	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		01	C / 20/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 000	Initial Comments		D 000			
	complaint investigation Infection Control survice 12/30/20 and 01/04/2 on 12/31/20 and 01/04 telephone exit on 01/ survey was reopened supervisor and upper review continued from	sure Section conducted a on and a COVID-19 focused yey with onsite visits on 21 and a desk review survey 05/21 - 01/07/21, and a 07/21. On 01/12/21, the d per the guidance from the r management, the desk m 01/12/21 to 01/20/21, and exit was done on 01/20/21.				
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings		D 079			
		s shall an uncluttered, clean and of all obstructions and				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	interviews, the facility was free of hazards a soiled furniture in a s items and a topical p unsecured in an unlo resident room and ba laundry room access Memory Care Unit (M	ns, record reviews and / failed to ensure the facility as evidenced by storage of ection of the hallway, toiletry ain medication left ocked and unoccupied athroom and a unlocked ible to all residents in a <i>I</i> CU) including residents ntia and/or wandering				
	The findings are:					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		01	C I/ 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 079	Continued From page	e 1	D 079			
	Unit (MCU) beside ro 1:22pm revealed: -The hallway was ass separated from the re- closed, double doors -There were 4 chairs against the left wall of on the wall. -The fourth chair had in the seat. Interview with the RC revealed: -The brown stains and chairs located in the feces. -She thought the chair hallway the week prior -Items were placed and could be addressed be -The Maintenance Diffinispecting the furnitur appropriate. -If the furniture could Maintence director wo Telephone interview of Director (MCD) on 07 she was not aware the stored in the hallway hallway. Observation of the latered	lined up beside one another if the hallway blocking the rail a set of wheelchair leg rests CD on 01/04/21 at 1:59pm d build-up substance in the hallway appeared to be irs were placed in the or. t the end of C-Hall until they by the Maintenance Director. rector was responsible for re/equipment and fixing it if not be cleaned, then the ould dispose of it. with the Memory Care 1/06/20 at 12:59pm revealed here were soiled chairs				
	-The unlocked laundi the hallway that was	ry room was in a section of separated from the U by closed, double doors				

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If continuation sheet 2 of 75

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		BENNI IOANON NOWBER.	A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	EGARNER		GLEWOOD DRIVE			
	1	GARNEI	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 079	Continued From page	e 2	D 079			
	opened position with from the doorway. -There was an enclos "chemical laundry dis wall with an unlocked -Inside the laundry di white substance.	spenser, there was a solid athroom in an unoccupied				
	01/04/21 at 1:03pm rd -The bathroom in the #C7) was separated I -There was an opene baby cornstarch powe the powder remaining external use only and irritated skin, stored of -There was a contain cleanser with a forme handwritten on the co of the sink. -There was a 16-ound shampoo wash with I external use only and stored on the side of	unoccupied room (room by closed, double doors. ed 22-ounce container of der with approximately ½ of g with labeled directions for d do not apply to broken or on the side of the sink. er of a liquid perineal er resident 's name ontainer, stored on the side ce bottle of a liquid body and abeled directions for d avoid contact with eyes, the sink. if liquid mouthwash stored				
	on the C hall of the M revealed: -The unoccupied room hallway that was sepa- the MCU by closed, c -The entrance room of position.	door was in an opened container in the top of the				

STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED		
		HAL092215	B. WING		01	C 01/20/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE				
	EGARNER	200 MIN	GLEWOOD DRIVE					
ADENCI	EGARNER	GARNEF	R, NC 27529					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CO				DF CORRECTION CTION SHOULD BE D THE APPROPRIATE NCY)	(X5) COMPLETI DATE
D 079	Continued From page 3		D 079					
	a lid, with approximation is a lid, with approximation on the turn of	be. nstructions if more of the rushing was accidentally sal help or contact a Poison way. e smaller tubes of een opened and were ontainer. m tube of Voltaren gel, n only, topical use only with of the medication remaining. cal pain medication used to and joint stiffness caused directions not to use the e bottle of skin moisturizer. the bottle of skin moisturizer. the bottle of cold cream p remover with the cream remaining. warning directions for roduct got into the eyes, ainers of antiperspirant (one nd the other as a liquid roll n toothbrushes with one of ed inside an enclosed esident's name written in the closed double doors on Memory Care Unit (MCU) on						

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
			A. BOILDING.			С	
		HAL092215	B. WING		01	01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN (OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLET	
D 079	Continued From page	9 4	D 079				
	toward the facility's exhallway. -The male resident ar the end of the hallway was redirected by the (RCD) away out of the double doors. Interview with the RC revealed: -The male resident set this section of the hall door's window. -The laundry room sh -There were residents with dementia and/or -Chemicals were stor could be harmful if ing -Room# C7 had been needed end of life can -The RCD was not av been deep cleaned. -Room# C7 had not b of weeks. -Housekeeping was r of residents' rooms af -She was not aware t or topical medications and the bathroom. -Medication cart. -Toiletry items were s closet near the nurse: -The RCD locked the the laundry room doo	a used for residents who re. vare that Room# C7 had not been occupied for a couple esponsible for the cleaning fter discharge. hat there were toiletry items a stored in residents' rooms ored on the locked tored in the locked storage s' station. e door to room# C7, locked r, and would notify the					
	Maintenance Director	of the furniture in the					
	hallway.						
	Telephone interview v	vith the Memory Care					

STATE FORM

TATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	IDENTIFICATION NOMBER.	A. BUILDING:		C 01/20/2021	
	HAL092215	B. WING			
IAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
ADENCE GARNER		GLEWOOD DRIVE R, NC 27529			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 079 Continued From pag	e 5	D 079			
 The laundry room sl -She was not aware resident room and ba including tubes of too cleanser, body wash creams, antiperspira left unsecured in the room. She thought housek and removed all item -She last monitored 1 MCU around 12/14/2 There should not ha topical pain medicati accessible to any of -The MCU had a lock all the residents' toile secured. She attempted to lin areas of the facility w positive for COVID-1 staff to ensure all are however she had not the double doors bed assigned to those re- -Staff were responsit redirect any resident of the hallway behind -She was not aware this area of the hallw -The male resident of 01/04/20 was at risk were undrinkable (da -The male resident w picking up items, pict thinking the product 	his area on C hall in the 20. ve been any toiletries or ons left unsecured and the residents. Kable cabinet space to keep etry items locked and hit exposure to different when residents were testing 9 and had assigned a named eas on C hall were cleaned; t monitored the area behind cause no residents were sident rooms. ble not to prohibit and s from entering that section d the double doors. a male resident went back in				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL092215	B. WING	01	C 01/20/2021	
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN	OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	O THE APPROPRIATE	COMPLET
D 079	Continued From page	e 6	D 079			
	monitored to keep the	e residents safe.				
p 8 ir c M h ir ir	Telephone interview with one of the primary care providers (PCPs) for the facility on 01/06/21 at 8:05am revealed: -She was the PCP for the male resident observed in the hallway of the facility on C Hall in the MCU on 01/04/21. -She had concerns if any of the residents' in the MCU had accessibility to any chemicals. -The male resident would pick up different items, had dementia and would not understand the importance of not touching items or use an item					
		Id potentially harm him.				
	Telephone interview v 01/05/21 at 3:32pm r -The facility had a ha					
	-He would attempt to provide a copy.					
	At the time of exit on hazard policy was no	01/07/21, the facility's t provided.				
	4:50pm revealed:	ministrator on 01/04/21 at ensure all areas of the				
	facility were free of harder of hard	azards. be done with all staff to				
	ensure all hazards we accessible to residen					
		ns, record reviews, and esident observed on the C not interviewable.				
	Attempted telephone Maintenance Director 01/05/21 and 01/06/2	r was unsuccessful on				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:		с	
		HAL092215			01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 079	Continued From page	e 7	D 079			
	including a laundry ro a topical pain medica toiletries; and unclea soiled with stains left including one resider that area of the hallw and/or wandering bel understand the impor or use an item he pic harm him. The facilit the health and safety constitutes a Type B The facility provided accordance with G.S this violation.	n furniture including a chair accessible to all residents at who was known to walk in ay frequently, had dementia haviors and would not rtance of not touching items ked up that could potentially y's failure was detrimental to of the residents which Violation a plan of protection in . 131D-34 on 01/05/20 for				
D 137		7(a)(5) Other Staff 7 Other Staff Qualifications n at an adult care home	D 137			
		tiated findings listed on the n Care Personnel Registry 1E-256;				
	facility failed to ensur B) had no substantia North Carolina Healtl	as evidenced by: and record reviews, the re 1 of 6 sampled staff (Staff ted findings listed on the n Care Personnel Registry ce with G.S. 131 E-256 upon				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		HAL092215	B. WING		01	C 01/20/2021	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE			
	GARNER		GLEWOOD DRIVE				
		GARNEF	R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 137	Continued From page	e 8	D 137				
	hire.						
	The findings are:						
	-Staff B was hired on aide (MA).	ersonnel record revealed: 12/16/20 as a medication nentation of a HCPR check					
	revealed: -She was hired as a l -She had only worked	on 12/30/20 at 5:15am MA. d at the facility for 7 days. ft as a MA and floated on all					
	Manager (BOM) on 0 revealed: -She was responsible the staff. -She could not find th date of the HCPR che -She printed one on 0 find the original. -She would continue	e for the HCPR checks for ne original document with the					
	Upon exit, no further received.	documentation was					
D 188	10A NCAC 13F .0604 Other Staffing	4(e) Personal Care And	D 188				
	Staffing	Personal Care And Other					

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If continuation sheet 9 of 75

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	GARNER		GLEWOOD DRIVE			
	-	GARNER	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 188	Continued From page 9		D 188			
	home is staffing to cee below 21 residents, t a home with a census (1) The home shall h the needs of the resid duty hours on each 8 be at least: (A) First shift (mornin for facilities with a ce residents; and 16 hou additional hours of ai 10 or fewer residents or capacity of 40 or n chart, see Rule .0606 (B) Second shift (afte duty for facilities with to 40 residents; and four additional hours additional 10 or fewe census or capacity of staffing chart, see Ru (C) Third shift (even per 30 or fewer residen resident census). (Fe .0606 of this Subchap (D) The facility shall meet the needs of the residents equal to the by Medicaid. As use "heavy care resident" "heavy care" by Medi	ernoon) - 16 hours of aide a census or capacity of 21 16 hours of aide duty plus of aide duty for every r residents for facilities with a f 40 or more residents. (For ile .0606 of this Subchapter.) ing) - 8.0 hours of aide duty ents (licensed capacity or or staffing chart, see Rule				
	(E) The Department if it determines the ne	shall require additional staff eeds of residents cannot be quirements of this Rule.				
	This Rule is not met Based on record revi					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:		C	
		HAL092215	B. WING		01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 188	facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility with a census of 24 - 28 were met for 3 of 8 shifts sampled from 11/16/20-11/20/20 and 4 of 10 shifts sampled from 12/12/20 -12/13/20, 12/18/20 and 12/25/20.		D 188			
	The findings are:					
	-The license was effe -There had been a cl 12/01/19. -The facility was licer beds including 36 be area and 48 beds for (MCU). -There was not any r	s current license revealed: ective 12/01/19 - 12/31/20. nange of ownership on nsed for a capacity of 84 ds for the assisted living (AL) the memory care unit notation in the license that paration of the MCU into 2				
	dated 11/16/20-11/20 census of 28 residen the AL area, which re	's resident census reports)/20 revealed there was a ts on each of those days in equired 16 staff hours on first 8 staff hours on third shift.				
		evealed there was a total of vided on first shift with a				
		revealed there was a total of vided on first shift with a				
	12/12/20 revealed th	's resident census reports for ere was a census of 27 rea, which required 16 staff				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		01	C / 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN ((X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	O THE APPROPRIATE	COMPLETE DATE
D 188	Continued From page 11		D 188			
	hours on first and see on third shift.	hours on first and second shift and 8 staff hours on third shift.				
	Review of the employee time cards dated 12/12/20 (Saturday) revealed:					
	-There was a total of 13.75 staff hours provided on first shift with a shortage of 2.25 hours. -There was a total of 10.75 staff hours provided					
	on second shift with	a shortage of 5.25 hours.				
	-There was a total of third shift with a shor	2.25 staff hours provided on tage of 5.75 hours.				
	12/25/20 revealed th	's resident census reports for ere was a census of 24 rea, which required 16 staff t.				
		ealed there was a total of vided on second shift with a				
	Living section on 12/ -The resident had live	lent residing on the Assisted 30/20 at 10:15am revealed: ed at the facility for 2 ½				
	minutes to one hour	e resident had to wait 30 for staff to respond to her				
		e call light for staff ght this depended on if staff were more staff on duty.				
	-The facility's first shi	ft staffing was "good", t quite as good", and third				
	shift staffing "don't ex	pect any body". Sonally would observe the				
	hallways of the facilit	y until she saw staff passing				
		e staff's attention when there				
	respond to her activa	ds of waiting for staff to				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
					с	
		HAL092215	B. WING		01	/20/2021
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	EGARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 188	Continued From page	e 12	D 188			
	on 01/20/21 at 10:11a -She was the one resistaff. -She had the monthly 15th of the month for -All staff who request ahead of time. -When there was a cl schedule was posted staff were to find cover -If staff could not find Supervisor/medicatio responsible to find cover -If the S/MA was not a she helped find cover -She completed a dat who was working. -The S/MA was respond assignment sheet bat -On first shift, she trie cover medication adm well as the personal cover as well as the personal cover residents on the 4 ha -On third shift, she trie medication administra as the personal care the 4 halls which was supervisor for a total -There were two super medication aides (MA	sponsible for scheduling the y schedule completed by the the next month. ed time off were to do so hange needed after the , such as if staff called-off, erage. coverage, the n aide (S/MA) was overage. able to find coverage, then rage. ily log that let the staff see onsible to complete the daily sed on the daily log. ed to schedule seven staff to ninistration on the 4 halls as care needs for the residents e tried to schedule 6 to 7 staff administration on the 4 halls ual care needs for the lls. ed to schedule staff to cover ation on the 4 halls as well needs for the residents on a usually three staff with a of four staff on third shift. ervisors on first shift, the A) could work as a MA or				
	then had at least thre one S/MA.	CA). ame for second shift and e PCAs on third shift and he census, she had tried to				

