| 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 |
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| SPICEWOOD COTTAGES WILLOWS | 65 LOVING WAY CLYDE, NC 28721 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Haywood County Department of Social Services conducted a follow-up survey on 11/16/22 and 11/17/22. | D 000 | | |
| D 187 | 10A NCAC 13F .0604 (d) Personal Care And Other Staffing<br><br>10A NCAC 13F .0604 Personal Care And Other Staffing<br><br>(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.<br>(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.<br>(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.<br>(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.<br>(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 | D 187 | | |


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

TITLE ADMINISTRATOR (X6) DATE 12/27/22



Reviewed and acknowledged 1/10/2023 RM

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| D 187 | Continued From page 1<br>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 where the residents are. The staff member on duty to attend to the residents shall not be assigned food service duties.<br>(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. | D 187 | | |
| | This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE B VIOLATION<br><br>Based on these findings, the previous Type B Violation was not abated.<br><br>Based on the observations, interviews, and record reviews, the facility failed to ensure at least one staff member was on duty at all times in the facility on evening shift to provide supervision to the residents.<br><br>The findings are:<br><br>Review of the facility's current census dated 11/17/22 revealed the current census was 18 residents.<br><br>Interview with a resident on 11/16/22 at 9:00am revealed:<br>-There was not enough staff to take care of everyone.<br>-If another resident needed help she would leave the building and go locate staff that were working | D187 | New fire alarm and call System has been installed throughout all buildings If a call light is activated in any building audio and visual notification is sent to each building identifying the building where the call originated. | 12/12/22 |

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| D 187 | Continued From page 2 | D 187 | | |
| | in other facilities and notify them there was an unsupervised resident that needed assistance.<br><br>Interview with a second resident on 11/17/22 at 9:11am revealed due to the staffing shortage, staff were not always available to be in the building throughout the night.<br><br>Interview with a third resident on 11/16/22 at 9:25am revealed:<br>-In the evening and throughout the night, staff periodically had to go to the other two sister facilities located on the same campus to help other staff or residents, leaving the building without staff. | D187 | Checklists have been completed on other staff members from other departments who have been cross-trained. | 11/28/22 |
| | -If help was needed the residents had to push the call bell and a staff would answer the call bell when they returned to the building and saw the bell had been activated.<br><br>Interview with a fourth resident on 11/16/22 at 9:32am revealed:<br>-She had heard other residents calling out for help in the night and there was no staff in the building to assist them.<br>-She had needed help in the night and she was unable to find staff to assist her. | D187 | Night Shift Supervisor has been hired that is a certified CNA and certified Med Tech. in addition to our other staff. | 1/1/23 |
| | Interview with a fifth resident on 11/16/22 at 9:35am revealed:<br>-Throughout the night there was typically one staff who worked between the three buildings on campus.<br>-If help was needed he could leave the building and go look in the other buildings for the staff.<br>-Sometimes it would take 5 or 10 minutes to locate staff.<br>-He had to leave the building twice in the past 6 months to search for staff. | D187 | We are offering sleeper pay for extra coverage for emergencies.<br><br>We are actively seeking and marketing for new employees on a daily basis. | 12/22/22<br><br>12/22/22 |

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Interview with a sixth resident on 11/16/22 at 10:15am revealed:
-There was no staff in the facility at night to care for the residents.
-She frequently heard other residents call out for help in the night and there was no one there to help them.
-On 11/15/2022 around 6:00pm her roommate fell in the bathroom and there was no staff in the building to help her roommate.
-Eventually a staff person came to help her roommate get up.

Interview with a seventh resident on 11/16/22 at 10:15am revealed:
-She fell yesterday in the bathroom, 11/15/2022 around 6:00pm, and there was no one to help her.
-She was able to use the call button and no one came.
-Her roommate called for help also and no one came.
-She laid in a puddle of urine on the bathroom floor for about one hour before a Medication Aide (MA) came to get her up.

Review of the facility's October and November 2022 staff schedule revealed:
-The staffing schedule included staffing information for the three separate facilities located on the campus.
-The schedule did not specify who was assigned to or who worked each shift in each of the three separate facilities.
-There was no way to distinguish which staff had provided coverage to the facility in October 2022.
-There was documentation 2 staff were scheduled to cover three facilities during the night shift on 10/04/22, 10/05/22, 10/10/22, 10/11/22, 10/12/22, 10/17/22, 10/18/22, 10/19/22,

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| D 187 | Continued From page 4 | D 187 | | |

10/24/22, 10/25/22, 10/26/22 and 10/31/22.
-There was documentation 2 staff were scheduled to cover three facilities during the night shift from 11/01/22 to 11/30/22.

