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 08/04/2022

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 complaint investigation on 08/03/22- 08/04/22.	D 000		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed	D 188	1. ED and or designee will review staff schedules and timecards daily for 4 weeks, and then weekly to ensure staffing requirements are met. In the event of an unforeseen circumstance, a qualified replacement will be added to the schedule 2. Date of Compliance: 9/12/22	

Reviewed and Acknowledged Theresa A. Floyd 10/03/22

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kristi Flores ED — TITLE — (X6) DATE: 9/20/22

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D 188	Continued From page 1 by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) unit with a census of 57 residents on 07/10/22, a census of 56 residents on 07/11/22 and a census of 59 residents on 07/31/22 were met for 3 of 18 shifts. The findings are: Review of the facility's license effective 01/01/22 revealed the facility was licensed for a capacity of 97 beds including 82 beds for the assisted living (AL) area and 15 beds for the special care unit (SCU). Review of the facility's resident census reports dated 07/10/22 revealed there was a census of 57 residents in the AL area, which required 28 staff hours on first and second shift and 16 staff hours on third shift. Review of the employee timecards dated 07/10/22 revealed there was a total of 21 staff hours provided on second shift in the AL area with a shortage of 7 hours. Review of the facility's resident census reports dated 07/11/22 revealed there was a census of 56 residents in the AL area, which required 28	D 188		

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D 188	Continued From page 2 staff hours on first and second shift and 16 staff hours on third shift. Review of the employee timecards dated 07/11/22 revealed there was a total of 20.5 staff hours provided on second shift in the AL area with a shortage of 7.5 hours. Review of the facility's resident census report dated 07/31/22 revealed there was a census of 59 residents in the AL area, which required 28 staff hours on first and second shifts and 16 staff hours on third shift. Review of the employee timecards dated 07/31/22 revealed there was a total of 23.37 staff hours provided on first shift in the AL area with a shortage of 4.63 hours. Interview with a resident on 08/03/22 at 10:00am revealed his biggest concern was there was not enough staff on duty. Interview with a medication aide (MA) on 08/03/22 at 9:23am revealed: -This past Sunday, 07/31/22, he was the only MA working on first shift for the entire facility. -He "ran really fast" in order to administer all of the residents' medications on time. -There was 3 staff working as personal care aides (PCAs) in the AL area on first shift on Sunday, 07/31/22. -He was not sure why the facility was short staffed on first shift on 07/31/22 except he knew at least one staff called out. -The facility had been short staffed for at least 3 to 4 months. -The facility was usually short staffed on the weekends, Mondays, and Thursdays. -There was supposed to be at least two MAs	D 188		

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working on first shift.
-The facility management team was aware the facility was short staffed.
-The Director of Resident Care (DRC) worked on the floor in the AL area as a PCA on Sunday, 07/31/22.

Interview with the DRC on 08/03/22 at 2:26pm revealed:
-She was aware the facility had been short staffed.
-There was supposed to be 2 MAs working on first shift and 3 PCAs, one on each floor of the AL area.
-There had been quite a few days when medications were administered late due to the facility being short staffed.
-She was working on hiring more MAs.
-She worked on the floor as a PCA to help fill in when staffing was short.
-She worked on first shift in the AL area on Sunday, 07/31/22, to help out because the facility was short staffed.

Interview with the Wellness Secretary on 08/03/22 at 1:12pm revealed:
-Staffing had been a concern since the pandemic and it had gotten worse.
-She was responsible for scheduling staff for the AL unit and memory care unit.
-She was trained to have two medication aides and three personal care aides in the AL unit.
-She did not have enough staff to schedule all shifts.
-She worked on the floor daily because the facility was short of staff.
-She was probably aware the facility was short of staff on 07/10/22 during second shift (she could not recall).
-She was told she could not contact an agency to

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D 188	Continued From page 4 assist with staffing. Interview with the Executive Director (ED) on 08/04/22 at 3:00pm revealed: -She and the Wellness Secretary discussed the schedule daily to determine what shifts were short. -When the schedule was short of staff, she would attempt to call staff to cover the shift. -She was told she could not contact an agency to assist with staffing.	D 188		
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: Refer to G.S. 131D- 21(7). Tag 917 Declaration of Resident's Rights.	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	D 358	1. An audit on residents medication orders was conducted to ensure accuracy of orders and no other residents were identified as being at risk. 2. Educations with clinical team members was conducted on 8/5/22 related to medication administration and regulations with documentation related to medication administration. 3. DRC/ED and or designee will review residents medication administration record for proper administration weekly for 4 weeks then monthly. 4. DRC/designee will monitor random med pass weekly for 4 weeks, then monhtly. 5. Date of Compliance: 9/18/22	

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reviews, the facility failed to administer medications as ordered for 2 of 3 residents (#6, #7) observed during the medication pass including errors with a medication for acid reflux (#6) and a medication used to treat and prevent constipation (#7).

The findings are:

The medication error rate was 8% as evidenced by the observation of 2 errors out of 25 opportunities during the 8:00am, 9:00am, and 10:00am medication passes on 08/03/22.

a. Review of Resident #6's current FL-2 dated 01/24/22 revealed:
-Diagnoses included Alzheimer's disease and osteoarthritis.
-There was an order for Pantoprazole 40mg DR take 1 tablet daily. (Pantoprazole is used to treat acid reflux. Pantoprazole DR is a delayed-release tablet and should not be crushed. Crushing a delayed-release tablet may result in the medication being released too early and being destroyed by stomach acid.)

Review of Resident #6's physician's orders dated 07/05/22 revealed medications may be crushed unless contraindicated and given in food.

Observation of the 8:00am medication pass on 08/03/22 revealed:
-The medication aide (MA) prepared morning medications for Resident #6, including one Pantoprazole 40mg DR tablet.
-The MA crushed all of Resident #6's oral medications, including the Pantoprazole 40mg DR tablet, mixed them in chocolate pudding and administered the medications to the resident at 9:30am.