EFICIENCIES RRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	HAL092215	B. WING		C 01/20/2021	
ER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	200 MIN	GLEWOOD DRIVE			
INER	GARNEF	R, NC 27529			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETI DATE
tinued From page	e 13	D 188			
edule two staff on e and the Memory itch in when they hen someone calle mes. November and De s short some shifts e facility started to istance from a loc elp cover shifts. e have had some nother." aff were to punch i eryone got 15 min t and another 15 i a total of 30 minut me staff chose to e facility has had f to make sure that minute breaks. r staff breaks, the ey could go to the y chose to take the ey were supposed in know as well as ng on break. e staff who were go bever was coverin er to cover the flo e facility had 2 ac ctor and activities As. aff were to clock ir ded. e monthly schedu ions, in the break ne staffs' phone n eived it.	 a B Hall at all times. b Care Director (MCD) tried were working. b out, it was hard to cover c cember 2020, the facility c on hire more staff and sought al temporary staffing agency c short shifts for one reason in and punch out for breaks. b outer in the first part of their n the latter part of their shift tes. take one 30-minute break. numerous meetings with at they clocked out for the staff did leave the floor. b break room or wherever eir break. d to report to the S/MA to let the PCA that they were going on break was to have g for them to take their tor. tivities staff, the activities assistant, that did work as n and clock out and help as le was posted at the nurses' room, and she would text it umbers to ensure they 				
	ER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Attinued From page edule two staff on e and the Memory itch in when they nen someone calle mes. November and De short some shifts e facility started to istance from a loc elp cover shifts. e have had some nother." off were to punch eryone got 15 mir t and another 15 in a total of 30 minut me staff chose to e facility has had f to make sure tha minute breaks. staff breaks, the ey could go to the v chose to take th ey were supposed in know as well as no break. e staff who were go ever was coverin er to cover the floe e facility had 2 ac ctor and activities As. off were to clock ir ded. e monthly schedu ions, in the break is staffs' phone n eived it. ring the monthly r	EFICIENCIES RRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092215 ER OR SUPPLIER STREET A 200 MINU GARNET ER OR SUPPLIER STREET A 200 MINU GARNET SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Attinued From page 13 edule two staff on B Hall at all times. e and the Memory Care Director (MCD) tried itch in when they were working. ien someone called out, it was hard to cover mes. November and December 2020, the facility is short some shifts. e facility started to hire more staff and sought istance from a local temporary staffing agency elp cover shifts. e have had some short shifts for one reason nother." iff were to punch in and punch out for breaks. eryone got 15 minutes in the first part of their is and another 15 in the latter part of their shift a total 030 minutes. me staff chose to take one 30-minute break. e facility has had numerous meetings with f to make sure that they clocked out for the minute breaks. * staff breaks, the staff did leave the floor. ey were supposed to report to the S/MA to let n know as well as the PCA that they were ig on break. e staff who were going on break was to have hever was covering for them to take their er to cover the floor. e facility had 2 acti	EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CLA INDENTIFICATION NUMBER: A. BUILDING: HAL092215 B. WING ER OR SUPPLIER STREET ADDRESS, CITY, STATE INER 200 MINGLEWOOD DRIVE GARNER, NC 27529 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES ID REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG D 188 edule two staff on B Hall at all times. e e and the Memory Care Director (MCD) tried Ithin when they were working. een someone called out, it was hard to cover Sovermber and December 2020, the facility short some shifts. e facility started to hire more staff and sought stance from a local temporary staffing agency elp cover shifts. e have had some short shifts for one reason nother." ff were to punch in and punch out for breaks. staff chose to take one 30-minute break. e facility has had numerous meetings with f to make sure that they clocked out for the minute breaks. staff did leave the floor. ay could go to the break room or wherever chose to take their break. e facility has had numerous meetings with f t	EFICIENCIES (X1) PROVIDER/SUPPLIENCIA (X2) MULTIPLE CONSTRUCTION A BUILDING:	REECTION IDENTIFICATION NUMBER: A BUILDING:

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION		SURVEY PLETED
ND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	
		HAL092215	B. WING		01	C / 20/2021
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	GARNER	200 MIN	GLEWOOD DRIVE			
ADENCE	GARNER	GARNEI	R, NC 27529			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	O THE APPROPRIATE	COMPLET DATE
D 188	Continued From page	e 14	D 188			
	Telephone interview with the Administrator on					
	01/06/21 at 11:07am					
	-Staffing schedules w	vere completed monthly				
	ahead of time.					
	-The facility tried to staff 6 staff on 1st and 2nd shift and 4 staff on 3rd shift.					
	-He was not aware of the facility being staffed					
		mbers" but was staffed below				
	• •	optimal" and what the				
	facility's goal would h	-				
		blished a 3rd party staffing				
	contract to ensure the	contract to ensure the facility stayed above				
	regulations.					
	-The first documentation noted with a 3rd party staff member on a daily assignment was on					
	Staff member on a da December 18, 2020.	illy assignment was on				
		e of the facility were only				
		and not used in the MCU.				
		not utilize the facility's clock				
	in and out time syste	-				
		ontracted staff were added to				
	the daily staffing log.					
		not work at the facility from				
	12/11/20 - 12/13/20.	only used on the AL side of				
	the facility.	only used on the AL side of				
	-	y staff to resign in December				
	2020.	, ,				
D 270	10A NCAC 13F .090	1(b) Personal Care and	D 270			
	Supervision					
	10A NCAC 13F .090	Personal Care and				
	Supervision					
		e supervision of residents in				
		n resident's assessed needs,				
	care plan and current	t symptoms.				

If continuation sheet 15 of 75

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
	GARNER	200 MIN	GLEWOOD DRIVE			
JADENCE	GARNER	GARNE	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	9 15	D 270			
	This Rule is not met TYPE A2 VIOLATION	-				
	reviews, the facility fa memory care unit (M0 supervise and meet th provide any supervisi	ne needs of the residents to on for 1 of 5 sampled g in one resident having a				
	The findings are:					
	11/05/20 revealed: -Diagnoses included failure, major depress diabetes.	t #5's current FL-2 dated dementia, congestive heart sive disorder, anxiety, and				
	status.	bulatory. nentation to her orientation on the assisted living side of				
	-The recommended le	evel of care was memory care unit (MCU).				
	10/04/20 revealed:	5's previous FL-2 dated				
	subsequent encounte healing, repeated falls	multiple fractures of ribs, r for fracture with routine s, and non-traumatic acute				
	nursing rehabilitation	viously resided in a skilled center.				
	-The resident was am -There was no docum orientation status. -The recommended le	nentation regarding her				
	documented as assis					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		С	
		HAL092215	B. WING		01	/20/2021
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLETI DATE
D 270	Continued From page	e 16	D 270			
	signed 10/08/2020 re -Resident #5 was add 10/09/20 from a reha -Resident #5 was forg reminders. -Resident #5 required ambulation with a wa place, and scheduling Review of Resident # revealed: -The fall assessment a date entered for the completed it. -This tool was noted it that were reviewed. -The scoring guideling falling, secondary dia tubing (such as foley status. -The total points give -Risk Levels were as -Level 1 = Score 0-22 and coordination of h -Level 2 = Score 25-5 prevention interventio -Level 3 = Score >or= prevention interventio -Level 3 = Score >or= prevention interventio -Level 3 = Score >or= prevention interventio -Level 4 = Score 3 = Score >or= prevention interventio -Level 5 = Score >or= prevention interventio -Level 6 = Score 3 = Score >or= prevention interventio -Level 7 = Score 3 = Score >or= prevention interventio -Level 8 = Score >or= prevention interventio	mitted to the facility on bilitation facility. getful and needed d assistance from staff with lker, orientation to time and g appointments. 45's fall assessment tool was completed without e assessment or who in other residents' records es were based on history of agnosis, ambulatory aid, or oxygen), gait, and mental n for Resident #5 was 45. follows: 4 Good basic resident care ealth services. 50 Implement standard fall ons. = 51 Implement high risk fall ons. 55's Licensed Health (LHPS) review dated e to ambulate independently ator (wheeled walker). e to let her needs be known.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED C 01/20/2021	
			A. BUILDING:			
		HAL092215	B. WING			
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C	OF CORRECTION	(X5)
PRÉFIX TAG	(Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLET DATE
D 270	Continued From pag	e 17	D 270			
	-On 11/05/20, third shift staff documented Resident #5 had wandered during the night, was					
	anxious and requeste	•				
	-On 11/22/20, third sl					
	minutes, and was ve	ble sleeping, got up every 20				
	roommate.					
	-On 11/23/20, third sl	hift staff documented				
		en out of bed every 10				
	minutes to ask for as	sistance and would get back				
	in bed, could not slee	ep and kept waking her				
	roommate.					
	Review of Resident #5's Licensed Health					
	Professional Support (LHPS) review dated 10/14/20 revealed:					
		le to ambulate independently				
		ator (wheeled walker).				
		le to let her needs be known.				
	-There were no LHPS					
		interviews with Resident				
		ey on 01/05/21 at 10:32am				
	and on 01/06/21 at 1	1:44am were unsuccessful.				
	Observations on 12/3	30/20 from 6:32am - 7:11am				
	on B Hall of the mem	ory care unit (MCU)				
	revealed:					
		e entrance door to B hall				
	looking through the v were no staff visible i	vindow slat in the door, there				
		eyor was let in to the locked				
		s Director (AD) when she				
	entered a code into a					
	-There were no staff	visible in the hallways upon				
	entering.					
	-The AD did not ente					
		ICU, a resident was heard aying, "I'm on the floor, help				
	me."	aying, Thi on the hoor, help				
		as coming from the last room				

	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
AND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	PLETED
		HAL092215	B. WING		C 01/20/2021	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	GARNER	200 MIN	GLEWOOD DRIVE			
CADENCE	GARNER	GARNE	R, NC 27529			
(X4) ID			ID PROVIDER'S PLAN			(X5) COMPLETE
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	D THE APPROPRIATE	DATE
D 270	Continued From page	e 18	D 270			
	on the right end of th	e hallway.				
		ying she was on the floor				
		ible coming to assist her.				
	-There were several	residents rooms with the				
	door closed.					
		Resident #5 who was yelling,				
	was in the room with					
		resident exited from room B				
		n the hallway without her ds the resident's room who				
	was yelling.	as the resident's room who				
		sident approached Resident				
		t5 said, "who's there, I need				
	help".					
	-Another resident wa	s "yelling" but was				
	incoherent.					
		observed in any open rooms				
	or in any hallways of					
		t #5 continues yelling "help				
	me".					
	for the MCU.	ued to search for any staff				
	-At 6:53am, Resident and no staff were obs	t #5 continued to yell for help served on any of the				
	hallways or exiting ar	-				
		n noted in the sound, tone or				
	volume of Resident #	5's voice when she				
	continued to call for h	•				
		een on the MCU for 21				
		erving any staff who may				
	have been present pr	roviding care to other				
	residents.	wore visible at the deserver				
	into B Hall but did no	were visible at the doorway				
		cation aide (MA) from third				
	shift and first shift MA					
	proceeded with medi					
	•	e nurse's station while				
	Resident #5 continue					
		urveyor was standing at the				1

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE, Z	ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D 270	Continued From pag	e 19	D 270			
	Continued From page 19 entry to B hall farthest away from Resident #5's room, the surveyor was able to hear her yelling, "I'm on the floor". -The MAs continued counting the narcotics on the medication cart. -At 7:05am, the third shift MA asked the surveyor if she needed to be let out of the hallway as Resident #5 continued to yell for help and the surveyor prompted staff to tend to Resident #5. -At 7:06am, the first shift MA had to get a key for Resident #5's door to unlock it. -Resident #5's door to unlock it. -Resident #5 was noted lying on the floor at the foot of her bed on her right side with bed linen covered in feces were to the side of the bed. -At 7:09am, a second staff member entered onto B Hall. -At 7:11am, the second staff member went to Resident #5's room but returned to the nurse's station to put on shoe covers and then returned to the room to assist MA in personal care for Resident #5.					
	dated 12/12/20 revea section, a handwritte	ift daily assignment sheet aled in the announcements n note stating, "B & C hall o on hall until end of shift" ne Supervisor.				
	7:35am revealed: -Resident #5 who ha and found to have no -Resident #5 "does th fell) all the time". -She would play in he -She did not always to say she fell.	nat (sits down and says she er own stool. fall; she would sit down and n Resident #5 "sit" on the				

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		HAL092215	B. WING		01	C / 20/2021	
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE			
	GARNER	200 MINC	ELEWOOD DRIVE				
	GARNER	GARNER	, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page	e 20	D 270				
	Interview with a perso 12/30/20 at 10:53am -Resident #5 was dec -Resident #5 recently did not use her walke -Resident #5 was inco 3 times yesterday. -Resident #5 was pro incontinent episodes. -Resident #5 did not i may have happened I was locked, and she -There were keys at t residents' doors, the I closet. -There were some res wandered. -The residents' doors -Resident #5's door w Second interview with 12/30/20 at 11:01am -She assessed Resid on the floor this morn -Resident #5's Power Primary Care Provide -Resident #5 did not " down on the floor". -Resident #5 and her Resident #5 sent to th further evaluation.	onal care aide (PCA) on revealed: clining. started falling more, if she r. ontinent of bowel frequently, vided perineal care for those ntentionally lock her door; it by mistake where the door pushed it closed. he nurse's station for the aundry room, and supply sidents on the MCU who were not normally locked. vas not normally locked. vas not normally locked. vas not normally locked. in the first shift MA on revealed: ent #5 after she was found ing. gns were good. of Attorney (POA) and er (PCP) were notified. normally fall but would get POA declined to have he emergency room (ER) for					
	-While on the AL side and going into the hal	, she had episodes of yelling					

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If continuation sheet 21 of 75

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		BENTI IOATION NOWBER.	A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	FCORRECTION	(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	THE APPROPRIATE	COMPLET DATE
D 270	Continued From pag	e 21	D 270			
	moved into the MCU around November. -Resident #5 originally had a roommate but					
		ons was moved into a private				
	room at the end of th (could not remember	e hall on B hall in the MCU				
	-	v with staff on 12/31/20 at				
	12:00pm revealed:	had verbal and physical				
		er residents, but no injuries				
	resulted.					
		oved into a private room.				
		and filled out any required				
	paperwork when altercations occurred.					
	-Resident #5 had bowel movements frequently.					
	-"She would play in h attention."	ner feces and did it for				
		rted to the Memory Care				
		the Administrator by MCU				
	. ,	's but was not aware of any				
	plans for changes in	care for Resident #5.				
	Confidential telephor	ne interview with a second				
	staff member reveale					
		CU should not be left alone				
	because it was a loc					
	MCU.	ed supervision always on the				
		ppen to residents if they				
	•	such as a resident walking				
	and accidentally fall/	•				
	Telephone interview	with the RCD on 01/05/21 at				
	1:08pm revealed:					
		y Resident #5's POA that				
	Resident #5 was able	e to be on the AL unit.				
		04/20 recommended level of				
	care as assisted livin					
		05/20 recommended level of				
	care as other memor	ry care unit (MCU).				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
		BERNI ISKIIGI KOMBER.	A. BUILDING:				
		HAL092215	B. WING	B. WING		C 01/20/2021	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page 22 -The POA was looking for a facility that could accommodate Resident #5's needs. -Resident #5 used a rollator to help ambulate. -The POA had told the RCD Resident #5 wanted to move back home. -Resident #5 began to become combative with residents using violent language, verbally abusive to staff and residents and would tell staff, "I'm acting this way because you won't let me go home". -Resident #5's POA requested to have Resident #5 moved to the MCU due to Resident #5's bowel and urinary incontinence. -Resident #5 would get outraged and throw feces at staff. -Resident #5 was currently waiting for psychiatric evaluation. -The POA had not paid the fee for the facility's provider to see Resident #5 and the previous mental health provider was no longer following Resident #5. -The POA was looking for a facility that could accommodate Resident #5's needs. Interview with the Administrator on 12/30/20 at		D 270				
	11:50am revealed: -His expectations we on the MCU. -If there were only 3 :	re always that someone stay staff, then one would be					
	between the two assi halls). -Resident #5 had ord						
	date). -She had been admit assisted living side (1 her behaviors led the	haviors (not sure of the ted as a resident on the 10/09/20) but an increase in em to transfer her to the MCU					
	(11/05/20) for closer -For several weeks n						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		HAL092215	B. WING		01	C 01/20/2021	
AME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE	1 .		
	CARNER	200 MIN	GLEWOOD DRIVE				
SADENCE	GARNER	GARNEF	R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page	e 23	D 270				
	on herself".	haviors through defecating					
	psychiatric evaluation	g to find someone to do her n. staff member on the MCU					
	could cause harm to	residents.					
	-It was the responsibi that the MCU had cov	lity of the S/MA to ensure /erage at all times.					
	the facility on 01/06/2	vith primary care provider for 1 at 8:05am revealed:					
		en on the floor and always coverage prior to leaving					
		een no times when staff					
		he MCU because the all had a diagnosis of					
		t transitioned over to the ey were trying to transition					
	her to the provider gro						
	the MCU and heard F and she had done that	Resident #5 call or yell out at frequently.					
	yelled out because of	k on the resident when she complications that could t had fallen and was behind					
	-There were concerns the resident after yelli	s that no one checked on ing out for help including the					
		that feces on the skin in the					
	risk for feces backing	t placed the resident at high up into the urinary tract that urinary tract infections.					
	-The PCP had "great' calling out for help an	' concern if a resident was d staff were observed not to					
		rns for the supervision lents on the MCU when staff					

