Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Spicewood Cottages, Willows
Address: 65 Loving Way, Clyde, NC 28721
County: Haywood
License Number: HAL-044-041

II. Date(s) of Visit(s): 8/5/24-8/9/24
Purpose of Visit(s): Complaint
Exit/Report Date: 10/9/2024

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0909 Resident Rights Rule/Statutory Reference: 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.	☐ POC Accepted _____ *DSS Initials*	
Level of Non-Compliance: The Rule is not met as evidenced by: Based on the observations, interviews, and record reviews, the facility failed to protect 3 of 5 sampled residents (#1, #4, and #5) from harm related to Resident #2 who was known to hit other residents. a. Review of Resident #2's FL-2 dated 8/25/23 revealed: -Diagnoses included "intellectual functioning", and mood disorder. -The resident was ambulatory. -Inappropriate behaviors of "childlike behavior". Review of Resident #2's psychiatric evaluation dated 3/7/24 revealed: -Resident #2 was being seen by mental health for medication management.		

-Staff reported Resident #2 had become obsessed with her roommate, not wanting her to leave the room or talk with other people.

Review of Resident #2's progress note dated 8/4/24 revealed:
-Resident #2 had an altercation with her roommate and "supposedly" hit roommate.
-Resident #2 was moved to a different room and notified the resident care coordinator (RCC) and power of attorney (POA).

Review of Resident #2's progress note dated 8/4/24 revealed:
-Resident #2 was seen by the nurse practitioner (NP).
-NP completed medications changes and sent orders to the pharmacy.

Review of Resident #2's progress note dated 8/6/24 revealed:
-The medication aide (MA) contacted Resident #2's mental health provider.
-Urine analysis was ordered. MA collected a urine sample and sent to the lab.

Refer to interview with a resident on 8/5/24 at 3:00pm.

Refer to interview with a second resident on 8/6/24 at 1:51pm.

Refer to interview with a third resident on 8/6/24 at 2:30pm.

Refer to interview with a MA on 8/7/24 at 11:53am.

2. Review of Resident #4's FL-2 dated 10/23/23 revealed:
-Diagnoses included mental retardation, neuropathy, and hypertension.
-The resident was semi-ambulatory and required the assistance of a walker.

Review of Resident #4's progress note dated 12/3/23 revealed:
-Resident #4 was in the living room when her roommate came up and hit her in the back.
Resident #4 had not provoked her roommate.
-The RCC was notified by the MA about the incident.
-Resident #4 was outside and Resident #2 hit her in the back again.
-The RCC was notified by the MA about the second hit.
-There was no documentation any action was taken by the facility.

Review of Resident #4's progress note dated 1/8/24 revealed:

-Resident #4 was very upset and stated her roommate was bullying her and calling her bad names.
-The RCC was notified.

Review of Resident #4's progress note dated 2/29/24 revealed Resident #4 was moved out of her room into a sister facility on the same campus.

Interview with Resident #4's Guardian on 8/8/24 at 8:30am revealed:
-She was aware that Resident #4's previous roommate, Resident #2, had behaviors.
-Staff told her Resident #2 followed Resident #4 everywhere, bullied her, and would intentionally move her walker away from her.
-Resident #4 told her if she tried to open the door Resident #2 would become angry and slam it shut.
-Around 12/3/23, Resident #2 shoved and slapped Resident #4 in the back of the head during the night. The MA told her the RCC was notified.
-She had observed Resident #2 slamming doors and cursing at Resident #4.
-She had requested Resident #4 be moved to a new room and staff told her this was not fair to Resident #4 as she was not the aggressor.
-Staff stated they were unable to move Resident #2 into a new room because it had not been approved by the facility.

Interview with Resident #4 on 8/8/24 at 9:16am revealed:
-She moved to a sister facility because her roommate (Resident #2) was hitting her.
-Resident #2 would try to lock her in the bathroom and not allow her to come out.
-Resident #2 would follow her around and not permit her to go anywhere.
-Resident #2 would hit her and it caused bruising on her arms and back.
-Staff told Resident #2 to stop hitting her, but Resident #2 did not stop hitting her.
-She went to the RCC crying and told her she needed a new room.

Interview with a MA on 8/8/24 at 9:26am revealed:
-She was aware of Resident #2's behavior.
-Resident #2 would say things to the other residents like, "I wish you would die!" and has a history of hitting other residents.
-Resident #2 and Resident #4 were roommates for about 5 months.

