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.	[X] POC Accepted AG *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.	Had meeting with staff to discuss when we have resident that hit other residents that they are to let Administrative staff know as soon as possible so that resident can be moved, evaluated and treated	10/23/24

-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:	Also was explained that resident needs to be moved immediately away from the situation Also resident with behaviors as such needs to be watched closely Will sumit proper documetation in appropriate time frame. And make sure documentation is taken care of.	10/23/24 10/23/24 10/28/24

-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.	Council/with resident about not touching anyone and about the name calling also spoke with residents. Close of kin about this matter and if it continued resident could recieve discharge notice. Moved resident to sister facility Resident recieves ongoing psych care.	10/28/24 2/29/24 10/28/24

-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	Resident was moved to another room	2/27/24

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.

Spoke with resident was told she can not hit other resident. Staff was informed to watch residents closely 8/16/24

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

8/5/24
Spoke w Pth resident explained to let staff know immediately if other resident touched her. Resident was moved to another room.

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.	Staff was instructed to take action immediately if a resident hits another resident. And that all proper paperwork be done and all documentation be completed.	8/5/24

IV. Delivered Via:	certified mail & email	Date: 10/9/24
DSS Signature:	Alli Hamill, SW III/AHS	Return to DSS By: 10/30/24

V. CAR Received by:	Administrator/Designee (print name): AARON CRAWFORD	
	Signature:	Date: 11/5/24
	Title: ADMINISTRATOR	

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: Alli Hamill, SW III/AHS	Date: 11/5/24
Comments:		