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D 358	Continued From page 6	D 358		

Observation of Resident #6's medications on hand on 08/03/22 at 2:04pm revealed:
-There was a medication card with Pantoprazole 40mg DR tablets dispensed on 07/01/22.
-There were instructions on the medication label with "Do NOT CHEW or CRUSH. Swallow whole.".

Review of Resident #6's August 2022 medication administration record (MAR) revealed:
-There was an entry for Pantoprazole 40mg DR 1 tablet daily scheduled for 8:00am.
-Pantoprazole 40mg DR was documented as administered daily from 08/01/22 - 08/03/22.
-There was no information noted on the MAR to indicate the medication should not be crushed.

Review of the facility's Do Not Crush (DNC) medication list revealed Pantoprazole was a slow-released medication and should not be crushed.

Interview with the MA on 08/03/22 at 2:04pm revealed:
-The facility had a DNC list in the medication cart as a guide.
-If a medication was included on the DNC list, the MAs were not supposed to crush them.
-He was not aware Resident #6's Pantoprazole should not be crushed.
-He did not check the DNC list because there were usually instructions on the MAR if a medication should not be crushed.
-He overlooked the instructions on the medication label indicating Pantoprazole should not be chewed or crushed.

Interview with the Wellness Secretary on 08/03/22 at 2:26pm revealed:

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D 358	Continued From page 7 -There were usually instructions on the MAR and medication label indicating if a medication should not be crushed. -There was also a DNC list in the MAR books with medications that should not be crushed. -The MAs should read the MARs and the medication labels and check the DNC list for medications that should not be crushed. -Resident #6's Pantoprazole should not have been crushed. Interview with the Director of Resident Care (DRC) on 08/03/22 at 2:26pm revealed: -The MAs had been trained on crushing medications as part of their MA training. -The MAs should check the DNC list and the instructions on the MAR and medication labels. -Medications on the DNC list should not be crushed. -Resident #6's Pantoprazole should not have been crushed. Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. Telephone interview with Resident #6's primary care provider (PCP) on 08/04/22 at 2:05pm revealed: -She was not aware Resident #6's Pantoprazole was being crushed. -Pantoprazole was slow-release medication and should not be crushed. -Crushing Pantoprazole could cause a gastrointestinal bleed later, over time. b. Review of Resident #7's current FL-2 dated 08/03/22 revealed: -Diagnoses included dementia without behavioral disturbance, hypertension, and hyperlipidemia.	D 358		

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D 358	Continued From page 8 -There was an order for Miralax 17 grams (g) mixed in 8 ounces of water twice a day. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and the inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the inner cap.) Review of Resident #7's August 2022 medication administration record (MAR) revealed there was an entry for Miralax, give 17g mixed in 8 ounces of water with a morning dose scheduled for 10:00am. Observation of the 10:00am medication pass on 08/03/22 revealed: -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17 g" imprinted near the top of the white section with an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap. -The medication aide (MA) poured the Miralax powder about ¼ inch below the marking for the 17g dose. -The MA did not measure the Miralax correctly and the full dosage was not mixed in the cup of water. -The MA mixed the Miralax powder in water and gave it to Resident #7 to take with his oral medications at 9:35am. -The resident drank all of the water with Miralax but a full 17g dosage was not prepared and administered to the resident. Interview with the MA on 08/03/22 at 2:11pm revealed: -He usually measured Resident #7's Miralax powder to the marking for 17g on the inner white cap.	D 358		

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D 358	Continued From page 9 -He could not explain why he did not measure the full 17g dosage of Miralax for Resident #7 that morning on 08/03/22. -He was not aware of Resident #7 having any current issues with constipation. Interview with the Director of Resident Care (DRC) on 08/03/22 at 2:26pm revealed: -The MAs should measure Miralax using the marking of 17g at the top of the inner white cap. -Resident #7 should have been administered the full 17g dose of Miralax. -Resident #7 had no current issues with constipation. Interview with the Administrator on 08/03/22 at 3:01pm revealed: -The MAs had been trained on how to properly measure medications. -Resident #7 should have received the full dosage of Miralax. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Telephone interview with Resident #7's primary care provider (PCP) on 08/04/22 at 2:10pm revealed: -Resident #7's Miralax needed to be measured correctly so he could receive the correct dosage. -Resident #7 could have constipation if he was not receiving the full dosage of Miralax due to not being able to empty his bowels properly. -Resident #7 had dementia and was not able to express if he was having concerns about constipation.	D 358		

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D 363	Continued From page 10	D 363		
D 363	10A NCAC 13F .1004(f) Medication Administration 10A NCAC 13F .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of each medication prepared and the resident's name; (3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and (4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.	D 363	1. Education with clinical team members was conducted on 8/5/22 related to medication administration and regulations with documentation related to medication administration. 2. DRC/ED and or designee will review residents medication administration record for proper administration weekly for 4 weeks then monthly. 3. DRC/designee will monitor random med pass weekly for 4 weeks, then monhtly. 4. Date of Compliance: 9/18/22	

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications prepared in advance were identified up to the point of administration and protected from contamination and spillage for 7 of 7 sampled residents (#9, #10, #11, #12, #13, #14, #15) on 08/03/22.

The findings are

Observation of the third floor assisted living (AL) on 08/03/22 from 11:45am to 12:58pm revealed:
-A medication aide (MA) was administering morning medications to residents.
-At 11:56am, the MA prepared morning medications for Resident #14, Resident #13, and Resident #10 at the same time.
-The MA put the morning oral pills for Resident #14, Resident #13, and Resident #10 in clear plastic medication cups labeled with the residents' first names.
-The medication cups were not covered or protected from contamination or spillage.
-There were no medication administration times labeled on the medication cups.
-The names and strengths of the medications were not labeled on the cups.
-After preparing the medications, the MA put the medication cups labeled with the first names of Resident #14, Resident #13, and Resident #10 in the top drawer of the medication cart.
-At 12:02pm, the MA prepared medications for Resident #9 by putting the morning oral pills in a clear plastic medication cup labeled with the resident's first name.
-The MA put Resident #9's medication cup in the top drawer of the medication cart.

