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-C 06/04/2025

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 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual and follow-up survey on 06/03/25-06/04/25.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff A, MA) had completed the 10-hour medication aide training within 60 days of employment as a medication aide. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired as a Medication Aide (MA) on 05/22/24. -Staff A completed the Medication Aide Clinical Skills Competency Validation checklist on 05/26/24. -Staff A passed the State written MA examination	D 125		

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D 125	Continued From page 1	D 125		

on 08/12/22.
-Staff A completed the MA 5-Hour training course on 06/16/22.
-There was no documentation Staff A had completed the MA 10-hour training course.

Review of April 2025 electronic medication administration records (eMAR) revealed there was documentation Staff A administered medications on 04/03/25, 04/04/25, 04/10/25, 04/12/25, 04/13/25, 04/17/25, 04/24/25, and 04/27/25.

Review of May 2025 eMAR revealed there was documentation Staff A administered medications on 05/04/25, 05/08/25, 05/11/25, 05/22/25, 05/23/25, 05/24/25, 05/25/25, 05/29/25, and 05/30/25.

Interview with the Manager on 06/04/25 at 2:24pm revealed:
-She and the Human Resources/Admissions staff were responsible for ensuring the MAs had the required qualifications prior to administering medications to residents.
-Staff A worked as a MA in another facility prior to employment at the facility.
-Staff A told them she received the 5 and 10-hour MA training at her previous employer.
-They had Staff A's 5-hour MA training certificate.
-They could not find Staff A's 10-hour MA training certificate.

Telephone interview with Staff A on 06/04/25 at 3:07pm revealed:
-She currently worked on evening shift as a MA at the facility.
-She administered medications to the residents as part of her responsibilities.
-She received the MA training at her former place

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D 125	Continued From page 2 of employment. Attempted interview with the Administrator on 06/04/25 at 2:15pm was unsuccessful. [Refer to tag D366, 10A NCAC 13F .1004(i) Medication Administration] _____ The facility failed to ensure Staff A, medication aide, completed the 10-hour medication aide training prior to administering medications which resulted in a resident receiving the wrong medications. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2025.	D 125		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures	D 167		

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from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure there was a least one staff person on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation (CPR) for 1 of 3 sampled 6:00pm to 6:00am staff (Staff A).

The findings are:

Review of Staff A's personnel record revealed:
-Staff A was hired as a Medication Aide (MA) on 05/22/24.
-Staff A had a CPR training certificate dated 02/06/23 with a validity period of two years.
-There was no current documentation of CPR training.

Interview with a MA on 06/04/25 at 11:37am and 12:05pm revealed:
-Staff A routinely worked as a MA on the 6:00pm to 6:00am evening shift in the facility on Thursday, Friday, Saturday, and Sunday nights.
-There was one MA in the facility on the 6:00pm to 6:00am evening shift.
-They had been unable to find a more recent CPR certification than the one completed on 02/06/23.
-Staff A had been scheduled to renew her CPR training in a class held on 05/06/25.
-Staff A did not attend the CPR class on 05/06/25.
-There were other CPR certified staff available on the 6:00pm to 6:00am evening shift nearby in three sister facilities on the property.

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D 167	Continued From page 4 Interview with the Manager on 06/04/25 at 1:35pm and 2:24pm revealed: -She and the Human Resources/Admissions staff were responsible for ensuring staff had current CPR certifications. -Staff A was scheduled to renew CPR certification in a class held on 05/06/25. -Staff A was unable to attend the CPR renewal class on 05/06/25. -The other staff who worked the 6:00pm to 6:00am evening shift on the property were current with CPR certification.	D 167		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to a medication used to treat diabetes. The findings are: Review of Resident #3's current FL2 dated 07/12/24 revealed diagnoses included type 2 diabetes, essential hypertension, blindness in left	D 358		

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eye, low vision in right eye, and chronic kidney disease.

Review of Resident #3's primary care provider (PCP) order dated 12/30/24 revealed Ozempic 8mg/3ml inject 2mg once a week on Wednesday for type 2 diabetes.

Review of Resident #3's PCP order dated 02/08/25 revealed Ozempic 8mg/3ml inject 2mg once a week on Wednesday for type 2 diabetes, refills 11.

Review of Resident #3's interventional radiology pre-procedure instructions for a left arm fistulagram dated 05/22/25 revealed hold Ozempic for one week prior to 05/22/25.