	OF DEFICIENCIES	Ilation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			C
		HAL092215	B. WING	01	C 01/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 24	D 270			
	residents. -If staff were not press not know if there wass resident. -There should always MCU. -Thirty minutes was a could have occurred addressed because of to monitor the resider resident being the hig Interview on 01/06/21 #5's mental health pr -Resident #5 was see location and was disc 10/09/20 and admitte -Resident #5 had not by her mental health -He was unable to pr information on Reside been seen in 4 month -He did not provide se Attempted telephone #5's power of attorne and on 01/06/21 at 1: The facility failed to p the residents on the r including Resident #5 for at least 34 minute floor in her own feces assist her. The failure supervision resulted in	of no staff being on the floor nts with possible death of a ghest risk. I at 10:58am with Resident ovider revealed: en at her previous facility charged from that facility on ed to her current location. been seen since 08/06/20 provider. ovide any current ent #5 since she had not				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED C	
			A. BUILDING:			
		HAL092215	B. WING		01/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
D 270	Continued From pag	je 25	D 270			
		a plan of protection in 5. 131D-34 on 01/07/21 for				
		E FOR THE TYPE A2 NOT EXCEED FEBRUARY				
D 338	10A NCAC 13F .090	9 Resident Rights	D 338			
	all residents guarant Declaration of Resid	9 Resident Rights shall assure that the rights of eed under G.S. 131D-21, ents' Rights, are maintained ed without hindrance.				
	This Rule is not met TYPE B VIOLATION	•				
- - - - - -	reviews, the facility f sampled residents w privacy, and respect	, observations and record ailed to ensure 1 of 6 vere treated with dignity, Resident #6 (female) who n with a male resident.				
	03/17/20 revealed: -Diagnoses included syndrome and a hist -The resident was co -The resident was no	onstantly disoriented				
	08/20/20 revealed: -The resident's orien	#6's Care Plan dated tation was severely impaired. ed total staff assistance with				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE,	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 338	Continued From pag	e 26	D 338			
		ansferring, grooming and ance with ambulation.				
	Attorney (POA) on 0 -The resident had liv years. -The resident passed facility. -The resident was re- memory care unit (M hall on the MCU due passed away. -On 12/14/20, the PO resident had passed -The resident's body a male resident. -The male resident we the door making "grub body was in a bed po of the room and there in the room. -The POA had no ide	was in a resident room with vas lying in a bed closer to inting" sounds, the resident's ositioned close to the window e was a named staff member ea who the male resident was ed staff member told him who				
	#6 was moved from thallway after testing -A male resident was with Resident #6. -The staff found out the Resident #6's POA's who made that deciss resident room with a -The staff was not su	of December 2020, Resident the B hallway to the C positive for COVID-19. s placed in the same room from another staff and hortly after and was not sure ion to place Resident #6 in a				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 27	D 338			
	in the same room with not related to her bed decided which reside isolation area on C ha -The staff had concer- resident being in the "just common sense" resident in the same not related. Confidential interview revealed: -The named male res- room with his female positive with COVID- same room with Resi -There was no barrie residents for privacy; the window of the root bed was by the door. -The staff thought Re- been placed in the sa- resident or vice versa- to happen. -Staff had concerns of the male resident bei with Resident #6; how staff could have done told staff to place the -There were additiona- the facility that were a model room was a ro visitors the living qua- -The male resident co	rns of a female/male same room because, it was ' not to place a male/female room if the residents were with a second staff member sident was in the same with roommate until he tested 19 then he was placed in the ident #6. r placed between the two Resident #6's bed was by om and the male resident's				
		as in the same room with				
	Confidential telephon	e interview with a third staff				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:			С	
		HAL092215	B. WING		01	01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE			
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 338	Continued From page	e 28	D 338				
2 3 3 8	revealed: -Resident #6 was more placed in a room on the -A named male resider room that he shared the hall into the same room named male resident COVID-19. -The named male resident COVID-19. -The named male resident room with Resident # away. Confidential interview -The staff had observer room with a male resident show with a female. Telephone interview of resident's POA on 01 -Since COVID-19, it has care was being provise -She talked with the resident's shaking"; on 12/11/20 emergency room (ER- -She was not aware the -She was	aved from the B hall and the C hall (around 12/09/20). Then was moved from his with his family member on C for with Resident #6 after the tested positive for sident was moved into the tested positive for si					
	upon returning from t Telephone interview v Director (RCD) on 01	he hospital ER. with the Resident Care /05/21 at 1:06pm revealed					
	male resident when s hallway of the MCU,						
	01/05/21 at 3:32pm r	with the Administrator on evealed: idents residing at the facility					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
AND PLAN C	JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		HAL092215	B. WING		01	C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	GARNER	200 MIN	GLEWOOD DRIVE				
	GARNER	GARNEI	R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 338	Continued From page	e 29	D 338				
	were not assigned to	the same resident room					
	unless they were rela						
		a room by herself when she					
	passed away.						
		ve been any roommate with					
		when she was moved to the					
		use she was in isolation.					
	-He remembered del	ivering fluids for her on the					
		ated and "peeped" in the					
		e only resident in the room					
	(unable to recall a sp	-					
	Telephone interview	with the Administrator on					
	01/06/21 at 10:54am						
		y there would be reports that					
	•	o staff to place Resident #6					
	in the same room wit						
	-He had never given	staff that directive.					
	Telephone interview	with Resident #6's primary					
		on 01/06/21 at 8:05am					
	revealed:						
	-She last visited the r	resident on 12/10/20 at the					
	facility and at that tim	e there was no other					
		with Resident #6 when she					
	visited.	that a named male resident					
		that a named male resident					
		me room with Resident #6.					
		elated to privacy and dignity the other male resident when					
	they were in the roon						
	•	sidents should not be placed					
	together unless they	-					
		rns with privacy and dignity					
		male resident was married					
		e at the facility on C Hall.					
	Based on observation	ns, interviews and record					
	reviews, the named r	nale resident was not					
	interviewable.						

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		C 01/20/2021	
		HAL092215	B. WING			
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
ADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 338	Continued From pag	e 30	D 338			
	on 01/04/20 at 12:36 resident was assigne his female family me Attempted interview	ale resident on the C hallway pm revealed the male ed and in the same room with mber. with the male resident's unsuccessful on 01/04/21 at				
	from neglect and treat consideration, dignity evidenced by Reside placed in a room with not related to nor mat facility's failure was of	ensure residents were free ated with respect, /, and right to privacy as ent #6 (female) who was n a male resident who was rried to one another. The detrimental to the residents' elfare which constitutes a				
		a plan of protection in . 131D-34 on 01/07/21 with plation.				
	CORRECTION DATE VIOLATION SHALL I 2021	E FOR THE TYPE B NOT EXCEED MARCH 06,				
D 454	10A NCAC 13F .121; and Incidents	2(e) Reporting of Accidents	D 454			
	And Incidents (e) The facility shall resident's responsible as indicated on the R	2 Reporting Of Accidents assure the notification of a e person or contact person, Resident Register, of the resident or his responsible rson objects to such				

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY IPLETED
			A. BUILDING:			С
		HAL092215	B. WING		0,	1/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
D 454	 Continued From page 31 (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter. 		D 454			
	facility failed to ensur of Attorney (POA) fo (#6) received leaving for staff at the facility and delayed notificat	as evidenced by: and record reviews, the re a family member (Power r 1 of 6 residents sampled g four messages on 12/12/20 with no return calls/contact ion to the POA of a change is by contacting the POA				
	The findings are:					
	03/17/20 revealed: -Diagnoses included syndrome and a histo -The resident was co -The resident was no	nstantly disoriented				

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STATEMEN	of Health Service Regu T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY	
		HAL092215	B. WING		01	C 01/20/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	E GARNER	200 MIN	GLEWOOD DRIVE				
		GARNEI	R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 454	Continued From page	e 32	D 454				
	Review of Resident # 08/20/20 revealed:	6's Care Plan dated					
	-The resident's orient	ation was severely impaired.					
		d total staff assistance with					
		ansferring, grooming and ance with ambulation.					
	Telephone interview with Resident #6's Power of Attorney (POA) on 01/05/21 at 10:32am revealed:						
	however, was moved	-					
	12/09/20 or 12/10/20. -The resident had tes	sted positive for COVID-19					
	around 12/03/20.						
	-The resident was tra the emergency room	nsferred from the facility to					
		ated for dehydration in the					
		ident on facility staff to					
	provide updates by p	-					
	visit due to COVID-19						
	-The POA had called 12/12/20 to get a tele	the facility 4 times on					
	resident's condition.						
		vith facility staff answering					
	on the floor a message	ed they would give the staff					
		erned about the resident's					
		as treated in the ER for					
	dehydration.						
	- The POA never rece the facility until 12:17	vived a call back from staff at					
		nat time of night "scared her					
	to death".						
		g ready to leave from the					
		told the POA the resident					
	taken her medication						
	I he POA felt frustrat alth Service Regulation	ted because it was so hard					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL092215	B. WING		01	C / /20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
D 454	Continued From page	e 33	D 454			
	Director (MCD) on 01	with the Memory Care //06/21 at 12:49pm revealed esident #6's POA had left 4 n 12/12/20.				
	01/05/21 at 3:32pm r -He was not aware R	with the Administrator on evealed: esident #6's POA had left 4 20 to get an update on				
	calls when messages	ble to return family members' were left and if the family turn call, he expected the him.				
D 465	10A NCAC 13F .1308	8(a) Special Care Unit Staff	D 465			
	(a) Staff shall be pre- sufficient number to r residents; but at no ti one staff person, who training requirements Section, for up to eigl second shifts and 1 h additional resident; a	ht residents on first and hour of staff time for each nd one staff person for up to shift and .8 hours of staff				
	interviews, the facility	ns, record reviews and				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
						С
		HAL092215	B. WING		01	/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	E GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 465	Continued From page	e 34	D 465			
	19-22 residents durin were 13 of 23 shifts v 11/16/20-11/20/20, 12 12/19/20, 12/20/20, 1	or the MCU ranged from Ig the sampled times. There vere sampled from 2/12/20-12/13/20, 12/18/20, 2/25/20 and 12/26/20 which the required hours on the				
	The findings are:					
	-The license was effe -There had been a ch 12/01/19. -The facility was licen beds including 36 bee area and 48 beds for (MCU). -There was not any n	s current license revealed: active 12/01/19 - 12/31/20. hange of ownership on head for a capacity of 84 ds for the assisted living (AL) the memory care unit hotation in the license that baration of the MCU into 2				
	-There were 2 separa -One was identified a Hall. -No staff was observe until 7:01am when the	0/20 at 6:30am revealed: ate, locked MCU halls. Is B Hall and the other as C ed on B Hall from 6:32am e 3rd shift medication aide e 1st shift MA to count the				
	(S/MA) on 12/30/20 a -She was in charge. -There were 2 persor with her. -There had been a 3r leave at 4:45am.	pervisor/medication aide at 5:38am revealed: nal care aides (PCA) working rd PCA but the PCA had to e assisted living (AL) halls				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		с	
		HAL092215	B. WING		01	/20/2021
NAME OF PI	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE,	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 465	in to cover for the 3rd -The AD was observe 6:28am. -The AD was not obs MCU halls. Review of the facility from B Hall dated 11/ there was census of the dates from 11/16 dates, which required second shifts. Review of the employ 11/16/20 revealed the hours provided on fir shortage of 3.67 hou Review of the employ 11/17/20 revealed the hours provided on fir shortage of 3.47 hou Review of the facility 12/13/20 revealed the	or (AD) was called to come d PCA and was on her way. ed to enter the facility at erved entering either of the d's resident census reports (16/20 - 11/20/20 revealed 22 residents on the MCU on (20-11/20/20 each of those d 22 staff hours on first and yee time cards dated ere was a total of 18.43 staff st shift on the MCU with a rs.	D 465			
	hours provided on se shortage of 1.54 hou	ere was a total of 19.46 staff cond shift in the MCU with a rs. s resident census reports				
		J, which required staff hours				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
--------------------------	---	---	------------------------------	---	----------------	-------------------------
			A. BUILDING:			
		HAL092215	B. WING		01	C /20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 465	Continued From page	e 36	D 465			
		ere was a total of 20 staff st shift on the MCU with a				
	12/25/20 revealed the	's resident census reports for e census for the MCU was equired 20 staff hours on				
		ere was a total of 13.42 staff cond shift in the MCU with a				
	staff hours provided of with a shortage of 0.9	ere was a total of 19.067 on second shift on the MCU 933 hours.				
	(POA) on 01/05/21 a -She was quite conce under-staffed, especi -She talked on the ph	lent's Power of Attorney t 10:34am revealed: erned as the facility had been ially on the weekends. none almost daily with her				
		acility to check on her family uble getting anyone to ends.				
	01/04/21 at 1:15pm r -She worked 7:00am	onal Care Aide (PCA) on evealed: -3:00pm shift about four				
		o she was relieving from 3rd vas no staff on the MCU				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		01	C /20/2021
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	F CORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
D 465	Continued From pag	e 37	D 465			
		o work on 01/04/21. ICU at approximately 6:55am to locate a staff member on				
	a couple of months. -There had been time would have to float b one of the MCU's un -Being short staffed of	erview revealed: n short staffed on all shifts for es when a staff member between both MCU's leaving attended for a period of time. caused residents to have fore services could be				
	revealed: -Staffing at the facility shifts had been short -The Resident Care I responsible for the so -Staffing was short o -The facility had been months mostly on 2n -There had been time between B hall and C would be left unatten staffed. -The residents could enough staff to monit needs. -The staff was not av or accidents that occ hall unattended. -Residents on the MC because it was a lock supervision at all time	Director (RCD) was chedule. n the weekends. n short staffed for about 3-6 id and 3rd shifts. es when staff had to float C hall meaning one MCU ided due to being short be harmed if there was not tor them and tend to their ware of any resident incidents surred when staff had left the CU should not be left alone ked unit and they need es.				
		ppen to residents if they such as a resident walking nce and falling.				

STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
	of connection	IDENTIFICATION NOWIDER.	A. BUILDING:			
		HAL092215	B. WING		01	C / 20/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	GARNER	200 MIN	GLEWOOD DRIVE			
CADENCE	GARNER	GARNE	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 465	Continued From page	e 38	D 465			
	-Staff were responsite replacement for miss find coverage then the -The Memory Care D to cover vacancies in outs. -Activities' personnel well and would occas Confidential telephor member revealed: -The daily staffing sc actual staff and number shift. -Many staff had recenses short. -There were more re- of the MCU which re- all times. -The staff was conce coverage was short to complete all of reside	ble for finding their sed shifts but if they could not hey notified the RCD. Director (MCD) and RCD tried in the schedule due to call were personal care aides as sionally help on the hall. The interview with a third staff hedules did not reflect the ber of staff that worked each ntly resigned leaving shifts sidents residing on the B hall quired two staff members at hen the staff had worked hall. The the staff had worked hall. The to care needs.				
	-The MCD and the R shifts when the facilit -The Supervisor/Med	CD worked some of the y was short staffed . lication Aide (S/MA) was				
	they were going to be coverage if a PCA ca	g their own replacement if e out as well as finding alled out. able to find placement, then				
	the they would notify -Staff were responsit in the MCU every 30 never leave the floor	the MCD or the RCD. ble to check on the residents minutes to one hour and to unattended.				
vision of Her	-Staff leaving the floc unacceptable. alth Service Regulation	n at any time was				

STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
			A. BUILDING:			
		HAL092215	B. WING		01	C / 20/2021
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN O	FCORRECTION	(X5)
PREFIX TAG		EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
D 465	Continued From pag	e 39	D 465			
	staff had arrived to re had been a few times	osed to leave the MCU until elieve them; however there s that third shift had left ed; incidents were reported				
	11:46am revealed it	ministrator on 12/30/20 at was the responsibility of the the MCU had coverage at all				
	revealed: -She was the one resistaff. -She had the monthly 15th of the month for -All staff who request ahead of time. -When there was a c	CD on 01/20/21 at 10:11am sponsible for scheduling the y schedule completed by the the next month. ted time off were to do so hange needed after the l, such as if staff called-off,				
	staff were to find cov -If staff could not find responsible to find co -If the S/MA was not she helped find cove	erage. coverage, the S/MA was overage. able to find coverage, then				
	assignment sheet ba -On first shift, she trie cover medication adr	ed to schedule seven staff to ministration on the 4 halls as				
	on the 4 halls. -On second shift, she to cover medication a	care needs for the residents e tried to schedule 6 to 7 staff administration on the 4 halls nal care needs for the				
	-On third shift, she tr	nis. ied to schedule staff to cover ation on the 4 halls as well				

STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION N		A. BUILDING:		COM	PLETED
	HAL092215	B. WING		01	C / 20/2021
OVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
CADNED	200 MIN	GLEWOOD DRIVE			
GARNER	GARNEI	R, NC 27529			
		ID			(X5) COMPLETI
		TAG	CROSS-REFERENCED TO	THE APPROPRIATE	DATE
Continued From page	e 40	D 465			
as the personal care i	needs for the residents on				
-					
	2				
•					
-She tried to do the sa	ame for second shift and				
then had at least three	e PCAs on third shift and				
one S/MA.					
•					
two staff on B Hall at	all times.				
-She and the MCD trie	ed to pitch in when they				
were working.					
-When someone calle	ed out, it was hard to cover				
at times.					
-In November and De	cember 2020, the facility				
was short some shifts	S.				
-The facility started to	hire more staff and sought				
assistance from a loca	al temporary staffing agency				
to help cover shifts.					
-"We have had some	short shifts for one reason				
of another."					
-Staff were to punch i	n and punch out for breaks.				
shift and another 15 in	n the latter part of their shift				
	5				
-	locked out for the 30-minute				
÷					
-					
• • • •					
	the PCA that they were				
	using on brook was to have				
-	-				
	-				
	GARNER SUMMARY ST, (EACH DEFICIENC) REGULATORY OR I Continued From page as the personal care of the 4 halls which was supervisor for a total of -There were two supe MAs could work as a -She tried to do the sa then had at least three one S/MA. -Currently based on the two staff on B Hall at -She and the MCD tri- were working. -When someone called at times. -In November and De- was short some shifts -The facility started to assistance from a loc to help cover shifts. -"We have had some of another." -Staff were to punch i -Everyone got 15 min shift and another 15 in for a total of 30 minut -Some staff chose to -There had been num- make sure that they co- breaks. -For staff breaks, the -Staff could go to the they chose to take the -They were supposed them know as well as going on break. -The staff who were go whoever was covering pager to cover the flo- -The facility had 2 act	GARNER 200 MIN (CARNER) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 40 as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. -There were two supervisors on first shift, the MAs could work as a MA or PCA. -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. -Currently based on the census, we have to have two staff on B Hall at all times. -She and the MCD tried to pitch in when they were working. -When someone called out, it was hard to cover at times. -In November and December 2020, the facility was short some shifts. -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. -We have had some short shifts for one reason of another." -Staff were to punch in and punch out for breaks. -Everyone got 15 minutes in the first part of their shift and another 15 in the latter part of their shift for a total of 30 minutes. -Fore had been numerous meetings with staff to make sure that they clocked out for the 30-minute breaks. -For staff breaks, the staff left the floor. -For staff breaks, the staff left the floor. -For staff breaks, the staff left the floor. <t< td=""><td>GARNER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 40 D 465 as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. - -There were two supervisors on first shift, the MAs could work as a MA or PCA. - -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. - -Currently based on the census, we have to have two staff on B Hall at all times. - -She and the MCD tried to pitch in when they were working. - -When someone called out, it was hard to cover at times. - -In November and December 2020, the facility was short some shifts. - -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. - -We have had some short shifts for one reason of another." - -Staff were to punch in and punch out for breaks. - -For staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. <t< td=""><td>GARNER Summary statement of deficiencies D D REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) D D PREFIX TAG D PREFIX CARDESTREAD PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT TAG Continued From page 40 D 465 D D as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. -There were two supervisors on first shift, the MAS could work as a MA or PCA. -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. -Currently based on the census, we have to have two staff on B Hall at all times. -She tried to do the same for second shift and then MAC tried to pitch in when they were working. -When someone called out, it was hard to cover at times. -In November and December 2020, the facility was short some shifts. -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. - - - - - - - - - - - - - - - - - - -</td><td>BOD MINICLEWOOD DRIVE CARRER, NO. 27529 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST EFRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) ID PREEX TAG PROVIDER'S FUN OF CORRECTIVE AND FORMATION) Continued From page 40 D 465 ECROSEREETERCED TO THE APPROPRIATE DEFICIENCY) Continued From page 40 D 465 ECROSEREETERCED TO THE APPROPRIATE DEFICIENCY) Mas could work as a MA or PCA. 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The activities staff, the activities director and activities asstant, that did work as</td></t<></td></t<>	GARNER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 40 D 465 as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. - -There were two supervisors on first shift, the MAs could work as a MA or PCA. - -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. - -Currently based on the census, we have to have two staff on B Hall at all times. - -She and the MCD tried to pitch in when they were working. - -When someone called out, it was hard to cover at times. - -In November and December 2020, the facility was short some shifts. - -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. - -We have had some short shifts for one reason of another." - -Staff were to punch in and punch out for breaks. - -For staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. - -Staff breaks, the staff left the floor. <t< td=""><td>GARNER Summary statement of deficiencies D D REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) D D PREFIX TAG D PREFIX CARDESTREAD PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT TAG Continued From page 40 D 465 D D as the personal care needs for the residents on the 4 halls which was usually three staff with a supervisor for a total of four staff on third shift. -There were two supervisors on first shift, the MAS could work as a MA or PCA. -She tried to do the same for second shift and then had at least three PCAs on third shift and one S/MA. -Currently based on the census, we have to have two staff on B Hall at all times. -She tried to do the same for second shift and then MAC tried to pitch in when they were working. -When someone called out, it was hard to cover at times. -In November and December 2020, the facility was short some shifts. -The facility started to hire more staff and sought assistance from a local temporary staffing agency to help cover shifts. - - - - - - - - - - - - - - - - - - -</td><td>BOD MINICLEWOOD DRIVE CARRER, NO. 27529 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST EFRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) ID PREEX TAG PROVIDER'S FUN OF CORRECTIVE AND FORMATION) Continued From page 40 D 465 ECROSEREETERCED TO THE APPROPRIATE DEFICIENCY) Continued From page 40 D 465 ECROSEREETERCED TO THE APPROPRIATE DEFICIENCY) Mas could work as a MA or PCA. 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The activities staff, the activities director and activities asstant, that did work as

STATE FORM

STATEMEN	of Health Service Regu TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED
		HAL092215	B. WING		01	C / 20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC	CTION SHOULD BE	(X5) COMPLETI DATE
		,		DEFICIEN		
D 465	Continued From page	e 41	D 465			
	needed. -The monthly schedu stations, in the break to the staffs' phone n received it. -During the monthly r were handed out to th -She was aware of in a unit prior to the stath had recently re-education issue. Telephone interview v 01/06/21 at 11:07am -Staffing schedules w time. -The facility tried to s shift and 4 staff on 3r -He was not aware of below "regulatory nur what he considered " facility's goal would h -The facility had estation cover staffing for the used in the MCU. -Contracted staff did in and out time system -He was not sure if out the daily staffing log. -Contracted staff did 12/11/20 - 12/13/20.	cidences when staff had left ff on next shift arriving and ated staff regarding this with the Administrator on revealed: vere done monthly ahead of taff 6 staff on 1st and 2nd 'd shift. f the facility being staffed mbers" but was staffed below 'optimal" and what the vave been. blished a 3rd party staffing e facility stayed above g PCAs were only used to AL side of the facility and not not utilize the facility's clock m. ontracted staff were added to not work at the facility from				
	-Contracted staff did in and out time syster -He was not sure if or the daily staffing log. -Contracted staff did 12/11/20 - 12/13/20.	m. ontracted staff were added to				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		HAL092215	B. WING		01/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
CADENCE	EGARNER		GLEWOOD DRIV R, NC 27529	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLET
D 612	Continued From page	e 42	D 612		
D 612	10A NCAC 13F .1801 Control Program (terr	l (c) Infection Prevention & וף)	D 612		
	(c) When a community been identified at the emerging infectious disease threat, the far implementation of the policies and procedur published guidance is if guidance or directiv communicable disease outbreak or emerging have been issued in v local health	CONTROL PROGRAM cable disease outbreak has facility or there is an cility shall ensure a facility 's IPCP, related res, and ssued by the CDC; however, res specific to the se infectious disease threat writing by the NCDHHS or ific guidance or directives by the facility. as evidenced by:		TYPE B VIOLATION	
	reviews, the facility fa recommendations and for Disease Control (Department of Health DHHS) and the Local were implemented and global Coronavirus (C reduce the risk of tran related to screening of signs and symptoms staff working while dis consistent with COVII of each resident's CC wearing personal pro- and redirection of res	d guidance from the Centers (CDC), the North Carolina and Human Services (NC Health Department (LHD) ad maintained during the COVID-19) pandemic to nemission and infection of staff and residents for consistent with COVID-19;		Based on observations, interviews, a record reviews, the facility failed to e recommendations and guidance fror Centers for Disease Control (CDC), North Carolina Department of Health Human Services (NC DHHS) and th Local Health Department (LHD) wer implemented and maintained during global Coronavirus (COVID-19) pan- to reduce the risk of transmission an infection related to screening of staff residents for signs and symptoms consistent with COVID-19; staff worl while displaying symptoms consistent COVID-19; and staff being aware of resident's COVID-19 diagnosis; staff wearing personal protective equipme	ensure m the , the h and e e the demic nd f and king nt with each f

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER			VE	
			R, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
D 612	Continued From page	e 43	D 612		
	their rooms.			(PPE); and redirection of residents to	
				maintain social distancing and use of f	ace
	The findings are:			masks when out of their rooms.	
	5				
		s for Disease Control (CDC)		The findings are:	
		r long term care facilities			- 4
	dated 11/20/20 revea			Review of the Centers for Disease Con	
		ent should be notified if		(CDC) recommendations for long term care facilities dated 11/20/20 revealed	
	residents or facility pe	ed or confirmed among		-The health department should be noti	
		ent should be notified if a		if COVID-19 is suspected or confirmed	
	•	severe respiratory infection		among residents or facility personnel.	•
	-	ation, or if three or more		-The health department should be noti	fied
		onnel develop new-onset		if a resident developed a severe	
		s within 72 hours of each		respiratory infection resulting in	
	other.			hospitalization, or if three or more	
	-All visitors and perso	onnel should be screened for		residents/facility personnel develop	
		r and symptoms consistent		new-onset respiratory symptoms within	n 72
		e the start of each shift/when		hours of each other.	
	they enter the facility			-All visitors and personnel should be	
		ever (temperature of 100.0		screened for the presence of fever and	t l
	-	or greater) or symptoms that		symptoms consistent with COVID-19	
		OVID-19 should be sent		before the start of each shift/when the	y
	home.	opposite and to waar face		enter the facility.	of
		e encouraged to wear face d) whenever they are around		-Anyone who has a fever (temperature 100.0 degrees Fahrenheit or greater) of	
	• •	n they leave their rooms and		symptoms that are consistent with	
	when they leave the	-		COVID-19 should be sent home.	
		e reminded to maintain social		-Residents should be encouraged to w	/ear
		6 feet apart from others		face coverings (if tolerated) whenever	
	when they are outsid	-		are around others, including when the	
	•	be screened for fever and		leave their rooms and when they leave	
	symptoms consistent	with COVID-19 at least		facility.	
	daily.			-Residents should be reminded to	
		for close contact with		maintain social distancing of at least 6	
		eye protection (goggles or		apart from others when they are outsid	le of
		195 mask or higher-level		their room.	
		nask if respirators are not		-All residents should be screened for f	
		and gloves should be used in		and symptoms consistent with COVID-	-19
	addition to PPE listed	above for direct contact.		at least daily.	

Division of Health Service STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRI ^N R, NC 27529	VE	
0(0)15				PROVIDER'S PLAN OF CORRECTIO	N
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLET
D 612	Continued From pag	e 44	D 612		
	-Cloth face coverings should not be used w facemask was indica -Staff using PPE sho PPE selection, use o use and removal of F self-contamination. Review of North Care and Human Service I revealed: -All health care perso fever and respiratory each shift and should -Residents should be fever and respiratory immediately isolated -The local health dep notified if there were suspected COVID-19 disease or if there war residents and/or HCF infections. -Social distancing an reinforced. -Facemasks should b facility by all resident -If COVID-19 was ide should wear recomm N95 mask (if availabl shields to care for res quarantine. -COVID-19 positive r dedicated staff in one negative residents sh staff in a separate an	a not considered PPE and when a respirator or ted. uld have received training on f PPE and demonstrated the PPE to prevent olina Department of Health Regulation (NC DHHS) onnel should be screened for symptoms before starting d be sent home if they are ill. e screened at least daily for symptoms and should be if symptomatic. oartment (LHD) should be any cases of confirmed or 9 or severe respiratory as a cluster (three or more P) of any respiratory nongst residents should be set staff and visitors. entified in the facility, staff hended PPE of facemask or le), gown, gloves and face sidents in isolation or residents should cohort with e area and COVID-19 nould cohort with dedicated		 -Recommended PPE for close contact with residents included: eye protection (goggles or face shield) and an N95 r or higher-level respirator (or a face me respirators are not available) and gow and gloves should be used in addition PPE listed above for direct contact. -Cloth face coverings not considered and should not be used when a respi- or facemask was indicated. -Staff using PPE should have received training on PPE selection, use of PPE demonstrated the use and removal or to prevent self-contamination. Review of North Carolina Departmen Health and Human Service Regulation (NC DHHS) revealed: -All health care personnel should be screened for fever and respiratory symptoms before starting each shift a should be sent home if they are ill. -Residents should be screened at lead daily for fever and respiratory sympton and should be immediately isolated if symptomatic. -The local health department (LHD) should be notified if there were any co of confirmed or suspected COVID-19 severe respiratory disease or if there a cluster (three or more residents and HCP) of any respiratory infections. -Social distancing amongst residents should be reinforced. -Facemasks should be worn through the facility by all residents, staff and visitors. -If COVID-19 was identified in the face 	on mask iask if vn n to PPE rator ed E and f PPE t of n and ist ims ases or was d/or
	dated 12/12/20 revea	-		staff should wear recommended PPE facemask or N95 mask (if available),	-

