McNeil, Jennifer

From: Newcomb, Lisa
Sent: Tuesday, November 5, 2019 8:56 AM
To: McNeil, Jennifer; Cole, Melissa
Cc: Wheatley, Elizabeth; Cooney, Lisa
Subject: FW: HeartFields at Cary ACH 2019-11-04 SODL QC4S12
Attachments: HeartFields at Cary 2019-10-18 SOD QC4S12.pdf

Lisa Newcomb
Licensing Manager
O:617-796-8173 M:617-584-6638

http://myfve.fve.ad.5ssl.com/legal/Wikipage%20Library/Licensing.aspx

From: Vogt, alison M [mailto:alison.m.vogt@dhhs.nc.gov]
Sent: Monday, November 4, 2019 3:02 PM
To: FVE-Licensing
Cc: Catherine Goldman; Conley, Theresa L; tworek, dai; dhsr.adultcare.email7; DHSR.AdultCare.Star; Kirby, Linda H; Talbot, Tamara M
Subject: [EXTERNAL] HeartFields at Cary ACH 2019-11-04 SODL QC4S12

Dear Mr. Mackey:

Please find the Statement of Deficiencies and accompanying letter for the follow-up survey on October 18, 2019 attached to this e-mail. If the Statement of Deficiencies includes citations or violations for which a plan of correction is required, please read the attached letter carefully for instruction on completing the plan of correction. **PLEASE NOTE: WE WILL NOT ACCEPT A FAXED PLAN OF CORRECTION! 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.

If you have any questions regarding the information provided in or attached to this email, please call 919-817-4383. Please be aware that information sent via electronic mail is immediately available for release to the public. Therefore, the information contained in and attached to this e-mail is now public information.

Sincerely,

Alison Vogt, RN, BSN
Nurse Consultant
Division of Health Service Regulation, Adult Care Licensure Section
North Carolina Department of Health and Human Services

Office/Mobile: 919-817-4383
Fax: 919-733-9379
alison.m.vogt@dhhs.nc.gov

2708 Mail Service Center, Brown Building
Raleigh, NC 27699-2708

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STAR RATING

If the Statement of Deficiencies attached to this email is a result of an annual, follow-up or complaint inspection a star rating certificate and worksheet will be issued within 45 days of the date of this email. If you would like to know more information about the NC Star Rated Certificate Program or view facility ratings, please visit the star rating website at http://www.ncdhhs.gov/dhsr/acls/star/index.html. If you have questions about this facility's star rating or the rating program in general, please send an email with your questions to the star rating customer service email address at DHSR.AdultCare.Star@lists.ncmail.net.

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, at 919-855-3750.

Customer Service Survey web site: **http://www2.ncdhhs.gov/dhsr/customerservice.html**

Division of Health Service Regulation

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 10/18/2019

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 Section conducted a follow-up survey from 10/17/2019 - 10/18/2019.	{D 000}		
{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: NON-COMPLIANCE CONTINUES 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: Observations of the third floor on 10/17/19 11:17am during initial tour revealed: -There were 22 residents on the third floor. -The residents' rooms had a call bell with an attached string on the wall near the bed. -All residents also had lanyards with an attached call pendant to be worn around their neck. -There was a laundry staff delivering clothes to the residents, a primary care provider (PCP) and a contract nurse administering flu shots to the residents. -There were no other staff on the third floor. Observation after a call pendant was pressed in room 301 on third floor on 10/17/19 from 11:05am through 11:35am revealed there was no staff response.	{D 338}	10A NCAC 13F .0909 Resident Rights 10/31/19 DRC re-educated staff on call bell system and importance of responding to in a timely manner. Reinforced 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. 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. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 11/5/19

Review and accepted with Linda Kirby, RN, Nurse Consultant.

Mari Vogt, RN, BSN 12/8/2019

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{D 338}	Continued From page 1 Observation on 10/17/19 at 3:12pm revealed: -A resident's hallway door was open. -The resident was asleep in a recliner with the foot elevated. -The resident had slipped down in the recliner so that her head was bent to the side at the back of the seat and her legs were bent at the knees hanging off the elevated foot of the recliner. Observation on 10/17/19 from 3:15pm to 3:31pm revealed no response to a pulled call bell until the personal care aide (PCA) delivering 3:00pm snacks stopped at the resident's room. Interview with a PCA on 10/17/19 at 3:35pm revealed: -She was not responding to the resident's call bell when she assisted the resident in the recliner. -The PCA had worked 3:00pm until 11:00pm on 10/16/19 and the resident's call pendant "kept going off so it must have been broken". -When the resident's call bell was pulled at 3:15pm, the PCA thought it was the call pendant "acting up again". -She did not know if the call pendant had been reported as broken on 10/16/19. -The PCA was giving snacks, walked by the open door and saw the resident slipped down in her chair and repositioned her. -When a resident pulled a call bell cord or pressed a call pendant, PCAs received a page identifying the resident and if the page came from the call bell or pendant. -The PCA could not explain why she did not respond to the page since it showed coming from the call bell rather than the call pendant. Interview with a resident on 10/17/19 at 11:24am revealed: -He did not like the facility's service, he had	{D 338}	DRC or designee will do weekly spot checks through documented Manager Walkthrough Checklists to ensure staff are responding timely to tested call bells and staff remain in compliance. New call bell system approved by corporate with Purchase Order number 00497277. Awaiting installation date by Vendor, Amplified Electronic Design.	11/01/2019