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(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 363	Continued From page 12 -The medication cup was not labeled with the time of administration or the names and strength of the medications. -The medication cup was not covered or protected from contamination or spillage. -The MA locked the medication cart. -At 12:08pm, the MA went to a second medication cart on the third floor and opened the top drawer. -There were 3 clear plastic medication cups with oral pills labeled with the first names of Resident #11, Resident #12, and Resident #15. -The medication cups were not covered or protected from contamination or spillage. -There were no medication administration times labeled on the medication cups. -The names and strengths of the medications were not labeled on the cups. -The MA administered the morning medications that were prepared in advance to the seven residents from 12:11pm - 12:58pm. Interview with the MA on 08/03/22 at 11:56am revealed: -She knew she was not supposed to prepare medications for more than one resident at a time but "I don't have a choice". -She was running late on administering the morning medications so she felt she had to prepare the more than one resident's medications to speed up the medication pass. -The Wellness Secretary and the Director of Resident Care (DRC) were aware she prepared medications in advance for more than one resident when she was running late with the medication pass. a. Review of Resident #11's current FL-2 dated 07/07/22 revealed diagnoses included stage 3 chronic kidney disease, hyperlipidemia, anemia, coronary artery disease, gastroesophageal reflux	D 363		

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disease, generalized anxiety, history of stroke, and fracture of right femur.

Review of Resident #11's August 2022 medication administration record (MAR) revealed:
-Bisacodyl (laxative), Celexa (antidepressant), and Centrum Silver (multivitamin) were scheduled at 10:00am.
Carvedilol (lowers blood pressure and controls heart rate), Oxybutynin (for overactive bladder), and Fiberlax (for constipation) were scheduled at 10:00am and 9:00pm.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #11's scheduled morning medications were prepared in advance prior to 12:08pm with other residents' medications and administered to Resident #11 at 12:11pm.

b. Review of Resident #15's current FL-2 dated 08/04/22 revealed diagnoses included Parkinson's disease, hypertension, hyperlipidemia, and insomnia.

Review of Resident #15's August 2022 medication administration record (MAR) revealed:
-Tylenol (for pain) was scheduled at 8:00am, 2:00pm, 8:00pm, and 3:00am.
-Sinemet CR (for Parkinson's disease) was scheduled at 10:00am, 2:00pm, and 9:00pm.
-Gabapentin (for seizures, nerve pain, or mood disorders) and Senna (a laxative for constipation) were scheduled at 10:00am and 9:00pm.
-Tramadol (a narcotic for moderate to severe pain), Lexapro (antidepressant), Furosemide (a diuretic for swelling), Potassium Chloride (a potassium supplement), Vitamin D3 (for Vitamin D deficiency), and Vitamin C (a vitamin supplement) were scheduled at 10:00am.

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D 363	Continued From page 14 Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #15's scheduled morning medications were prepared in advance prior to 12:08pm with other residents' medications and administered to Resident #15 at 12:26pm. c. Review of Resident #14's current FL-2 dated 04/08/22 revealed diagnoses included memory impairment, macular degeneration, mixed anxiety and depression, and Vitamin B12 deficiency. Review of Resident #14's August 2022 medication administration record (MAR) revealed Sertraline (antidepressant), Aspirin (used to prevent heart disease), Vitamin D3 (for Vitamin D deficiency), and Vitamin B12 (for Vitamin B12 deficiency) were scheduled at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #14's scheduled morning medications were prepared in advance at 11:56am with other residents' medications and administered to Resident #14 at 12:30pm. d. Review of Resident #13's current FL-2 dated 01/24/22 revealed diagnoses included atrial fibrillation, altered mental status, and urinary tract infection. Review of Resident #13's August 2022 medication administration record (MAR) revealed: -Keppra (for seizures, nerve pain, or mood disorders) and Tylenol (mild pain reliever) were scheduled at 10:00am and 9:00pm. -Losartan (lowers blood pressure) and Metoprolol ER (lowers blood pressure and controls heart rate) were scheduled at 10:00am.	D 363		

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D 363	Continued From page 15 Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #13's scheduled morning medications were prepared in advance at 11:56am with other residents' medications and administered to Resident #13 at 12:34pm. e. Review of Resident #9's current FL-2 dated 12/08/21 revealed diagnoses included neuro-cognitive impairment, history of pulmonary embolism, and history of breast cancer. Review of Resident #9's August 2022 medication administration record (MAR) revealed: -Norco (a narcotic for moderate to severe pain) and Senna Plus (for constipation) were scheduled at 10:00am and 9:00pm. -Bupropion (antidepressant) was scheduled at 9:00am. -Aspirin (prevents heart disease) and Omeprazole (for acid reflux) were scheduled at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #9's scheduled morning medications were prepared in advance at 12:02pm and administered to Resident #9 at 12:41pm. f. Review of Resident #12's current FL-2 dated 06/30/22 revealed diagnoses included hypertension, coronary artery disease, chronic kidney disease - stage 3, history of stroke, dysphagia, and peripheral vascular disease. Review of Resident #12's August 2022 medication administration record (MAR) revealed: -Metformin (lowers and controls blood sugar in	D 363		

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diabetes) and Aspirin (used to prevent heart disease) were scheduled at 10:00am and 9:00pm.
-Amlodipine (lowers blood pressure), Jardiance (lowers and controls blood sugar in diabetes), Losartan/HCTZ (lowers blood pressure), Metoprolol (lowers blood pressure and controls heart rate), Advil (for pain and inflammation), Tylenol Arthritis (for arthritis pain), Zetia (lowers cholesterol), Turmeric (supplement for health benefits), Vitamin E (supplement for health benefits), and Coenzyme Q10 (antioxidant used for heart benefits) were scheduled at 10:00am.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #12's scheduled morning medications were prepared in advance prior to 12:08pm with other residents' medications and administered to Resident #12 at 12:46pm.

g. Review of Resident #10's current FL-2 dated 12/13/21 revealed diagnoses included diabetes mellitus type 2, gastroesophageal reflux disease, and obesity.