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		C
		HAL092215	B. WING		C 01/20/2021
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRIN R, NC 27529	/E	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	DN (X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLET
D 612	Continued From page	e 45	D 612		
	COVID-19 screening recorded temperature (start and end of shift -Team members shou immediately if they w difficulty breathing, fe with chills, muscle pa nausea, vomiting, ne -Team members that moderate illness may ten days have passed appeared and; at leas fever without fever re symptoms are resolven negative results are r -Confirmed positive to critical illness may re 20 days have passed appeared and; at leas since last fever witho medications and; sym retesting with negativ -If a team member de consistent with COVI immediately stop wor medical care. Staff w work for at least 14 d and return with a neg -All staff assignments daily/weekly to ensur can be identified. -Any isolated or quar- identified within the c full PPE to include: N	check list to include e check, two times per shift c). uld notify their supervisor ere exhibiting: cough or ever, chills, repeated shaking in, headache, sore throat, w loss of taste or smell. test positive with mild to return to work when at least d since symptoms first st 24 hours passed since last ducing medications and; ed and retesting with equired. eam members with severe to turn to work when: At least l since symptoms first st 24 hours have passed ut the use of fever reducing nptoms have improved and e results are required. eveloped symptoms D-19 they should k, isolate at home, and seek vill then need to remain off ays from the first symptom ative COVID-19 test result. s were to be documented e appropriate contact tracing antined resident or outbreak ommunity will require use of 95 Mask, gown, bouffant		gown, gloves and face shields to car residents in isolation or quarantine. -COVID-19 positive residents should cohort with dedicated staff in one are COVID-19 negative residents should cohort with dedicated staff in a separ area. Review of the Facility's Infection Con Policy dated 12/12/20 revealed: -All team members were required to complete the COVID-19 screening of list to include recorded temperature of two times per shift (start and end of s -Team members should notify their supervisor immediately if they were exhibiting: cough or difficulty breathif fever, chills, repeated shaking with c muscle pain, headache, sore throat, nausea, vomiting, new loss of taste of smell. -Team members that test positive wit mild to moderate illness may return t work when at least ten days have pa since symptoms first appeared and; i least 24 hours passed since last fever without fever reducing medications a symptoms are resolved and retesting negative results are required. -Confirmed positive team members w severe to critical illness may return to when: At least 20 days have passed symptoms first appeared and; at leas hours have passed since last fever w the use of favor reducing medications and symptoms first appeared and; at least hours have passed since last fever w	ea and rate atrol heck check, shift). ng, hills, or th o ssed at er ind; g with with o work l since st 24 vithout
	cap, booties, gloves a be put on prior to ent	and face shield. All PPE to ry but removed prior to in a biohazard trash bag at		the use of fever reducing medication symptoms have improved and retest with negative results are required.	s and;
	the door. The team r	nember will immediately st hand washing station		-If a team member developed sympto consistent with COVID-19 they shoul immediately stop work, isolate at hor	ld

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TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BENTH IOATION NOMBER.	A. BUILDING:		
	HAL092215	B. WING		C 01/20/2021
AME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
ADENCE GARNER			/E	
		R, NC 27529		
PREFIX (EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLE
D 612 Continued From pag	e 46	D 612		
 Review of the resistesting results docum Administrator on 12/3 -The week of 11/30/2 residents tested, of w -The week of 12/07/2 residents tested, of w -The week of 12/14/2 residents tested, of w -The week of 12/14/2 residents tested, of w -Further testing was 12/28/20 and 01/04/2 available. All the COVID-19 pot the MCU halls B & C Telephone interview Department (LHD) R at 11:49am revealed -Staff should not wor signs or symptoms on notify the Administration member immediately -Staff should be quant testing positive for C Telephone interview 01/06/21 at 10:02am -He was not aware of and required to work -It was hard to common were not feeling well shift because each s "staff's track record" -He thought it would establish if the staff th feeling ill and unable -He would have expending 	dent roster with COVID-19 nent provided by the 30/20 revealed: 20-12/04/20, there were 47 which 3 were positive. 20-12/11/20, there were 43 which 3 were positive. 20-12/18/20, there were 39 which 12 were positive. done during the weeks of 21 but no results were ositive residents resided on with the Local Health egistered Nurse on 01/05/21 t k if they were experiencing f COVID-19 and should tor or a management staff antined for 14 days after OVID-19. with the Administrator on revealed: f any staff not feeling well their shift. nent on staff reporting they and needing to leave their ituation was different and had to be taken into account. have been important to nad a temperature and were		 and seek medical care. Staff will the need to remain off work for at least 1 days from the first symptom and retur with a negative COVID-19 test result -All staff assignments were to be documented daily/weekly to ensure appropriate contact tracing can be identified. -Any isolated or quarantined resident outbreak identified within the commu will require use of full PPE to include Mask, gown, bouffant cap, booties, g and face shield. All PPE to be put on to entry but removed prior to exiting the apartment in a biohazard trash bag a door. The team member will immedia proceed to the nearest hand washing station before conducting any addition care. 1. Confidential staff interview revealer-She reported to work on specified date and shift withheld to maintain confidentiality) and had a headache afatigue. -The staff member reported symptom the Resident Care Director (RCD) and was advised that the facility was short and the staff was not able to go home -Normal procedure was for staff to fir their own coverage if they were calling for their scheduled shift. -The staff was not able to find a replacement and stayed and worked shift. -Worked multiple dates in December while having headache, fatigue and or the initial report to the RCD 	4 rn a or nity : N95 loves prior he t the ately mal d: ate and hs to d rt staff e. nd g out the 2020 chills.

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SUF COMPLET	
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				would not listen to concerns.		
	Telephone interview	with a resident's primary care		-The staff went to the emergency roor	m for	
	•	1/06/21 at 8:05am revealed:		these ongoing health concerns and w		
	-If a staff member co	mplained of feeling fatigue, ache during the pandemic		diagnosed with COVID-19.		
	•	t been exposed themselves		Telephone interview with the Local He	ealth	
	or cared for the resid	•		Department (LHD) Registered Nurse		
	-It was important for	staff not to be sick when		01/05/21 at 11:49am revealed:		
		residents due to risk of		-Staff should not work if they were		
	potentially passing ill	nesses on to the residents		experiencing signs or symptoms of		
	and other staff.			COVID-19 and should notify the		
				Administrator or a management staff		
	Telephone interview	with the Memory Care		member immediately.		
	Director (MCD) on 0	1/06/20 at 12:59pm revealed:		-Staff should be quarantined for 14 da	ays	
		[:] any staff member working ms of temperature or fatigue.		after testing positive for COVID-19.		
		k when they were sick to		Telephone interview with the Administ	trator	
	because they could	bass germs and infections to		on 01/06/21 at 10:02am revealed:		
	residents and other s	staff.		-He was not aware of any staff not fee	eling	
	-If she had been awa	are that a staff member was		well and required to work their shift.	_	
	sick, she would have	e either worked the shift or		-It was hard to comment on staff repo	rting	
	found someone else	to work so that staff member		they were not feeling well and needin	g to	
	could leave.			leave their shift because each situation	on	
				was different and "staff's track record	" had	
	Confidential staff inte			to be taken into account.		
		k on specified date (date and		-He thought it would have been impor		
		ntain confidentiality) and had		to establish if the staff had a temperat		
	a headache and fatig			and were feeling ill and unable to wor	K.	
		eported symptoms to the		-He would have expected the staff		
		tor (RCD) and was advised		reporting they were sick and unable to		
		hort staff and the staff was		work their shift to have reported that t	0	
	not able to go home.	ion for staff to find their our		him.		
	-	vas for staff to find their own		Tolophono intonview with a regidentia		
	coverage if they were scheduled shift.			Telephone interview with a resident's primary care provider (PCP) on 01/06	101	
		ble to find a replacement and		at 8:05am revealed:	" ∠	
	stayed and worked th			-If a staff member complained of feeli	na	
	•	es in December 2020 while		fatigue, temperature or headache dur		
	having headache, fat			the pandemic they should have not be		
		ort any symptoms beyond		exposed themselves or cared for the		

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		HAL092215	B. WING		C 01/20/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRI ^N R, NC 27529	Æ	
	SUMMARY ST			PROVIDER'S PLAN OF CORRECTIO	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE
D 612	Continued From pag	e 48	D 612		
	the management wo -The staff went to the	e RCD because the staff felt uld not listen to concerns. e emergency room for these erns and was diagnosed with		residents. -It was important for staff not to be si when providing care to the residents to risk of potentially passing illnesses the residents and other staff.	due
	report for facility staff Screening of Infection Staff/Visitor Screenin 12/23/20 and 12/30/2 -On 12/16/20, there w in for duty with no sc -On 12/23/20, there w clocked in for duty with -On 11/05/20, there w	were 6 out of 11 staff clocked		Telephone interview with the Memory Director (MCD) on 01/06/20 at 12:59 revealed: -She did not know of any staff memb working while having symptoms of temperature or fatigue. -Staff should not work when they we sick to because they could pass gerr and infections to residents and other -If she had been aware that a staff member was sick, she would have el	pm er re ns staff.
	facility on 12/30/20 ir -5:38am revealed: -The supervisor/med the entrance door an enter the facility. -The S/MA was prom 5:36am and again at anything that needed entering the facility. -The S/MA advised th temperature check ne using the electronic of prompted. -The three surveyors COVID-19 screening through the electronic the table located to the	main front entrance of the intermittently between 5:25am ication aide (S/MA) opened d invited the survey team to apted by the surveyor at 5:38am, if there was to be completed prior to hat COVID-19 screening and eeded to be completed by computer pad after being completed the facility's and a temperature check c computer pad stored on he right of the main walkway room at 5:40am, 5:45am		 worked the shift or found someone e work so that staff member could leave 2 a. Review of the facility's weekly tir card report for facility staff compared the facility's Screening of Infection or Communicable Disease Staff/Visitor Screening Forms for 12/16/20, 12/23 and 12/30/20 revealed: On 12/16/20, there were 6 out of 11 clocked in for duty with no screening and 2 of those 6 screened in after wor7 hours. On 12/23/20, there were 14 out of 3 clocked in for duty with no screening On 12/23/20, there were 12 out of 2-clocked in for duty with no screening Observations of the main front entrar the facility on 12/30/20 intermittently 	re. me with with 3/20 staff form prking 2 staff form. 4 staff form.
	and 5:47am.	with a confidential staff		between 5:25am -5:38am revealed: -The supervisor/medication aide (S/N opened the entrance door and invited	

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NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	GARNER		GLEWOOD DRIV	/E	
		GARNEI	R, NC 27529		
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D 612	Continued From page	e 49	D 612		
	COVID-19 screening to work because staft walk to the floor and -There were times the complete the COVID- before beginning a st Telephone interview Department (LHD) Re at 11:49am revealed to complete a COVID scheduled shift and th	e staff would forget to -19 screening process nift.		survey team to enter the facility. -The S/MA was prompted by the surve at 5:36am and again at 5:38am, if the was anything that needed to be comp prior to entering the facility. -The S/MA advised that COVID-19 screening and temperature check need to be completed by using the electron computer pad after being prompted. -The three surveyors completed the facility's COVID-19 screening and a temperature check through the electron computer pad stored on the table local to the right of the main walkway of the front entrance room at 5:40am, 5:45am	eded ic pnic ated
	Telephone interview of provider (PCP) on 01 was important for sta facility to complete a prevent bringing COV	with a resident's primary care /06/21 at 8:05am revealed it ff and anyone entering the COVID-19 screening to /ID-19 into the facility.		and 5:47am. Telephone interview with a confidentia staff member revealed: -Management was not monitoring the facility's COVID-19 screening process when staff reported to work because s	al staff
	12/31/20 at 3:01pm r -Staff were responsib COVID-19 screening check and questionna shift.	ole for completing a including a temperature aire prior to the start of each		could walk in, clock in and walk to the and start the shift. -There were times the staff would forg complete the COVID-19 screening process before beginning a shift.	let to
	questionnaire form at to the current electron temperature check th 2020. -The Concierge were	g a COVID-19 screening nd temperature checks prior nic screening system with nat started in December responsible to check the eening forms and place		Telephone interview with the Local He Department (LHD) Registered Nurse of 01/05/21 at 11:49am revealed that all were expected to complete a COVID- screening prior to their scheduled shift there should be a process in place to monitor for completion of screening.	on staff 19
	checks to ensure stat			Telephone interview with a resident's primary care provider (PCP) on 01/06 at 8:05am revealed it was important for staff and anyone entering the facility to	or

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	SI CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		
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D 612	Continued From page	e 50	D 612		
	-The electronic scree	ning system with		complete a COVID-19 screening to	
		was new, so the staff were		prevent bringing COVID-19 into the fa	acility.
	-	the reports out and compare			
	to time punch record			Telephone interview with the Adminis	trator
		was assigned their own		on 12/31/20 at 3:01pm revealed:	
		ed each time to log in and log		-Staff were responsible for completing	ga
	out of the electronic s	-		COVID-19 screening including a	
		es when staff attempted to		temperature check and questionnaire	e prior
	-	ning and their code would not		to the start of each shift.	
	work.	e been responsible for		-The facility was using a COVID-19 screening questionnaire form and	
				temperature checks prior to the curre	nt
	completing the paper screening questionnaire. -The facility was in the middle of a transition			electronic screening system with	
	-	en forms and the electronic		temperature check that started in	
	screening system.			December 2020.	
		rts were compared with the it time		-The Concierge were responsible to or the staff's COVID-19 screening forms	
		pleted the handwritten		place completed forms into a binder.	
	screening forms after			-A report was generated weekly from	the
	u	copy of all handwritten		electronic screening system with	
	screening forms after			temperature checks to ensure staff w completing the required screening pro-	
	Telephone interview	with the Administrator on		for COVID-19.	
	01/06/21 at 10:02am			-The electronic screening system with	h
	-The facility had a ha	ndwritten screening tool prior		temperature checks was new, so the	
	to initiating an electro	onic screening system in		were learning how to print the reports	out
	December 2020.			and compare to time punch records.	
		ning system had "holes" in		-Each staff member was assigned the	
	staffs' screenings.			own special code they used each tim	e to
		as going to take a look at the		log in and log out of the electronic	
		determine if staff was gs or if there were any		screening machine. -There were instances when staff	
		did not allow staff to screen		attempted to complete their screening	n and
	in.			their code would not work.	
		oring process in place to		-The staff would have been responsib	ble
		screening in prior to the start		for completing the paper screening	
	of their shift.	U		questionnaire.	
	-He had given staff v	erbal reminders to ensure		-The facility was in the middle of a	
		in prior to the start of their		transition period with handwritten forr	ns
	shift.			and the electronic screening system.	