Review of the staff time cards dated 11/15/22 revealed:
-On 11/15/22 from the hours of 4:47pm to 10:44pm there were only two people working in the 3 facilities on campus.
-There was one MA and one personal care aide (PCA) working.

Interview with MA on 11/16/2022 at 11:30am revealed:
-On 11/15/2022 around 5:15pm, a resident came to the other facility where she was working from to inform her a resident had fallen and needed help in another facility.
-At the time of the fall, she was working alone in the other facility, a second staff person was working in another facility, and the current facility was without staff and unsupervised when the seventh resident fell in the bathroom.
-She was the only person working in both facilities and she was by herself from 4:30pm until 10:00pm.
-When she would have to help a resident in one facility she was forced to leave the other facility without staff and residents unsupervised.

Interview with a PCA on 11/16/22 at 12:17pm revealed sometimes there was staff to cover each building but usually throughout the night there was one or two staff to cover the three buildings.

Interview with the Resident Care Coordinator (RCC) on 11/16/22 at 2:25pm revealed:
-On some evenings, from 10:30pm until 3:00am there was not always someone in the facility

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| D 187 | Continued From page 5<br><br>because of the staff shortage.<br>-The goal was to have one staff in each building but generally, there were 2 staff to cover three buildings.<br>-He lived close to the facility and was usually on call if help was needed.<br><br>Interview with the Regional RCC on 11/16/22 at 4:12pm revealed:<br>-She was responsible for making the schedule.<br>-She tried to schedule one MA and one PCA in the building, but they were short staffed and did not always have the staff available.<br>-On 10/24/22 one building was left without staff because the only PCA available for the campus was in a sister facility.<br><br>Interview with the Administrator on 11/17/22 at 12:25pm revealed:<br>-The facility has hired many new staff, but they do not always come to work.<br>-He did not intentionally plan for the building to be understaffed but he had no control over people calling in sick or failing to report to work.<br>-He had kitchen and activity staff in the building that provided care but were not officially trained because his focus was providing care to residents not making sure every "t" was crossed and every "i" was dotted in the paperwork.<br><br>______<br><br>The facility's failure to ensure residents were not left unattended when staff left the building to assist staff or other residents in sister facilities with resident care or in an emergency, left the residents' in the facility unsupervised and without personal care assistance for undetermined periods of time. This was detrimental the health, safety, and welfare of the residents and constitutes a Type Unabated B Violation.<br><br>______ | D 187 | | |

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| D 187 | Continued From page 6<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/17/22 for this violation. | D 187 | | |
| D 271 | 10A NCAC 13F .0901(c) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. | D 271 | | |
| | This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews and record reviews the facility failed to respond immediately to an incident for 2 of 3 sampled residents (#2 and #3) related to a resident falling off the toilet (#2) and a resident rolling out of bed (#3).<br><br>The finding are:<br><br>Review of Resident #2's current FL-2 dated 07/11/12 revealed:<br>-Diagnoses included follicular lymphoma, anemia, and hernia.<br>-She was semi-ambulatory, constantly disoriented, required the assistance of both a walker and wheelchair. | D271 | New fire alarm and call system has been installed throughout all buildings. If a call light is activated in any building - audio and visual notification is sent to each building identifying the building where the call originated. | 12/12/22 |

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| D 271 | Continued From page 7<br><br>Review of Resident #2's Care Plan dated 03/07/2022 revealed she required assistance with toileting, assistance with ambulation, dressing, bathing, transfers and grooming.<br><br>Interview with a resident on 11/16/22 at 10:15am revealed:<br>-There was no staff in the facility at night to care for the residents.<br>-On 11/15/2022 around 6:00pm her roommate fell in the bathroom and there was no staff in the building to help her roommate.<br>-Eventually a staff person came to help her roommate get up.<br><br>Review of Resident #2's Incident and Accident Reports revealed there was no Incident and Accident Report for the fall on 11/15/22.<br><br>Review of the facility's 11/15/22 timecards revealed:<br>-From the hours of 4:47pm to 10:44pm there were only two people working on a 3 building campus.<br>-There was one medication aide (MA) and one personal care assistant (PCA) working.<br><br>Interview with a Resident #2 on 11/16/22 at 10:15am revealed:<br>-She fell yesterday in the bathroom on 11/15/22 around 6:00pm, and there was no one to help her get up.<br>-She was able to use the call button but no one came to help her get up.<br>-Her roommate called for help also and no one came.<br>-She laid in a puddle of urine on the bathroom floor for about one hour before a MA came to get her up. | D 271<br><br>D271<br><br>D271<br><br>D271 | Checklists have been completed on other staff members from other departments who have been cross trained<br><br>Night Shift Supervisor has been hired that is a certified CNA and certified Med Tech. in addition to our other staff.<br><br>We are offering sleeper pay for extra coverage for emergencies.<br><br>We are actively seeking and marketing for new employees on a daily basis. | 11/28/22<br><br>1/1/23<br><br>12/22/22<br><br>12/22/22 |

