Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Spicewoods, Elms-SCU
Address: 39 Loving Way. Clyde, NC 28721_____
County: Haywood_____
License Number: HAL-044-039

II. Date(s) of Visit(s): 8/23/23 and 8/24/23
Purpose of Visit(s): Complaint

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 10/20/2023

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: TYPE A1 VIOLATION The Rule is not met as evidenced by: Based on the observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled residents (#1 and #3) were free from abuse and neglect. The findings are: Review of Staff A's personnel record revealed: -Staff was hired on 4/18/23 as a personal care aide (PCA). 1.) Review of Resident #1's current FL-2 dated 3/14/23 revealed: -Diagnosis of dementia, ataxia (a condition that impairs muscle coordination affecting hands, arms, and legs), history of falls, dysphagia (difficulty swallowing), muscle weakness, anxiety, and mood disorder. -Resident was non-ambulatory and required the assistance of a		

wheelchair.

A.) Review of Resident #1's Care Plan dated 6/8/23 revealed:
-Resident required daily assistance with transfers, grooming, dressing, ambulation, toileting, and eating.
-Resident had wandering behaviors.

Observations of Resident #1 on 8/23/23 at 9:00am revealed:
-Resident #1 was lying in her bed with her eyes closed.
-She had a large, dark, red, and purplish mark on her left hand between her pointer finger and thumb.
-The mark was about 2 inches long and one inch wide.
-The mark was shaped like a thumb.
-She lifted her hand to show a medication aide (MA) the bruise while furrowing her brow.
-The MA gently reached toward the hand and Resident #1 pulled her hand toward her chest and she did not want the MA to touch the injury.

Interview with a MA on 8/23/23 at 9:30am revealed:
-On the morning of 8/22/23 she noticed a large bruise between the thumb and pointer finger on the left hand of Resident #1.
-She worked with Resident #1 on 8/21/23 and the bruise was not present the day before.
-She asked the personal care aide (PCA) how Resident #1 was injured and the PCA was told her Staff A was doing "pressure points" on Resident #1.
-Staff A demonstrated and told other staff "pressure points" was the act of squeezing or applying pressure to a nerve on a person's body, such as the hand or shoulders.
-She had never heard of using "pressure points" until she heard that Staff A was performing it on residents about a month ago.
-Staff have never been trained or instructed to use "pressure point" techniques on residents as it could cause bruising.
-On 8/22/23, she told the Resident Care Coordinator (RCC) that Staff A was hurting Resident #1 and there was a new bruise on her hand.
-She attended a meeting about a month ago and the Administrator was told by several PCAs and MAs that Staff A used "pressure points" on Resident #1. The Administrator said he would take care of it, but Staff A continued to work and her use of "pressure points" did not change. Staff A was not at the meeting.
-The Administrator did not ask any questions about the incident.
-She saw bruising of unknown origin on Resident #1 about 2 weeks ago on her neck and collar bone area.

Interview with Activities Director on 8/23/23 at 10:30am revealed:
- On 8/17/23, she was working late and helping with personal care and housekeeping.
-The only staff in the building were her and Staff A.
-She was standing in the hallway folding a sheet and Resident #1 was close by, in her wheelchair, swinging her legs like she was kicking.
-Staff A approached, then stood behind Resident #1's wheelchair, placed her hands on the tops of her shoulders and squeezed down hard.
-She witnessed Staff A squeeze Resident #1's shoulders in a rough and painful manner.
-She asked Staff A what she was doing, and Staff A said she was using "pressure points" to calm Resident #1 down.
-She did not know what "pressure points" were or what Staff A was talking about and was confused by Staff A's behavior.
-She told Staff A to stop because she was hurting Resident #1.
-She told Staff to stop what she was doing to Resident #1 immediately.
-Staff A said nothing to her and walked away.
-She was confused and startled by Staff A's behavior as she had never heard of "pressure points".
-On 8/18/23 she called and notified the Administrator as to what happened.
-The Administrator asked her to write a statement.