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{D 338}	Continued From page 2	{D 338}		

pushed the call button in his room and did not receive a response from staff on several occasions (no additional details provided).
-The response time to the call bell system was slow to no response on an intermittent basis.
-He noticed the slow to no response with the call bell system mostly occurred on the weekends and at night.
-When pushed, the call bell system would ring to the staff's pagers and to the front desk of the facility.

Interview with a second resident on 10/17/19 at 11:35am revealed:
-The staff's response to the call bell system took a little longer on the nights and weekends.
-The staff's response time to the resident's call bell would vary and could be fifteen to thirty minutes.

Interview with the Resident Care Coordinator (RCC) on 10/18/19 at 1:40pm revealed:
-She expected the PCAs to remain in their assigned work area unless paged to assist in another area.
-She expected a resident's call for assistance to be answered "as soon as possible".
-If staff was assisting a resident when a second resident called for assistance, the staff should either call for another staff or let the second resident know she will be there as soon as possible.
-The RCC could not explain why the page to room 301 was not answered.
-She would have maintenance check the resident's call pendant.

Interview with the Executive Director (ED) on 10/18/19 at 2:40pm revealed:
-A new call bell system had been approved for the

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{D 338}	Continued From page 3 facility. -She expected instillation would be completed as soon as all ordered components arrived. -The new system would allow reports to be generated showing staff response time to call bells and would identify any problem areas.	{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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #5) including errors with insulin. The findings are: Review of Resident #5's current FL2 dated 06/20/19 revealed: -Diagnoses included hypertensive kidney disease, weakness, cognitive communication deficit and aphasia following cerebral infarction [diabetes mellitus was not listed]. -There was a medication order for Novolog (Novolog is a rapid acting insulin used to lower blood sugar) sliding scale insulin (SSI) according to the following scale: for fingerstick blood sugars	{D 358}	10A NCAC 13.F .1004(a) Medication Administration 10/31/19 DRC re-educated staff on insulin parameters and the importance of following and adhering to physician orders. On 10/31/19 Med Techs were also in-serviced on the importance of notifying MD when appropriate as per physician's orders. All insulin dependent resident MARs were reviewed for accuracy of units given per prescribed parameters by 11/1/19. DRC or designee will observe an insulin medication pass weekly for compliance to prescribed insulin parameters. Compliance will be tracked and documented through weekly Medication Audit checklists. Frequency of weekly checks will be re-evaluated January 2020.	11/01/2019

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{D 358}	Continued From page 4 (FSBS) result of 0-150= 0 units; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; greater than 400 call the physician. Review of Resident #5's August 2019 Medication Administration Record (MAR) revealed: -There was a computer generated entry for Novolog SSI to be administered 3 times a day with administration times of 7:30am, 11:30am, and 4:30pm according to the following scale for FSBS result of 0-150= 0 units; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; greater than 400 call the physician. -Resident #5's FSBS was documented as 162 on 08/13/19 at 11:30am and would have required 1 unit of insulin; 0 units were documented as administered. -Resident #5's FSBS was documented as 180 on 08/14/19 at 4:30pm and would have required 1 unit of insulin; 0 units were documented as administered. -Resident #5's FSBS was documented as 233 on 08/15/19 at 11:30am and would have required 2 units of insulin: 1 unit was documented as administered. -Resident #5's FSBS was documented as 183 on 08/18/19 at 4:30pm and would have required 1 unit of insulin: 3 units were documented as administered. Review of Resident #5's September 2019 MAR revealed: -There was a computer generated entry for Novolog SSI to be administered 3 times a day with administration times of 7:30am, 11:30am, and 4:30pm according to the following scale for FSBS result of 0-150= 0 units; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301	{D 358}		

