STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092156	A. BUILDING: _____ B. WING _____	R 05/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

(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 a follow-up survey and a complaint investigation on May 8, 9 and 10, 2019 with exit via telephone on May 13, 2019.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Follow-Up to Type A1 Violation Based on these findings, the previous A1 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to assure the physician was notified for 1 of 5 sampled residents (#1) related to an unwitnessed fall, which resulted in a left hip fracture and uncontrolled pain for 3 days. The findings are: Review of Resident #1's current FL-2 dated 03/29/19 revealed: -Diagnoses included left hip fracture with surgical repair, atrial flutter, hypertension, dementia. -The resident was constantly disoriented. -The resident was semi-ambulatory. -There was no documentation of any assistive	D 273	10A NCAC 13F .0902(b) Health Care As of 5/9/19 and per plan of protection all staff were advised and reminded that with every fall each resident will be assessed for pain and changes in condition. All falls will continue to be reported to DRC or designee. Family members and MD to be notified at time of fall. Any residents showing pain, grimaces, change of condition, or increased use of PRN medication will have EMS services called immediately to assess and send to hospital for follow up if needed. Staff meeting 5/29/19 staff re-trained on fall procedures and policy by DRC. With every reported fall, DRC or designee to ensure assessment for pain and calls to MD and family are completed in addition to EMS services called with any pain, signs of distress, or change in condition. This is to happen with every fall occurrence to ensure compliance. ED or designee will review reported falls during weekly At Risk meeting to ensure compliance.	5/9/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 06/11/19

Reviewed and accepted. J. Bowen, RN 06/11/19

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D 273	Continued From page 1 devices required for the resident. Review of Resident #1's Resident Service Notes revealed: -On 03/08/19 third shift documented Resident #1 was found on the floor in the hallway near room 6. When found on the floor, Resident #1 did not have on any "Bottoms". Resident #1 complained of left leg pain. -There were no entries dated 03/09/19. -On 03/10/19 first shift documented Resident #1 had complained of left leg pain and as needed acetaminophen (used to treat pain) was given and was effective. -On 03/10/19 at 10:30 pm, there was documentation that Resident #1 had left leg pain and had received acetaminophen. -On 03/10/19 on third shift, there was documentation that Resident #1 complained of leg pain. Resident 1's family was aware of the fall that occurred on 03/08/19. -On 03/11/19 2nd shift documented mobile x-ray came and x-rayed Resident #1's left hip at which time Resident #1 did not complain of pain. -On 03/11/19 3rd shift documented no complaints of pain. -On 03/12/19 there was a late entry at 7:30 am documented Resident #1 was seen by her primary care provider and had an order for x-ray. -On 03/12/19 1st shift documented x-ray results were received which were positive for fracture and Resident #1 was sent to local hospital for further observation and Resident #1's family was notified. Review of the medication administration records revealed: -There was a computer-generated entry for acetaminophen 500mg 1 tab po q6hrs as needed for pain.	D 273		

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D 273	Continued From page 2 -There was documentation of acetaminophen 500mg tablet given for leg pain on 03/09/19 at 6:00 pm which was "semi-effective". -There was documentation of acetaminophen 500mg tablet given for leg pain on 03/10/19 at 4:00 pm and no documentation of effectiveness. -There was documentation of acetaminophen 500mg tablet given on 03/10/19 but there was no documentation of the reason given nor effectiveness. -There was documentation of acetaminophen 500mg tablet given on 03/10/19 but there was no documentation of the reason given nor effectiveness. -There was documentation of acetaminophen 500mg tablet given on 03/12/19 but there was no documentation of the reason given nor effectiveness. Interview with a medication aide (MA)/personal care aide (PCA) on 05/09/19 at 10:24 am revealed: -She was working as a PCA not a MA when Resident #1 fell. -Resident #1 was found on the floor in front of room #6 and did not have on any "bottoms". -She and the other PCA assessed Resident #1 and called the MA who did not respond. -She and the other PCA put Resident #1 back to bed. -She did report her findings to the MA when she "finally showed up" on the unit. -The day after the fall, Resident #1 complained of pain and was unable to pivot transfer which she normally could do. -Resident #1 was normally able to walk with her rollator from her room to the dining room and activity room. -After the fall, Resident #1 had difficulty and pain when trying to walk and stand.	D 273		

