without staff for 10 to 15 minutes.

Interview with the RCC on 11/30/22 at 9:00am revealed:
-He lived about 5 minutes away from the facility.
-Because they had a staff shortage on 2nd and 3rd shifts there were short periods of time when no one was in the facility.
-This did not occur for more than 30 minutes at a time.
-They did not have an Administrator in Charge (AIC).
-The facility normally had one MA and two PCA's at night between the facility and the two sister facilities on the same campus.
-Sometimes there was only one MA and one PCA at night.
-This most recently occurred on 11/28/22 when there was only one MA and one PCA for 3 facilities.

Telephone interview with a PCA on 11/30/22 at 9:21am revealed:
-She worked third shift mostly.
-Most nights there were only 2 staff for all three

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facilities.
-There was always one MA and one PCA for all three facilities.
-Sometimes there were 3 staff at night.
-The residents were left alone for a few minutes each night when staff went to another facility to provide personal care.
-This usually occured between 10:30pm and anywhere between 2:00am and 3:00am most nights.

Interview with the Corporate Resident Care Coordinator on 11/30/22 at 9:38am revealed:
-They normally had at least one staff in the facility at night.
-Department heads were on call around the clock and should be notified if there was a staffing issue.
-There were occasions when there was only one MA and one PCA for all three facilities.
-On shifts when there was only one MA and one PCA, the MA went between facilities to provide supervision, personal care assistance and medication administration.

Interview with the Administrator on 11/30/22 at 12:44pm revealed:
-They did not have an AIC.
-There was always a Department Head on-call, but staff would not call them.
-Staffing was an issue.
-They were no longer admitting residents since they did not have the staff to care for them.

_____

The facility failed to ensure there was an Administrator, Supervisor in Charge, or a staff member in the facility at all times to provide supervision and personal care assistance to residents. This failure was detrimental to the health, safety, and welfare of the residents and

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D 187	Continued From page 6 constitutes a Type B Violation. The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 11/20/22 for this violation. THE CORRECTION DATE FOR THIS B VIOLATION SHALL NOT EXCEED JANUARY 14, 2023.	D 187		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) observed residents take their morning medications for 4 of 5 sampled residents (Resident's #1, #2, #3 and #4). 1. Review of the facility's Medication Administration Policies and Procedures dated October 2014 revealed: -Medications should be administered at the time they are prepared. -Observe the resident taking the medication.	D 366		

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Observations of Resident #1's room during the initial tour on 11/29/22 at 8:58am revealed:
-There was a paper medication cup on Resident #1's nightstand.
-There were 10 pills observed inside the paper medication cup.

Interview with Resident #1 on 11/29/22 at 8:58am revealed:
-The medications in the paper medication cup were her morning medications.
-The medication aide (MA) had left the medications in the room for her to take.
-The MA frequently left her morning medication in her room and did not observe her take the medications.

Review of Resident #1's current FL2 dated 06/14/22 revealed diagnoses included dementia, major depressive disorder, anxiety and hyperlipidemia.

Review of physician's orders for Resident #1 dated 06/14/22 revealed:
-Acidophilus (used to treat or prevent infections) capsule daily.
-Buspirone HCL (used to treat anxiety) 15mg tablet twice daily.
-Clonazepam (used to prevent and control seizures) 0.5mg ODT tablet twice daily.
-Escitalopram (used to treat depression and anxiety) 5mg tablet - 3 tablets daily.
-Lisinopril (used to treat high blood pressure) 5mg tablet daily.
-Meloxicam (used to treat arthritis) 7.5mg tablet daily.
-Omeprazole (used to treat gastric reflux) 20mg capsule daily.
-Vitamin D3 (used to treat vitamin deficiency)

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D 366	Continued From page 8 5,000-unit tablet daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for 11/29/22 revealed: -There was an entry for acidophilus capsule daily at 8:00am and documented as administered at 8:00am. -There was an entry for buspirone HCL 15mg tablet twice daily at 8:00am and 8:00pm and documented as administered at 8:00am. -There was an entry for clonazepam 0.5mg ODT tablet twice daily at 8:00am and 8:00pm and documented as administered at 8:00am. -There was an entry for escitalopram 5mg tablet - 3 tablets daily at 8:00am and documented as administered at 8:00am. -There was an entry for lisinopril 5mg tablet daily at 8:00am and documentated as administered at 8:00am. -There was an entry for meloxicam 7.5mg tablet daily at 8:00am and documented as administered at 8:00am. -There was an entry for omeprazole 20mg capsule daily at 8:00am and documented as administered at 8:00am. -There was an entry for vitamin D-3 5,000-unit tablet daily at 8:00am and documented as administered at 8:00am. Interview with the Resident Care Coordinator (RCC) on 11/29/22 at 9:16am revealed: -He prepared Resident #1's 8:00am medications for administration. -When he took Resident #1's morning medication to her room she was awake. -Normally Resident #1 took her medications right away. -He usually did not stay and watch Resident #1 take her medications.	D 366		

