Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Heartfields at Cary
Address: 1050 Crescent Green Dr., Cary, NC 27511
County: Wake
License Number: HAL-092-216

II. Date(s) of Visit(s): 06/10/25; 07/02/25; 07/09/25; 08/04/25
Purpose of Visit(s): Complaint Investigation
Exit/Report Date: 08/04/25

Instructions to the Provider *(please read carefully)*:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this Corrective Action Plan. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Unabated Type B, Citation)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent**: *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: **10A NCAC 13F .0909** Resident's Rights Rule/Statutory Reference: Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights: To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations. Level of Non-Compliance: **TYPE A1 VIOLATION** This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#1) received care and services that were adequate and appropriate, who had a fractured right shoulder, redness/swelling to left elbow, and bruising to left arm, hip, chest, and flank areas. The findings are: Review of Resident #1's FL-2 dated 04/08/25 revealed: -Diagnoses included acute cholangitis and E. Coli bacteremia. -The resident was semi-ambulatory. Review of Resident #1's Care Plan dated 03/18/25 revealed: -Resident #1's ambulation needs were stand-by supervision. -Resident #1 was a high fall risk. -Resident #1 needed physical assistance for transfers and was	☐ POC Accepted _____ *DSS Initials*	

able to bear weight during transfers.
-Resident #1 needed physical assistance with bathing, grooming, dressing, and toileting.
-Resident #1 was independent in eating.
-Resident #1 was mildly confused.

Review of Resident #1's Licensed Health Professional Support (LHPS) dated 02/19/25 revealed LHPS personal care tasks provided were:
-Physical Therapy referral.
-Ambulates with standby assistance with a walker.
-Ambulates with wheelchair with assistance.
-Transfer with standby assistance.

Review of Resident #1's Physician Orders dated 05/05/25 revealed there was an order for Sit-to-Stand for transfers.

Review of Resident #1's Resident Service Notes revealed:
-On 05/04/25, the Director of Health and Wellness (DHW) notified the family of increased level of care due to more hands on for Activities of Daily Living (ADL).
-The resident was requiring hands on for all ambulation/transfers.
-The resident was refusing care when family was present, and the primary care provider (PCP) was notified.
-On 05/08/25, the resident had extreme bruising from her left armpit down the left arm past the elbow, down the left side and left breast.
-The DHW was notified and Hospice.
-On 05/09/25, results from an x-ray that was ordered by the PCP were received and it was noted that Resident #1 had a fracture to the right shoulder.
-There were no complaints of shoulder pain.

Review of Resident #1's X-Ray findings ordered on 05/08/25 by the PCP revealed:
-Indications were extensive bruising of the right shoulder and extensive bilateral shoulder and upper arm bruising.
-Right shoulder impression was fracture fragment involving lateral proximal right humeral head/neck, upper arm.
-The bones were osteoporotic.
-Impacted right humeral neck fracture.
-Bones were osteoporotic, adjacent soft tissues appeared unremarkable.

Review of Resident #1's Hospice Notes revealed:
-On 05/06/25, the resident was admitted to Hospice with a diagnosis of cerebral atherosclerosis.
-On 5/07/2025, a Hospice Registered Nurse (RN) conducted a

first visit and "aides assisted to examine pressure wounds" on buttocks.
-On 5/08/2025, Hospice checked on the resident and the PCP was notified.
-The resident required 2 plus assistance for transfers.
-The resident "stays in her chair making positioning and turning difficult."

Telephone interview with Resident #1's family member on 05/16/25 at 12:17pm revealed:
-The resident had severe bruises on her left side and a fractured right shoulder noticed at the hospice house on 05/09/25.
-She was notified by a MA on 05/09/25 that staff had "messed up" Resident #1's shoulder.
-The staff expressed this at the time of discharge of Resident #1 on 05/09/25.
-She took pictures of the bruises on 05/09/25 the day the resident left the facility and was admitted to the Hospice House.

Review of pictures received from Resident #1's family member revealed:
-Picture 1 was of a bruise that was deep purple in color that extended from the left armpit down the left side to the hip area.
-Picture 2 was the same color of bruising on the left upper arm area from armpit to elbow. There was also bruising to outer portion of left breast towards the nipple area back to armpit.
-Picture 3, on the left upper chest area there was bruising that was yellowish in color from the armpit around to the front area of the chest and breast.
-Picture 4 was a bruise on the upper left arm, from the armpit to elbow area, that was purplish in color with some redness and a swollen area on the outer left arm near the elbow.
-Picture 5 was of a protrusion of the right outer upper arm near shoulder area.

Interview with a medication aide (MA) on 05/14/25 at 1:01pm revealed:
-She assisted staff with transfers for Resident #1 as the resident was a 2-person assist.
-Resident #1 received an order on 05/05/25 for use of the Sit-to-Stand to assist with transfers as the resident was not able to assist staff with standing or pivoting.
-The resident was resistant to the usage of the Sit-to-Stand and would jerk around, attempting to slip out of the harness.
-Staff were required to provide a 2-person assist prior to Resident #1's decline around April 2025.

