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	HAL044040	A. BUILDING: _____ B. WING _____	07/22/2022

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 conducted an annual survey and a a complaint investigation on 07/21/22 through 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 interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff C) who provided personal care to residents had documentation of successful completion of an 80	D 150		

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D 150	Continued From page 1	D 150		

hour personal care training and competency evaluation program.

The findings are:

Review of Staff C's, personal care aide (PCA), personnel record revealed:
-Staff C was hired as a PCA on 04/26/21.
-There was no documentation Staff C had completed an 80 hour personal care training and competency training.

Interview with the Business Office Manager (BOM) on 07/21/22 at 2:25pm revealed:
-She was responsible for auditing the personnel records for required documentation.
-She knew Staff C had not completed the 80 hour PCA training.
-She had spoken to Staff C about the issue.
-The scheduled 80 hour PCA training classes had been canceled and rescheduled a few times.

Interview with Staff C on 07/22/21 at 8:50am revealed:
-She had been working in the facility as a PCA approximately one year.
-She assisted residents with showers, incontinence care, and transfers from their wheelchairs to the bed.
-She had not received the 80 hour PCA training.
-A medication aide in the facility had trained her regarding resident care.
-Staff at the facility was to have enrolled her in the 80 hour PCA training class scheduled for 07/21/22 but had forgotten.

Interview with the Administrator on 07/21/22 at 2:20pm revealed:
-He knew Staff C had not received the 80 hour PCA training.

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D 150	Continued From page 2 -A Registered Nurse (RN) with the facility's contracted pharmacy that conducted the 80 hour PCA training had canceled the class two or three times. -The facility's contracted pharmacy had changed ownership recently and that led to problems with the classes.	D 150		
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	D 187		

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D 187	Continued From page 3	D 187		

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 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 interviews and record reviews, the facility failed to ensure when the Administrator or Administrator-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:

Review of the facility census dated 07/21/22 revealed there were 18 residents who resided at the facility.

Review of the facility's July 2022 staffing schedule revealed:
-The staffing schedule was written to cover three separate facilities located on the campus.
-There was documentation 2 personal care aides

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(PCAs) were scheduled to work 2nd shift on 07/07/22 but the time for 2nd shift was not specified.
-There was documentation 1 Medication Aide (MA) and one PCA were scheduled to work 3rd shift on 07/04/22, 07/05/22, 07/06/22, 07/09/22, 07/10/22, 07/13/22, 07/16/22 and 07/17/22 but the time for 3rd shift was not specified.
-There was documentation 1 PCA was scheduled to work 3rd shift on 07/07/22 and 07/21/22.
-A hand-written note at the bottom of the schedule documented staff could volunteer for extra shifts for extra cash on 07/05/22, 07/06/22, 07/09/22, 07/10/22, 07/13/22, 07/14/22, 07/16/22, 07/17/22 and 07/21/22.
-The schedule did not specify who was assigned to or who had 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 July 22022.

Interview with a medication aide (MA) on 07/21/22 at 3:20pm revealed:
-She worked in the facility from 2:30pm to 6:30am fulltime.
-There were times during her shifts she was the only staff in the facility.
-There were times during her shifts when she would need to leave the facility and go to a sister facility to assist the staff with transferring residents or assisting with incontinence care.
-When she left the facility to go to a sister facility the residents were left alone without staff.

Interview with a personal care aide (PCA) on 07/21/22 at 8:50am revealed:
-She sometimes worked in the facility evenings and nights.
-Sometimes she was the only staff in the facility.
-About every two weeks she would leave the

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facility for approximately 20 minutes to go to a sister facility and assist staff, leaving the residents alone.
-She felt the residents were safe because the residents were in bed or in their wheelchairs when she would leave them alone.
-Management was aware because the facility was short of staff.

Interview with a second MA on 07/22/22 at 9:15am revealed:
-She worked dayshift at the facility and some evenings as late as 10:30pm.
-Sometimes there was only one PCA or MA in the facility.
-About once weekly residents were left alone in the facility when she would leave to assist staff in a sister facility if a resident fell.
-The amount of time she left the residents alone varied and could be about 20 minutes.
-She had not reported the residents being left alone to management because she thought they already knew.