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D 273	Continued From page 3 Interview with personal care aide (PCA) on 05/10/19 at 12:24 pm revealed: -Resident #1 fell on 3rd shift. -When Resident #1 was found on the floor around 11:45 pm -12:00 am, the Medication Aide (MA) was called well over 3 times using the phone and the walkie talkie. -The MA never responded but after about an hour, the MA just showed up on the unit. -The MA went straight to the med cart. -The PCA's said to the MA, 'We called you" with no response from the MA. -The MA then said, "gave her (Resident #1) acetaminophen, let it kick in". -The PCA's put Resident #1 back to bed. -The Wellness Coordinator (WC) came to the facility on Saturday 03/09/19 around 8:00 am - 9:00 am and was made aware of Resident #1's fall to which she responded "OK". -On Tuesday 03/12/19, everybody was talking about what's wrong with Resident #1. -The other PCA who worked that morning reported that Resident #1 complained she hurt when the PCA got her up for breakfast. -No one was contacted (not family nor supervisors) when Resident #1 fell not until she was sent out "That was when it became a big deal". -The 3rd shift MA gave Resident #1 "Tylenol" that night of the fall and the 1st shift MA gave her some "Tylenol" on 1st shift that day. Interview with family member of Resident #1 on 05/10/19 at 10:32 am revealed: -He had been out of town but usually visits daily. -He went to the facility on 03/10/19 and was told by staff that Resident #1 had difficulty getting out of chair, turning and trying to bear weight on her left side.	D 273		

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D 273	Continued From page 4 -During his second visit to the facility on 03/10/19, he attempted to get Resident #1 out of her chair as she was tired. -Resident #1 was unable to stand to get out of her chair and the family member had to carry her to her bed. -He reported this to the staff. -On his third visit to the facility on 03/10/19, he was not told of the fall that Resident #1 had on 03/09/19. -The staff informed him on this third visit that something was "wrong" with Resident #1 as they had difficulty taking her to the restroom. -The staff never told him that Resident #1 had fallen. -Resident #1 was unable to pivot or lift her left leg and he saw she was in pain. -Resident #1 could not raise her left leg. -He attempted to raise her left leg and he noticed a grimace on her face. -He called the staff and told the personal care aide (PCA) and the medication aide (MA) of the pain and inability to lift her left leg. -The MA working in the special care unit called the second MA who called the supervisor. -He spoke with the supervisor. -The supervisor was not aware of the fall that Resident #1 had on 03/09/19. -This was at 11:00 pm on Sunday night and Resident #1 was already in bed and because of that, he requested she be seen by her Primary Care Provider on Monday 03/11/19. -He had talked to third shift about how his family member was doing and that third shift staff person informed him that Resident #1 had fallen on Friday 03/08/19. -He said the third shift staff had not been working the night of the fall but had been informed of the fall. -The third shift staff "checked documentation and	D 273		

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D 273	Continued From page 5 said it was actually Friday night/Saturday morning" (03/08/19-03/09/19). Interview with a third shift MA on 05/09/19 at 6:50 am revealed: -He was not working when Resident #1 fell. -He was notified of Resident #1's fall during shift change. -He worked the night when Resident #1's family member visited. -The family member came to him to report Resident #1 had difficulty in standing when he tried to assist her to bed and she complained of pain. -"We gave (as needed) pain medication acetaminophen which seemed to help." Review of a physician's note by Resident #1's primary care provider (PCP) dated 03/11/19 at 2:38 pm revealed: -The chief complaints were gait impairment, pain in the left lower extremity, and dementia. -Resident #1 was not able to communicate effectively due to cognitive impairment and limited availability of other reliable sources of information. -The resident had a fall 3 days ago. -Resident #1's fall was not witnessed. -Resident #1's family member visited the facility, later on the day of the fall and noticed Resident #1 had pain in her left lower extremity. -Resident #1's family member expressed worry about a possible fracture. -Resident #1 had not been walking for the past few weeks and had been in a wheelchair. -Resident #1 had been able to walk with a walker prior to that. -Resident #1's examination revealed no bruising, denied pain, able to stand with assistance, "did not want to walk stated she felt weak", stiffness	D 273		