-She had observed Resident #2 being very possessive of Resident #4.
-Resident #4 told her Resident #2 hit her in the arm.
-On 1/8/24, she told the RCC that Resident #2 was hitting, cursing, and controlling Resident #4 and the RCC instructed her to "monitor" them.
-On 1/18/24, the nurse practitioner (NP) ordered medication changes, labs, and psychiatric consult for Resident #2's behavior towards Resident #4.
-The RCC did not move Resident #2 into a new room because Resident #2 could not help her behavior and should not have to change rooms.
-Resident #4's Guardian requested a room change around 2/24.
-Resident #2 did not have a roommate until 7/26/24 when Resident #1 was admitted to the facility and was moved into the room.

3. Review of Resident #1's FL-2 dated 7/22/24 revealed:
- Diagnoses included hypertension, atrial fibrillation, and chronic back and hip pain.
-The resident was semi-ambulatory and required the assistance of a walker.
-Admission date was 7/26/24.

Review of a police report dated for 8/4/24 at 11:54am revealed:
-The incident was documented as simple assault, and the victim was Resident #1.
-Resident #1 told police she had been assaulted by her roommate (Resident #2).
-Resident #1 stated she went to the bathroom during the night, Resident #2 yelled and then assaulted her by grabbing her arms and punching her. She thought this happened a few days ago.
-Resident #1 stated she had been hit by Resident #2 four times since she had been admitted to the facility.
-Resident #1 stated facility staff were aware of one incident because a staff member entered the room immediately after the assault and informed Resident #2 if she continued the assaultive behavior she would be moved to another facility.
-Officers observed several bruises on Resident #1's arms consistent with assault. Resident #1 had two bruises consistent with being punched to the back of the upper left arm as well as a bruise on both forearms consistent with being grabbed. The bruises to the forearm appeared to show differentiation between fingers of a hand within the bruising.
-The officer contacted the RCC via telephone call, and the RCC told the officer she was previously aware of the incident

involving Resident #1 and Resident #2.
-The RCC told the officer this was a "mutual affray" between the two residents and the facility was in the process of separating Resident #1 and Resident #2.

Observations on 8/5/24 at 1:54pm revealed:
-Resident #1 was sitting on her bed.
-There was no indication the second half of the room was occupied by another resident.
-There was a large oval shaped bruise on the back of her left arm. The bruise was blueish green color.
-There were 4 oval shaped bruises on the adult's forearm. The bruises resembled the shape of fingers on a hand and were bluish purple color.

Interview with Resident #1 on 8/5/24 at 1:45pm revealed:
-Her roommate was beating her (Resident #2).
-A couple of days ago Resident #2 hit her, staff heard it and came in the room. The staff told Resident #2 to stop and get back in her bed.
-She did not feel safe and wanted to hit Resident #2 back.

Interview with a family friend on 8/5/24 at 11:02am revealed:
-He went to see Resident #1 at the facility 8/4/24 around 11:00am and discovered she had bruising.
-Resident #1 was covered in bruises on her arms, elbows, and hands.
-Resident #1 was very scared.
-If staff knew Resident #1 was being hurt by Resident #2 something should have been done.
-He was very upset about the lack of care for Resident #1's safety.

Interview with a personal care aide (PCA) on 8/8/24 at 9:50am revealed:
-She was working the day Resident #1 was admitted.
-She bathed Resident #1 the day of her admission and observed no bruising or marks on her body.
-She was working on the evening of 8/2/24.
-She heard Resident #1 yell "Stop hitting me!" from the bedroom.
-She went to the bedroom and the door was cracked; through the cracked door she could see Resident #2 hitting Resident #1 two times before she could intervein. She told the MA about the incident. Nothing was done.
-On 8/3/24 she found bruising and marks on Resident #1.
-She asked the RCC on 8/3/24 if she could move Resident #2 to a different room, and the RCC told her no, to just keep an eye on Resident #2 and Resident #1.