Review of Resident #10's August 2022 medication administration record (MAR) revealed:
-Glipizide (lowers and controls blood sugar in diabetes) was scheduled at 8:00am.
-Lisinopril (lowers blood pressure), Sertraline (antidepressant), Aspirin (prevents heart disease), Vitamin B12 (for Vitamin B12 deficiency), and Centrum Silver (multivitamin) were scheduled at 10:00am.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed Resident #10's scheduled morning medications were prepared in advance at

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D 363	Continued From page 17 11:56am with other residents' medications and administered to Resident #10 at 12:58pm. Interview with the Wellness Secretary on 08/03/22 at 2:26pm revealed: -She was not aware the MA was preparing medications in advance for multiple residents. -The MAs were not allowed to prepour medications. Interview with the DRC on 08/03/22 at 2:26pm revealed: -The MA should have communicated with her or the Wellness Secretary that she was running late with administering medications. -The MAs knew they were not allowed to prepare medications for multiple residents at one time. -The MAs were supposed to prepare and administered one resident's medications at a time. Interview with the Administrator on 08/03/22 at 3:01pm revealed: -She was not aware the MA had prepared medications in advance for seven residents on 08/03/22. -The facility policy did not allow prepouring of medications.	D 363		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by:	D 364	1. Education with clinical team members was conducted on 8/5/22 related to medication administration and regulations with documentation related to medication administration. 2. DRC/ED and or designee will review residents medication administration record for proper administration weekly for 4 weeks then monthly. 3. DRC/designee will monitor random med pass weekly for 4 weeks, then monhtly. 4 Date of Compliance: 9/18/22	

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D 364	Continued From page 18 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 8 of 8 residents observed (#8, #9, #10, #11, #12, #13, #14, #15) on the third floor on 08/03/22 resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and medications not being administered at consistent time intervals to ensure therapeutic effectiveness. The findings are: Review of the facility's Medication Management Policy with an effective date of 04/01/19 revealed: -Medication administration was performed in accordance with state laws and regulations. -There was no specific information related to medication administration times in the policy provided. Review of the facility's census report dated 08/03/22 revealed: -The facility's current census was 77 residents. -There were 72 residents currently in the facility. -There were 15 residents in the special care unit (SCU) on the ground floor; 16 residents on first floor assisted living (AL); 22 on second floor AL; and 19 residents on third floor AL. Observation of the third floor AL on 08/03/22 from 11:45am to 12:58pm revealed a medication aide (MA) was administering 8:00am, 9:00am, and 10:00am medications to residents. Interview with the MA on 08/03/22 at 11:45am revealed: -She was still administering the 8:00am, 9:00am,	D 364		

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D 364	Continued From page 19 and 10:00am medications to the residents on third floor AL halls. -She was late administering morning medications every day because there were only 2 MAs on first shift to administer medications to all residents in the facility. -She had 8 residents left to administer their morning medications for today (08/03/22). Observations on 08/03/22 from 12:03pm - 12:05pm revealed: -At 12:03pm, the Wellness Secretary came to the MA at the medication cart on third floor AL and asked the MA for some residents' medication administration records (MARs). -At 12:05pm, the MA told the Wellness Secretary that she had not finished administering the morning medications. -The Wellness Secretary responded by telling the MA which residents' MARs she needed from the MAR book. -The Wellness Secretary offered no assistance to the MA with administering the late medications and left the third floor when the MA handed her the MARs she requested. Observations on 08/03/22 from 12:13pm - 12:18pm revealed: -The Wellness Secretary came back to the medication cart on third floor AL while the MA was still administering the morning medications. -The Wellness Secretary returned the MARs to the MA who put the MARs back in the MAR book. -The Wellness Secretary requested more MARs but they had to go to the second floor to retrieve the MARs. -At 12:18pm, the MA gave additional MARs to the Wellness Secretary from the second floor AL medication cart. -At 12:19pm, the Wellness Secretary left with the	D 364		

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D 364	Continued From page 20 MARs and the MA went back to third floor AL to continue administering morning medications. -The Wellness Secretary did not offer any assistance or guidance to the MA who continued to administer the late morning medications. Observation on 08/03/22 revealed the MA finished the morning medication pass (medications scheduled for 8:00am, 9:00am, and 10:00am) on the third floor AL at 12:58pm. Interview with the Wellness Secretary on 08/03/22 at 2:26pm revealed: -There were usually 2 MAs administering morning medications to all residents in the facility on first shift. -One MA was assigned to the SCU and the first floor AL. -The second MA was assigned to the second and third floor AL. -Some days she helped with administering the morning medications especially when the MAs had to help the residents with personal care. -The facility had been struggling with being short staffed. -She had just gotten to work that day on 08/03/22 when she went to the medication cart and the MA was still administering the morning medications around lunchtime. -She did not assist the MA because she was working on gathering some paperwork. Interview with the Director of Resident Care (DRC) on 08/03/22 at 2:26pm revealed: -Medications should be administered 1 hour before or 1 hour after the scheduled time. -There were usually 2 MAs on first shift to administer the morning medications. -There had been "quite a few days" when medications were administered late because the	D 364		