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D 366	Continued From page 9 Refer to interview with the Corporate Resident Care Coordinator (RCC) on 11/29/22 at 12:28pm. Refer to interview with the Administrator on 11/30/22 at 12:44pm. 2. Observation of Resident #2's room during the initial tour on 11/29/22 at 9:15am revealed: -There was a paper medication cup on Resident #2's nightstand. -Inside the cup were 11 medications. Interview with Resident #2 on 11/29/22 at 9:16am revealed: -The medications in the cup were her morning medications. -The Resident Care Coordinator (RCC) left the medication in the room for her to take. -She had asked the RCC to leave the medications, so she could take them later. Review of Resident #2's current FL2 dated 03/15/22 revealed diagnoses included diabetes type 2 with peripheral neuropathy, hypertension, and obstructive apnea. Review of Resident #2's Nurse Practitioner's (NP) order dated 05/12/22 revealed: -Acidophilus probiotic blend (used to improve digestion and improve normal flora) 1 tablet daily -Amlodipine (used to treat high blood pressure) 5mg daily. -Aspirin (used to prevent blood clots) 81mg daily. -Cetirizine (used to relieve allergy symptoms) 10mg daily. -Clonazepam (used to treat anxiety) 0.5mg every morning. -Escitalopram (used to treat depression) 20mg	D 366		

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daily.
-Hydroxyzine (used to treat anxiety) 25mg twice daily.
-Latuda (used to treat schizophrenia) 40mg daily.
-Levothyroxine (used to treat hypothyroidism) 25mg daily.
-Metformin (used to treat high blood glucose) 1000mg twice daily.
-Propranolol (used to treat high blood pressure) 20mg daily.

Review of Resident #2's electronic medication administration record (eMAR) for 11/29/22 revealed:
-There was an entry for acidophilus probiotic blend daily at 8:00am and documented as administered at 8:00am.
-There was an entry for amlodipine 5mg daily at 8:00am and documented as administered at 8:00am.
-There was an entry for aspirin 81mg daily at 8:00am and documented as administered at 8:00am.
-There was an entry for cetirizine 10mg daily at 8:00am and documented as administered at 8:00am.
-There was an entry for clonazepam 0.5mg every morning at 8:00am and documented administered at 8:00am.
-There was an entry for escitalopram 20mg daily at 8:00am and documented as administered at 8:00am.
-There was an entry for hydroxyzine 25mg twice daily at 8:00am and 8:00pm and documented as administered at 8:00am.
-There was an entry for Latuda 40mg daily at 8:00am and documented as administered at 8:00am.
-There was an entry for levothyroxine 25mcg daily at 8:00am and documented as administered at

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8:00am.
-There was an entry for metformin 1000mg twice daily at 8:00am and 8:00pm and documented as administered at 8:00am.
-There was an entry for propranolol 20mg three times daily at 8:00am, 2:00pm, and 8:00pm and documented as administered at 8:00am.

Interview with the RCC on 11/29/22 at 9:20am revealed:
-He administered Resident #2's 8:00am medications.
-He went into Resident #2's room and administered an injection to the resident.
-He left the medication cup on Resident #2's nightstand, because he had to leave the room to answer a call light.
-He "assumed" Resident #2 would take the medications.

Refer to interview with the Corporate Resident Care Coordinator (RCC) on 11/29/22 at 12:28pm.

Refer to interview with the Administrator on 11/30/22 at 12:44pm.

3. Observation of Resident #3's room during the initial tour on 11/29/22 at 9:25am revealed:
-There was a paper medication cup on Resident #3's nightstand.
-Inside the cup were 7 medications.

Interview with Resident #3 on 11/29/22 at 9:26am revealed:
-The medications in the cup were her morning medications.
-She "probably just didn't wake up" and the medication aide (MA) left the medications in the room for her to take later.
-She had no idea which staff left the medications