Interview with a second MA on 8/23/23 at 1:15pm revealed:
-About 5-6 weeks ago a PCA reported to her they saw Staff A hit Resident #1.
-She relayed to information to the RCC and Administrator.
-Staff A continued to work.
-She was in a meeting about a month ago and a staff member told the Administrator they saw Staff A hit Resident #1.
-A couple of weeks ago the RCC told her that Staff A was to no longer work in the Special Care Unit (SCU) alone, but Staff A continued to work in the SCU alone.

Interview with a third MA on 8/23/23 at 2:11pm revealed:
-She heard from other staff that Staff A uses "pressure points" on Resident #1.
-She witnessed Staff A using "pressure points" on other residents.
-She did not know where Staff A got the idea of "pressure points" as the facility did not train nor instruct staff to use this technique.
-She was at a meeting on 7/6/23 and she heard a PCA tell the Administrator she had witnessed Staff A hitting Resident #1.
-The Administrator told staff that he would look into it.

Interview with a PCA on 8/23/23 at 2:30pm revealed:
-Sometime in July 2023, she had assisted Resident #1 to bed with pajamas and tucked her into bed.
- Staff A came in the room, pulled the covers down, and began taking Resident #1's pants off.
-She stated there was no need for Staff A to remove Resident #1's pants, this was just the preference of Staff A for residents to not wear pants at bedtime.
-Resident #1 asked her to stop.
-Staff A did not stop taking off Resident #1's pants.
-Resident #1 smacked Staff A's hand.
-Staff A hit Resident #1 on the wrist hard.
-She told the Administrator what she saw one week later while in a meeting, and he did not respond or react to this information.

Interview with a fourth MA on 8/24/23 at 12:00pm revealed:
-She was in a meeting with the Administrator and RCC on 8/3/23.
-In the meeting staff told the Administrator and RCC they had witnessed Staff A using pressure points and slapping Resident #1.
-The Administrator told staff they would take care of it.

Interview with a second PCA on 8/24/23 at 4:14pm revealed:
- Staff A showed her how to perform pressure points on residents about a month ago.
- Staff A did pressure points on Resident #1's shoulders and hands.
-She saw Staff A squeeze the top of Resident #1's shoulders hard about 2 weeks ago.
-She stated Resident #1 often attempted to hit or kick, due to her dementia and ataxia diagnoses, and Staff A pulled Resident #1's arms behind her head in response to Resident #1's hitting and kicking behavior.
-She noticed the bruise on Resident #1's hand the morning of 8/22/23 and told a MA.

Based on the observation and record review, it was determined Resident #1 was not interviewable.

Attempted telephone interview with Staff A on 8/24/23 at 3:14pm and 9/8/2023 at 8:45am was unsuccessful.

b.) Interview with a resident on 8/23/23 at 9:46am revealed:
-One night she was awoken by the sound of crying.
-She got out of the bed and went to Resident #1's room.
-She witnessed Staff A standing in the room while another

resident held Resident #1 down in the bed.
-All three were struggling and fighting with each other while Resident #1 laid in the bed.
-Resident #1 was screaming "help, help, help".
-She thought that Staff A asked the other resident to assist her with putting Resident #1 to bed, as Staff A has done this in the past.
-She did not think the resident should assist Staff A with caring for other residents because the resident had dementia, and this was inappropriate.
-The resident was holding Resident #1 down in a rough manner and Staff A could not get the resident off of Resident #1.
-She did not think Staff A was protecting Resident #1 from the other resident.
-She thought this happened a few weeks ago, but could not remember and exact date.
-She told a MA what she saw the following morning.

Confidential interview with Staff revealed:
-A resident told her they had observed Staff A make another resident put Resident #1 to bed and that Resident #1 was screaming.
-The resident told her, the other resident was being rough, holding her down in the bed, and Staff A was not separating them.
-The resident told her residents should not assist with personal care due to their progressed dementia diagnosis.
-She told the Resident Care Coordinator (RCC) what happened to Resident #1 that same day.
-A couple of days later, the RCC told Staff A that she was not allowed to ask other residents to perform personal care tasks.

Interview with the transportation aide on 8/23/23 at 10:41am revealed:
-On 8/10/23 at 4:45pm, she was walking to her car and saw residents fighting through the window.
-She entered the building and saw Resident #1 surrounded by two other residents and Staff A.
-One resident was holding Resident #1's arms down against the armrests of Resident #1's wheelchair.
- Staff A was standing behind Resident #1's wheelchair and was smacking Resident #1's arms and hands.
-All the residents were screaming and yelling including Staff A.
- Staff A was doing nothing to separate the residents.
-She intervened and had to pry the other resident's hands off Resident #1's arms before she could separate them.
-Resident #1 had bruising on her arms the next day.