Interview with the Resident Care Coordinator (RCC) on 07/22/22 at 8:53am revealed:
-The facility did not assign the PCAs or MAs to work in a specific facility on the schedule.
-The totals at the bottom of the July 2022 schedule indicated how many total people were scheduled daily to work each shift across all the facilities on the campus.
-On days that there were not enough PCAs or MAs scheduled to work 2nd and 3rd shift, he felt sure that someone had come in to work.
-It was not clear from looking at the schedule who worked in the facility on any given day because when staff reported to work the MA on duty told the PCA which building they were assigned to.

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D 187	Continued From page 6 Interview with the Resident Care Coordinator (RCC) on 07/22/22 at 9:25am revealed: -He knew there were times on 2nd and 3rd shift when residents were left alone if a staff needed to assist in a sister facility. -It concerned him "a little bit" that the residents were left alone. -There was one resident who had a diagnosis of dementia. -The residents were left alone for 10 or 15 minutes at a time. -There were times when the facility was short of staff. -Management had tried to get more staff, but it was difficult. Interview with the Administrator on 07/22/22 at 9:36am revealed: -The facility needed to have at least one staff in the building at all times. -There was time the facility was short on staff but it was not planned that way; it just happened because an employee called out or walked off the job. -He attempted to schedule agency staff but they did not come to work either. -The facility's census did not fluctuate by more than one resident in the past 2 weeks. _____ The facility failed to ensure there was at least one staff in the facility at all times during second and third shift to care for residents. This failure resulted in 18 residents, including one with dementia, being left alone in the facility while the staff went to assist staff at a sister facility. This failure was detrimental to the safety of the 18 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	D 187		

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D 187	Continued From page 7 this violation. THE CORRECTION DATE FOR THIS B VIOLATION SHALL NOT EXCEED SEPTEMBER 05, 2022.	D 187		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure a therapeutic diet menu was available for 1 of 3 sampled residents (Resident #3) who had an order for a regular diet with ground meat. The findings are: Review of Resident #3's current FL2 dated 04/25/22 revealed there was an order for a regular diet with ground meat. Observation of the kitchen on 07/21/22 at 10:00am revealed: -There was an alcove to the side of the main kitchen that contained a desk. -Above the desk was a shelf that contained 5 menu books for each of the 5 spring/summer 2022 cycle weeks.	D 296		

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D 296	Continued From page 8 -There was a paper laying on the counter that documented the menu to be served on 07/21/22. -There was no menu posted near the serving line. Review of the facility's Spring/Summer 2022 menus revealed: -The menu was written for a regular diet. -There was no menu extension for a ground meat diet. Interview with the Food Service Director on 07/21/22 at 10:00am revealed: -The facility's spring /summer 2022 menus were new and only provided menu information for a regular diet. -Therapeutic diet menu extensions were not available. -She did not need therapeutic diet menu extensions because she knew how to prepare therapeutic diets. Interview with the Administrator on 07/22/22 at 9:36am revealed: -There should be a book somewhere in the kitchen that contained all the therapeutic menus. -The food service director should have and know where the therapeutic menus were in the kitchen.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews the facility failed to ensure an accurate and current listing of residents with physician ordered therapeutic diets for guidance of dietary staff for 1 of 3 sampled residents (Resident #3) who had an order for a regular diet with ground meats.

The findings are:

Review of Resident #3's current FL2 dated 04/25/22 revealed:
-Diagnoses included dementia, syncope and diabetes.
-There was an order for a regular diet with ground meat.

Review of the facility's diet order roster provided upon entrace to the facility revealed:
-This diet order roster was not the same as the roster posted in the kitchen.
-The diet order roster was printed in the morning on 07/21/22.
-Resident #3's diet was documented as regular with ground meat.