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D 366	Continued From page 12 in her room because she was asleep. Observation of Resident #3 on 11/29/22 at 9:27am revealed she took the medications in the cup on her nightstand. Review of Resident #3's current FL2 dated 10/17/22 revealed: -Diagnoses included unspecified dementia, schizoaffective disorder bipolar type, hypertension, and sclerosis. -There was an order for acetaminophen (used to treat pain) 325mg 2 tablets twice daily. -There was an order for metoprolol ER (used to treat high blood pressure) 25mg daily. -There was an order for olanzapine (used to treat schizophrenia) 10mg 1/2 tablet twice daily. -There was an order for vitamin C (an antioxidant which protects your cells from free radicals) 500mg daily. -There was an order for vitamin D3 (used to treat and prevent bone disorders) 1000 units daily. -There was an order for zinc sulfate (used to prevent zinc deficiency) 50mg daily. Review of Resident #3's electronic medication administration record (eMAR) for 11/29/22 revealed: -There was an entry for acetaminophen 325mg 2 tablets twice daily at 8:00am and 8:00pm and documented administered at 8:00am. -There was an entry for metoprolol ER 25mg daily at 8:00am and documented administered at 8:00am. -There was an entry for olanzapine 1/2 tablet twice daily at 8:00am and 2:00pm and documented administered at 8:00am. -There was an entry for vitamin C 500mg daily at 8:00am and documented administered at 8:00am.	D 366		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY 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 366	Continued From page 13 -There was an entry for vitamin D3 1000u daily at 8:00am and documented administered at 8:00am. -There was an entry for zinc 50mg daily at 8:00am and documented administered at 8:00am. Interview with the RCC on 11/29/22 at 9:20am revealed he had administered Resident #3's 8:00am medications. Refer to interview with the Corporate Resident Care Coordinator (RCC) on 11/29/22 at 12:28pm. Refer to interview with the Administrator on 11/30/22 at 12:44pm. 4. Review of Resident #4's current FL2 dated 12/02/21 revealed diagnoses included chronic obstructive pulmonary disease, history of partial colectomy, leukocytosis, and thrombophlebitis. Review of Resident #4's Nurse Practitioner's (NP) orders dated 05/12/22 revealed: -Oxycodone/acetaminophen (used to treat pain) 5/325mg twice daily. -Topiramate (used to treat seizures) 50mg twice daily. -Diazepam (used to relieve anxiety) 2mg twice daily as needed for anxiety/agitation/sleep. -Pain reliever plus tablet (used to treat pain) 2 tablets daily as needed. Review of Resident #4's NP order dated 11/14/22 revealed oxycodone/acetaminophen 5/325mg twice daily. Review of Resident #4's electronic Medication Administration Record (eMAR) for 11/28/22 revealed:	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044040	A. BUILDING: _____ B. WING _____	R 11/30/2022

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D 366	Continued From page 14 -There was an entry for oxycodone/acetaminophen 5/325mg twice daily at 8:00am and 8:00pm and documented as administered at 8:00pm. -There was an entry for topiramate 50mg twice daily at 8:00am and 8:00pm and documented as administered at 8:00pm. -There was an entry for headache relief caplet take 2 tablets every day as needed and documented as administered at 8:29pm. Telephone interview with a personal care aide (PCA) on 11/29/22 at 12:05pm revealed: -She observed the medication aide (MA) leave Resident #4's evening medications in his room on 11/28/22. -The PCA had gone back "later" and reminded Resident #4 to take his medication and he refused to take it. -She did not know if Resident #4 ever took his evening medications on 11/28/22. Interview with the MA on 11/29/22 at 3:20pm revealed: -She administered Resident #4's 8:00pm medications on 11/28/22. -She went in to give Resident #4 the 8:00pm medications and the resident started "cussing" and he asked her to leave the medications. -She put the cup of medications on the resident's nightstand. -Resident #4 often refused to take medications while she was in the room. -She would leave the medications and wait for a period of time at the resident's door to see if he was going to take the medication. -If she did not observe Resident #4 take the medication, she would return later to "make sure" the medication cup was in the resident's trash. -She did not take the medications with her when	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044040	A. BUILDING: _____ B. WING _____	R 11/30/2022

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D 366	Continued From page 15	D 366		

he refused to take them.
-She returned to the room a little after 8:00pm and she did observe Resident #4 take the medications.

Refer to interview with the Corporate Resident Care Coordinator (RCC) on 11/29/22 at 12:28pm.

Refer to interview with the Administrator on 11/30/22 at 12:44pm.

_____

Interview with the Corporate Resident Care Coordinator (RCC) on 11/29/22 at 12:28pm revealed:
-Staff were never supposed to leave medications on a residents bedside table.
-This has been reviewed "over and over again" with the MAs that medications cannot be left at the bedside and the MA must observe the resident take the medication.

Interview with the Administrator on 11/30/22 at 12:44pm revealed:
-MAs should not be leaving medications at the bedside.
-He was not aware MAs were leaving medications at the bedside.

_____

The facility failed to ensure medications were administered as ordered by not observing four residents take their morning medications which resulted in multiple medications including controlled substances being left in medication cups in their rooms which were easily accessible to other residents. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.

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The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on

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D 366	Continued From page 16 11/29/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 16, 2023.	D 366		