-She told the RCC and Administrator, and the Administrator told her that Staff A had done nothing wrong.
-Staff A continued to work.

Review of incident reports for Resident #1 revealed there was no report completed on 8/10/23.

Interview with Resident #1's power of attorney (POA) on 9/8/23 at 9:03am revealed:
-For the past 2 months she had noticed bruising of unknown origin on Resident #1.
-On 8/22/23, she noticed a bruise on Resident #1's left hand.
-She asked staff what happened and was told that Staff A was performing "pressure points" on Resident #1.
-She was also told that another resident witnessed Staff A and another resident holding Resident #1 down in the bed, and Resident #1 was crying.
-On 8/22/23, she told the RCC that she wanted to notify law enforcement about the abuse of Resident #1, and the RCC told her not to because the facility would investigate.

Interview with Administrator on 8/23/23 at 3:45pm revealed:
-He knew there was allegations of abuse involving Staff A and Resident #1.
-He asked staff to come forward if they had seen Staff A abuse residents, and no one was willing to talk.
-He heard that Staff A was hurting Resident #1 around 8/9/23 from the transportation worker.
-He was notified that Staff A was using "pressure points" on Resident #1 on 8/21/23 from the RCC.
-He had never heard of staff using "pressure points" before 8/21/23.
-Staff have never been trained or educated about the use of "pressure points" because was not a technique used in his facility.
-He did not think that Staff A abused Resident #1 because "no one saw her do it".
-He was not concerned about the bruising on Resident #1's hand, because Resident #1 was covered in other bruising of unknown origin.
-On 8/10/23, the transportation aide notified him about a fight involving Resident #1. He viewed the incident on the camera and saw Staff A trying to break up the fight.
-He did not see Staff A hit Resident #1 on the video footage.
-No one could view the video because the footage was too old and no longer available.
-He had a meeting with staff about a month ago and it was never brought up that Staff A was using pressure points or

hurting residents.
-Staff A was reported to the Health Care Personnel Registry yesterday and she would not be permitted to return to work.

2.) Review of Resident #3's current FL-2 dated 1/23/23 revealed:
-Diagnosis of Alzheimer's.
-She was intermittently disoriented.
-She was a low fall risk

Interview with a medication aide (MA) on 8/23/23 at 2:11pm revealed:
-Around 3 weeks ago, she and Staff A took Resident #3 outside to the porch.
-Resident #3 became upset and Staff A was trying to get her back inside the building.
- Staff A told Resident #3 to go back inside and Resident #3 grabbed onto the fence.
- Staff A grabbed Resident #3 hands and squeezed them hard, forcing Resident #3's hands to open.
-She told Staff A to "stop!", Staff A said "If you squeeze the pressure points her hands will release".
-She yelled for Staff A to stop as she was hurting Resident #3.
- Staff A then put her arms under Resident #3's armpits and started to drag her back into the building.
-She yelled for Staff A to stop a second time and this time Staff A stopped.
-She was able to verbally direct Resident #3 back into the building.
-She told the RCC about the incident, and he said he would take care of it.

Interview with a PCA on 8/23/23 at 2:30pm revealed:
-A couple of weeks ago, Resident #3 was outside and did not want to come in.
-Staff A was frustrated at Resident #3 for not coming back inside.
-Staff A stood behind Resident #3 and placed her hands on top on her shoulder's and squeezed hard.
-Staff A then pushed Resident #3 back inside the building while squeezing Resident #3's shoulders.
-She did not tell anyone because they were alone, and she did not know what to do.

Interview with a second PCA on 8/23/23 at 3:03pm revealed:
-On 8/21/23, she saw Staff A yell at Resident #3 "Can you not (expletive) hear me?"
-She did not report it, because she has reported Staff A in the past to the RCC and nothing was done.

-The facility did not protect the residents.

Interview with Administrator on 8/23/23 at 3:45pm revealed:
-No staff told him of allegations of abuse involving Staff A and Resident #3.
-He would report Staff A to the Health Care Personnel Registry (HCPR) for abusing Resident #3.