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D 273	Continued From page 6 noted in left knee with swelling. -Assessment was documented as knee joint pain, hip joint pain, fall, gait abnormality, frailty and Alzheimer's disease. -The PCP ordered left knee and left hip x-rays. Interview with Resident #1's physician on 05/09/19 at 3:54 pm revealed: -She was notified of the residents fall when she came to the facility on 03/11/19 for her normal visit. -Resident #1 was assessed and found to be able to stand with assistance and no complaints of pain. -She was informed that Resident #1's family was concerned that she was having difficulty weight bearing after the fall. -She ordered left hip and left leg x-rays to rule out fractures. -She would expect to be notified when the resident fell. Interview with the Director of Resident Care (DRC) on 05/09/19 at 4:59 pm revealed: -When the physician assessed Resident #1, the physician did not think it was anything like a fracture. -Resident #1's family member had told her of a previous fracture, so the physician wanted to rule out a fracture. -Resident #1 had surgeries years ago for the previous fracture but didn't know which leg. -On Monday 03/11/19, Resident #1 was so sore she could not get out of bed. Interview with the regional nurse on 05/09/19 at 4:59 pm revealed: -Resident #1 had gotten out of bed and ambulated down the hall from her room on 03/09/19 around midnight.	D 273		

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D 273	Continued From page 7 -She was found lying on the floor in front of another resident's room wearing a soiled brief. -She was assessed by the staff and there were no complaints of pain. -The staff assisted her back to bed. -When her family member visited that weekend, Resident #1 was noted to be tired. -The physician evaluated Resident #1 on Monday 03/11/19 to rule out a fracture. -The process when a resident was found on the floor was described as follows: "We look for facial expressions/grimaces with the cognitively impaired residents when they can't verbalize pain. There was no special policy for the memory care unit. We follow the same procedure for any unwitnessed fall. The resident was to be sent out. The physician was to be notified as well as the family." -If the fall occurred on a weekend, the resident would be seen on Monday following the weekend fall. -Resident #1 had been documented on by the staff starting from the time of the fall and continued until transferred to the hospital for evaluation and surgery regarding her inability to transfer, pain, and mobility. -After the fracture was confirmed by x-ray results, Resident #1 was sent out immediately to the hospital for further evaluation and treatment. Interview with Resident #1's physician's assistant (PA) on 05/09/19 at 12:50 pm revealed: -Her expectations of the facility regarding incidents/accidents were if not witnessed or if a head injury that the resident would be evaluated by emergency medical services (EMS). -She expected the staff to get vital signs and check range of motion, and check for scrapes, bruises, skin tears etc. -There was an office line that was available 24	D 273		

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D 273	Continued From page 8 hours a day and 7 days a week to be notified. -When a resident was found on the floor, she would expect to be notified immediately. -She would expect the staff to check range of motion for each joint and look for any sign of pain. -When asked would pain be expected with a fractured hip, the PCP would expect there to be pain. -She first notified of the fall after the x-ray on 03/11/19. -The medication aides (MA) were the ones who normally contacted the office with incidents/accidents. Review of Resident #1's hospital admission summary dated 03/12/19 at 12:58 pm revealed: -The chief complaint was left hip pain. -Resident #1 had a history of dementia, hypertension, and presented with complaint of left hip pain after an episode of a fall 3 days prior to admission. -Resident #1's family member provided health history. -Resident #1 was unable to provide detailed history due to her dementia. -Past medical history was documented as Alzheimer's disease, hypercholesteremia, hypertension and osteoarthritis. -Documentation noted that Resident #1 moved all 4 extremities but left lower extremity was limited with discomfort/pain. -X-ray result of left hip on 03/12/19 revealed a fracture. Review of Resident #1's hospital discharge summary dated 03/15/19 at 9:42 am revealed: -Resident #1 was admitted on 03/12/19 with a diagnosis of left hip fracture. -Resident #1 had a history of dementia and presented to the emergency room (ER) because	D 273		