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	of Health Service Regu of DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE		
			GLEWOOD DRIV			
CADENCE	GARNER		R, NC 27529			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CC	RRECTION	(X5)
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D 612	Continued From page	e 51	D 612			
	something he could r not have time. No additional staff CG were provided prior to b. Review of the resid log revealed: -The forms were prin number, name and te -There was no sectio symptoms of COVID-	e screenings for staff was not monitor because he did OVID-19 screening forms o survey exit. dents' temperature recording ted with the resident's room emperature. in for screening for other		-Staff screening reports were with the staffs' clock in and ou -Some staff had completed th handwritten screening forms a 12/16/20. -He would provide a copy of a handwritten screening forms a 12/16/20. Telephone interview with the <i>A</i> on 01/06/21 at 10:02am revea -The facility had a handwritter tool prior to initiating an electr screening system in Decembe -The electronic screening sys "holes" in staffs' screenings.	ut time. e after all after Administrator aled: n screening ronic er 2020. tem had	
	residents for October -There was no docum checks or screening COVID-19 for Reside documentation of a to 10/02/20, 10/04/20, to one on 10/22/20, 10/ on 10/25/20 and two -There was no docum checks or screening COVID-19 for Reside documentation of a to 10/19/20, 10/22/20, to 10/30/20. -There was no docum checks or screening COVID-19 for Reside documentation of a to 10/22/20 and 10/23/2 -There was no docum	nentation of temperature for other symptoms of ent #1 with exceptions of emperature recording on wo readings on 10/21/20, 23/20, two on 10/24/20, one on 10/30/20. nentation of temperature for other symptoms of ent #5 with exceptions of emperature recording on wo on 10/25/20, and two on nentation of temperature for other symptoms of ent #2 with exceptions of emperature recording on		 The Administrator was going look at the staffs' screenings if staff was completing screen there were any technical issue not allow staff to screen in. There was no monitoring proto ensure all staff were screer to the start of their shift. He had given staff verbal renensure they were screening in start of their shift. Because the facility was tryin "COVID-19 fires", the screeni was something he could not rebecause he did not have time. No additional staff COVID-19 forms were provided prior to so b. Review of the residents' terrecording log revealed: The forms were printed with room number, name and tem 	to determine ings or if es that did acess in place ning in prior ninders to n prior to the ag to put out ngs for staff nonitor screening survey exit. mperature the resident's	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRI ¹ R, NC 27529	VE	
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	documentation of a te 10/03/20, two on 10/2 10/24/20 and 10/31/2 -There was no docum checks or screening f COVID-19 for Reside documentation of a te on 10/21/20, one on 10/31/20. -There was no docum checks or screening f COVID-19 for Reside documentation of a te 10/22/20 and 10/23/2 Review of the screen residents for Novemb -There was no docum checks or screening f COVID-19 for Reside documentation of a te three readings on 11/ 11/27/20 and 11/30/2 -There was no docum checks or screening f COVID-19 for Reside documentation of a te three readings on 11/ 11/27/20 and 11/30/2 -There was no docum checks or screening f COVID-19 for Reside documentation of a te one reading on 11/01 -There was no docum checks or screening f	emperature recording on 21/20, one on 10/22/20, 20. Inentation of temperature for other symptoms of emperature recording on two 10/22/20, 10/24/20, and Inentation of temperature for other symptoms of ent #6 with exceptions of emperature recording on 20. Ing logs for 6 sampled ber 2020 revealed: Inentation of temperature for other symptoms of ent #1 with exceptions of emperature recording with /01/20 and one on 11/02/20, 10. Inentation of temperature for other symptoms of emperature recording with /01/20 and one on 11/02/20, 10. Inentation of temperature for other symptoms of emperature recording with //20. Inentation of temperature for other symptoms of emperature recording with //20.		other symptoms of COVID-19 for the residents. - There were multiple screening log for without dates. Review of the screening logs for 6 sampled residents for October 2020 revealed: - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a resident exceptions of documentation of a temperature recording on 10/02/20, 10/04/20, two readings on 10/21/20, 10/22/20, 10/23/20, two on 10/24/20, 10/25/20 and two on 10/30/20. - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a second resident with exceptions of documenta of a temperature recording on 10/19/2 10/22/20, two on 10/25/20, and two or 10/30/20. - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a third resident with exceptions of documenta of a temperature recording on 10/22/2 and 10/23/20. - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a third resident with exceptions of documenta of a temperature recording on 10/22/2 and 10/23/20. - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a fourth resident with exceptions of documenta of a temperature recording on 10/02/2 and 10/23/20. - There was no documentation of temperature checks or screening for of symptoms of COVID-19 for a fourth resident with exceptions of documenta of a temperature recording on 10/03/2 two on 10/21/20, 10/22/20, 10/24/20 a	ether with ation 0, n ether ation 0 other ation 0,
	documentation of a te one reading on 11/01	emperature recording with		10/31/20. -There was no documentation of temperature checks or screening for c	
		for other symptoms of		symptoms of COVID-19 for a fifth resi	

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE : COMPI	
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D 612 Continued From pag	e 53	D 612			
COVID-19 for Reside documentation of a t one reading on 11/0 -There was no docur checks or screening COVID-19 for Reside November 2020. Review of the screer residents for Decemi -There was no docur checks or screening COVID-19 for Reside documentation of a t 12/02/20, 12/03/20, 1 12/19/20, 12/21/20, - There was no docur checks or screening COVID-19 for Reside documentation of a t 12/03/20, 12/04/20, - 12/17/20, two on 12/ 12/20/20 and 12/22/2 -There was no docur checks or screening COVID-19 for Reside documentation of a t 12/03/20, 12/04/20, - There was no docur checks or screening COVID-19 for Reside documentation of a t on 12/04/20, two on two on 12/20/20, one 12/29/20 and three of -There was no docur checks or screening COVID-19 for Reside documentation of a t 12/04/20 (The reside 12/14/20). -There was no docur checks or screening	ent #2 with exceptions of emperature recording with 1/20. mentation of temperature for other symptoms of ent #5 for the month of aning logs for 6 sampled ber 2020 revealed: mentation of temperature for other symptoms of emperature recording on two on 12/05/20, one on 12/30/20 and 12/31/20. mentation of temperature for other symptoms of ent #1 with exceptions of emperature recording on 12/05/20, 12/15/20, 12/16/20, 18/20, one on 12/19/20, 20. mentation of temperature for other symptoms of emperature recording on 12/17/20, one on 12/19/20, e on 12/21/20 12/23/20, on 12/30/20. mentation of temperature for other symptoms of emperature recording on two 12/17/20, one on 12/19/20, e on 12/21/20 12/23/20, on 12/30/20. mentation of temperature for other symptoms of emperature recording on two 12/17/20, one on 12/19/20, e on 12/21/20 12/23/20, on 12/30/20.		with exceptions of documentation of temperature recording on two on 1 10/22/20, 10/24/20, and 10/31/20. -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a sixth resident with exceptions of docume of a temperature recording on 10/2 and 10/23/20. Review of the screening logs for 6 sampled residents for November 2 revealed: -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a resid exceptions of documentation of a temperature recording with three re on 11/01/20, 11/02/20.oner reading 11/02/20, one reading on 11/27/20 one reading on 11/30/20. -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a secon resident with exceptions of docume of a temperature recording with on reading on 11/02/20. -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a secon resident with exceptions of docume of a temperature recording with on reading on 11/02/20. -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a third resident with exceptions of docume of a temperature recording with on reading on 11/02/20. -There was no documentation of temperature checks or screening f symptoms of COVID-19 for a third resident with exceptions of docume of a temperature recording with on reading on 11/02/20.	0/21/20, for other entation 22/20 2020 for other lent with eadings g on and for other entation le for other entation le for other entation le	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL092215	B. WING		C 01/20/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIV R, NC 27529	/E		
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D 612	Continued From pag	e 54	D 612			
	12/04/20. two on 12/	17/20, one on 12/19/20, two		temperature checks or screening for a	other	
	on 12/20/20, one on			symptoms of COVID-19 for a fifth res		
	12/29/20, three on 12			with exceptions of documentation of a		
	12/31/20			temperature recording with one reading		
		mentation of temperature		11/01/20.	-	
		for other symptoms of		-There was no documentation of		
	COVID-19 for a Resi	dent #3 with exceptions of		temperature checks or screening for a	other	
	documentation of a t	emperature recording on		symptoms of COVID-19 for a sixth		
		two on 12/05/20, one on 12/30/20 and 12/31/20.		resident for the month of November 2	2020.	
				Review of the screening logs for 6	^	
	-	onal care aide (PCA) working		sampled residents for December 202	0	
	•	section of the facility on		revealed:		
	12/30/20 at 6:00am r			-There was no documentation of	othor	
	-	eratures were taken twice nning and end of shift.		temperature checks or screening for a		
		ions were asked however if a		symptoms of COVID-19 for a residen exceptions of documentation of a		
	÷ .	n, it was documented on the		temperature recording on 12/02/20,		
	report sheet.	i, it was documented on the		12/03/20, two on 12/05/20, 12/19/20,		
	-The report sheet wa	as given to the		12/21/20, 12/30/20 and 12/31/20.		
	Supervisor/Medicatio	-		-There was no documentation of		
		emperature of 99 degrees		temperature checks or screening for o	other	
) F, then the PCA would		symptoms of COVID-19 for a second		
	report it to the (S/MA			resident with exceptions of document	ation	
		·		of a temperature recording on 12/03/2		
	Telephone interview	with the Administrator on		12/04/20, 12/05/20, 12/15/20, 12/16/2		
		revealed he would review		12/17/20, two on 12/18/20, 12/19/20,		
	and provide the six s	ampled residents'		12/20/20 and 12/22/20.		
	temperature logs that			-There was no documentation of		
	October-December 2	2020.		temperature checks or screening for o	other	
				symptoms of COVID-19 for a third		
		lent residing in room# A8 on		resident with exceptions of document		
	÷ ,	AL) section on 12/30/20 at		of a temperature recording on two on		
	7:57am revealed:			12/04/20, two on 12/17/20, 12/19/20,		
		emperature at least daily for		on 12/20/20, 12/21/20 12/23/20, 12/2	9/20	
	COVID-19 screening			and three on 12/30/20.		
		any questions about		-There was no documentation of	- 41	
	symptoms of COVID	-		temperature checks or screening for o	otner	
	temperatures were o	DIAINEO.		symptoms of COVID-19 for a fourth	otion	
				resident with exceptions of document	auon	

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STATEMENT OF AND PLAN OF (DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROV	/IDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE G	ARNER		GLEWOOD DRIV R, NC 27529	VE	
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D 612 C	ontinued From page	e 55	D 612		
In room set in the set of the set	aterview with a seco boom# D13 on the AL 15am revealed: Staff obtained his te mes per day for CO Staff did not ask him uestions for COVID elephone interview we epartment (LHD) R t 11:49am revealed: Residents should be emperatures and as resence of COVID- He discussed with the n-site visit on 12/17, creening residents, OVID-19 symptoms elephone interview we 2/31/20 at 4:00pm r The LHD provided the ritten recommended Resident COVID-19 nly documented if the uch as a cough or te When the LHD RN r nonth, he was more hecks of the resider Staff were responsite esidents had sympto- nat resident. elephone interview we chart resident.	and resident residing in section on 12/30/20 at mperature readings several VID-19. any symptom screening -19. with the Local Health egistered Nurse on 01/05/21 secreened daily by checking king questions about the 19 symptoms. he Administrator during the /20 about the importance of staff and visitors for s. with the Administrator on evealed: he facility with verbal and d guidance for COVID-19. screening questions were he resident had symptoms emperature. made an onsite visit this concerned with temperature ths. ble for documenting if oms that were not normal for with the Memory Care 1/06/21 at 12:59pm revealed: ble for screening residents y obtaining temperatures. ID-19 screening questions on the MCU; however, staff		of a temperature recording on 12/04/2 (The resident passed away on 12/14/ -There was no documentation of symptoms of COVID-19 for a fifth res with exceptions of documentation of a temperature recording on 12/04/20, th 12/17/20, 12/19/20, two on 12/20/20, 12/21/20, 12/23/20, 12/29/20, and thr on 12/30/20. -There was no documentation of temperature checks or screening for symptoms of COVID-19 for a sixth resident with exceptions of document of a temperature recording on 12/02/2 12/03/20, two on 12/05/20, 12/19/20, 12/21/20, 12/30/20 and 12/31/20. Interview with a personal care aide (F working on the assisted living section the facility on 12/30/20 at 6:00am revealed: -The residents' temperatures were ta twice per shift, at the beginning and e shift. -No screening questions were asked however if a resident had a cough, it documented on the report sheet. -The report sheet was given to the Supervisor/Medication Aide (S/MA) -If a resident had a temperature of 99 degrees Fahrenheit (F) to 100 F, ther PCA would report it to the (S/MA). Telephone interview with the Adminis on 01/06/21 at 10:54am revealed he would review and provide the resident temperature logs that were missing fr October-December 2020.	220). other ident a wo on ree other cation 20, PCA) of ken end of was on the trator its'

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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ADENCE	GARNER		GLEWOOD DRIV R, NC 27529	Æ		
	SUMMARY ST			PROVIDER'S PLAN OF CORRECTIO	N (XE)	
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D 612	Continued From pag	e 56	D 612			
	guidance and inform procedures for COVI			Interview with a resident residing on t Assisted Living (AL) section on 12/30 at 7:57am revealed: -Staff obtained her temperature at lea daily for COVID-19 screening.)/20	
	No additional resident COVID-19 temperature screening forms were provided by the Administrator prior to survey exit. 3. Review of Resident #4's FL-2 dated 07/28/20			-Staff did not ask her any questions a symptoms of COVID-19 daily when h temperatures were obtained.		
	(severe dementia), m hypertension and art -Resident #4 was inter	neuro cognitive disorder najor depressive disorder, hritis. ermittently disoriented. nmended level of care was		Interview with a second resident resid on the AL section on 12/30/20 at 8:15 revealed: -Staff obtained his temperature readin several times per day for COVID-19. -Staff did not ask him any symptom screening questions for COVID-19.	ōam	
	revealed there was n	on 12/30/20 at 6:35am to precautions sign posted on door related to isolation.		Telephone interview with the Local He Department (LHD) Registered Nurse 01/05/21 at 11:49am revealed: -Residents should be screened daily	on	
	7:14am revealed: -Resident #4 tested p 12/18/20 and was sti and should still be or precautions. -Resident #4 had a d	ministrator on 12/30/20 at positive for COVID-19 on Il within the 14-day window n contact isolation Iry cough which was close to		checking temperatures and asking questions about the presence of COVID-19 symptoms. -He discussed with the Administrator during the on-site visit on 12/17/20 at the importance of screening residents staff and visitors for COVID-19 symptomic	pout s,	
	his baseline. -COVID-19 positive r isolation sign on thei	residents should have an r room doors.		Telephone interview with the Adminis on 12/31/20 at 4:00pm revealed: -The LHD provided the facility with ve	erbal	
	Director (MCD) on 0 ⁻ -Precaution signs rel	with the Memory Care 1/06/21 at 12:59pm revealed: ated to isolation were placed f residents who tested		and written recommended guidance f COVID-19. -Resident COVID-19 screening quest were only documented if the resident	tions	
	-	er COVID-19 positive rooms s, face masks, gowns,		symptoms such as a cough or temperature. -When the LHD RN made an onsite v this month, he was more concerned v	visit	

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	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	E GARNER		GLEWOOD DRIV R, NC 27529	/E	
	SUMMARY ST		ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
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D 612	Continued From page	e 57	D 612		
	she assigned a name isolation signage on f -Resident #4 had a h from the wall. -She was not sure if sign on Resident #4's the sign down. Based on observation reviews, Resident #4 Interview with the sup (S/MA) on 12/30/20 a -The residents with a cohorted on the B ha memory care units (M -She was not sure of and was not sure of t COVID-19 positive re- time but "heard" there	istory of pulling things down staff ever placed an isolation s door or if Resident #4 tore ns, interviews and record was not interviewable. pervisor/medication aide at 5:24am revealed: COVID-19 diagnosis were II and C hall which were also ACUs). the facility's current census the total number of esidents in the facility at that		 temperature checks of the residents. Staff were responsible for documenti residents had symptoms that were no normal for that resident. Telephone interview with the Memory Director (MCD) on 01/06/21 at 12:59p revealed: Staff were responsible for screening residents for COVID-19 daily by obtai temperatures. There were no COVID-19 screening questions for residents residing on the MCU; however, staff monitored how r the residents ate. The Administrator provided staff upda guidance and informed staff of proces and procedures for COVID-19. No additional resident COVID-19 temperature screening forms were provided by the Administrator prior to 	t Care om ning e nuch ates,
	who tested negative Interview with a perso 12/30/20 at 6:31am r -She could identify C by the isolation signs doors. -She was unsure of t of some of the reside -She believed there w residents that were C Observation on the C 12/30/20 at 6:57am. -There were Isolation six residents' rooms	onal care aide (PCA) on evealed: OVID-19 positive residents posted at the residents' he current COVID-19 status ents residing on the C hall. was a total of six current COVID-19 positive. C hall of the MCU on a signs posted on the door of		 survey exit. 3. Review of Resident #4's FL-2 date 07/28/20 revealed: Diagnoses included neuro cognitive disorder (severe dementia), major depressive disorder, hypertension and arthritis. Resident #4 was intermittently disoriented. The resident's recommended level of care was memory care. Observation of MCU on 12/30/20 at 6:35am revealed there was no precau- sign was posted on Resident #4's roo door related to isolation. 	tions