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D 364	Continued From page 21 facility was short staffed and the MAs had to help more with providing personal care to the residents. -She was not aware the morning medications were late that morning on 08/03/22. -The MA should communicate with her or the Wellness Secretary when medication administration was running late. -The facility was working on hiring more MAs. Interview with the Administrator on 08/03/22 at 3:01pm revealed: -The Wellness Secretary and the DRC were responsible for overseeing medication administration with the MAs. -Medications should be administered within 1 hour before or 1 hour after the scheduled time. -No one had reported to her that medications were administered late. -No residents had complained to her about receiving medications late -She had observed MAs administering medications at different times during her daily walk throughs in the facility but she did not know which medications the MAs were administering. -There were usually 2 MAs on duty to administer morning medications on first shift for all 4 floors in the facility. -She was not aware the morning medications were administered up to 12:58pm that day on 08/03/22. -That was "way out of the time frame". -She was new at the facility and she did not know what the process was if the MAs were running late administering medications. -She thought the process would be to ask for help. -If medications were administered too close together, it could increase side effects which could increase a resident's risk of falls.	D 364		

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-If pain medications were administered late it could cause the resident to experience pain.
-When the Wellness Secretary became aware the medications were late that morning (08/03/22), she should have helped the MA administer the medications because the Wellness Secretary was also a qualified MA.

Review of the August 2022 MARs for 8 residents on the third floor AL who received late medications on 08/03/22 revealed:
-All 8 resident had morning medications scheduled at 8:00am, 9:00am, and/or 10:00am.
-Six of 8 residents had medications ordered either twice daily, 3 times daily, and/or 4 times a day. [For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

a. Review of Resident #15's current FL-2 dated 08/04/22 revealed diagnoses included Parkinson's disease, hypertension, hyperlipidemia, and insomnia.

Review of Resident #15's August 2022 medication administration record (MAR) revealed:
-Tylenol 650mg (for pain) was scheduled 4 times a day at 8:00am, 2:00pm, 8:00pm, and 3:00am.
-Sinemet CR 50/200mg (controlled release medication for Parkinson's disease) was scheduled 3 times a day at 10:00am, 2:00pm, and 9:00pm.
-Gabapentin 100mg and 300mg (for seizures, nerve pain, or mood disorders) and Senna 8.6mg (a laxative for constipation) were scheduled twice a day at 10:00am and 9:00pm.
-Tramadol 100 mg (a narcotic for moderate to severe pain), Lexapro 10mg (antidepressant), Furosemide 40mg (a diuretic for swelling),

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D 364	Continued From page 23 Potassium Chloride 10mEq (a potassium supplement), Vitamin D3 50mcg (for Vitamin D deficiency), and Vitamin C 500mg (a vitamin supplement) were scheduled daily at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed: -The MA administered Resident #15's Tylenol scheduled for 8:00am at 12:26pm, 3 hours and 26 minutes beyond the allowed time frame. -The MA administered Resident #15's medications scheduled for 10:00am at 12:26pm, 1 hour and 26 minutes beyond the allowed time frame. -Tylenol and Sinemet CR were scheduled to be administered again at 2:00pm. -Gabapentin was scheduled to be administered again at 9:00pm. Interview with the MA on 08/04/22 at 1:11pm revealed: -She administered the 2:00pm dose of Resident #15's Tylenol and Sinemet CR sometime after 1:15pm but before 2:00pm when she left on 08/03/22. -She did not know if the 2:00pm doses should have been held or if the resident's primary care provider (PCP) should have been contacted since the resident had just received the two medications late at 12:26pm on 08/03/22. Interview with Resident #15 on 08/04/22 at 12:44pm revealed: -She never received her medications on time. -The MAs "run behind a lot" and her morning medications were late most of the time. -She had problems with "freezing" of her joints especially when she received her medication for Parkinson's disease late.	D 364		

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D 364	Continued From page 24 -She had moderate pain in both legs in the mornings while she waited to receive her morning pain medication. Telephone interview with Resident #15's PCP on 08/04/22 at 2:10pm revealed: -Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects. -Administering doses of Tylenol and Sinemet CR too close together could cause side effects such as sedation or increase risk of falls. -Receiving Sinemet CR late could cause Resident #15 to suffer more symptoms from her Parkinson's disease such as "on and off" movements, longer periods of shuffling gait which could cause the resident to be a higher fall risk. -Tramadol and Gabapentin should be given on time to keep the levels in her system consistent to prevent pain. b. Review of Resident #9's current FL-2 dated 12/08/21 revealed diagnoses included neuro-cognitive impairment, history of pulmonary embolism, and history of breast cancer. Review of Resident #9's August 2022 medication administration record (MAR) revealed: -Norco 5/325mg (a narcotic for moderate to severe pain) and Senna Plus 8.6/50mg (for constipation) were scheduled twice a day at 10:00am and 9:00pm. -Bupropion 75mg (antidepressant) was scheduled daily at 9:00am. -Aspirin 81mg (prevents heart disease) and Omeprazole 20mg (for acid reflux) were scheduled daily at 10:00am. Observation of the medication aide (MA)	D 364		

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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 364	Continued From page 25 administering morning medications on 08/03/22 revealed: -The MA administered Resident #9's Bupropion scheduled for 9:00am at 12:41pm, 2 hours and 41 minutes beyond the allowed time frame. -The MA administered Resident #9's medications scheduled for 10:00am, including Norco for pain, at 12:41pm, 1 hour and 41 minutes beyond the allowed time frame. -Norco and Senna were scheduled to be administered again at 9:00pm. Interview with Resident #9 on 08/04/22 at 12:41pm revealed: -She did not recall receiving her medications late often. -She was not in pain on 08/03/22, when she received her morning medications late. -If she had been in pain, she would have asked for the medication. Telephone interview with Resident #9's primary care provider (PCP) on 08/04/22 at 2:10pm revealed: -Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects. -Resident #9's Norco should be administered on time to keep the levels in her system consistent to prevent pain. -Resident #9's was receiving hospice care and Norco was ordered in an effort to keep her comfortable and to keep her pain under control. -Resident #9 was confused but she had displayed signs of pain during visits with the PCP. -Resident #9 needed the Norco on time to prevent longer moments without pain management. -Resident #9's Bupropion should be administered	D 364		