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D 273	Continued From page 9 of left hip pain after a fall about 3 days prior to admission. -Resident #1 was not able to give any significant history because of dementia. -Resident #1 had a surgical repair of the left hip. -Discharge diagnoses revealed closed left hip fracture, essential hypertension, hyperlipidemia, dementia, arrhythmia, pre-op evaluation, and atrial flutter. -Resident #1 was discharged to an acute rehabilitation facility. Review of Resident #1's assessment and care plan dated 04/16/19 revealed: -The resident was ambulatory with wheelchair. -The resident was always disoriented. -The resident had significant memory loss and must be directed. -The activities of daily living (ADL) revealed the resident required supervision for eating, limited assistance for transferring, and extensive assistance for toileting, ambulation/locomotion, bathing, dressing, and grooming/personal hygiene. Attempted interview on 05/10/19 and 05/13/19 with third shift medication aide who worked on 03/08/19 was unsuccessful. Attempted interview on 05/10/19 and 05/13/19 with first shift personal care aide who worked on 03/09/19 was unsuccessful. The facility failed to notify Resident #1's physician for 3 days after an unwitnessed fall of the resident, which resulted in uncontrolled pain and a left hip fracture. The facility's noncompliance resulted in serious injury to Resident #1 which constitutes an Unabated Type A1 Violation.	D 273		

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D 273	Continued From page 10 The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/09/19 for this violation.	D 273	10A NCAC 13F .0909 Resident Rights 5/29/19 DRC re-educated staff on call bell system and importance of responding to in a timely manner. Re-enforced that all nursing are to carry pagers and walkie radios. If PCAs are unable to respond timely, then Med Tech should respond. If both PCA and Med Tech are unable to respond, a call should be placed to another clinical team member to assist. PCAs and Med Techs will continue to carry their pagers and walkie radios and be responsible to ensure their own devices are in working order at all times. Staff will continue to receive pagers and walkies at time of hire and ensure devices are checked prior to start of their shift to be in working order. Additional devices are available in the event staff fail to bring their pagers and radios with them, or if they are found to not be in working order. Assigned Med Techs for each shift to ensure care team is equipped with working devices and that call bells are responded to in a timely manner. This is to happen each shift. DRC or designee to follow up daily to ensure compliance.	5/29/19
D 338	10A NCAC 13F .0909 Resident Rights 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. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure residents received a reasonable response time from staff when they pulled their call light. The findings are: Observation of call light pulled in a resident's room on third floor at 2:37pm thru 2:52pm revealed there was no staff response to resident's room. Interview with a resident on 05/08/19 at 11.01am revealed the staff respond 15 to 30 minutes after they pull their call light at nights.	D 338		

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D 338	Continued From page 11 Interview with another resident on 05/08/19 at 11:11 am revealed staff did not always respond to the call lights in the evenings and at nights. Interview with the medication aide (MA) on 05/10/19 at 2:49pm revealed: -The call light rang to the personal care aide's (PCA) pager. -There was one PCA working on the floor today. -There were 26 residents on the floor. -The MAs did not carry pagers. Interview with the PCA on 05/10/19 at 2:54pm revealed: -She was not on the floor at 2:37pm when the call light was pulled. -Her pager did not buzz until the MA called her to come to the floor. -Her pager was time stamped with the incorrect time. It had 8:30am. -She was not aware of any place in the facility where the pager did not work. -Her pager had only buzzed once more upon returning to the floor. Interview with the maintenance staff on 05/10/19 at 3:01pm revealed: -He was not sure if the pager would buzz more than one time. -There should only be a 30 second delay if the PCA was outside. -He was not aware of anywhere in or around the facility that the PCA's pagers would not work. -When a call light was pulled, it also shows up on the computer screen in the wellness office and at the reception desk. Interview with the wellness director on 05/10/19 at 3:12pm revealed:	D 338		

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D 338	Continued From page 12 -The computer in the wellness office has not been working since 12:00pm today. -She was not always in the office. -When she was in the office she would let the PCA or MA know if a call light was ringing. -She was not aware of any way to run a tracking report on the call lights or pagers. -It was the PCAs responsibility to make sure their pager was working. -The facility provided batteries if the battery was dead. -The PCAs could get another pager from the facility if their pager did not work. Interview with the receptionist on 05/10/19 at 3:30pm revealed: -Someone was at the front desk all the time. -Her typical shift ends at 8pm, she never worked past 8pm. -She was unsure who answered the call light after 8pm. -When a call light was pulled, it appeared on the computer screen at the reception desk, and the wellness office. -She was trained, after five minutes if the call light was not answered, then page a PCA over the intercom for resident assistance. -The medication aides (MA) did not carry pagers. Interview with the Resident Care Coordinator (RCC) on 05/10/19 at 4:13pm revealed: -The pagers should buzz immediately when residents pulled their call lights. -They should work anywhere in the facility. -The receptionist computer would light up with assistance needed with the room number. -The receptionist would use the radio and announce what room assistance was needed in. -There was no set time for the receptionist to wait before announcing what room was needing	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092156	A. BUILDING: _____ B. WING _____	R 05/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