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| D 271 | Continued From page 8<br><br>Interview with MA on 11/16/22 at 11:30am revealed:<br>-She was working on 11/15/22 and around 5:15pm, and a resident from the facility came to the other facility where she was working and said that Resident #2 had fallen and needed help.<br>-She found Resident #2 on the bathroom floor sitting in a puddle of urine.<br>-At the time of the fall, she was working alone in the other facility, a PCA was working in another facility, and the facility was without staff when Resident #2 fell in the bathroom.<br>-She was the only person working in two of the facilities from 4:30pm until 10:00pm on 11/15/22.<br>-When she would have to help a resident in one facility she was forced to leave the other facility without staff and the residents unsupervised.<br><br>Interview with Resident Care Coordinator (RCC) on 11/16/22 at 2:00pm revealed:<br>-He was aware of the fall on 11/15/22, and said Resident #2 was uninjured.<br>-The MA called him around 6:00pm and reported she found Resident #2 on the bathroom floor and she was working alone in another facility at the time of the accident.<br>-There were only two staff members working on campus at the time of the fall and the residents in the facility could have been unsupervised.<br>-There should have been 3 staff persons working on campus at the time of the fall but there was only two.<br>-He was off campus from 4:00pm-10:00pm.<br><br>Interview with Regional RCC on 11/16/22 at 4:12pm revealed:<br>-None of the residents in the facilities should be left unsupervised.<br>-She made the schedule and that 2 other staff | D 271 | | |

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people should have been working that day, but one called out sick and the other called out also.
-There were 3 facilities on campus and that each building should have one staff person inside to supervise and care for the residents at all times.

Interview with Administrator on 11/17/2022 at 12:25pm revealed:
-He did not want his facilities to be unsupervised, but he would not deny that this did unfortunately happen from time to time.
-He wanted to have enough staff to work in his facilities and cannot find them.

2. Review of Resident #3's current FL2 dated 11/01/22 revealed diagnoses included heart failure.

Review of Resident #3's care plan dated 10/08/22 revealed she required supervision with ambulation and transfers.

Interviews with Resident #3 on 11/16/22 at 9:21am and 11/17/22 at 8:58am revealed:
-She rolled out of her bed onto the floor about a month ago at about 3:00am or 4:00am.
-She was not injured and was able to get to a seated position but unable to stand up or get back into her bed.
-She had leg weakness, walked with a cane and was unable to get from the floor to standing without help.
-She could not reach the call light from the floor.
-Her roommate went to get help but could not locate any staff in the building, so when her roommate returned to the room she pushed the call light near her bed.
-The RCC came into the building about 30 minutes later and came to their room.
-The RCC asked if she was hurt but since he was

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unable to help her get up by himself, he let her sit on the floor until a man that worked in the kitchen came to work about 30 minutes later and was able to help.

Interview with Resident #3's roommate on 11/16/22 at 9:21am and 11/17/22 at 8:58am revealed:
-It took about 30 minutes for staff to come help Resident #3 after she rolled out of bed.
-She did not know about what time the incident occurred.
-She left the room to get help but could not find anyone, so she returned to the room and pushed the call light by her bed.

Review of Resident #3's incident report dated 10/24/22 revealed:
-The report was completed by the RCC.
-The incident occurred at 5:00am.
-Resident #3 was found on the floor by her bed in her room.
-Resident #3 was assessed by a MA and the RCC and no apparent injuries were noted.

Interview with the RCC on 11/16/22 at 11:59am revealed:
-He and a MA were in the medication room when they heard someone scream for help.
-He and the MA found Resident #3 on the floor by her bed, assessed her and found no injuries so they helped her back to bed.
-It could not have taken more than 5 minutes for him to locate who had screamed out for help and get Resident #3 back into her bed.