Review of Resident #3's discharge instructions dated 05/22/25 revealed Ozempic 8mg/3ml inject 2mg once a week on Wednesday.

Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday.
-Ozempic 2mg was documented as administered 5 occurrences out of 5 opportunities on 01/01/25, 01/08/25, 01/15/25, 01/22/25, and 01/29/25.

Review of Resident #3's February 2025 eMAR revealed:
-There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday.
-Ozempic 2mg was documented as administered 3 occurrences out of 4 opportunities on 02/12/25, 02/19/25, and 02/26/25.
-There was no documentation as to the reason Ozempic 2mg was not administered on 02/05/25.

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D 358	Continued From page 6 Review of Resident #3's March 2025 eMAR revealed: -There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday. -Ozempic 2mg was documented as administered 4 occurrences out 4 opportunities on 03/05/25, 03/12/25, 03/19/25, and 03/26/25. Review of Resident #3's April 2025 eMAR revealed: -There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday. -Ozempic 2mg was documented as administered 5 occurrences out of 5 opportunities on 04/02/25, 04/09/25, 04/16/25, 04/23/25, and 04/30/25. Review of Resident #3's May 2025 eMAR revealed: -There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday. -Ozempic 2mg was documented as administered 2 occurrences out of 3 opportunities on 05/07/25 and 05/14/25. -There was no documentation as to the reason Ozempic 2mg was not administered on 05/28/25. Review of Resident #3's June 2025 eMAR from 06/02/25-06/04/25 revealed: -There was an entry for Ozempic 8mg/3ml inject 2mg every week on Wednesday. -There were no documented administrations of Ozempic 2mg. Observation of Resident #3's medications on hand on 06/03/25 at 2:20pm revealed: -There was one unopened box of Ozempic 8mg/3ml which contained 1 Ozempic pen and 4 administration needles. -There was a pharmacy label for Ozempic inject	D 358		

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2mg every week on Wednesday with a dispense date of 04/09/25 with nine refills remaining.

Interview with Resident #3 on 06/03/25 at 3:45pm revealed:
-He had missed his weekly dose of Ozempic the last two weeks.
-The medication aide (MA) held his Ozempic on 05/21/25, for a procedure on 05/22/25.
-The Ozempic was supposed to be restarted the next week on Wednesday.
-The Ozempic was not restarted the next week on 05/28/25.

Telephone interview with the facility's contracted pharmacy on 06/03/25 at 2:50pm and 06/04/25 at 8:25am revealed:
-The pharmacy received a prescription for Resident #3 on 12/27/24 for Ozempic 8mg/3ml inject 2mg every week on Wednesday.
-The pharmacy dispensed Ozempic 8mg/3ml one pen (4 doses per pen, a one month supply) on 12/27/24, 02/11/25, 03/21/25, and 04/10/25.

Telephone interview with Resident #3's PCP on 06/04/25 at 10:39am revealed:
-She ordered Ozempic to treat type 2 diabetes for Resident #3.
-Resident #3's last hemoglobin A1c (a test that measures your average blood sugar levels over the past 2-3 months) was 6.1% (normal result below 5.7%).
-If Resident #3 had missed more than four consecutive doses he would have needed the Ozempic to be titrated up to reach his current dose of 2mg per week or it could cause nausea.

Interview with the Manager on 06/04/25 at 2:24pm revealed:
-If Resident #3's Ozempic was not available, the

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D 358	Continued From page 8 MAs should have ordered it from the facility's contracted pharmacy. -If the Ozempic did not come in from the pharmacy, the MAs should have notified the Resident Care Coordinator and the PCP to figure out why the medication did not arrive. -On 05/22/25, the transport person should have given Resident #3's discharge orders to the MA when they returned to the facility. -The MA should have faxed the orders to the facility's contracted pharmacy "immediately" upon Resident #3's return. -This would have prompted the pharmacy to change the eMAR to restart the Ozempic on 05/28/25. -The MAs were supposed to do weekly cart audits for all of the residents. -She did not know why they did not discover on an audit the Ozempic dispensed 04/09/25 was still unopened and not used during April or May 2025.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: TYPE B VIOLATION	D 366		

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Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (Resident #1) was observed to actually take oral medications administered.

The findings are:

Review of the facility's expectations of medication aides (MA) policy revealed:
-Administer medications to residents as ordered by their physician, under the direction of the facility supervisor and administrator.
-Must follow the Six Rights of medication administration: Right Resident, Right Medication, Right Dose, Right Route, Right Time, and Right Documentation.
-Always use the medication administration record (MAR) when preparing and administering medications.
-After medications are administered, correctly document that the medications were taken.
-Give medication to one resident at a time. Focus on giving all medications to one resident before moving to another resident.