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D 338	Continued From page 13 assistance. -The expectation was for the call lights to be answered as soon as possible. -It was the expectation that PCAs and MAs all have a pager. -Each PCA and MA had pagers assigned to them and they were responsible for making sure they were working. -The staff were trained on how to answer the call light in orientation by her and by maintenance staff. Interview with the Administrator on 05/10/19 at 4:38pm revealed: -The expectation was that all MAs and PCAs have a pager. -When the PCA could not respond they were to call the MA to respond to the call light. -When the MA was busy and could not respond to them, they were to call any of the clinical staff. -The receptionist left at 8:00pm but the MA and PACs should have a pager. -The facility had extra pagers in the event staff need one.	D 338		
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.	D 358		

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D 358	Continued From page 14 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#2, #5) with missed doses of a medication ordered to treat depression (#5), and missed doses of medications for constipation and to thin mucus (#2). The findings are: 1.Review of Resident #5's current FL-2 dated 02/21/19 revealed: - Diagnoses included atrial fibrillation, hyperthyroidism, and malignant neoplasm breast. - A physician order for Celexa 40mg take 1/2 tablet by mouth daily (Celexa is used to treat depression). Review of Resident #5's March 2019 electronic medication record (eMAR) revealed: -There was a computer generated entry for Celexa 40mg take 1/2 tablet by mouth daily with a scheduled administration time of 8am. -There was documentation Celexa was not administered from 03/01 /19 to 03/14/19 with a reason of unavailable documented in exception section of the eMAR. Review of Resident #5's April 2019 and May 2019 eMAR revealed Resident #5 had not missed any does of Celexa 20mg.	D 358	10A NCAC 13 F. 1004(a) Medication Administration 5/29/19 RN consultant re-educated Med Techs on process of documentation and transcription of orders. 5/30/19 newer Med Techs were sent to state approved 15hr Med Tech Training for further clinical support. Resident chart audits will be completed by DRC and designee to ensure accuracy of FL2 orders versus MAR orders. Effective immediately DRC or designee will continue to review any new admission FL2s and clarify with MD to verify FL2 for accuracy. Once FL2 and MAR reviewed, orders will be placed in New Order Tracking System to ensure orders are complete and properly transcribed. DRC or designee will monitor New Order Tracking System daily for Compliance with physician orders as it relates to current FL2.	7/5/19

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D 358	Continued From page 15 Interview with the medication aide (MA) on 05/09/19 at 11:30am revealed: -The pharmacy did not send any medication for March 1,2019 - March 14,2019. -She did not know if the physician was notified. -She had not notified the physician that the medication was not given. -The process would have been to notify the physician if there were no medications available. Interview with the Pharmacy Technician on 05/09/19 at 12:22pm revealed: -The dosage of Celexa was changed from 40mg to 20 mg on 02/18/19. - The insurance would not pay for a new prescription. - On 04/20/19 the facility paid for a 4 day supply of the Celexa 20mg for Resident #5. -A local hospice paid for a 30 day supply of the Celexa 20mg on 03/13/19. Interview with the Primary Care Physician (PCP) on 05/09/19 at 4:00pm revealed: -She had changed the dosage of Celexa on02/18/19 from 40mg to 20mg. -She was not made aware Resident #5 was not getting the Celexa until after the medication was made available. -She found out when she returned to the facility to do a follow up visit on Resident #5 in regards to the Celexa dosage change. -Celexa should be tapered off and not stopped due to having withdrawal symptoms. -The staff did not report any withdrawal symptoms to her when she was there for the follow up. -Some of the withdrawal symptoms were irritability, anxiety and depression.	D 358		

