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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 000	Initial Comments The Adult Care Licensure Section conducted a follow up survey from 11/22/22 to 11/23/22.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#1, #6) observed during the medication pass including errors with an antidepressant, a medication for acid reflux, and a lubricant eye drop (#1); and a medication used to lower triglycerides (#6); and for 1 of 5 sampled residents (#4) for record review related to a vitamin supplement used to treat Vitamin D deficiency. The findings are: 1. The medication error rate was 13% as evidenced by the observation of 4 errors out of 30 opportunities during the 8:00am/9:00am/10:00am and 2:00pm medication passes on 11/22/22. a. Review of Resident #6's current FL-2 dated 08/26/21 revealed: -Diagnoses included malignant neoplasm of the	D 358		

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brain, muscle weakness, conversion disorder with seizures or convulsions, and syncope.
-There was an order for Omega-3 Fish Oil 2000mg once a day. (Omega-3 Fish Oil is a supplement used to lower triglyceride levels.)

Review of Resident #6's physician's orders dated 08/03/22 revealed an order for Omega-3 Fish Oil 1000mg take 2 capsules (2000mg) every day.

Review of Resident #6's most current lab results for triglycerides dated 08/01/22 revealed the resident's triglyceride level was 174.4 (reference range was 0 - 150).

Review of Resident #6's November 2022 medication administration record (MAR) revealed:
-There was an entry for Omega-3 Fish Oil 1000mg take 2 capsules every day scheduled for 9:00am.
-Omega-3 Fish Oil was documented as administered daily from 11/01/22 - 11/21/22.

Observation of the morning medication pass on 11/22/22 revealed:
-The medication aide (MA) prepared and administered 1 Omega-3 Fish Oil 1000mg capsule to Resident #6 at 9:09am.
-The resident was administered 1 Omega-3 Fish Oil 1000mg capsule instead of 2 capsules (2000mg) as ordered.

Observation of Resident #6's medications on hand on 11/22/22 at 12:56pm revealed:
-There was a supply of Omega-3 Fish Oil 1000mg capsules dispensed on 10/20/22.
-There were instructions on the medication label to take 2 capsules every day.

Interview with the MA on 11/22/22 at 12:55pm

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revealed:
-She did not usually work on the medication cart with Resident #6's medications.
-She did not notice the instructions on the MAR and the medication label for Resident #6's Omega-3 Fish Oil was to take 2 capsules every day.

Interview with Resident #6 on 11/22/22 at 1:19pm revealed:
-He usually received 2 Fish Oil capsules with his morning medications.
-He did not count the pills in the cup that morning on 11/22/22, so he was unsure how many Fish Oil capsules he received that morning.

Interview with the Director of Resident Care (DRC) on 11/22/22 at 2:11pm revealed:
-The MAs were supposed to read the instructions on the MAR and the medication labels and administer medications according to the order.
-Resident #6 should have received 2 Omega-3 Fish Oil 1000mg capsules instead of 1 capsule.

Interview with Resident #6's primary care provider (PCP) on 11/23/22 at 11:01am revealed:
-Resident #6 was supposed to receive 2 Omega-3 Fish Oil 1000mg capsules every day because his triglyceride level was elevated.
-The resident needed 2 capsules each day to consistently help keep his triglyceride levels down.

b. Review of Resident #1's current FL-2 dated 01/24/22 revealed:
-Diagnoses included depression, lymphedema, and gastroesophageal reflux disease.
-There was an order for Sertraline 25mg take 1 tablet once daily for depression. (Sertraline is an antidepressant.)

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D 358	Continued From page 3 Review of Resident #1's November 2022 medication administration record (MAR) revealed: -There was an entry for Sertraline 25mg take 1 tablet once daily scheduled for 10:00am. -Sertraline was documented as administered daily from 11/01/22 - 11/21/22. Observation of the morning medication pass on 11/22/22 revealed: -The medication aide (MA) prepared and administered morning medications to Resident #1 at 9:45am. -Sertraline was not prepared or offered to Resident #1 when she received her other morning medications scheduled for 9:00am and 10:00am at 9:45am. Interview with the MA on 11/22/22 at 9:45am revealed: -She did not prepare and administer Sertraline 25mg to Resident #1 because she could not find any in the medication cart. -She was not sure if the pharmacy had been contacted to refill the resident's Sertraline. A second interview with the MA on 11/22/22 at 1:41pm revealed: -She contacted the pharmacy about Resident #1's Sertraline after the morning medication pass on 11/22/22. -The pharmacy staff told her a supply of Sertraline was sent to the facility on 11/15/22. -She would have to look for the Sertraline sent on 11/15/22 to see if she could find it. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/23/22 at 10:48am revealed the pharmacy last dispensed and delivered 30 Sertraline 25mg tablets to the facility on 11/15/22 for Resident #1.	D 358		