Based on the observation and record review, it was determined Resident #3 was not interviewable.

The facility failed to protect residents from abuse and neglect. Staff A was witnessed by multiple staff performing abusive and unapproved procedures on Resident#1 and #3 which resulted in bruising of Resident #1's. Staff A was also seen hitting and failing to protect Resident #1 from harm by another resident. Staff A was also witnessed verbally and physically abusing Resident #3. The Administrator was made aware of the allegations and did not conduct an investigation, report to HCPR or completed any other protective measures for the residents. This failure resulted in serious physical harm and neglect and constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 8/23/23 for this violation.

THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED _____

Rule/Statute Number: 10A NCAC 13F .1205 Health Care Personnel Registry

Rule/Statutory Reference: 10A NCAC 13F .1205 Health Care Personnel Registry
The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0101

Level of Non-Compliance: A1 VIOLATION

The Rule is not met as evidenced by:

Based on record reviews and interviews the facility failed to report allegations of neglect and abuse of 2 of 2 sampled residents (Resident # 1 and Resident # 3) by a personal care aide [PCA (Staff A)] to the Health Care Personnel Registry (HCPR).

The findings are:

Review of Staff A's personnel file revealed the following:
- She was hired as a PCA on 4/18/23.
- There was documentation of a criminal background check on 4/18/2023.
- There was documentation of a HCPR check dated 4/17/2023 with no substantiated findings.

1. Review of Resident # 1's current FL2 dated 3/14/2023 revealed:
-Diagnoses included dementia, ataxia (a condition that impairs muscle coordination affecting hands, arms and legs, history of falls, dysphagia (difficulty swallowing) muscle weakness, anxiety and mood disorder.

Review of Resident #1's care plan dated 6/8/2023 revealed she required assistance with eating, toileting, ambulation, bathing, dressing, grooming, and transfer.

a. Interview with a medication aide (MA) on 8/23/23 at 9:30am revealed:
- On the 8/22/23 she noticed a large bruise between the thumb and the pointer finger on the left hand of Resident #1.
- She worked with Resident #1 the day before 8/21/23 and the bruise was not present.
- Another PCA told her Staff A was doing "pressure points" on Resident #1.
- The PCA stated pressure points was the act of squeezing or applying pressure to a nerve on a person's body such as the hands or the shoulders.
- She had also noticed bruising of unknown origin on Resident #1 about her neck and collar bone area.
- She attended a staff meeting "about a month ago" and the Administrator was told by multiple PCAs and MAs that Staff A was using "pressure points" on Resident #1.

Interview with the Activities Director on 8/23/23 at 10:30am revealed:
- On 8/17/23, she witnessed Staff A squeeze Resident #1's shoulders in a rough manner.
-Staff A stood behind Resident #1 who was sitting in her wheelchair, placing her hands on the tops of her shoulders and

squeezing hard.
-On 8/18/23, she called and told the Administrator what she witnessed.
- The Administrator requested she provide him with a written statement.

Interview with a second MA on 8/23/23 at 1:15pm revealed:
- About 5-6 weeks ago, a PCA told her that had witnessed Staff A hit Resident #1.
- She told the RCC and the Administrator.
- Staff A continued to work at the facility.

Interview with a third MA on 8/23/23 at 2:11pm revealed:
- She was attending a staff meeting on 07/06/23 and witnessed a PCA tell the Administrator she saw Staff A hitting Resident #1.
- The Administrator said he would look into it.

Interview with a PCA on 8/23/23 at 2:30pm revealed:
- Sometime in July 2023 she assisted Resident #1 to bed.
- Staff A came into Resident #1's room, proceeding to take the bedcovers down away from Resident #1 and began removing her pants.
- She told Staff A there was no reason to remove Resident #1's pants.
- Removing Resident #1's pants were a preference of Staff A.
- Staff A did not want Residents' to wear pants at bedtime.
- Resident #1 smacked Staff A on the hand.
- Staff A then smacked Resident #1 hard on her wrist.
- The Administrator was informed of Staff A's actions about a week later in a meeting but did not respond to the information

Interview with a fourth MA on 08/24/23 at 12:00pm revealed:
- The Administrator and the RCC were both present in a staff meeting on 8/3/23.
- She informed the Administrator and the RCC she had witnessed Staff using "pressure points" on Resident #1 and slapping her.
- The Administrator stated he would take care of it.