Interview with the RCC on 8/8/24 at 2:31pm revealed:
-On 8/3/24 a PCA told her Resident #1 and Resident #2 were arguing.
-She told the PCA to monitor both residents.
-On 8/4/24 she received a call from the police that Resident #1 had bruises all over her arms.
-She instructed staff to move Resident #2 to a new room.
-She did not believe Resident #1's injuries were caused by Resident #2 hitting her.
-On the morning of 8/5/24, she and the NP went to check on Resident #1. The NP deduced Resident #1's bruising was caused by a previous blood draw completed on 7/31/24.
-She agreed the bruising was caused by a previous blood draw completed on 7/31/24 and Resident #1 hitting the wall.
-She didn't have any concerns about Resident #2 being placed in a new room with a new roommate and stated "hopefully there will not be any problems".

Second Interview with Resident #1 on 8/8/24 at 10:30am revealed:
-She stated "My bruises are not from a blood draw. It is from that woman beating me."
-She felt safer because Resident #2 was no longer her roommate.

Review of Resident #5's FL-2 dated 11/1/23 revealed:
-Diagnoses included congestive heart failure, and systolic and diastolic congestive heart.
-The resident was semi-ambulatory.

Interview with Resident #5 on 8/6/24 at 2:10pm revealed:
-Resident #2 was moved into her room on 8/4/24.
-On the night of 8/4/24, Resident #2 cursed at her and called her a (expletive). Later that night, Resident #2 hit her right foot when she did not turn off her lamplight.
-She told a staff person Resident #2 smacked her foot, and the staff told Resident #2 if she hit her again the staff would call the police.
-She was miserable and did not want Resident #2 as a roommate.
-On the night of 8/4/24 she was afraid to fall asleep because she feared Resident #2.

Interview with the RCC on 8/7/24 at 9:40am revealed:
-She did not think Resident #2 hit Resident #5 on the foot because a MA told her Resident #2 bumped into Resident #5's foot.
-She stated Resident #2 and Resident #5 were arguing and

cursing at each other all night.

Interview with the Administrator on 8/8/24 at 3:23pm revealed:
-Resident #2 was very childlike.
-He had spoken with Resident #2 on two separate occasions about her behaviors.
-Resident #2 was seen by the NP and mental health.
-It had been said that Resident #2 hits others, but no one has seen it.
- "If a resident was hit by another resident, staff should separate the residents, and immediately report the incident to him or the RCC.
-He did not want residents injuring one another, and if there were continued reports of a resident hitting another resident, the resident who was the aggressor would be discharged.

Based on the observations and record review, it was determined Resident #2 was not interviewable.

Interview with a resident on 8/5/24 at 3:00pm revealed:
-Resident #2 was "very grumpy" and called residents "bad names".
-Resident #2 had slapped him in the face on a previous occasion.
-He told staff about being slapped in the face by Resident #2 and staff would tell Resident #2 to not hit others.

Interview with a second resident on 8/6/24 at 1:51pm revealed:
-Resident #2 was "mean" to anyone who walked by her.
-He heard Resident #2 cursing at other residents.
-She would say "I hope you die" to other residents.
-He had witnessed Resident #2 pick up another resident's walker and throw it against the wall.
-Resident #2's behavior was upsetting to him.

Interview with a third resident on 8/6/24 at 2:30pm revealed:
-He witnessed Resident #2 cursed at other residents.
-Resident #2 used a racial slur when addressing him on several occasions.
-Staff intervened and told Resident #2 to stop using the racial slur.
-He has heard Resident #2 say to him and other residents "(Expletive) you I hope you die."

Interview with a MA on 8/7/24 at 11:53am revealed:
-Resident #2 experienced mood swings and was unpredictable.

-She made the RCC aware that Resident #2 "stalks" other residents, slams doors, and bully's other residents.
-She informed the RCC Resident #2 was hitting her roommate and the RCC instructed her to complete a urine analysis.
-She was unaware of any other actions taken by management related to Resident #2's behavior.

The facility failed to ensure residents were free from neglect related to not protecting residents from physical and mental abuse when Resident #2 verbally assaulted and hit residents (#1, #4, & #5) resulting in Resident #1 being hit and grabbed on the arm causing bruising and fear of being assaulted again, Resident #5 being called expletives and hit after Resident #2 was moved into Resident #5 without additional measures were put in place to protect the residents from any additional abuse. This failure resulted in serious neglect and constituted a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 8/9/24 for this violation.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED 11/8/2024.

IV. Delivered Via:	Certified mail & email	Date: 10/9/24
DSS Signature:	Ali Harrell, SW III/APS	Return to DSS By: 10/30/24

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*		