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D 358	Continued From page 4 Interview with the Director of Resident Care (DRC) on 11/22/22 at 2:11pm revealed: -The MAs should check the medication cart thoroughly when administering medications. -The MA should have double checked the medication cart for Resident #1's Sertraline that morning during the morning medication pass on 11/22/22. Interview with the Administrator on 11/22/22 at 4:09pm revealed: -Resident #1's Sertraline was found this afternoon in the medication cart with the resident's other medications. -The MA had overlooked the Sertraline in the medication cart that morning on 11/22/22. Observation of Resident #1's medications on hand on 11/22/22 at 4:09pm revealed: -There was a supply of Sertraline 25mg tablets dispensed on 11/15/22. -There were 30 of 30 tablets remaining. Interview with Resident #1 on 11/22/22 at 3:44pm revealed: -She was unsure if she was receiving a medication for depression. -At one time, she thought she was depressed because she did not like being at the facility because she wanted to be at home. Interview with Resident #1's primary care provider (PCP) on 11/23/22 at 11:01am revealed: -Resident #1's Sertraline should be administered daily as ordered. -She was not concerned of any long-term effects of Resident #1 missing one dose of the Sertraline.	D 358		

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c. Review of Resident #1's physician's orders dated 08/03/22 revealed an order for Systane Ultra, instill 2 drops in the right eye once daily. (Systane Ultra is a lubricant eye drop used to treat dry eyes.)

Review of Resident #1's November 2022 medication administration record (MAR) revealed:
-There was an entry for Systane Ultra, instill 2 drops in the right eye once daily scheduled for 10:00am.
-Systane Ultra was documented as administered daily from 11/01/22 - 11/21/22, except documentation was blank for 11/08/22.

Observation of the morning medication pass on 11/22/22 revealed:
-The medication aide (MA) prepared and administered morning medications to Resident #1 at 9:45am.
-Systane Ultra eye drops were not offered to Resident #1 when she received her other morning medications scheduled for 9:00am and 10:00am at 9:45am.

Interview with the MA on 11/22/22 at 9:45am revealed:
-She did not administer Systane Ultra eye drops to Resident #1 because she could not find any in the medication cart.
-She was not sure if the pharmacy had been contacted to refill the resident's Systane Ultra eye drops.

A second interview with the MA on 11/22/22 at 1:41pm revealed:
-She contacted the pharmacy for a refill request for Resident #1's Systane Ultra eye drops after the morning medication pass on 11/22/22.
-Resident #1's Systane Ultra eye drops should

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come in the pharmacy tote to the facility tonight.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/23/22 at 10:48am revealed:
-The pharmacy last dispensed one 10ml bottle of Systane Ultra eye drops for Resident #1 on 07/15/22.
-The pharmacy would be dispensing one 10ml bottle of Systane Ultra eye drops today, 11/23/22.

Interview with the Director of Resident Care (DRC) on 11/22/22 at 2:11pm revealed:
-She was not aware Resident #1's Systane Ultra eye drops were not available.
-All MAs and clinical staff were responsible for ordering medications when there was a one-week supply of medication left on hand.
-For eye drops, the MAs could go by the open date to determine when there was a one-week supply remaining to reorder the eye drops.

Interview with Resident #1 on 11/22/22 at 3:44pm revealed:
-When she woke up in the mornings, her eyes were usually "closed and stuck together".
-She usually got eye drops in her right eye, but she could not remember if she received the eye drops that morning on 11/22/22.

Interview with Resident #1's primary care provider (PCP) on 11/23/22 at 11:01am revealed:
-Resident #1 had dry eye syndrome.
-Resident #1 needed to receive the Systane Ultra eye drops as ordered to prevent corneal abrasions and tears that could be caused by dry eyes.

d. Review of Resident #1's current FL-2 dated 01/24/22 revealed an order for Omeprazole 20mg

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1 tablet daily. (Omeprazole is used to treat acid reflux disease.)

Review of Resident #1's physician's order sheet dated 08/03/22 revealed an order for Omeprazole 20mg take 2 tablets every morning.

Review of Resident #1's physician's order dated 10/24/22 revealed an order for Omeprazole 20mg take 1 capsule 30 minutes before morning meal once a day.