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{D 358}	Continued From page 5 - 350 = 4 units; 351 - 400 = 5 units; greater than 400 call the physician. -Resident #5's FSBS was documented as 199 on 09/19/19 at 11:30am and would have required 1 unit of insulin: 0 units were documented as administered. -Resident #5's FSBS was documented as 191 on 09/21/19 at 11:30am and would have required 1 unit of insulin: 0 units were documented as administered. -Resident #5's FSBS was documented as 386 on 09/19/19 at 4:30pm and would have required 5 units of insulin: 4 units were documented as administered. -Resident #5's FSBS was documented as 376 on 09/26/19 at 4:30pm and would have required 5 units of insulin: 4 units were documented as administered. Review of Resident #5's October 2019 MAR revealed: -There was a computer generated entry for Novolog SSIto be administered 3 times a day with administration times of 7:30am, 11:30am, and 4:30pm according to the following scale for FSBS result of 0-150= 0 units; 151 - 200 = 1 units; 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units; greater than 400 call the physician. -Resident #5's FSBS was documented as 169 on 10/02/19 at 7:30am and would have required 1 unit of insulin: 0 units were documented as administered. -Resident #5's FSBS was documented as 388 on 10/05/19 at 7:30am and would have required 5 units of insulin; 3 units were documented as administered. -Resident #5's FSBS was documented as 166 on 10/05/19 at 11:30am and would have required 1 unit of insulin; 0 units were documented as	{D 358}		

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{D 358}	Continued From page 6	{D 358}		

administered.
-Resident #5's FSBS was documented was 253 on 10/13/19 at 7:30am and would have required 3 units of insulin; 5 units were documented as administered.
-Resident #5's FSBS was documented as 252 on 10/14/19 at 7:30am and would have required 3 units of insulin; 2 units were documented as administered.
-Resident #5's FSBS was documented as 258 on 10/16/19 at 7:30am and would have required 3 units of insulin; 2 units were documented as administered.
-Resident #5's FSBS was documented as 261 on 10/16/19 at 11:30am and would have required 3 units of insulin; 2 units were documented as given.
-Resident #5's FSBS was documented as 225 on 10/17/19 at 7:30am and would have required 2 units of insulin; 3 units were documented as administered.

Interview with Medication Aide (MA) on 10/18/19 at 5:06pm revealed:
-Before administering insulin to a resident, she would obtain a FSBS.
-She would reference the insulin sliding scale ordered by the primary care physician (PCP) and would administer insulin to the resident according to the sliding scale.
-If the resident's FSBS result was higher than the ordered sliding scale she would know notify the Director of Resident Care/Licensed Practical Nurse (DRC/LPN).
-She would notify the DRC/LPN if she observed on the resident's MARs the resident did not receive enough or too much insulin per the sliding scale orders.

Interview with a second MA on 10/18/19 at

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{D 358}	Continued From page 7	{D 358}		

5:14pm revealed:
-She would reference the insulin sliding scale ordered by the PCP and would administer insulin to the resident according to the sliding scale.
-If she observed on the MARs the resident was not administered the accurate number of units of insulin per the PCP's orders on a previous shift, she would notify the DRC/LPN.
-She had not noticed any inaccuracies on the residents' MARs related to insulin administration.

Interview with a third MA on 10/18/19 at 5:19pm revealed:
-Before administering insulin to a resident, she would reference the insulin sliding scale orders on the MARs.
-She would administer the insulin to the resident per the insulin sliding scale orders depending on the resident's FSBS results.
-If she noticed any inaccuracies on the MARs related to the resident's insulin administration, she would notify the DRC/LPN.
-She would chart her notification of the DRC/LPN in the resident's progress notes.

Interview with the DRC on 10/18/19 at 1:30pm revealed:
-The MARs are reviewed monthly by the DRC, Regional Nurse and area managers.
-The MARs were reviewed for omissions rather than the correct dosage of insulin if the resident was on "sliding scale insulin".
-Resident #5 had not complained of symptoms of high or low blood sugars (shakiness, sweating, excessive thirst or hunger) nor been sent out [to the emergency department] because of her blood sugars.
-Resident #5 had a prescription for glucose tablets she could keep at bedside for self administration if she felt her blood sugar was too

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{D 358}	Continued From page 8 low. -The MA that made several of the SSI errors was no longer employed by the facility. Interview with the regional nurse on 10/18/19 at 3:40pm revealed: -She reviewed MARs when she was in the facility. -The reviews were to assure that medications were administered not the accuracy of SSI coverage. -Sliding scale insulin coverage would be reviewed closer in future audits. -The facility had also contracted a nursing consultant to review records. -Errors in insulin coverage had not been reported to her by the consultant. Interview with the Executive Director (ED) on 10/18/19 at 3:15pm revealed she knew the DRC and the regional nurse reviewed the MARs, but she did not know if they went "line by line" reviewing dosage. Attempted telephone interview with Resident #5's PCP on 10/18/19 at 4:55pm was unsuccessful.	{D 358}		