Refer to interview with the Administrator on 8/23/23 at 3:45pm

Interview with Resident #1's Power of Attorney on 9/8/23 at 9:03am

b. Interview with a resident on 8/23/23 at 9:46am revealed:

- One night was awoken by the sound crying.
- She walked to Resident #1'was room and witnessed Staff A in the room while another resident was holding down Resident #1 down in her bed.
- Resident #1 was screaming "help, help, help."
- She did not think Staff A was protecting Resident #1 from the other resident.
-She reported the incident on 8/11/23 to a MA and two PCA's

Interview with a MA on 8/24/23 at 10:55am revealed:
-A resident reported to her on 8/11/23 that the night before, Staff A had gotten another resident to hold Resident #1 down in the bed.
-She reported the incident to the RCC the same day.
-The RCC told Staff A "she could not do that" a few days later.

Interview with the Transportation Aide on 8/23/23 at 10/41am revealed:
- On 8/10/23 at 4:45pm, she witnessed residents fighting through a window of the facility
- She entered the building and saw Resident #1 in her wheelchair, surrounded by Staff A and two other residents.
- Staff A was standing behind Resident #1, smacking her arms and hands.
- She informed the Resident Care Coordinator (RCC) around 5:30pm the same day, and the RCC told the Administrator the next morning on 8/11/23.
- The Administrator told her Staff had done nothing wrong.
- Staff A continued to work her scheduled shifts.

Interview with the Administrator on 8/23/23 at 3:45pm revealed:
- He knew there were allegations of abuse that involved Staff A.
- On 8/10/23, the Transportation Aide notified him of a "fight" involving Resident #1.
- He viewed video surveillance footage and did not see Staff A hit Resident #1.
- He did not think Staff A abused Resident #1 because "no one saw her do it."
- He did not report Staff A to the HCPR.

2. Review of Resident #3's FL2 dated 1/23/23 revealed:
- Diagnoses included Alzheimer's disease.
- Resident #3 was intermittently disoriented.

Interview with a medications aide (MA) on 8/23/22 at 2:11pm revealed:

- About 3 weeks ago she and Staff A were outside the facility with Resident #3.
- Resident #3 did not want to go back inside and grabbed onto a nearby fence.
- Staff A grabbed Resident #3's hand and squeezed them, forcing them to open.
-Staff A then grabbed Resident #3 under her arms and began to drag her back into the building.
- She yelled at Staff A for her to stop.
- She told the RCC about the incident the same day.

Interview with Resident #1's Power of Attorney on 9/8/23 at 9:03am revealed:
- On 8/22/23 she noticed Resident #1's left hand was bruised.
- Staff informed her Staff A was performing "pressure points" on Resident #1.
- She told the RCC on the same day (8/22/23) she wanted law enforcement notified about the abuse of Resident #1.- The RCC told her not to inform law enforcement because the facility would investigate.

Interview with the Administrator on 8/23/23 at 3:45pm revealed:
- He knew there were allegations of abuse that involved Staff A.
- He did not report Staff A to the HCPR.
- He did not think Staff A abused Resident #1 because "no one saw her do it."

The facility failed report allegations of abuse of 2 of 2 residents (Resident # 1 and Resident # 3) by a personal care aide [PCA (Staff A)] to the HCPR after the Administrator was made aware of the allegations a month prior to 8/22/2023 in staff meetings and did not investigate or report them to HCPR or complete any other protective measures for the residents. This failure resulted in serious physical harm and neglect and constitutes a Type A1 violation.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 8/23/23 for this violation.

THE CORRECTION DATE FOR THIS A1 VIOLATION SHALL NOT EXCEED

IV. Delivered Via:	In person @ Lodge	Date: 10/20/23
DSS Signature:	Ali Yarrell, SRO III / AHS	Return to DSS By: **11-13-23**

V. CAR Received by:	Administrator/Designee (print name):	
	Signature: Cathy Lowderman	Date 10/20/23
	Title: RCA	

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.*			