Interview with the Dietary Manager on 11/16/22 at 3:43pm revealed:
-When he came to work at about 5:00am on 10/24/22 the RCC called him on his cell phone

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just as he got into the kitchen at the building next door.
-The RCC requested his assistance in getting Resident #3 up off the floor.
-He was not sure who else was working at the time as he had just reported to work when he got the call.

Review of staff timecards dated 10/24/22 revealed:
-The Dietary Manager clocked in at 4:54am.
-The MA clocked out at 4:00am and another MA clocked in atl 6:05am.

Second interview with the RCC on 11/16/22 at 3:49pm revealed:
-He asked the Dietary Manager to help because it took 3 people to safely assist Resident #3.
-The MA clocked out at 4:00am but returned to work a little while later to help sort medications.

Interview with the Regional RCC on 11/16/22 at 4:12pm revealed she had no record the MA referred to by the RCC was in the building after 4:00am.

Interview with the Administrator on 11/17/22 at 12:25pm revealed:
-Staff should be available to provide assistance as needed and respond to incidents promptly, but the facility was short staffed.
-When a resident pushed a call light it only alerted staff that were in that building and if no staff were in the building at the time they would not notice it until they returned.
-A new call bell system that would alert staff in all of the surrounding buildings was arranged to be installed but it was on backorder.

Attempted interview with the MA on 11/16/22 at

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 ______ | R 11/17/2022 |

| 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 271 | Continued From page 12<br>11:59am was unsuccessful.<br>______<br>The facility failed to respond immediately when Resident #2 fell off the toilet and sat in urine for an unknown amount of time until another resident went to the building next door to get help and failed to respond immediately when Resident #3 rolled out of bed and had to sit on the floor for an hour until staff were available to help her up. This failure was detrimental to the safety of the residents and constitutes a Type B Violation.<br>______<br>The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 11/17/22 for this violation.<br><br>THE CORRECTION DATE FOR THIS B VIOLATION SHALL NOT EXCEED JANUARY 2, 2023. | D 271 | | |
| D 618 | 10A NCAC 13F .1802 (a) Reporting & Notification of a Suspected or C<br><br>10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK<br>(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.<br><br>This Rule is not met as evidenced by: | D 618<br><br>D618 | From this point forward any active cases of a communicable disease will be reported to local health department | 11/18/22 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| SPICEWOOD COTTAGES WILLOWS | 65 LOVING WAY CLYDE, NC 28721 |

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|---|---|---|---|---|
| D 618 | Continued From page 13<br><br>Based on interviews and record review the facility failed to report an outbreak of COVID 19 to the Local Health Department (LHD) related to an outbreak that started on 11/14/22.<br><br>The findings are:<br><br>Interview with the assistant Resident Care Coordinator (RCC) on 11/16/22 at 9:00am upon initial entry into the building revealed there was one resident and one staff who tested positive for COVID-19 on 11/14/22.<br><br>Review of the facility's COVID-19 testing schedule revealed:<br>-All residents tested negative for COVID-19 on 11/14/22 after a staff tested positive.<br>-One resident was symptomatic and was therefore retested on 11/15/22 and was positive.<br>-All residents were retested on 11/16/22 and three more were returned as positive for COVID-19.<br><br>Interview with the Regional RCC on 11/16/22 at 2:15pm revealed:<br>-There was an outbreak several months ago at a sister facility and when they called the LHD to report it they were informed that they did not need to report an outbreak to the LHD if the state had been informed.<br>-The laboratory that completed the COVID-19 testing at the facility was required to report the results to the state so she thought she did not need to do any further reporting.<br><br>Interview with RN at the local health department on 11/16/2022 at 8:10am revealed:<br>-There was no record of Spicewood Cottages reporting any COVID positive clusters to Haywood County Health Department.<br>-All facilities are required to report COVID cases | D 618 | | |

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| SPICEWOOD COTTAGES WILLOWS | 65 LOVING WAY CLYDE, NC 28721 |

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|---|---|---|---|---|
| D 618 | Continued From page 14<br><br>to the state, unless there is a cluster (2 or more) than it must be reported to the Health Department also.<br><br>Interview with the Administrator on 11/17/22 at 12:25pm revealed:<br>-The laboratory that processed all COVID-19 tests was responsible for reporting results to the state.<br>-He was informed about 6 months ago by a representative from the LHD that they did not need to report results to the LHD anymore. | D 618 | | |