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STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CADENCE G	ARNER		GLEWOOD DRI\ R, NC 27529	/E	
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D 612 C	ontinued From pag	e 58	D 612		
cł	nange before and a	fter care.			
Te 12 -T fo www -T re qu or re -T B In re -S S po ww -S bo -N he C -S re -T fo re -T fo re -T fo s to -S fo ww -S fo -S S S S (S S C -S S S (S S S S (S S S S S S S S S S S	elephone interview 2/31/20 at 3:01pm r There were multiple r COVID-19 within ere currently outsid indow. There were isolation esident's doors who uarantine window a n isolation precaution move the signs. The isolation precaution terview with a PCA evealed: The floated on A, B, She was aware that positive residents, but ere positive for CO She knew of some r ecause of "hearsay to one from manage of the COVID-19 states confidential staff interview esident tested position the staff did not known r COVID-19 until 4 esident (01/01/21). Elephone interview epartment (LHD) R are should be award	with the Administrator on revealed: residents that tested positive the same time frame and e of their 14-day quarantine a precaution signs on some were outside of their 14-day nd no longer required to be ons because staff did not attion signs for all residents on e updated on 12/30/20. a on 01/04/21 at 3:24pm C and D Hall. there were COVID-19 at unsure which residents VID-19. esidents' COVID-19 status " from other staff members. ement communicated with atus of any residents. erview revealed: ted by management when a		Interview with the Administrator on 12/30/20 at 7:14am revealed: -Resident #4 tested positive for COVII on 12/18/20 and was still within the 14 window and should still be on contact isolation precautions. -Resident #4 had a dry cough which we close to his baseline. -COVID-19 positive residents should H an isolation sign on their room doors. Telephone interview with the Memory Director (MCD) on 01/06/21 at 12:59p revealed: -Precaution signs related to isolation we placed on the room doors of residents who tested positive for COVID-19. -PPE required to enter COVID-19. -PPE required to enter COVID-19. -PPE required to enter COVID-19 pos rooms included: face shields, face mat gowns, gloves and shoe covers. -She placed isolation signage on the E and she assigned a named staff mem to post isolation signage on the C hall -Resident #4 had a history of pulling the down from the wall. -She was not sure if staff ever placed isolation sign on Resident #4's door of Resident #4 tore the sign down. Based on observations, interviews and record reviews, Resident #4 was not interviewable. Interview with the supervisor/medicati aide (S/MA) on 12/30/20 at 5:24am revealed: -The residents with a COVID-19 diagr were cohorted on the B hall and C hall	A-day

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
н		HAL092215	B. WING		C 01/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRIN R, NC 27529	/E	
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D 612	Continued From page	e 59	D 612		
D 612	 4. Observation of a S (S/MA) on 12/30/20 a The S/MA was observation hallway Hall of the Memory Operated windows. The S/MA was not were a symbol of the Memory Operated windows. The S/MA was not were a symbol of the S/MA was moving device across her clock. Interview with S/MA or a symbol of the S/MA was moving device across her clock. She provided care for positive for COVID-1 residents who were a symbol of the sy	Supervisor/Medication Aide at 5:48am revealed: rved from the Assisted Living standing at the door on the B care Unit (MCU) through the vearing a personal protective wn. ng a handheld disinfectant othing. on 12/30/20 at 6:19am or residents who were 9 and provided care for negative for COVID-19. e PPE isolation gowns bo tight. ported to the Resident Care r's handheld disinfecting g whenever she exited w with staff revealed: uld not wear the facility's	D 612	 (MCUs). -She was not sure of the facility's curcensus and was not sure of the total number of COVID-19 positive resident the facility at that time but "heard" the were four. -She administered medications to be residents who tested positive for COVID-19 and residents who tested negative for COVID-19. Interview with a personal care aide (on 12/30/20 at 6:31am revealed: -She could identify COVID-19 positive residents by the isolation signs poster the residents' doors. -She was unsure of the current COV status of some of the residents residents residents that were COVID-19 positive. Observation on the C hall of the MC 12/30/20 at 6:57am. -There were Isolation signs posted of door of six residents' rooms labeled "Isolation Protocol" with instructions PPE required, change before and af care. -The isolation signs were rolled inwas 	I ents in here both (PCA) ve ed at (ID-19 ting on x 19 U on the as for full ter
	-The staff had worker could not wear the fa Memory Care Director -There were times th	w with second staff revealed: d with a named staff that cility's PPE gowns and the or (MCD) was aware of this. e staff had to care for positive for COVID-19		the edges of the sign. Telephone interview with the Admini on 12/31/20 at 3:01pm revealed: -There were multiple residents that t positive for COVID-19 within the sar time frame and were currently outsid their 14-day quarantine window. -There were isolation precaution sig	tested ne de of

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
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			R, NC 27529		
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D 612	Continued From page	e 60	D 612		
	Confidential interviev	v with a third staff revealed:		some resident's doors who were outsid	de
	-	ble to wear the PPE isolation		of their 14-day quarantine window and	
		ne facility because they were		longer required to be on isolation	
	too small.	,,		precautions because staff did not remo	ove
	-The concern was re	ported to the MCD		the signs.	
	approximately 1-2 m	-		-The isolation precaution signs for all	
		are for residents who tested		residents on B hall and C hall were	
		9 and residents who tested		updated on 12/30/20.	
	negative for COVID-				
		when able, by providing care		Interview with a personal care aide (PG	CA)
		ted positive for COVID-19		on 01/04/21 at 3:24pm revealed:	,
		not wear the PPE isolation		-She floated on A, B, C and D Hall.	
	gowns.			-She was aware that there were	
	-When other staff were not available, the staff			COVID-19 positive residents, but unsu	Ire
	provided care for res	idents with COVID-19 and		which residents were positive for	
	did not use the PPE	isolation gowns.		COVID-19.	
				-She knew of some residents' COVID-	19
	Telephone interview	with a resident's primary care		status because of "hearsay" from othe	r
	provider (PCP) on 01	1/06/21 at 8:05am revealed:		staff members.	
	-The PCP expressed	I concern that if PPE was not		-No one from management communic	ated
	worn appropriately it	could increase the spread of		with her the COVID-19 status of any	
	COVID-19 amongst i	residents and staff.		residents.	
		s, face shields, gowns,			
	gloves and shoe cov	erings offered better		Confidential staff interview revealed:	
		OVID-19 than using a		-Staff were not updated by manageme	nt
	handheld disinfecting	,		when a resident tested positive for	
		ecting device would not be		COVID-19.	
	able to disinfect your	whole body and clothes.		-The staff did not know Resident #4 wa	
				positive for COVID-19 until 4 days ago	
		with the Local Health		after caring for the resident (01/01/21)	.
	,	egistered Nurse (RN) on			
	01/05/21 at 11:49:			Telephone interview with the Local He	
		for residents diagnosed with		Department (LHD) Registered Nurse of	on 🛛
		ear the recommended PPE:		01/05/21 at 11:49am revealed staff	
	-	5 mask, face shield, gown,		providing direct patient care should be	
	gloves and shoe cov	•		aware of residents' COVID-19 status s	0
		appropriately it could further		that correct PPE can be utilized.	
		other residents and staff.			
		ar all recommended PPE		4. Observation of a Supervisor/Medica	ation
	appropriately then the	ey should not be assigned to		Aide (S/MA) on 12/30/20 at 5:48am	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRIN R, NC 27529	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
D 612	Continued From pag	e 61	D 612		
	work with residents of -If the facility had cor on PPE gowns could Telephone interview 01/05/21 at 3:34pm r -He was not aware th to wear PPE isolation - The facility had differ isolation gowns and different sizes. -He was only aware used the handheld d personal clothing. - The use of the hand personal clothing wa and it was not a "sub Telephone interview 01/06/21 at 10:02am -He had spoken with regarding any staff n gowns. - There was one partit to work this weekend PPE gown that would 5. Review of the Cer (CDC) Infection Prev Guidance for Memor on 05/12/20) reveale -Staff should provide hand hygiene, social coverings. -Limit the number of at least six feet apart in a common area, a	diagnosed with COVID-19. Intacted the LHD, guidance I have been provided. with the Administrator on revealed: nat some staff were not able in gowns. erent sizes available of PPE he has personally seen the of one staff member who isinfecting device on their likeld disinfecting device on s not a "common practice" ostitution for PPE." with the Administrator on in revealed: all department managers ot being able to wear PPE icular staff who would return d and ensured there was a d fit the staff.		revealed: -The S/MA was observed from the Assisted Living (AL) section hallway standing at the door on the B Hall of th Memory Care Unit (MCU) through the paned windows. -The S/MA was not wearing a personal protective equipment (PPE) gown. -The S/MA was moving a handheld disinfectant device across her clothing. Interview with S/MA on 12/30/20 at 6:19am revealed: -She provided care for residents who w positive for COVID-19 and provided car for residents who were negative for COVID-19. -She did not wear the PPE isolation go because they were too tight. -This concern was reported to the Resident Care Director (RCD). -She used the facility's handheld disinfecting device on her clothing whenever she exited COVID-19 areas. Confidential interview with staff reveale -One named staff could not wear the facility's PPE isolation gowns. -The RCD was notified the named staff was unable to wear the PPE gowns and the RCD informed the Administrator and more PPE gowns would be ordered. Confidential interview with second staff revealed: -The staff had worked with a named staff revealed: -The staff had worked wit	vere re wns ed: d d
	other residents or sta	· ·		(MCD) was aware of this. -There were times the staff had to care	for

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STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		HAL092215	B. WING		C 01/20/2021	
			DDRESS, CITY, ST		01/20/2021	
	ROVIDER OR SUPPLIER		GLEWOOD DRIV			
CADENCE	GARNER		R, NC 27529			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
D 612	Continued From page	e 62	D 612			
	residents who were 0 MCU.	COVID-19 positive on the		residents who tested positive for COVID-19 without a PPE gown.		
	revealed:	30/20 on B Hall (MCU)		Confidential interview with a third star revealed:	aff	
		resident exited from room# in the hallway without her		-The staff was not able to wear the l isolation gowns provided by the faci		
	•	ls another residents' room e to redirect her or assist with		because they were too small. -The concern was reported to the M	CD	
	donning a mask.			approximately 1-2 months ago.		
	-At 6:48am, a male re wearing only one sho	esident exited room# B3		-The staff provided care for resident tested positive for COVID-19 and	s who	
	÷ .	ite in the hallway with no		residents who tested negative for		
		rect or assist with getting his		COVID-19.		
	other shoe or donning	g a mask.		-Other staff helped, when able, by providing care for residents who tes	ted	
	Observation of Resid			positive for COVID-19 since the stat		
	intermittently between	n 9:57am - 10:17am		not wear the PPE isolation gowns.	the	
	revealed: -At 9:57am. the resid	ent entered the hallway from		-When other staff were not available staff provided care for residents with		
		ce mask and walked down		COVID-19 and did not use the PPE		
		sident Care Director (RCD) office with the door in an		isolation gowns.		
	opened position.			Telephone interview with a resident		
		view of the RCD as he		primary care provider (PCP) on 01/0	06/21	
	passed the office doo	or. ovide any redirection back to		at 8:05am revealed: -The PCP expressed concern that if	PPF	
		ce to the resident to apply a		was not worn appropriately it could		
	face mask or redirect			increase the spread of COVID-19		
		ied walking down the hallway		amongst residents and staff.		
		oom, removed a cup from		-Wearing face masks, face shields,	fferred	
	the cabinet and pour	ed water into the cup and ater		gowns, gloves and shoe coverings of better protection against COVID-19		
		nal care aide (PCA) was in		using a handheld disinfecting device		
		passed the MCU's dining		-The handheld disinfecting device w		
	•	lent was walking out of the		not be able to disinfect your whole b and clothes.		
	-	view of the PCA in the				
	-	er, the PCA did not provide		Telephone interview with the Local H		
	any redirection for the alth Service Regulation	e resident to apply a face		Department (LHD) Registered Nurse	e (RN)	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		BENTI IOATION NOMBEN.	A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRIN R, NC 27529	/E	
	SUMMARY ST			PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE
D 612	Continued From page	e 63	D 612		
	mask.			on 01/05/21 at 11:49:	
		to walk to the back area of		-Staff providing care for residents	
		h the double doors carrying a		diagnosed with COVID-19 should wea	r the
	resident's laundry to	, .		recommended PPE: surgical mask or	
		ident was walking down the		N95 mask, face shield, gown, gloves a	
	hall of the MCU with	-		shoe coverings.	
	-At 10:14am, the resident was walking down the			-If PPE was not worn appropriately it of	ould
		sk and passed the RCD		further spread COVID-19 to other	
	sitting in the office.			residents and staff.	
	-The RCD was not observed providing any redirection to the resident to return to his room and or apply a face mask.			-If staff could not wear all recommende	ed
				PPE appropriately then they should no	
				assigned to work with residents diagno	
		ninistrator entered the MCU		with COVID-19.	
	hallway.			-If the facility had contacted the LHD,	
		alking back up the hallway		guidance on PPE gowns could have b	een
	without a face mask,	passing the Administrator the RCD in the office.		provided.	
		ot provided any redirection or		Telephone interview with the Administ	ator
		Administrator or the RCD to		on 01/05/21 at 3:34pm revealed:	
	return to his room or			-He was not aware that some staff we	re
		ident was observed walking		not able to wear PPE isolation gowns.	
		t a face mask passing the		-The facility had different sizes availab	le of
	-	h office door in an opened		PPE isolation gowns and he has	
	position.			personally seen the different sizes.	
		bserved providing any		-He was only aware of one staff memb	ber
		ident to return to his room		who used the handheld disinfecting de	
	and or apply a face n			on their personal clothing.	
				-The use of the handheld disinfecting	
	Observations of the I	MCU on 01/04/21		device on personal clothing was not a	
		2:34pm-12:59pm revealed:		"common practice" and it was not a	
	-A personal care aide			"substitution for PPE."	
		ning room to their rooms, via			
	wheelchair.	~		Telephone interview with the Administ	ator
	-Neither resident wor	e a mask, and neither were		on 01/06/21 at 10:02am revealed:	
	prompted to put a ma			-He had spoken with all department	
	-The PCA was wearing	-		managers regarding any staff not bein able to wear PPE gowns.	g
	Observations of the I	MCU on 01/04/21 at 3:16pm		-There was one particular staff who we	buld
	revealed:	100 01 01/04/21 at 5. 10pm		return to work this weekend and ensu	
	-There were four resi			there was a PPE gown that would fit the	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			X3) DATE SURVEY COMPLETED
		BERTH TOX HOW NOW BER.	A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, ST	ATE, ZIP CODE	
	GARNER	200 MIN	GLEWOOD DRIV	/E	
JADENOL	OARREN	GARNEI	R, NC 27529		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
D 612	Continued From page	e 64	D 612		
	socializing and three	of the four residents were		staff.	
		feet apart from each other.			
	-	e not wearing a mask and		5. Review of the Centers for Disease	
		mask placed on top of her		Control (CDC) Infection Prevention and	
		ig her nose or mouth.		Control (IPC) Guidance for Memory Ca	
		lents sitting in the TV room		Units (Last updated on 05/12/20)	
		D-19 diagnosis, was not		revealed:	
	÷	t apart from other residents		-Staff should provide assistance with	
		ve COIVD-19 diagnosis and		frequent hand hygiene, social distancin	g
	was not wearing a ma	ask.		and use of face coverings.	
	-A PCA was at the nu	irses' station, across from		-Limit the number of residents or space	
	the TV room; residents were visible to the PCA			residents at least six feet apart as much	า
	from the nurses' station.			as feasible when in a common area, an	d
	-Residents were not encouraged by the PCA to			gently redirect residents who are	
	maintain social distar	ncing, not redirected to their		ambulatory, and within close proximity t	to
	rooms and were not	encouraged to wear masks.		other residents or staff.	
				- The facility should dedicate staff to ca	re
		with one of the facility's		for residents who were COVID-19 posit	ive
		rs (PCPs) on 01/06/21 at		on the MCU.	
		residents in the MCU			
	0	d redirection from staff to		Observations on 12/30/20 on B Hall	
	wear a face masks a			(MCU) revealed:	
	distancing to minimiz	e the spread of infections		-At 6:44am, a female resident exited fro	
	when out of their roor	ms.		room# B11 and was walking in the hall	,
				without her mask heading towards anot	
	Telephone interview			residents' room with no staff available to	
		egistered Nurse (RN) on		redirect her or assist with donning a ma	
		revealed staff should		-At 6:48am, a male resident exited room	
		stay in their room, encourage		B3 wearing only one shoe and no mask	
	•	remind residents to wear		and proceeded to ambulate in the hallw	-
	masks when in comn	non areas.		with no staff available to redirect or ass	
	- , , , , ,			with getting his other shoe or donning a	
		with the Administrator on		mask.	
	01/05/21 at 3:34pm r			Observation of Desident #4 40/00/00	
	-	out in common areas of the		Observation of Resident #4 on 12/30/20	
	-	ocial distancing amongst		intermittently between 9:57am - 10:17a	m
	residents.	4		revealed:	
	-Staff were expected			- At 9:57am, the resident entered the	
		sidents to wear masks and		hallway from his room without a face m	ask
	redirect residents to s	stay in their rooms as often		and walked down the hall, past the	