-She was aware and noticed bruising on Resident #1's left side under the arm and down that side of the resident's body on 05/08/25 which was reported to the DHW on the same day.
-She noted it in the Resident Service Notes on 05/08/25.
-The cause of the bruising was unknown.
-"It was not unlikely that it occurred from transferring the resident because she stopped helping with transferring and was resistant to staff using the Sit-to-Stand".
-The resident would just buckle and fall, putting all her weight onto the staff to hold her up.

Interview with a personal care aide (PCA) on 05/14/25 at 12:25pm revealed:
-He was required by the administration to provide 2-person assistance at all times with Resident #1's care.
-He transferred the resident manually with the assistance of another staff member and did not use the Sit-to-Stand.
-He was assisted by another staff member with transfer of the resident on 05/07/25.
-He noticed the bruising of the resident which stopped at the upper part of the arm, though could not recall which arm nor side but it was not there the day before on 05/07/25.
-The bruising was reported to him by the night shift staff that morning with the cause of the bruising unknown and he believed it to be around 05/08/25.
-He was not sure of the dates, but it was around the timeframe during the week of Resident #1's discharge.
-It was reported to the MA per procedure that same day.
-Resident #1 had received an order for use of the Sit-to-Stand to assist with transfers as the resident was not able to assist staff with standing or pivoting.
-He was trained to use the Sit-to-Stand when he was hired at the facility, though he had not used it with Resident #1.
-He was unable to recall the person who trained him at the facility though assumed it was DHW.

Interview with a second MA on 07/09/25 at 3:35pm revealed:
-She was aware of the bruising beginning at the armpit and running down the side of Resident #1.
-She was unable to recall the date of noticing the bruising.
-She reported these injuries to the DHW by protocol though could not recall the date she reported it.
-The bruising under Resident #1's arm at the armpit and down the side looked consistent with the use of the harness with the Sit-to-Stand.

Telephone interview with a third MA on 07/08/25 at 11:40am revealed:
-Resident #1 was a 2-person assist and always used 2 people

to assist with transfers.
-She only assisted when needed with transfers and it was done manually.
-She had not observed the bruises on the resident.
-She was not able to recall the last time she needed to assist staff with transferring.

Telephone interview with members of Resident #1's Hospice Care Team on 07/02/25 revealed:
-The RN noticed the bruise of left side under armpit and left side flank during her first visit with Resident #1 on or about 05/08/25.
-She was notified by the facility of the bruising on 05/08/25.
-The PCP ordered x-rays that same day due to the bruising of the resident.
-The resident was transported to Hospice House on 05/09/25, arranged by them using a transportation service, and that same day was notified per x-ray results of a fractured right shoulder prior to leaving the facility.
-According to the RN it was possible that bruising was caused by the Sit-to-Stand during transferring though there were no markings to indicate that was the cause.

Interview with the DHW on 07/02/25 at 12:30pm revealed:
-She was made aware of the unexplained injuries of Resident #1 on 05/08/25 by both MAs.
-She notified the PCP who ordered x-rays to be done.
-The DHW was notified of Resident #1's right shoulder fracture on 05/09/25 per the x-ray findings.
-The family, Hospice, and PCP were notified as well as the Executive Director (ED) of the facility.
-Resident #1 had an order from her PCP dated 05/05/25 to use the Sit-to-Stand for transfers.
-Resident #1 was the only resident using the Sit-to-Stand for transfers.

Telephone interview with the facility's RN on 07/31/25 at 2:29pm revealed:
-Bruising would be something to look for when transferring a resident whether trained or not on the use of Sit-to-Stand and could be caused by a number of things.

Interview with the ED on 07/02/25 revealed:
-She was aware of the injuries on the day of Resident #1's discharge on 05/09/25.
-She was not aware of the cause of the injuries.
-An internal investigation was not conducted.
-All parties (family, PCP, Hospice) were notified of the unexplained injuries to the resident prior to the resident being

discharged and transferred to the Hospice House.

Telephone interview with Resident #1's PCP on 07/02/25 revealed:
-She was made aware of Resident #1's bruising from the facility's DHW on 05/08/25.
-She ordered x-rays due to the bruising.
-The resident's bones were brittle due to osteoporosis which turned the bones into powder and any slight movement could cause a fracture.
-There was no documentation provided to her of a recent fall.
-The fracture could have occurred during transfer with Sit-to-Stand as the resident was not assisting staff with transfers anymore.
-The resident was not sleeping in bed and only sat in a recliner, in which she would slide down, making transferring more challenging.

The facility failed to ensure that Resident #1 received care and services that were adequate and appropriate which resulted in an impacted right shoulder fracture, multiple bruised areas of unknown origin to the left arm, hip, chest, and flank areas, and redness/swelling of the left elbow. The failure of the facility resulted in serious physical harm and constitutes a Type A1 violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 08/04/25 for this violation.

IV. Delivered Via:	Electronic Mail	Date: 08/08/25
DSS Signature:	*Carla Adams*	Return to DSS By: 08/29/25

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		

☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:		Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:	
Comments:			
**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*			