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D 358	Continued From page 16 Interview with Resident Care Coordinator (RCC) on 04/09/19 at 09:34am revealed: -When they received new orders, they were faxed to pharmacy. -Then they were transcribed on the eMAR by the MA or the clinical staff. -An order tracking sheet was filled out and put in the order tracking book. -Third shift checked the medications in. -She or the Assistant RCC double checked the order tracking book to make sure the medication had arrived. 2. Review of Resident #2's current FL-2 dated 03/22/19 revealed: -Diagnoses that included cognitive communication deficit, aphasia following cerebral vascular accident, and diabetes mellitus (unspecified). -Medication orders included Mucinex DM (used to thin mucus in the head, nose and chest) 600mg daily for 10 days and Benefiber (a fiber supplement) 3 gm daily. a Review of a Physician Order form dated 04/18/19 revealed: -There was an order for Mucinex 600mg daily for 10 days. -There was an order for Benefiber 3gm daily. Review of a hand-written medication administration record (MAR) for Resident # 2 dated March 2018 revealed: -There was an entry for Benefiber 3gm, take 1 pack daily with water. -Benefiber was documented as administered as ordered on 03/27/19, 03/28/19,03/29/19, 03/30/19 and 03/31/19. Review of a hand-written MAR for Resident # 2	D 358		

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D 358	Continued From page 17 dated March 2019 revealed: -There was an entry for Mucinex DM 600mg daily for 10 days. -Mucinex DM was documented as not administrated because it was unavailable on 03/27/19, 03/28/19, 03/29/19, 03/30/19 and 03/31/19. Review of an electronic generated MAR for Resident #2 dated April 2019 revealed: -There was no entry for Benefiber 3gm daily. -There was no entry for Mucinex DM 600mg daily for 10 days. Review of an electronic generated MAR for Resident #2 dated May 2019 revealed: -There was no entry for Benefiber 3gm daily. -There was no entry for Mucinex DM 600mg daily for 10 days. Observation of Resident #2's medication on hand on 05/09/19 at 11:20am revealed: -There was a punch card of Mucinex DM 600mg, ten tablets with instructions to take one tablet daily. -Ten tablets of Mucinex were in the punch card. -The punch card of Mucinex had been filled by the facility's providing pharmacy 04/18/19. -There was no Benefiber available for administration. Interview with the Resident Care Coordinator (RCC) on 05/09/19 at 2:20pm revealed: -She did not know why the Mucinex was on the March MAR but not on the April MAR. -She did not know why the Benefiber was on the March MAR and not on the April and May MAR. -MARs were checked with orders as they arrived by either her or the assistant RCC. -The RCC was unsure how the 2 medications	D 358		

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D 358	Continued From page 18 were missed. A second interview with the RCC on 05/09/19 at 4:50pm revealed she had called the providing pharmacy and was told Benefiber was never dispensed for Resident #2. Interview with Resident #2 on 05/09/19 at 11:50am revealed that she did not remember receiving either the Mucinex or Benefiber. Review of a Physician Order form dated 05/13/19 received by fax on 05/13/19 revealed: -The primary care provider (PCP) was notified that Resident # 2 had not received Mucinex or Benefiber since date of admission. -The PCP ordered both medications to be discontinued.	D 358		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure that medications were administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent	D 371	10A NCAC 13F. 1004(n) Medication Administration 5/29/19 RN Consultant re-educated Med Techs on hand washing techniques, infection control, transmission or disease and prevention of cross contamination during med administration. Infection control training will continue to be given upon hire and annually thereafter. ED or designee to ensure annual training calendar is in compliance. DRC or designee to do weekly cart audits to ensure carts are stocked with sanitizer and gloves.	5/29/19

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D 371	Continued From page 19 cross-contamination and provide a safe and sanitary environment for staff and residents as evidenced by 2 of 2 medication aides (MAs) (Staff B and G) medication aides (MA) not using appropriate hand hygiene techniques during medication administration. The findings are: 1. Observations during the medication pass on 05/09/19 at 8:33am revealed: -There was no hand sanitizer or gloves visible on the medication cart. -A different staff member provided a handful of gloves for Staff G's use when Staff G could not located gloves on the medication cart. -Staff G administered oral medications and a nasal spray for a resident. -Staff G wore gloves while administering the nasal spray to the resident. Interview with Staff G on 05/09/19 at 8:43 revealed: -She stated that hand sanitizer should be used between every third resident during the medication pass. -She was unclear on who had instructed her hand sanitizer should be used after every 3rd resident. -There was no hand sanitizer on the medication cart. Observations during medication pass on 05/09/19 at 9:07am revealed: -There was no hand sanitizer visible on the medication cart. -Staff B prepared and administered oral medications and a nutritional drink for a resident. -Staff B returned to the medication cart and prepared and administered oral medications to	D 371		