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(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 364	Continued From page 26 on time to ensure consistent levels of the medication throughout the day for the best therapeutic effect to treat depression. c. Review of Resident #12's current FL-2 dated 06/30/22 revealed diagnoses included hypertension, coronary artery disease, chronic kidney disease - stage 3, history of stroke, dysphagia, and peripheral vascular disease. Review of Resident #12's August 2022 medication administration record (MAR) revealed -Metformin 500mg (lowers and controls blood sugar in diabetes), Cosopt (eye drops for glaucoma), and Aspirin 81mg (used to prevent heart disease) were scheduled twice a day at 10:00am and 9:00pm. -Amlodipine 5mg (lowers blood pressure), Jardiance 25mg (lowers and controls blood sugar in diabetes), Losartan/HCTZ 50/12.5mg (lowers blood pressure), Metoprolol ER 100mg (lowers blood pressure and controls heart rate), Advil 200mg (for pain and inflammation), Tylenol Arthritis 650mg ER (for arthritis pain), Zetia 10mg (lowers cholesterol), Miralax (for constipation), Turmeric 1000mg (supplement for health benefits), Vitamin E 268mg (supplement for health benefits), and Coenzyme Q10 100mg (antioxidant used for heart benefits) were scheduled daily at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed: -The MA administered Resident #12's medications scheduled for 10:00am at 12:46pm, 1 hour and 46 minutes beyond the allowed time frame. -Metformin, Cosopt, and Aspirin were scheduled to be administered again at 9:00pm.	D 364		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 364	Continued From page 27 Interview with Resident #12 on 08/04/22 at 12:54pm revealed: -He usually received his morning medications around 12:00pm each day. -His medications were late often because the staff "run behind". -He had not experienced any pain or other symptoms while waiting for his medications. -His blood sugar had been "good". Telephone interview with Resident #12's primary care provider (PCP) on 08/04/22 at 2:10pm revealed: -Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects. -Resident #12's Metformin and Jardiance should be administered at the same time every day to best control his blood sugar. -Administering Metformin and Jardiance late could cause inconsistent blood sugar levels. -Administering Metformin too close to the next scheduled dose could lead to low blood sugars. -Amlodipine, Losartan/HCTZ, and Metoprolol ER were blood pressure medications that should be administered on time so the resident's targeted blood pressure would stay consistent throughout the day. -It was especially important for Resident #12's blood pressure medications to be administered on time because he had a history of stroke and his blood pressure needed to be stable. d. Review of Resident #10's current FL-2 dated 12/13/21 revealed diagnoses included diabetes mellitus type 2, gastroesophageal reflux disease, and obesity.	D 364		

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D 364	Continued From page 28 Review of Resident #10's August 2022 medication administration record (MAR) revealed: -Glipizide 2.5mg (lowers and controls blood sugar in diabetes) was scheduled at 8:00am with breakfast. -Lisinopril 5mg (lowers blood pressure), Sertraline 50mg (antidepressant), Aspirin 81mg (prevents heart disease), Vitamin B12 3000mcg (for Vitamin B12 deficiency), and Centrum Silver (multivitamin) were scheduled daily at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed: -The MA administered Resident #10's Glipizide scheduled for 8:00am at 12:58pm, 3 hours and 58 minutes beyond the allowed time frame. -The MA administered Resident #10's medications scheduled for 10:00am at 12:58pm, 1 hour and 58 minutes beyond the allowed time frame. Interview with Resident #10 on 0/04/22 at 12:56pm revealed: -He did not always receive his morning medications in the morning but sometimes in the afternoon. -The medications had been late on more occasions recently than in the past. -He did not recall having symptoms or side effects while waiting to receive his morning medications. Telephone interview with Resident #10's primary care provider (PCP) on 08/04/22 at 2:10pm revealed: -Resident #10's Glipizide should be administered at 8:00am with breakfast to best control his blood sugar. -She was concerned that Resident #10's blood	D 364		

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sugar would never be controlled if the Glipizide was administered late frequently.
-Administering Glipizide late could also lead to "false" high blood sugar readings, which could affect the resident's treatment for diabetes.
-Lisinopril was blood pressure medication that should be administered on time so the resident's targeted blood pressure would stay consistent throughout the day.
-Sertraline should be administered on time to ensure consistent levels of the medication throughout the day for the best therapeutic effect to treat depression.

e. Review of Resident #13's current FL-2 dated 01/24/22 revealed diagnoses included atrial fibrillation, altered mental status, and urinary tract infection.

Review of Resident #13's August 2022 medication administration record (MAR) revealed:
-Genteal Tears (lubricating eye drops) were scheduled 3 times daily at 10:00am, 2:00pm, and 9:00pm.
-Keppra 250mg (for seizures, nerve pain, or mood disorders) and Tylenol 650mg (mild pain reliever) were scheduled twice daily at 10:00am and 9:00pm.
-Losartan 50mg (lowers blood pressure) and Metoprolol ER 75mg (lowers blood pressure and controls heart rate) were scheduled daily at 10:00am.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed:
-The MA administered Resident #13's medications scheduled for 10:00am at 12:34pm, 1 hour and 34 minutes beyond the allowed time frame.

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D 364	Continued From page 30 -Genteal Tears was scheduled to be administered again at 2:00pm. -Keppra and Tylenol were scheduled to be administered again at 9:00pm. Interview with the MA on 08/04/22 at 1:11pm revealed: -She administered the 2:00pm dose of Resident #13's Genteal Tears eye drops sometime after 1:15pm but before 2:00pm when she left on 08/03/22. -She did not know if the 2:00pm dose should have been held or if the resident's primary care provider (PCP) should have been contacted since the resident had just received Genteal Tear eye drops late at 12:34pm on 08/03/22. Interview with Resident #13 on 08/04/22 at 12:49pm revealed: -She did not know if she received medications late. -She had not noticed if she had any symptoms or side effects while waiting to receive her medications. Telephone interview with Resident #13's PCP on 08/04/22 at 2:10pm revealed: -Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects. -Genteal Tear eye drops should be administered in time because it could cause the resident to have dry eyes if the doses were not administered consistently. -Administration of Keppra should be consistent to prevent breakthrough seizures. -Losartan and Metoprolol ER were blood pressure medications that should be administered on time so the resident's targeted	D 364		

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blood pressure and heart rate would stay consistent throughout the day.

f. Review of Resident #8's current FL-2 dated 06/02/22 revealed diagnoses included dementia and hypothyroidism.