Observation of the morning medication pass on 11/22/22 revealed:
-The medication aide (MA) prepared and administered 2 Omeprazole 20mg tablets (40mg) to Resident #1 at 9:45am.
-The resident was administered 2 Omeprazole 20mg tablets instead of 1 as ordered on 10/24/22.

Review of Resident #1's November 2022 medication administration record (MAR) revealed:
-There was an entry for Omeprazole 20mg take 2 tablets (40mg) every morning scheduled at 9:00am.
-Omeprazole 20mg 2 tablets every morning was documented as administered from 11/01/22 - 11/22/22.
-There was no entry for Omeprazole 20mg take 1 tablet daily as ordered on 10/24/22.

Interview with the MA on 11/22/22 at 1:41pm revealed:
-She administered Resident #1's Omeprazole according to the instructions on the MAR.
-She did not notice the label on Resident #1's Omeprazole dispensed on 10/24/22 had instructions to administer 1 Omeprazole 20mg capsule.
-She was not aware the resident's order for

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D 358	Continued From page 8 Omeprazole had changed on 10/24/22. Observations of Resident #1's medications on hand on 11/22/22 at 1:45pm and 11/23/22 at 10:20am revealed: -There was an over-the-counter (OTC) supply of Omeprazole 20mg tablets with no pharmacy label in unit dose packaging. -There was a supply of Omeprazole 20mg capsules dispensed on 10/24/22 with instructions to take 1 capsule 30 minutes before the morning meal. -There were 28 of 30 capsules remaining. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/23/22 at 10:48am revealed: -The pharmacy received and dispensed the order dated 10/24/22 for Omeprazole 20mg 1 capsule 30 minutes before the morning meal on 10/24/22. -The pharmacy or the facility staff could enter orders onto the MAR. -The new order dated 10/24/22 may not have been entered by the pharmacy on the November 2022 MAR because the new monthly MARs had likely already been mailed/delivered to the facility when the order was received. -The facility would have been responsible for transcribing the order onto the November 2022 MAR if that was the case. Interview with the Director of Resident Care (DRC) on 11/22/22 at 2:11pm revealed: -If the instructions on the medication label and the MAR did not match, the MAs should stop and check the orders or notify her. -She was unaware of the order change for Omeprazole dated 10/24/22. -She thought the new order dated 10/24/22 had the wrong dose and should have been verified	D 358		

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with the provider by either her or the MAs.

Interview with Resident #1 on 11/22/22 at 3:44pm revealed:
-She took medication for acid reflux but she was unsure what or how much she received.
-She had symptoms of acid reflux "at times".

Interview with Resident #1's primary care provider (PCP) on 11/23/22 at 11:01am revealed:
-Her company had recently launched an effort to take residents off unnecessary medications.
-Part of that effort was to slowly wean residents off medications like Omeprazole that were not necessary and could prevent other medications from working properly.
-Resident #1's Omeprazole dose was ordered at a lower dose on 10/24/22 to implement a slow taper off the medication.
-The resident was still having intermittent symptoms with acid reflux so she would plan to see the resident at a visit next week.

2. Review of Resident #4's current FL-2 dated 07/15/22 revealed:
-Diagnoses included Type II diabetes, congestive heart failure, pulmonary hypertension, hypersensitivity lung disease edema and presence of a cardiac pacemaker.
-She was ambulatory.
-There was no information documented regarding orientation status.

Review of Resident #4's endocrinology visit summary dated 08/01/22 revealed a history of Vitamin D deficiency.

Review of Resident #4's lab results collected on

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10/24/22 revealed her Vitamin D level was 28.87. (Normal range is 30-100)

Review of Resident #4's physician's order dated 10/26/22 revealed an order for Vitamin D3 2,000 units to be administered each day. (Vitamin D3 is a supplement used to treat Vitamin D deficiency.)

Review of Resident #4's medication administration record (MAR) for October 2022 revealed:
-There was a hand-written entry for Vitamin D 2000 units to be administered each day.
-There was documentation Vitamin D 2000 units was administered daily on 10/29/22 through 10/31/22.

Review of Resident #4's MAR for November 2022 revealed there was no entry for Vitamin D3 2000 units to be administered each day.

Observation of Resident #4's medications on hand on 11/23/22 at 11:50am revealed there was no Vitamin D3 available for administration.

Interview with the medication aide (MA) on 11/23/22 at 11:55am revealed:
-She had never administered Vitamin D to Resident #4.
-She had never known Resident #4 to have an order for Vitamin D.