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D 371	Continued From page 20 the next resident without any type of hand cleaning. -When prompted, the MA washed her hands. Interview with Staff B on 05/08/19 at 9:18am (after medication was administered to 2nd resident) revealed: -When asked if she had hand sanitizer, Staff B located a bottle of hand sanitizer in the bottom drawer of the medication cart. -Staff B stated she did not like to use hand sanitizer. Interview with the facility's regional nurse on 05/08/19 at 2:25pm revealed: -Appropriate hand hygiene was included in both the medication administration training and the infection control training that each MA had completed. -She would expect each MA to follow proper infection control guidelines. -"The guidelines we follow are the state's not ours." -She did not know Staff G was using hand sanitizer after every 3rd resident rather than after every resident. Interview with the facility's Executive Director (ED) and the Resident Care Director (RCD) on 05/09/19 at 3:20pm revealed: -Neither the ED or the RCD were aware the staff were not following infection control guidelines. -A training class would be scheduled as soon as possible to re-train staff.	D 371		
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:	D912		

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D912	Continued From page 21 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, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to health care. The findings are: Based on observations, interviews, and record reviews, the facility failed to assure the physician was notified for 1 of 5 sampled residents (#1) related to an unwitnessed fall, which resulted in a left hip fracture and uncontrolled pain for 3 days. [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Unabated Violation)].	D912	G.S. 131D-21(2) Declaration of Residents' Rights As of 5/9/19 and per plan of protection all staff were advised and reminded that with every fall each resident will be assessed for pain and changes in condition. All falls will continue to be reported to DRC or designee. Family members and MD to be notified at time of fall. Any residents showing pain, grimaces, change of condition, or increased use of PRN medication will have EMS services called immediately to assess and send to hospital for follow up if needed. Staff meeting 5/29/19 staff re-trained on fall procedures and policy by DRC. With every reported fall, DRC or designee to ensure assessment for pain and calls to MD and family are completed in addition to EMS services called with any pain, signs of distress, or change in condition. This is to happen with every fall occurrence to ensure compliance. ED or designee will review reported falls during weekly At Risk meeting to ensure compliance.	5/9/19

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

Certified Mail and Electronic Mail
Certified #7014-2120-0002-0137-8280

June 4, 2019

Bruce J. Mackey, Jr., President
Five Star Cary Heartfields, LLC, Licensee
HeartFields at Cary
Attention Licensing 400 Centre Street
Newton, MA 02458

email address: licensing@5sqc.com

Re: Follow-up Survey and Complaint Investigation completed May 13, 2019 (QC4S11)
Unabated Type A1 Violation

Facility: HeartFields at Cary
Licensure Number: HAL-092-156
County: Wake

Dear Mr. Mackey:

Thank you for the cooperation and courtesy extended during the survey completed May 13, 2019 by staff with the Adult Care Licensure Section.

As a result of the follow up survey, it was determined that some of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. Additional deficiencies were cited during the survey.

The Type B Violation in the rule areas of **10A NCAC 13F. 1004(a) Medication Administaration** was abated as of the correction date, March 8, 2019. Therefore a penalty will not be recommended.

Based on the survey findings, 1 of 3 complaint allegations was substantiated resulting in deficiencies 10A NCAC 13 F .0909, Resident's Rights.

Enclosed you will find all violations/deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with the state regulations. You must provide an acceptable Plan of Correction for each violation/deficiency cited in the left column. In the spaces to the right of the form, state your plan for correcting the problem and the completion date by which you will correct each violation/deficiency identified and return it to our office within 15 working days of receipt of this letter. Below you will find what to include in the Plan of Correction for all deficiencies; and, if violations were identified, details of the type of violation(s) and the time frame(s) for compliance are also provided below.

Unabated Type A1 Violation

- Unabated Type A1 Violation is cited for **10A NCAC 13F. 0902(b) Health Care** and **G.S. § 131D-21 Resident Rights.**
- A correction date of May 14, 2019 has been provided.
- Information regarding any penalty recommendation and imposition for the violation will be mailed to you separately.

As set forth in G. S. § 131D-34 where the facility has failed to correct a Type A1 Violation within the time specified for correction, the Department shall assess the facility a civil penalty in the amount of up to $1,000.00 per day for each day the violation continues beyond the date specified for correction.