Review of Resident #8's August 2022 medication administration record (MAR) revealed:
-Trazodone 25mg (antidepressant) was scheduled twice a day at 10:00am and 8:00pm.
-Levothyroxine 175mcg (for underactive thyroid disease) was scheduled to be administered on an empty stomach at 8:00am.
-Sertraline 25mg (antidepressant) and Vitamin D3 1000mcg (for Vitamin D deficiency) were scheduled daily at 10:00am.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed:
-The MA administered Resident #8's Levothyroxine scheduled for 8:00am on an empty stomach at 11:48am, 2 hours and 48 minutes beyond the allowed time frame.
-The MA administered Resident #8's medication scheduled for 10:00am at 11:48am, 48 minutes beyond the allowed time frame.
-Trazodone was scheduled to be administered again at 8:00pm.

Interview with Resident #8 on 08/04/22 at 12:21pm revealed:
-She sometimes received her morning medications late.
-She did not recall having any problems or side effects when she received the medications late.

Telephone interview with Resident #8's primary care provider (PCP) on 08/04/22 at 2:10pm

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revealed:
-Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects.
-Resident #8's Levothyroxine should be administered on an empty stomach for best absorption to get the best therapeutic effect.
-Resident #8's Trazodone and Sertraline should be administered on time to ensure consistent levels of the medications throughout the day for the best therapeutic effect to treat depression.

g. Review of Resident #11's current FL-2 dated 07/07/22 revealed diagnoses included stage 3 chronic kidney disease, hyperlipidemia, anemia, coronary artery disease, gastroesophageal reflux disease, generalized anxiety, history of stroke, and fracture of right femur.

Review of Resident #11's August 2022 medication administration record (MAR) revealed:
-Bisacodyl 10mg (laxative for constipation), Celexa 20mg (antidepressant), Flonase Nasal Spray 50mcg (for allergies), and Centrum Silver (multivitamin) were scheduled daily at 10:00am.
-Carvedilol 6.25mg (lowers blood pressure and controls heart rate), Oxybutynin 5mg (for overactive bladder), and Fiberlax 500 mg (for constipation) were scheduled twice daily at 10:00am and 9:00pm.

Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed:
-The MA administered Resident #11's medications scheduled for 10:00am at 12:11pm, 1 hour and 11 minutes beyond the allowed time frame.
-Carvedilol, Oxybutynin, and Fiberlax were

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D 364	Continued From page 33 scheduled to be administered again at 9:00pm. Interview with Resident #11 on 08/04/22 at 12:29pm revealed: -She received her morning medications late, "once in a while". -She did not recall having any problems or symptoms when her medications were administered late. Telephone interview with Resident #11's primary care provider (PCP) on 08/04/22 at 2:10pm revealed: -Administering medications late that were ordered 2, 3, or 4 times a day could shorten the time interval between doses and increasing the risk of side effects. -Carvedilol was blood pressure medication that should be administered on time so the resident's targeted blood pressure and heart rate would stay consistent throughout the day. -It was especially important for Resident #11's blood pressure medication to be administered on time because she had a history of stroke and her blood pressure needed to be stable. -Resident #11's Oxybutynin should be administered on time to ensure consistent levels throughout the day. -Administering Resident #11's Oxybutynin late could cause the resident to have urinary retention, urinary dribbling, and increase the risk of urinary tract infections. -Resident #11's Celexa should be administered on time to ensure consistent levels of the medication throughout the day for the best therapeutic effect to treat depression. h. Review of Resident #14's current FL-2 dated 04/08/22 revealed diagnoses included memory impairment, macular degeneration, mixed anxiety	D 364		

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D 364	Continued From page 34 and depression, and Vitamin B12 deficiency. Review of Resident #14's August 2022 medication administration record (MAR) revealed Sertraline 100mg (antidepressant), Aspirin 81mg (used to prevent heart disease), Vitamin D3 25mcg (for Vitamin D deficiency), and Vitamin B12 1000mcg(for Vitamin B12 deficiency) were scheduled daily at 10:00am. Observation of the medication aide (MA) administering morning medications on 08/03/22 revealed the MA administered Resident #14's medications scheduled for 10:00am at 12:30pm, 1 hour and 30 minutes beyond the allowed time frame. Interview with Resident #14 on 08/04/22 at 12:51pm revealed she was not sure when she received her medications or if they were administered late. Telephone interview with Resident #14's primary care provider (PCP) on 08/04/22 at 2:10pm revealed Resident #14's Sertraline should be administered on time to ensure consistent levels of the medication throughout the day for the best therapeutic effect to treat depression. --- The failure of the facility to administer medications on time resulted in eight residents' morning medications being administered late on 08/03/22 from 11:48am - 12:58pm, up to 3 hours and 58 minutes beyond the allowed time frame. Resident #15 was administered Tylenol over 3 hours late and Tramadol, a narcotic pain reliever, over 1 hour late resulting in the resident complaining of pain in both legs. Resident #15 also received Sinemet CR for Parkinson's	D 364		