Observation of the facility's kitchen on 07/21/22 at 10:00am revealed:
-There was a resident diet order roster dated 05/10/22 posted to a bulletin board in the office alcove the kitchen.
-There was a paper taped to the top of the meal delivery hot box that documented resident diet orders.

Review of the facility's diet order roster dated 05/10/22 revealed the roster documented

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D 309	Continued From page 10 Resident #3's diet as a regular diet with chopped meat. Review of the paper taped to the top of the meal delivery hot box revealed Resident #3's diet was documented as chopped. Observation of the dining room on 07/21/22 at 12:42pm revealed: -At each place setting was a dry-erase, plastic table tent card that documented the residents name and diet order. -One table contained a plastic table tent card with Resident #3's name and diet order. Review of Resident #3's dry-erase, plastic table tent card in the dining room revealed: -She was on a regular diet. -There was no documentation to indicate if her meat should be ground or chopped. Interview with the Food Service Director (FSD) on 07/21/22 at 10:00am and 12:05pm revealed: -She did not keep a list of resident diet orders near the serving line because she had every resident's diet memorized. -The resident diet order roster was not accurate because management did not print her a new one. -Resident #3's diet order just changed recently from chopped but everyone knew she received ground meat. -The paper taped to the top of the meal delivery hot box was just a quick reference for new employees and she made a mistake when she typed up Resident #3's diet order as chopped. Interview with the FSD on 07/21/22 at 12:28pm revealed: -She needed to update the table tent cards.	D 309		

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D 309	Continued From page 11 -The Resident Care Coordinator (RCC) was responsible for providing her with current resident diet order rosters. -She did not have access to resident's diet orders on the computer and did not have the ability to type up on the diet order roster. -When diets changed the RCC or a medication Aide would bring her a copy of the diet order and she filed it in the kitchen. -She received an updated roster whenever diet orders changed, which was usually monthly. Interview with a cook on 07/21/22 at 1:55pm revealed: -She and the FSD were responsible for keeping the table tent cards up-to-date. -She thought the table tent cards were last updated about 6 or 8 weeks ago. -She had not noticed that Resident #3's table tent card was incorrect. -She thought current diet order rosters were provided by the RCC or someone from management. -There was not a diet order roster posted near the serving line because she and the FSD had all the resident diets memorized. Interview with the RCC on 07/21/22 at 3:15pm revealed: -He never provided the FSD with resident diet order rosters. -The FSD was responsible for keeping the diet order roster up-to-date. -The FSD had access to the computer and could print whatever she needed for the kitchen. -When a residents' diet changed he placed a copy of the order on the FSD's desk but he always made sure to personally tell her about it also.	D 309		

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D 309	Continued From page 12 Interview with the Administrator on 07/22/22 at 9:36am revealed: -He was not aware that the diet order roster posted in the kitchen was not up-to-date. -The FSD was responsible for maintaining an accurate, up-to-date diet order roster. -The FSD received a copy of any diet order changes when they occurred. -She had the ability to create a diet order roster.	D 309		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to	D 363		

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Subparagraph (1) or (2) of this Paragraph; and
(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to ensure medications prepared for administration in advance were kept enclosed in a sealed container that identified the name and strength of each medication prepared and the resident's name observed in the top drawer of the medication cart.

The findings are:

Review of the facility's Medication Administration Policy and Procedure dated October 2014 revealed:
-Medications should be administered at the time they are prepared.
-Oral medications should not be prepared in advance.

Observation of the medication cart on 07/21/22 at 10:50am revealed:
-There were 9 paper medication cups in the top drawer of the medication cart.
-There were medications in each medication cup.
-Handwritten on each medication cup were various letters, 5pm on 1 cup and 2pm on 8 cups.