Review of Resident #1's current FL2 dated 07/24/24 revealed diagnoses included type 2 diabetes, asthma, hypothyroidism, and spinal stenosis.

Review of Resident #1's primary care physician (PCP) orders dated 12/12/24 revealed:
-There was an order for benztropine (used to treat side effects caused by antipsychotic medications) 5mg one tablet two times daily.
-There was an order for buspirone (used to treat generalized anxiety disorder) 15mg one tablet three times daily.
-There was an order for diclofenac (used to treat

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pain) 1% gel to the left hand two times daily.
-There was an order for divalproex DR (used to treat bipolar disorder) 250mg one capsule daily in the evening.
-There was an order for dicyclomine (treats irritable bowel syndrome) 10mg one capsule three times daily.
-There was an order for gabapentin (used to treat nerve pain) 100mg one capsule three times daily.
-There was an order for gabapentin 400mg one capsule three times daily.
-There was an order for melatonin (used to treat delayed sleep phase) 3mg three tablets at bedtime.
-There was an order for methocarbannol (used to treat muscle pain and stiffness) 500mg two tablets three times daily.
-There was an order for rosuvastatin (used to lower cholesterol) 40mg one tablet daily.
-There was an order for tamsulosin (used to treat kidney stones) 4mg one capsule at bedtime.
-There was an order for topiramate (used to treat bipolar disorder) 25mg one tablet twice daily.
-There was an order for trazodone (used to treat insomnia) 150mg one tablet at bedtime.
-There was an order for trazodone 50mg one half tablet three times daily.

Review of Resident #1's subsequent PCP orders revealed:
-On 01/31/25, there was an order to change divalproex DR 500mg one capsule at bedtime.
-On 04/16/25, there was an order for prazosin (used to treat high blood pressure) 1mg every eight hours.
-On 04/29/25, there was an order to change trazodone 100mg one tablet at bedtime.

Review of Resident #1's May 2025 electronic medication administration record (eMAR)

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D 366	Continued From page 11 revealed: -There was an entry for benztropine 0.5mg one tablet twice daily scheduled at 8:00am and 8:00pm. -There was an entry for buspirone 15mg one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an entry for divalproex ER 500mg one tablet at bedtime scheduled at 8:00pm. -There was an entry for gabapentin 100mg one capsule three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an entry for gabapentin 400mg one capsule three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an entry for melatonin 3mg three tablets at bedtime scheduled at 8:00pm. -There was an entry for methocarbamol 500mg two tablets three times daily scheduled at 8:00am, 2:00pm, and 8:00pm. -There was an entry for prazosin 1mg one tablet at bedtime scheduled at 8:00pm. -There was an entry for tamsulosin 0.4mg one capsule at bedtime scheduled at 8:00pm. -There was an entry for topiramate 25mg one tablet twice daily scheduled at 8:00am and 8:00pm. -There was an entry for trazodone 100mg one tablet at bedtime scheduled at 8:00pm. Review of Resident #1's medication error report dated 05/24/25 at 7:54pm revealed: -Resident #1 was documented as administered the following medications in error benztropine 1mg, famotidine (used to treat heartburn) 20mg, gabapentin 400mg, lubiprostone 8mcg, olanzapine ODT (used to treat schizophrenia)10mg, prazosin 2mg, senna (used to treat constipation) 8.6mg, topiramate 50mg two tablets, trazodone 50mg one half tablet,	D 366		

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trazodone 50mg one tablet.
-The route of administration was documented as by mouth.
-The reason for making the error was documented as Resident #1 picked up Resident #5's medications and took them.
-There were no documented side effects of Resident #1 receiving the wrong medications.
-The error was documented as discovered on 05/24/25 at 7:55pm.
-Resident #1's primary care provider (PCP) was documented to have been notified of the medication error by the Manager.
-There was no documented date and time of PCP notification.
-The documented PCP orders for resident care were to "watch" the resident "closely" as the two residents were on "a lot of the same meds."

Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for baclofen 10mg one tablet twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for benztropine 1mg one tablet twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for ciprofloxacin 500mg one tablet twice daily for seven days scheduled at 8:00am and 8:00pm for 05/22/25-05/29/25.
-There was an entry for clonazepam 0.5mg one tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was an entry for famotidine 20mg one tablet at bedtime scheduled at 8:00pm.
-There was an entry for gabapentin 400mg one capsule three times daily scheduled at 8:00am, 2:00pm, and 8:00pm.
-There was an entry for lubiprostone 8mcg one capsule twice daily scheduled at 8:00am and

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-C 06/04/2025

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
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8:00pm.
-There was an entry for magnesium oxide 400mg one tablet daily scheduled at 8:00pm.
-There was an entry for metformin 1,000mg one tablet twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for olanzapine ODT 10mg one tablet twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for prazosin 2mg one capsule at bedtime scheduled for 8:00pm.
-There was an entry for senna 8.6mg one tablet twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for temazepam 15mg one capsule at bedtime scheduled at 8:00pm.
-There was an entry for topiramate 50mg two tablets twice daily scheduled at 8:00am and 8:00pm.
-There was an entry for trazodone 50mg one tablet twice daily scheduled at 1:00pm and 8:00pm.

Interview with Resident #1 on 06/04/25 at 9:15am revealed:
-Staff A placed a cup of medications and her inhaler on her bedside table.
-Staff A placed a cup of medications on Resident #5's bedside table.
-Staff A was "doing something" with Resident #5.
-Resident #1 swallowed the medications left by Staff A in the cup on her bedside table.
-Resident #1 discarded the medication cup in the trash and went to the bathroom.
-Resident #5 looked at the medications in the cup on her bedside table before taking them and discovered the medications were not her medications and the cup was labeled with Resident #1's name.
-The medication cup discarded earlier by Resident #1 was checked and it had Resident

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES WILLOWS	65 LOVING WAY CLYDE, NC 28721

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#5's name written on it.
-Resident #1 was "groggy" the next morning as a result of receiving the wrong medications.

Interview with Resident #5 on 06/04/25 at 10:05am revealed:
-Resident #1 had taken her scheduled bedtime medications in error one evening of the previous week.
-Staff A came into their room and set a medication cup with oral medications on her bedside table and a cup on Resident #1's bedside table and "walked away."
-Resident #1 took the medications in the cup on her bedside table.
-She looked in the cup Staff A left on her bedside table before taking the medications and realized the medications were not correct.
-She then noticed the cup had Resident #1's name written on it.
-She called Staff A into the room to let her know what had happened.
-Staff A then administered her correct 8:00pm medications.
-Staff A told her she notified the Manager about the incident.
-Staff A told her the Manager contacted Resident #1's PCP about the incident.
-Staff A routinely left her 8:00pm oral medications in a cup on her bedside table and did not observe her to take the medications.
-Staff A routinely left Resident #1's 8:00pm oral medications in a cup on her bedside table and did not observe her to take the medications.

Telephone interview with Staff A on 06/04/25 at 3:07pm revealed:
-She placed Resident #1's and Resident #5's oral medications in cups on their bedside tables.
-The cups were labeled with the resident's

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	HAL044041	A. BUILDING: _____ B. WING _____	R-C 06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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names.
-Resident #5 took the wrong cup of medications off the bedside table.

Telephone interview with Resident #1's PCP on 06/04/25 at 10:39am revealed:
-She was notified of medications given in error to Resident #1 on the evening of 05/24/25.
-She reviewed the medications Resident #1 received.
-She told the staff to monitor Resident #1 closely for any changes and notify with any concerns.
-She told the staff if anything Resident #1 "might be sleepy" from the medications she received.

Interview with the Manager on 06/04/25 at 2:24pm revealed:
-Staff A notified her immediately when she realized there had been a medication error.
-Staff A told her she took all of the medications for both Resident #1 and Resident #5 into the room at the same time to administer.
-Staff A told her Resident #1 took the wrong cup of oral medications.
-She then notified Resident #1's PCP to get instructions on how to care for Resident #1.
-The PCP asked them to monitor Resident #1 and report any concerns.
-The MAs were trained to watch the resident take their medications prior to moving on to prepare and administer medications to the next resident.

Attempted interview with the Administrator on 06/04/25 at 2:15pm was unsuccessful.

[Refer to tag D125 10A NCAC 13F .0403(a) Qualifications of Medication Staff]

_____
The facility failed to ensure Staff A, MA, observed Resident #1 to take administered oral

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D 366	Continued From page 16 medications which lead to Resident #1 taking incorrect 8:00pm medications. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/04/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2025.	D 366		