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D 364	Continued From page 35 disease over an hour late which according to the PCP put the resident at risk of suffering from Parkinson's symptoms including "off and on" movements, longer periods of shuffling gait, and increased risk of falls. Resident #9, a hospice resident, received Norco for pain late and according to the PCP put the resident at risk of breakthrough pain and lack of pain control. Resident #12 who had a history of stroke received 3 medications used to control blood pressure and heart rate late putting the resident at risk of not maintaining targeted blood pressure control and he received two diabetes medications late which could lead to uncontrolled blood sugars. The facility's 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 08/04/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 18, 2022.	D 364		
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	D 366	1. An audit on MARs was conducted to review proper documentation of medication administered and no other residents were identified as being at risk. 2. Education with clinical team members was conducted on 8/5/22 related to medication administration and regulations with documentation related to medication administration. 3. DRC/ED and or designee will review residents medication administration record for proper administration weekly for 4 weeks then monthly. 4. DRC/designee will monitor random med pass weekly for 4 weeks, then monhtly. 5. Date of Compliance: 9/18/22	

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D 366	Continued From page 36 medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide (MA) documented the administration of medications immediately following the administration and observation of the residents actually taking the medications for 8 of 8 residents (#8, #9, #10, #11, #12, #13, #14, #15) observed during the morning medication pass on 08/03/22. The findings are: Review of the facility's Medication Management Policy with an effective date of 04/01/19 revealed medication administration is documented on the medication administration record (MAR) at the time the medication is provided or taken. Observation of the third floor assisted living (AL) on 08/03/22 from 11:45am to 12:58pm revealed: -A medication aide (MA) was administering morning medications to residents. -At 11:48am, the MA administered medications to Resident #8. -At 11:56am, the MA prepared morning medications for Resident #14, Resident #13, and Resident #10. -At 12:02pm, the MA prepared medications for Resident #9. -At 12:08pm, the MA went to a second medication cart on the third floor and opened the top drawer. -There were 3 clear plastic medication cups with oral pills labeled with the first names of Resident #11, Resident #12, and Resident #15. -The MA administered medications to Resident	D 366		

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D 366	Continued From page 37	D 366		

#11 at 12:11pm; Resident #15 at 12:26pm; Resident #14 at 12:30pm; Resident #13 at 12:34pm; Resident #9 at 12:41pm; Resident #12 at 12:46pm; and Resident #10 at 12:58pm.
-The MA did not document the administration of the morning medications on the MARs for any of the 8 residents observed.

Review of the August 2022 MARs for Residents #8, #9, #10, #11, #12, #13, #14, and #15 on 08/03/22 at 1:02pm revealed:
-The residents' morning medications were scheduled for 8:00am, 9:00am, and/or 10:00am.
-None of the residents' morning medications that were administered between 11:48am - 12:58pm had been documented as administered at 1:02pm.

Interview with the MA on 08/03/22 at 1:03pm revealed:
-She had not documented any of the morning medications she had administered on 08/03/22.
-She would document her initials on the MARs for the morning medications at 2:00pm before she left for the day.
-That was the way she normally documented on the MARs.
-She did not have time to document on the MARs when she administered the morning medications because she usually ran late on the medication pass.

Interview with the Wellness Secretary on 08/03/22 at 2:26pm revealed:
-She observed the MA documenting the morning medications on the MARs sometime after 1:00pm today, 08/03/22.
-The MAs were supposed to document administration of medications on the MARs after observing the resident take their medication and

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 08/04/2022

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 366	Continued From page 38 prior to the next resident. Interview with the Administrator on 08/03/22 at 3:01pm revealed: -She was not aware a MA was not documenting administration of medications on the MAR when the medications were administered. -The MAs were supposed to document on the MAR right after medications were administered to a resident, prior to going to the next resident.	D 366		
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: 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 observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to medication administration. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 8 of 8 residents observed (#8, #9, #10, #11, #12, #13, #14, #15) on the third floor on 08/03/22 resulting in medications ordered multiple times a day being administered too close to the next scheduled administration time and	D912		

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D912	Continued From page 39 medications not being administered at consistent time intervals to ensure therapeutic effectiveness. [Refer to Tag D364, 10A NCAC 13F .1004(g) Medication Administration (Type B Violation)].	D912		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to respond to residents' call lights in a timely manner, resulting in staff responding after an hour or not responding at all. The findings are: Review of the answering call lights policy dated 09/01/19 revealed: -Respond to residents' call lights in a timely manner. -Answer emergency lights immediately. Interview with Resident #2 on 08/03/22 at 9:20am revealed: -On Saturday, 07/30/22, she slid from her chair to the floor; she was not hurt but she needed assistance to get off the floor. -She pressed her call light and it took staff over one hour and a half to respond. Review of the facility's device activity report dated 07/30/22 revealed -Resident #2's call light was activated at 9:47am. -The call light was reset one hour and forty minutes later.	D917	1. ED and or designee will review call bell response time daily for 4 weeks then weekly to ensure residents needs are met in a timely manner. 2. Education provided to the staff on the call bell system and timely response time. 3. Date of Compliance: 9/12/22	

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D917	Continued From page 40 Interview with a second resident on 08/03/22 at 9:30am revealed: -He used his call light daily. -Staff responded to his call light sometimes, depending on how busy they were. Review of the facility's device activity report dated 07/29/22 revealed -The resident's call light was activated at 12:35pm. -The call light was reset ten hours and forty-six minutes later. -The resident's call light was activated at 11:21pm. -The call light was reset ten hours and forty-six minutes later. Review of the facility's device activity report dated 07/31/22 revealed -The resident's call light was activated at 6:15am. -The call light was reset six hours and seventeen minutes later. -The resident's call light was activated at 12:31pm. -The call light was reset six hours and seventeen minutes later. Interview with a third resident on 08/03/22 at 10:18am revealed he had pressed his call light, but staff did not come until the next morning (not sure of the date). Interview with the Executive Director (ED) on 08/04/22 at 11:41am revealed: -She was not aware staff were not responding to call lights in a timely manner. -She was not aware residents' call lights were not being answered by staff. -She expected staff to respond to call lights in a	D917		

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D917	Continued From page 41 timely manner, at least within 20 minutes.	D917		