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRI ^N R, NC 27529	VE	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	(7.0)
PREFIX TAG	1	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	
D 612	Continued From page	e 65	D 612		
	COVID-19 precaution Telephone interview v Director (MCD) on 01 -Staff were responsib	with the Memory Care I/06/21 at 12:59pm revealed: ole for monitoring and		Resident Care Director (RCD) who w sitting in an office with the door in an opened position. -The resident was in view of the RCD he passed the office door. -The RCD did not provide any redirect	as
	redirecting residents to wear masks and maintain social distancing when residents were out of their rooms. -She reminded staff on the MCU "all the time" to ensure residents were redirected to social			 back to his room or assistance to the resident to apply a face mask or redirection. The resident continued walking down hallway to the MCU's dining room, 	n the
	common areas such rooms. -Staff were responsib	face mask when out in as the halls and living ole for redirecting residents		removed a cup from the cabinet and poured water into the cup and began drinking the water. -At 10:03am, a personal care aide (P	
	testing positive for Co -If staff were unable t quarantine back to th have been responsib	nen quarantined due to OVID-19. to redirect a resident on leir room, the staff would le for redirecting the resident		was in the hallway and had passed th MCU's dining room where the resider was walking out of the dining room. -The resident was in view of the PCA the hallway MCU, however, the PCA	in did
	directives given and i	aff that did not follow the required reminders and cting residents as needed.		 not provide any redirection for the rest to apply a face mask. The PCA continued to walk to the baarea of the MCU and through the dout doors carrying a resident's laundry to 	ick ible
	The facility failed to maintain the recommendations established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC			laundry room. -At 10:05am, the resident was walking down the hall of the MCU without a fa mask.	g
	DHHS) and the Local Health E for the screening of staff and r working while displaying symp with COVID-19, staff wearing u	taff and residents, staff		-At 10:14am, the resident was walking down the hall with no face mask and passed the RCD sitting in the office. -The RCD was not observed providin	-
	equipment inappropri encouraging resident distancing or wear fa	iately and staff not is to maintain social ce masks. The facility's		redirection to the resident to return to room and or apply a face mask. -At 10:15am, the Administrator entered	his
	prevention for COVIE risk for increased tran	uidance related to infection 0-19 placed the residents at nsmission for the virus to esulted in substantial risk of		MCU hallway. -The resident was walking back up th hallway without a face mask, passing Administrator who was talking with th	the

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL092215	B. WING		C 01/20/2021
IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
ADENCE	GARNER		IGLEWOOD DRIV R, NC 27529	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
D 612	Continued From pag	e 66	D 612		
	physical harm and no Type A2 Violation. The facility provided accordance with G.S this violation with add CORRECTION DAT	e 66 eglect which constitutes a a plan of protection in 5. 131D-34 on 12/30/20 for dendum on 01/07/21. E FOR THE TYPE A2 NOT EXCEED FEBRUARY		 RCD in the office. The resident was not provided any redirection or assistance from the Administrator or the RCD to return to h room or apply a face mask. At 10:17am, the resident was observe walking in the hallway without a face m passing the RCD in the office with offic door in an opened position. The RCD was not observed providing redirection to the resident to return to h room and or apply a face mask. Observations of the MCU on 01/04/21 intermittently from 12:34pm-12:59pm revealed: A personal care aide (PCA) assisted the residents from the dining room to their rooms, via wheelchair. Neither resident wore a mask, and neither were prompted to put a mask or by the PCA. The PCA was wearing a face mask. Observations of the MCU on 01/04/21 3:16pm revealed: There were four residents sitting in the TV room socializing and three of the for residents were not sitting at least six fer apart from each other. Three resident had the mask placed top of her forehead, not covering her more mouth. A PCA was at the nurses' station, acrossing the residents were visib 	d nask e any nis wo n at e ur et ask on ose
inion of Llo	alth Service Regulation			to the PCA from the nurses' station. -Residents were not encouraged by the PCA to maintain social distancing, not redirected to their rooms and were not	

STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL092215	B. WING		C 01/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
	EGARNER	200 MIN	IGLEWOOD DRIV	/E	
		GARNE	R, NC 27529	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLE
D 612	Continued From pag	e 67	D 612		
				encouraged to wear masks.	
				Telephone interview with one of the facility's primary care providers (PC 01/06/21 at8:05am revealed the resin the MCU needed guidance and redirection from staff to wear a face masks and to maintain social distar minimize the spread of infections wo out of their rooms.	Ps) on sidents
				Telephone interview with the Local Department (LHD) Registered Nurs on 01/05/21 at 11:49am revealed si should redirect residents to stay in room, encourage social distancing remind residents to wear masks wh common areas.	se (RN) taff their and
				Telephone interview with the Admin on 01/05/21 at 3:34pm revealed: -Chairs were spaced out in commo of the MCU to encourage social dis amongst residents. -Staff were expected to encourage distancing, remind residents to wea masks and redirect residents to sta their rooms as often as they saw th getting close or not following COVII precautions.	n areas tancing social ar y in em
				Telephone interview with the Memo Director (MCD) on 01/06/21 at 12:5 revealed: -Staff were responsible for monitori redirecting residents to wear masks maintain social distancing when res were out of their rooms. -She reminded staff on the MCU "a time" to ensure residents were redi	i9pm ng and s and sidents II the

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
					с
		HAL092215	B. WING		01/20/2021
AME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, ST		
ADENC	E GARNER		IGLEWOOD DRIN R, NC 27529	VE.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
D 612	Continued From pag	e 68	D 612		
				to social distance and wear a face m when out in common areas such as halls and living rooms. -Staff were responsible for redirectin residents back to their room when quarantined due to testing positive for COVID-19. -If staff were unable to redirect a rest on quarantine back to their room, th would have been responsible for redirecting the resident to wear a ma -There were some staff that did not for the directives given and required reminders and re-education for direct residents as needed. The facility failed to follow the recommendations and guidance from Centers for Disease Control (CDC), North Carolina Department of Health Human Services (NC DHHS) and th Local Health Department (LHD) for COVID-19 during the global pandem the screening of staff and residents, working while displaying symptoms consistent with COVID-19, staff weat personal protective equipment inappropriately and staff not encourar residents to maintain social distancin wear face masks. The facility's failu was detrimental to the residents' heat safety and welfare and constitutes a B Violation. The facility provided a plan of protection	the ing indent is staff in ask. follow is the in and is for staff ing ing or re alth, Type is staff in the indent is the indent
				The facility provided a plan of protect accordance with G.S. 131D-34 on 12/30/20 for this violation with adder on 01/07/21.	

STATEMENT	of Health Service Regu FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		с
		HAL092215	B. WING		01/20/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	
CADENCE	GARNER		GLEWOOD DRIV R, NC 27529	/E	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET
D 612	Continued From page	e 69	D 612		
				CORRECTION DATE FOR THE TYP VIOLATION SHALL NOT EXCEED FEBRUARY 21, 2021	EB
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912		
	Every resident shall h 2. To receive care ar adequate, appropriate	ration of Residents' Rights have the following rights: nd services which are e, and in compliance with state laws and rules and			
	interviews, the facility residents received ca adequate, appropriate	ns, record reviews, and r failed to ensure the ure and services that were e, and in compliance with state laws and rules and housekeeping and			
	The findings are:				
	reviews, the facility fa sampled residents we privacy, and respect	ere treated with dignity, Resident #6 (female) who with Resident #3 (male). 0A NCAC 13F .0909			
	interviews, the facility was free of hazards a soiled furniture in a so items and a topical pa unsecured in an unlo				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
AND PLAN (of CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	
		HAL092215	B. WING		01	C / 20/2021
IAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	GARNER	200 MIN	GLEWOOD DRIVE			
		GARNE	R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T(DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D912	Continued From page	e 70	D912			
	Memory Care Unit (M known to have deme behaviors.[Refer to T	ible to all residents in a ICU) including residents ntia and/or wandering ag 0079, 10A NCAC 13F eeping and Furnishings				
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914			
	G.S. 131D-21 Declaration of Residents' RightsEvery resident shall have the following rights:4. To be free of mental and physical abuse, neglect, and exploitation.					
	reviews, the facility fa were free from menta neglect, and exploitat	ns, interviews, and record ailed to ensure residents				
	The findings are:					
	reviews, the facility fa memory care unit (Me supervise and meet to provide any supervise residents (#5) resulting fall and being found of to Tag 0270, 10A NC	ations, interviews, and record ailed to ensure staff on the CU) were available to the needs of the residents to ion for 1 of 5 sampled ing in one resident having a on the floor in feces. [Refer AC 13F .0901 (b) Personal in (Type A2 Violation)].				
	reviews, the facility far recommendations an	ations, interviews, and record ailed to ensure Id guidance from the Centers (CDC), the North Carolina				

STATEMENT	of Health Service Regu FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COMF	SURVEY PLETED
		HAL092215	B. WING			C / 20/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	E GARNER		GLEWOOD DRIVE R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
D914	Continued From page	e 71	D914			
	were implemented ar global Coronavirus (C reduce the risk of trai related to screening of signs and symptoms staff working while di consistent with COVI of each resident's CC wearing personal pro and redirection of residistancing and use of	D-19; and staff being aware DVID-19 diagnosis; staff otective equipment (PPE); sidents to maintain social f face masks when out of D Tag D612, 10A NCAC 13F evention and Control				
D980	G.S. § 131D-25 Impl G.S. 131D-25 Implen		D980			
	Responsibility for imp this Article shall rest facility. Each facility training to staff to imp	blementing the provisions of with the administrator of the shall provide appropriate blement the declaration of ided in G.S. 131D-21. as evidenced by:				
	reviews, the Administ overall management, procedures and total were implemented, m compliance with the r and maintain rules re infection control and	ns, interviews, and record trator failed to ensure the , operations, and policies and operations of the facility naintained, and in substantial rules and statutes to meet elated to supervision, prevention, residents rights, nd furnishings, all of which				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092215		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		B. WING		C 01/20/2021		
NAME OF PR	OVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE			
			R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	ACTION SHOULD BE COMPL TO THE APPROPRIATE DAT	
D980	Continued From page 72		D980			
	are the responsibility of the Administrator.					
	The findings are:					
	Telephone interview with the Administrator on					
	01/07/21 at 9:02am revealed: -He was responsible for the administration of the					
	community.					
	-His job responsibilities included finances,					
	budgetary guidelines and for the overall					
	regulatory needs of the facility including the					
	facility's policies and procedures.					
	-He was responsible for all staff and departments within the facility.					
	-His work hours varied ranging from 9:00am -					
	5:00pm and approximately every 6th weekend					
	covering manager on duty responsibilities.					
	-The facility was actively hiring for a Resident					
	Service Director nurse position that had been vacant since approximately 3 months.					
	Non-compliance was	identified in the following				
	rule areas at violatior	n level:				
	1. Based on observa	ations, interviews, and record				
	reviews, the facility failed to ensure staff on the					
	memory care unit (MCU) were available to					
		the needs of the residents to				
		ion for 1 of 5 sampled				
	residents (#5) resulting in one resident having a fall and being found on the floor in feces. [Refer					
	to Tag 0270, 10A NCAC 13F .0901 (b) Personal					
	-	n (Type A2 Violation)].				
		ations, interviews, and record				
	reviews, the facility failed to ensure					
		d guidance from the Centers				
		(CDC), the North Carolina n and Human Services (NC				
		I Health Department (LHD)				
	th Service Regulation		1			

STATE FORM

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If continuation sheet 73 of 75

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092215		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NOMBER.	A. BUILDING:			
		B. WING		C 01/20/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENCE	GARNER		GLEWOOD DRIVE			
			R, NC 27529			
(X4) ID PREFIX TAG	(EACH DEFICIENC	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D980	Continued From page	e 73	D980			
	 were implemented and maintained during the global Coronavirus (COVID-19) pandemic to reduce the risk of transmission and infection related to screening of staff and residents for signs and symptoms consistent with COVID-19; staff working while displaying symptoms consistent with COVID-19; and staff being aware of each resident's COVID-19 diagnosis; staff wearing personal protective equipment (PPE); and redirection of residents to maintain social distancing and use of face masks when out of their rooms. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)]. 3. Based on interviews, observations and record reviews, the facility failed to ensure 1 of 6 sampled residents were treated with dignity, privacy, and respect Resident #6 (female) who was placed in a room with Resident #3 (male). [Refer to Tag 0338, 10A NCAC 13F .0909 					
	interviews, the facility was free of hazards a soiled furniture in a s items and a topical p unsecured in an unlo resident room and ba laundry room access Memory Care Unit (M known to have deme behaviors.[Refer to T	tions, record reviews and / failed to ensure the facility as evidenced by storage of ection of the hallway, toiletry				
	overall management,	ho was responsible for the , administration, supervision, facility, failed to ensure staff				

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL092215		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					C		
		B. WING		01/20/2021			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
CADENCE	E GARNER		GLEWOOD DRIVE R, NC 27529				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLET D THE APPROPRIATE DATE		
D980	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D980				

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