Interview with the medication aide (MA) on

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	HAL044040	A. BUILDING: _____ B. WING _____	07/22/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY CLYDE, NC 28721

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D 363	Continued From page 14 07/21/22 at 11:00am revealed: -She had prepared the medications she was to administer to residents at a later time during her shift. -The initials on the medication cups were the initials of the residents the medications were for. -The times on the medication cups were the times the medications were scheduled to be administered. -She had to administer medications to residents in this facility and at a sister facility and it was "really hard" to do that. -She did not remember when she put the medications in the cups. -She knew she should not have done it because she had been trained not to. Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 11:00am revealed: -The MAs sometimes medications were prepared in advance for the residents. -Sometimes he administered medication to residents and he would prepare the medications for the next scheduled medication pass in advance. -A staff from the local Department of Social Services had informed him he could prepare the medications in advance. Interview with the Administrator on 07/21/22 at 2:30pm revealed: -He had instructed the MAs that they could only prepare medications in advance they were responsible for in the event of an emergency. -An emergency would be if the facility was short of staff.	D 363		
D 366	10A NCAC 13F .1004 (i) Medication Administration	D 366		

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D 366	Continued From page 15 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: Based on observations, interviews, and record review, the facility failed to ensure a medication aide (MA) observe a resident take their medications for 1 of 3 sampled residents (#1). The findings are: Observation of Resident #1's room during the initial tour on 07/21/22 at 8:55am revealed: -There was a paper medication cup on Resident #1's nightstand. -Inside the medication cup were 7 medications. Review of Resident #1's current FL2 dated 12/02/21 revealed: -Diagnoses included colectomy, Chronic Obstructive Pulmonary Disease, and leukocytosis. Review of physician's order for Resident #1 dated 05/12/22 revealed lisinopril 20mg daily, oxycodone/APAP 5/325mg twice daily, pantoprazole 40mg daily, tamsulosin 0.4mg daily, Topiramate 50mg twice daily and pain reliever plus 2 tablets daily as needed.	D 366		

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D 366	Continued From page 16 Review of a physician's order for Resident #1 dated 06/13/22 revealed decrease pantoprazole to 20mg daily. Review of Resident #1's electronic Medication Administration Record (eMAR) for 07/21/22 revealed: -There was an entry for lisinopril 20mg daily at 8:00am and documentation the lisinopril was administered at 8:00am. -There was an entry for oxycodone/APAP 5/325mg twice daily at 8:00am and 8:00pm and documentation the oxycodone/APAP 5/325mg was administered at 8:00am. -There was an entry for pantoprazole 20mg daily at 8:00am and documentation the pantoprazole 20mg was administered at 8:00am. -There was an entry for tamsulosin 0.4mg daily at 8:00am and documentation the tamsulosin 0.4mg was administered at 8:00am. -There was an entry for Topiramate 50mg twice daily at 8:00am and 8:00pm and documentation the Topiramate 50mg was administered at 8:00am. -There was an entry for headache relief caplets two tablets daily as needed and documentation the headache relief caplets were administered at 8:35am. Interview with Resident #1 on 07/21/22 at 8:56am revealed: -The medications in the cup were his morning medications. -The medication aide (MA) had left the medications in the room for him to take. -The MA frequently left the medications in his room and did not observe him take the medications.	D 366		

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D 366	Continued From page 17 Interview with the MA on 07/21/22 at 9:18am revealed: -She had handed the medication cup with the medications to Resident #1 to take and then she walked out of the room. -She should have stayed and observed the resident take the medication but she had been "too busy". -She would normally observe the residents take their medications because she had been trained to do so. Interview with the Resident Care Coordinator (RCC) on 07/21/22 at 11:00am revealed the MA should have observed Resident #1 take his medication as she had been trained that way. Interview with the Administrator on 07/21/22 at 2:30pm revealed: -The MAs should not leave medication in residents' rooms. -The MAs have been trained to observe the residents take their medication.	D 366		
D912	G.S. 131D-21(2) Declaration of Residents' Rights 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 observation, interview and record review the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant	D912		

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D912	Continued From page 18 federal and state laws and regulations as related to staffing. The findings are: Based on interviews and record reviews, the facility failed to ensure when the administrator or administrator-in-charge was not on duty within the facility, that there was at least one staff member on duty at all times on second and third shifts. [Refer to Tag 187 10A NCAC 13F .0604(d)(2), Personal Care and Other Staffing (Type B Violation)].	D912		