Telephone interview with the pharmacy technician with the facility's contracted pharmacy on 11/23/22 at 11:37am revealed the pharmacy had not received an order for Resident #4 to receive Vitamin D3 2000 units to be administered each day and none had been dispensed.

Interview with Resident #4's primary care provider

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D 358	Continued From page 11 (PCP) on 11/23/22 at 11:08am revealed: -Resident #4 was prescribed Vitamin D 2000 units each day because her Vitamin D level was low on previous bloodwork. -Resident #4 was a high fall risk because of toe amputations that impaired her balance and Vitamin D was important to prevent fractures if she were to fall. Interview with the Director of Resident Care (DRC) on 11/23/22 at 12:26pm revealed: -New orders should have been faxed to the pharmacy when it was received. -Medications were typically delivered to the facility within 24-48 hours. -She and the MA on duty were responsible for transcribing the order onto the MAR for administration. -The pharmacy would enter the order onto the MAR for the following month if the order was received prior to MARs for the following month being sent to the facility. -The facility received the MARs for the following month on or about the 24th of each month and she was responsible for checking the MARs for accuracy. -Medication orders received after the 24th of each month would not be printed on the MAR and had to be transcribed on the MAR for administration. -It was human error that the Vitamin D3 order for Resident #4 was not transcribed onto the November 2022 MAR.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the	D 366		

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medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication aides (MAs) documented the administration of medications immediately following the administration and observation of the residents actually taking the medications for 3 of 3 residents (#1, #6, #7) observed during the morning medication pass on 11/22/22.

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 first floor assisted living (AL) on 11/22/22 at 9:09am revealed:
-A medication aide (MA) prepared and administered 10 oral medications to Resident #6 at 9:09am.
-The MA did not document the administration of the morning medications on the MAR for Resident #6 after observing the resident take his medication.

Interview with the MA on 11/22/22 at 9:17am revealed:
-She usually initialed the MARs right after she observed a resident take their medications.

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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 366	Continued From page 13	D 366		

-She forgot to document her initials on the MAR for Resident #6's 10 oral medications she administered that morning.
-She would write her initials on the MAR for Resident #6's morning medications now.

Observation of the third floor AL on 11/22/22 from 9:32am - 10:18am revealed:
-A second MA prepared and administered 5 oral medications to Resident #7 at 9:32am.
-The MA documented the administration of 1 of the 5 oral medications but not the other 4 medications administered.
-The MA continued with the medication pass for the next resident.
-The MA administered 11 oral medications and an inhaler to Resident #1 at 9:45am and an oral medicated mouthwash at 9:46am.
-The MA documented the administration of 1 of the 11 oral medications but not the other 10 medications administered, the inhaler, or the medicated mouthwash.
-The MA prepared and administered a powdered medication in water to Resident #7 at 10:18am.
-The MA did not document the administration of the powdered medication in water to Resident #7 after observing the resident take it at 10:18am.

Review of Resident #7's November 2022 MAR on 11/22/22 at 10:21am revealed:
-There were 4 of 5 oral medications administered to the resident at 9:32am on 11/22/22 that were still not documented as administered.
-The resident's powdered medication administered in water at 10:18am was not documented as administered.

Review of Resident #1's November 2022 MAR on 11/22/22 at 10:22am revealed:
-There were 10 of 11 oral medications and the

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 11/23/2022

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D 366	Continued From page 14	D 366		

inhaler administered to the resident at 9:45am on 11/22/22 that were still not documented as administered.
-The medicated mouthwash administered to the resident at 9:46am on 11/22/22 was still not documented as administered.

Interview with the second MA on 11/22/22 at 1:41pm revealed:
-She usually only documented one medication for each resident during the morning medication pass right after she observed the resident take their morning medications.
-She would wait to document the residents' other morning medications she administered after she completed the entire morning medication pass.
-It took too much time to document all of the residents' medications she administered during the medication pass.
-She thought it saved time to wait until the end of the medication pass to write her initials on the MARs.

Interview with the Director of Resident Care (DRC) on 11/22/22 at 2:11pm revealed:
-The MAs had been trained and they knew to document the administration of medications on the MAR immediately after observing a resident take their medication and prior to going to the next resident.
-The MAs should not document the administration of medications at the end of the medication pass.

Interview with the Administrator on 11/22/22 at 2:11pm revealed:
-She was not aware MAs were not documenting administration of medications on the MAR when the medications were administered.
-The MAs were supposed to document on the

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D 366	Continued From page 15 MAR right after medications were administered to a resident, prior to going to the next resident.	D 366		