What to include in the Plan of Correction

- Indicate what measures will be put in place to correct the deficient area of practice (i.e. changes in policy and procedures, staff training, changes in staffing patterns, etc.)
- Indicate what measures will be put in place to prevent the problem from occurring again
- Indicate who will monitor the situation to ensure it will not occur again
- Indicate how often the monitoring will take place
- Completion dates by which the plan of correction will be completed. The completion dates must be acceptable to the State.
- Sign and date the bottom of the first page of the State Form.

Return the signed and dated Statement of Deficiencies form within 15 working days from the date of receipt of this letter. We are unable to accept faxed reports at this time; therefore, a copy must be mailed to our office or e-mailed to the survey team leader. Please make sure the copy you mail or e-mail to us is SIGNED AND DATED or it will not be accepted. A response to the plan of correction will be sent ONLY if the plan of correction is not accepted. Please retain a copy for your files.

Informal Dispute Resolution

In accordance with G.S. § 131D-2.11(a2), you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest the severity of noncompliance that resulted in a violation determination. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by **June 25, 2019**. An explanation of why you are disputing those deficiencies (or why you are disputing the severity of noncompliance that resulted in a violation determination) along with any supporting documentation must be sent and postmarked by **June 25, 2019**. You must submit 2 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to: IDR Coordinator, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: http://www.ncdhhs.gov/dhsr/acls/idr.html.

If you have questions about the enclosed Statement of Deficiencies or the violations, please contact me at 910-990-0045. A follow up survey will be conducted to determine compliance in all areas cited. If this agency can be of any assistance in providing consultation relative to licensure rules, please let us know.

Sincerely,

Twila Bowen, RN

Twila Bowen, RN, Licensure Consultant
Adult Care Licensure Section
Division of Health Service Regulation

Enclosures: Statement of Deficiencies
Revisit Report

cc: Catherine Goldman, Supervisor, Wake CCounty Department of Social Services
Jennifer McNeil, Administrator w/enclosures (included in certified mail # 7014-2120-0002-0137-8280
Theresa Conley, Team Supervisor, East 7 Region, Adult Care Licensure Section
Facility File

Please note information regarding Customer Service Survey below.

In an ongoing effort to improve the inspection process with the providers we serve, we would like you to complete a Customer Service Survey. The Survey can be accessed at the web site below. Your opinion is important to us, and will assist us in developing new and better ways to do our job.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

Thank you for participating in this confidential survey as we strive to improve the services we provide to licensed health care providers across the state of North Carolina. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Mark Payne, Director, Division of Health Service Regulation, at 919-855-3750.

Customer Service Survey web site: http://www2.ncdhhs.gov/dhsr/customerservice.html
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA/ IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
HAL092156 Y1	A. Building B. Wing Y2	5/13/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTFIELDS AT CARY	1050 CRESCENT GREEN DRIVE CARY, NC 27511

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0209 Reg. # 10A NCAC 13F .0604 (2-e) LSC	Correction Completed 04/01/2019	ID Prefix D0234 Reg. # 10A NCAC 13F .0703(a) LSC	Correction Completed 03/31/2019	ID Prefix D0276 Reg. # 10A NCAC 13F .0902(c) (3-4) LSC	Correction Completed 02/20/2019
ID Prefix D0280 Reg. # 10A NCAC 13F .0903(c) LSC	Correction Completed 01/29/2019	ID Prefix D0282 Reg. # 10A NCAC 13F .0904(a) (1) LSC	Correction Completed 03/01/2019	ID Prefix D0297 Reg. # 10A NCAC 13F .0904(d) (1) LSC	Correction Completed 02/11/2019
ID Prefix D0298 Reg. # 10A NCAC 13F .0904(d) (2) LSC	Correction Completed 03/29/2019	ID Prefix D0299 Reg. # 10A NCAC 13F .0904(d) (3)(A) LSC	Correction Completed 03/27/2019	ID Prefix D0306 Reg. # 10A NCAC 13F .0904(d) (3)(H) LSC	Correction Completed 03/27/2019
ID Prefix D0310 Reg. # 10A NCAC 13F .0904(e) (4) LSC	Correction Completed 03/27/2019	ID Prefix D0375 Reg. # 10A NCAC 13F .1005 (b) LSC	Correction Completed 03/08/2019	ID Prefix D0464 Reg. # 10A NCAC 13F .1307 LSC	Correction Completed 01/30/2019
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
			Linda G. Bauer, RN	06/04/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/22/2019

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO