STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey, and a complaint investigation survey from December 14 - 16, 2021. The complaint investigation was initiated by the Wake County Department of Social Services on December 10, 2021.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to the 29 residents including a paring knife left in an unlocked drawer in the dining room kitchen not monitored by staff. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a capacity of 96 residents with a Special Care Unit (SCU) capacity of 36 residents. The facility's policy for Storage of Hazardous Items on the SCU was requested on 12/14/21 at 4:15pm and was not provided prior to survey exit.	D 079		

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D 079	Continued From page 1 Observation of the SCU dining room on 12/14/21 at 9:18am revealed: -There was an unlocked utensil drawer beside the stove. -There was a non-serrated paring knife with a 3 ½ inch blade. -The door to the kitchen and dining room was unlocked and accessible to residents. -The dining room tables were to the right of the kitchen and there was no separation between the dining room and kitchen. -There was one resident observed sitting at a dining room table. -There was no staff present in the kitchen or the dining room. Observation of the SCU dining area on 12/14/21 at 9:36am revealed a resident walked in the dining room next to the kitchen area without staff present. Telephone interview with a medication aide (MA) on 12/15/21 at 11:45am revealed: -There were at least three residents in the SCU that wandered into other resident's rooms. -Hazardous items were to be locked in the SCU so that residents did not have access to them. Telephone interview with a second MA on 12/16/21 at 9:54am revealed: -Residents were not typically left in the dining room alone without staff but the door to the dining room stayed unlocked. -If a resident was to find a hazardous item such as a knife it would be concerning because they could cause injury to themselves or others. Interview with the Special Care Unit Manager (SCUM) on 12/14/21 at 9:25am revealed:	D 079		

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D 079	Continued From page 2	D 079		

-She was not aware there was a non-serrated paring knife in the utensil drawer.
-She was not aware the utensil drawer was unlocked.
-She removed the non-serrated paring knife from the utensil drawer.
-The utensil drawer should have been locked to ensure dangerous objects were not accessible to residents.
-Residents went into the kitchen and dining room area several times a day; at times unsupervised.
-There were at least 3 residents that wandered.
-She and staff on the SCU were responsible for ensuring kitchen storage areas were locked for the safety of residents.
-She was concerned that if a resident had found the knife, they could have injured themselves or another resident.

Interview with the Resident Services Coordinator (RSC) on 12/16/21 at 1:45pm revealed:
-She expected all hazardous items included knives to be locked on the SCU.
-She was concerned with the resident population on SCU that their behaviors and memory issues may cause problems with hazardous items such as a knife.

Interview with the Administrator on 12/14/21 at 12:04pm revealed:
-A sharp knife should not be accesible to residents.
-All SCU staff was responsible for locking up hazardous and harmful items.
-Not all of the dining room cabinets had to be locked but he expected any cabinets or drawers that had sharp items in them to remain locked.
-Residents were allowed in the dining room unattended by staff.
-He was concerned that the knife was not locked

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D 079	Continued From page 3 and that a knife could cause injury to a resident. Telephone interview with the facility's primary care provider (PCP) on 12/16/21 at 1:01pm revealed: -She expected hazardous items such as a knife to be locked in the SCU. -She was concerned that with the resident population with dementia that an item such as a knife could cause serious harm. The facility failed to protect the residents diagnosed with dementia in a Special Care Unit (SCU) and at least three residents with wandering behaviors by not securing hazardous materials, which included a sharp knife. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 12/14/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2022.	D 079		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide	D 188		

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D 188	Continued From page 4 duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the required staffing hours for the assisted living unit (AL) with a census of 36 residents were met for 3 of 9 shifts sampled from 11/30/21 to 12/10/21.	D 188		

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D 188	Continued From page 5 The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 96 beds including a special care unit (SCU) with a capacity of 36 beds. Review of the facility's resident census report dated 11/30/21 revealed there was an AL census of 35 residents, which required 16 staff hours on second and third shift. Review of the employee timecards dated 11/30/21 revealed there was a total of 14 staff hours provided on second shift in the AL with a shortage of 2 hours. Review of the employee timecards dated 11/30/21 revealed there was a total of 15 staff hours provided on third shift in the AL with a shortage of 1 hour. Review of the facility's resident census report dated 12/06/21 revealed there was an AL census of 36 residents, which required 16 staff hours on third shift. Review of the employee timecards dated 12/06/21 revealed there was a total of 15 staff hours provided on first shift in the AL with a shortage of 1 hour. Interview with a resident on 12/14/21 at 8:37am revealed: -She used the call bell around her neck to call for staff. -There were times where it took staff 20 minutes to respond to her call bell. -She was hesitant to call for assistance because she knew the facility was short on staff and that a	D 188		

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D 188	Continued From page 6	D 188		

lot of the staff members were working double shifts.
-She sometimes did not call because she was aware that the facility was short staffed, especially in the afternoon and evenings.

Interview with a second resident on 12/14/21 at 8:40am revealed:
-There was a lot of staff turnover at the facility.
-She noticed that the facility was short staffed.
-She felt that the facility was short staffed because of the amount of turnover.

Interview with a third resident on 12/14/21 at 9:37am revealed she was aware that it was a hard time to find staff to work so it put a strain on the staff that were working at the facility.

Interview with a medication aide (MA) on 12/14/21 at
-The facility recently hired additional staff about two weeks ago that has helped with staffing because the facility had an increase in the number of residents.
-First shift was often asked to stay over to help on second shift because there was not enough staff for second shift.

Confidential telephone interview with a previous staff member revealed when the facility was short staffed the Resident Services Coordinator (RSC), Resident Services Director (RSD), and the Administrator were aware of the shortage but would not assist on the floor with resident care.

Interview with the RSC on 12/15/21 at 4:00pm revealed:
-She was responsible for making the schedule for the facility.
-If staff was not able to work a scheduled shift,

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D 188	Continued From page 7 they were to call the facility and let the lead MA on duty know, who then would work on finding coverage. -If the supervisor was not able to find coverage, then she was to be made aware so that she could try and find coverage for the shift. -She would pass medications to the residents on the AL side when she was aware that they were short staffed. -She was aware that there was only one MA for the entire facility on night shift, making them short. -She was aware that the facility was short staffed and that it was mainly for second shift when staff from first shift could not extend or staff from third shift were not able to come in early. Interview with the RSD on 12/16/21 at 3:30pm revealed staff would make her aware that they were short staffed on a shift after the shift when she was not able to do anything about it. Interview with the Administrator on 12/16/21 at 4:00pm revealed resident care staff would make him aware that they were short staffed after the fact but that they never felt it was unsafe.	D 188		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by:	D 270		

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D 270	Continued From page 8 TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision to 2 of 6 sampled residents (#4, #7) in accordance with their current diagnoses, assessed needs, and facility policy resulting in residents (#4, #7) having unwitnessed falls in which they were found on the floor sustaining head injuries and lacerations requiring emergency medical interventions. The findings are: Review of the facility's Falls Reduction Program revealed: -The goal was to create a safe culture and implement fall reduction strategies. -A fall risk assessment was to be completed on all residents to identify individual risks and needs upon admission and at each service plan update: -Score 0-24 = basic resident care and coordination of health services (annual vision/hearing exams, apartment safety check tool, and offer and encourage fitness classes) -Score 25-50 = standard fall prevention interventions (annual vision/hearing exams, medication review, request for physical therapy, apartment safety check tool, offer and encourage fitness classes, and interview and service plan) -Score >50 = high fall risk prevention interventions (fall risk interventions must be reflected in the service plan, annual vision/hearing exams, medication review, request for physical therapy, apartment safety check tool, request for a referral for a neurological and orthopedic exam, evaluation of the need for a bowel/bladder program, scheduled activity participation, offer and encourage fitness classes, and all department notification) -Using daily awareness to observe resident fall	D 270		

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D 270	Continued From page 9 risks to take immediate action to reduce the risk. -Communication with the resident's primary care provider (PCP), family, and facility staff members as needed to reduce falls. -Utilization of health care partners such as home health and physical therapy to assist residents in minimizing their fall risk. -Review of the resident's cause or circumstances surrounding each fall to include resident awareness and understanding of the fall, environmental contributions, or any symptoms the resident may have experienced just before falling. -A physician or physical therapist should evaluate the resident after each fall for contributing factors. -The resident's service plan and fall scale assessment shall be updated after a first fall, after repeat falls, after a fall with injury requiring medical intervention or treatment, or a change in condition. -Implementation of interventions to include but not limited to: reminding residents to use assistive devices, monitor activity in room with a nursery intercom, place a commode at the bedside, install a bell on the bathroom floor, placement of a fall mat, anticipate needs surrounding habits and toileting schedules, assisting the resident to the toilet, reminding the resident to call for assistance, using of a non-slip chair cushion, have a wheelchair assessment done by physical or occupational therapy, install anti-tips on wheelchairs, place resident in view of staff, place resident in bed when fatigued, implement a toileting schedule, ensure call lights are within reach and encourage use of call lights, obtain a medical evaluation for a urinary tract infection (UTI), systematically assess toileting needs to prevent further falls, and obtain an assessment and treatment plan from the PCP. -All staff members would receive training upon hire and annually thereafter.	D 270		

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D 270	Continued From page 10 1. Review of Resident #4's current FL-2 dated 12/03/21 revealed: -Diagnoses of dementia, Alzheimer's disease, atrial fibrillation, coronary artery disease, cardiac pacemaker, and gastrointestinal reflux disease (GERD). -He was intermittently disoriented, semi-ambulatory with a walker, and had impulsive behaviors. -He had limitations in his sight and hearing. Review of Resident #4's previous FL-2 dated 11/23/21 revealed: -Diagnoses of dementia, Alzheimer's disease, atrial fibrillation, coronary artery disease, cardiac pacemaker, and gastrointestinal reflux disease (GERD). -He was intermittently disoriented, semi-ambulatory with a walker, and had impulsive behaviors. -He had limitations in his sight and hearing. Review of Resident #4's Resident Register dated 11/23/21 revealed: -He was admitted to the facility on 11/29/21. -He required assistance with getting in and out of bed, bathing, dressing, ambulation (walking), and orientation to time and place. Review of Resident #4's Physician Documents Packet of Medical History dated 11/23/21 revealed he was blind in his left eye. Review of Resident #4's current assessment and care plan dated 12/06/21 revealed: -The resident had wandering behaviors, was always disoriented, and had significant memory loss requiring direction. -He had limited strength in his upper extremities.	D 270		

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D 270	Continued From page 11	D 270		

-He required extensive assistance with ambulation and needed someone to push his wheelchair for him.
-He required extensive assistance with transferring, dressing, and bathing, and total assistance with bathing and grooming requiring hands on assistance with all associated tasks.

Review of Resident #4's hospice nurse assessment dated 11/30/21 revealed:
-The resident was assessed for safety concerns and the assessment was communicated with the Special Care Coordinator (SCC) and the Resident Service Director (RSD).
-There was an order for a medical grade wheelchair, chair alarm, hospital bed, scoop mattress, and bed alarm.

Review of Resident #4's Hospice Coordinated Task assessment dated 12/01/21 revealed:
-The resident was to see the hospice aide on Mondays, Wednesdays, and Fridays beginning 11/29/21.
-The resident was to see the hospice nurse on Tuesdays beginning 11/30/21.
-There was an order on 11/30/21 with facility notification to obtain a hospital bed with a scoop mattress, a medical grade wheelchair, and a bed and chair alarm.

Review of Resident #4's Health, Safety, and Environment (HSE) assessment dated 11/30/21 revealed:
-The resident had severe impairment of orientation requiring repeated verbal prompts or direction and difficulty following directions.
-The resident required extensive assistance with transferring, mobility and ambulation (walking) requiring hands on staff maneuvering of limbs and other non-weight bearing assistance.

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D 270	Continued From page 12	D 270		

-The resident required extensive assistance with dressing and toileting requiring hands on assistance from staff.

Review of Resident #4's Morse Fall Scale Results dated 12/01/21 revealed:
-He totaled a score of 90 out of 150 with factors that may contribute to falls including a history of falling, secondary diagnoses, use of ambulatory aids, impaired gait, and being forgetful of limitations.
-A score of 90 placed the resident in a high fall risk category recommending high fall risk prevention interventions be implemented.

Review of Resident #4's progress notes revealed:
-On 11/29/21 at 5:23pm, it was documented that the resident was admitted to the facility's special care unit requiring assistance with all activities of daily living (ADLs) and needing cueing, reminders, and direction at all times.
-On 11/30/21 at 10:55am, it was documented that the resident required a lot of verbal ques and reassurance overnight with several instances of having to be redirected back to his bed.
-On 11/30/21 at 11:28pm, it was documented that the resident had a fall from his wheelchair, and he was observed lying in the hallway where he hit his head and had a large laceration to his scalp. He was sent via emergency medical services (EMS) to the hospital and his family and hospice provider were notified.

Review of an Incident and Accident Report dated 11/30/21 at 10:15pm revealed:
-The resident was observed lying in the floor outside of another resident's room with his wheelchair next to him.
-He suffered a large laceration to his scalp with bleeding that required repair and 911 was called.

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CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13 -Assistance and first aid were provided to the resident while awaiting EMS arrival, no vital signs were obtained. -The resident's responsible party was notified via phone call on 11/30/21 at 11:00pm. -The hospice nurse was to manage the wound care for the resident's sutures (stitches) and a 24/7 sitter was to be put in place after the fall. Review of Resident #4's EMS records dated 11/30/21 revealed: -It was reported by the facility that resident fell from his wheelchair hitting the door frame, but they were unsure what the resident was doing at the time he fell. -Upon EMS arrival, the resident was lying on his back in the hallway of the SCU stating his left eye hurt. -There was an approximately 8-inch skull avulsion (severe skull injury in which a body structure was torn off) reaching from the left eye, across the top of his head, and down to his left ear. -Facility staff had folded the skin back across the scalp and bandaged it. -A c-collar (immobilizing neck brace) was applied to the resident's neck and then he was secured to a stretcher where he was transported to the emergency room (ER). Review of Resident #4's ER records dated 11/30/21-12/01/21 revealed: -He was assessed for a fall from a non-moving wheelchair resulting in scalp and facial lacerations and a closed head injury (strong blow to brain that could cause bruising, swelling or bleeding around the brain). -There was trauma to the skin, subcutaneous tissue (lower layers of skin tissue), and the breast.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14 -There was a traumatic full thickness 16 cm (6.3 inch) scalp laceration with rolled and unattached edges that reached from the left eyelid/nose across the forehead and continued toward the middle top of the head with bruising and swelling. -There was another 6 cm (2.3 inch) laceration to the back of the scalp. -Both lacerations required repair with sutures. -He had left supraorbital (around the eye) tissue swelling with a laceration. -The resident was to follow up with an ear, nose, and throat (ENT) specialist within one week. Review of event notes provided by Resident #4's family via email on 12/16/21 revealed: -Resident #4 was admitted to the facility on 11/29/21 at 11:45am in time to eat lunch. -After hearing an unknown raised voice in the resident's room on 11/29/21, the family requested to move the resident to a private room. -At 5:00pm on 11/29/21, the family moved the resident's belongings to a private room. -The resident received frequent visitors throughout the day on 11/30/21 and seemed to be adjusting well to his new surroundings. -The family received a phone call just before 11:00pm on 11/30/21 that the resident had fallen and was being transported to the hospital, but no other details were available. -The resident received a significant but unknown amount of stitches while at the hospital after the fall. -The resident was transported back to the facility on the morning on 12/01/21 and the family went to visit him. -An employee who had been on duty during Resident #4's fall on 11/30/21 came to the resident's room while the family was visiting on 12/01/21 and stated that the resident did not want to go to bed and wanted to move his	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 15	D 270		

wheelchair up and down the hall with his feet prior to falling.
-This did not make sense to the family because the resident was unable to move himself with his feet in his wheelchair and he should have been in bed during the time of the accident.
-The family was told by the facility on 12/01/21 to hire a 24/7 sitter for the resident.
-The family was told by the facility staff that the facility was unable to provide the care that the resident needed and that on the night of his fall (11/30/21) because the facility was understaffed and that was why the resident had been out in the hall; there were only two staff members to place 30 residents to bed that night (11/30/21).
-The family was told by the facility on 12/01/21 that the resident's wheelchair may have contributed to his fall even though they were told the previous day (11/30/21) that his wheelchair was sufficient for his needs.
-The family questioned on 12/01/21 why the facility agreed to admit the resident if they could not provide him the care he needed because the facility had assessed him in his home prior to admittance and had been made aware of his fall risk and history of previous falls requiring supervision.
-On 12/03/21, a staff member told the family the resident had not been wandering the halls and propelling himself in his wheelchair as previously stated the night of the fall.
-The employees had left the resident in the hall the night of 11/30/21 because they were trying to put other residents to bed (bedtime was 9:00pm) but they were short staffed and unable to complete the task as needed.

Review of Resident #4's hospice nurse assessment dated 12/01/21 at 11:59am revealed:
-He was seen status post fall with a large scalp

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 16 wound that had been sutured in the ER. -She provided the resident with a medical grade wheelchair, physical assessment, and ordered wound care and Tylenol 650mg for pain control. -The resident appeared fatigued and weaker than before and was encouraged to lie down and rest with the head of bed elevated. Review of Resident #4's hospice nurse assessment dated 12/06/21 at 11:35am revealed: -He was seen for a scalp wound re-evaluation, physical assessment, vital signs, and care collaboration with the facility. -It was noted that his scalp sutures were dry and intact. -There was an order for the resident to receive Ativan (frequently used for anxiety) as needed for restless agitation that was not relieved with repositioning, fluids, and incontinence care. Review of Resident #4's record revealed: -There was no documentation of a fall risk assessment performed on the resident upon admission per facility policy. -Thre was no documentation for a plan to have increased supervision for the resident despite his fall history and risk of falls. -There was no documentation of any fall prevention interventions per facility policy in place upon admission or prior to his fall on 11/30/21. -There were no physical therapy/occupational therapy (PT/OT) services documented as being requested per facility policy. -There was no documentation of a request for a PCP visit to assess for fall causes and future prevention. -There was no documentation of department wide notification of the resident's fall risk or supervision needs being communicated to the staff per facility policy.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 17 Interview with Resident #4's hospice nurse on 12/15/21 at 4:34pm revealed: -She was very familiar with Resident #4 as she had cared for him the last six months, even prior to him being admitted to the facilty from home and she saw him weekly. -Upon admission to the facility, Resident #4 required fall supervision and assistance in getting up, ambulation with a walker, and transfers. -Resident #4 would try to get up independently and spontaneously because he had cognitive deficits from his dementia and was unable to understand and retain directions to call for help. -She assessed Resident #4 on the morning of 11/30/21 before his fall while he sat in his wheelchair in his room and she explained to the medication aide (MA), Special Care Director (SCD), and Resident Service Director (RSD) that he required safety interventions with increased supervision and transfer assistance due to his fall risk and history; she also suggested the facility obtain a medical grade wheelchair for the resident because the transport wheelchair the resident had been using was lightweight and not sturdy or meant for long-term use. -Resident #4 should have been directly supervised during the time of his fall on 11/30/21 because it would have been very unusual for the resident to independently propel himself in his wheelchair and he should not have been unattended due to his nature of impulsive behaviors to get up on his own. -Since Resident #4's fall, he had been transferred home on 12/10/21 and seemed to be less active and weaker requiring wheelchair use all of the time; prior to the fall he used a walker to ambulate. Telephone interview with Resident #4's family	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 18	D 270		

member on 12/15/21 at 8:50am revealed:
-Resident #4 was admitted on 11/29/21 at 12:00pm and fell the next day on 11/30/21 between 10:00pm and 11:00pm.
-Upon admission to the facility, she discussed Resident #4's history of minor falls at home and the need for him to be supervised and assisted to prevent falling with the RSD; the facility promised the resident would get 24/7 supervision and that interventions would be in place to prevent him from falling.
-She was told he turned over in his wheelchair in the hallway on 11/30/21 because he was wandering which did not make sense because the resident did not have a history of wandering.
-She was later told by the previous Special Care Director (SCD) after Resident #4's fall that the facility was understaffed on the night of his fall, 11/30/21, and was unable to provide the resident the care and supervision he required.
-Resident #4 was not in bed on the night of the fall on 11/30/21 due to only having two staff members on that shift to care for 31 residents who were unable to provide him the care he required and put him to bed before the fall.
-Upon admission, she questioned if the transport wheelchair that did not have anti-tip brackets Resident #4 was using would be safe after the facility removed the footrests from it, but the Resident Care Director told her it was fine.
-After the fall on 11/30/21, she was told by the facility that if he had a medical grade wheelchair at the time of the fall, Resident #4 would not have been able to tip the wheelchair and may not have fallen.
-She was not sure how long Resident #4 laid in the hallway before being found but there was a lot of blood and she thought the resident received over 100 stitches to his head.
-The facility requested that she provide a 24/7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19	D 270		

sitter for increased supervision of Resident #4 after the fall.
-Once the sitter was in place, the staff rarely came into the room to check on Resident #4.
-Prior to the fall, Resident #4 walked with a walker, but since the fall, he required two people to assist him in transferring to a wheelchair push him around.

Telephone interview with Resident #4's second family member on 12/15/21 at 2:05pm revealed:
-Resident #4 had a history of several minor falls without injury prior to his admission to the facility, he had fallen on the morning of his admission, 11/29/21, and they had made the facility aware of his fall risk prior to his admission.
-The family decided to admit him to the facility because they felt like Resident #4 needed increased supervision and assistance with care and activities of daily living that they could no longer provide for him at home.
-The facility promised Resident #4's family that they would provide the resident with frequent interaction, and the staff would provide the care and supervision he required.
-A bed and chair alarm were supposed to be in place as fall prevention measures for Resident #4 upon admission.
-The facility told the family that the transport wheelchair Resident #4 had in place at the time of admission was sufficient and had never made the family aware that his wheelchair was not supportive enough or that he needed a medical grade wheelchair until after the fall on 12/01/21.
-Resident #4 should have been in bed at the time he fell on 11/30/21, but he was still in the same clothes he had worn earlier that day when they saw him at the hospital after the fall.
-They were told by staff at the facility that there were only 2 employees staffing on the night of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20	D 270		

Resident #4's fall on 11/30/21, in which they placed the resident in the hall to try and keep a closer eye on him, but they were unable to supervise the resident in the hall and care for the other residents at the same time.
-Prior to being admitted to the facility, Resident #4 walked independently with a walker with intermittent assistance; after the fall on 11/30/21 at the facility, the resident was unable to walk and required assistance in and out of his wheelchair.

Interview with a personal care aide (PCA) on 12/15/21 at 3:55pm revealed:
-She was sent from the assisted living (AL) unit to the special care unit (SCU) on 11/30/21 at 9:00pm to assist with staffing on the SCU because there was only one other staff member on the SCU for 2nd shift at that time until 11:00pm.
-There should have been at least four staff members present on the 2nd shift on SCU on 11/30/21.
-The SCU unit was short staffed 2-3 times per week on 2nd shift making it difficult to care for residents and supervise them according their needs.
-She worked the SCU the evening of 11/30/21 and there were only two staff members present that shift, she was unable to supervise Resident #4 as he needed and prevent him from falling.
-Resident #4 had been in his wheelchair parked in the hallway that evening, 11/30/21, around 10:30pm; he kept leaning and he was not falling asleep when she saw him, but she was worried he might fall.
-She tried to check on Resident #4 every 20-30 minutes that night to reposition him because he continued to lean but she was also providing resident care to other residents.
-She did not witness Resident #4's fall on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21	D 270		

night of 11/30/21, but she did hear him fall when she was caring for another resident in another room; the fall sounded very loud.
-She responded to Resident #4 when he fell where she found him on the floor in the hallway in a pool of blood after hitting his head; she did not touch or move him.
-When she saw that Resident #4 had fallen on 11/30/21, she called for the MA who was on a break and had left the SCU unit and was on the AL unit.
-She also called a supervisor from AL to come help while she called 911.
-During Resident #4's fall on 11/30/21, she had been alone on the SCU without any other staff members for approximately 5-10 minutes while the MA went to the AL unit.

Interview with a MA on 12/15/21 at 10:03am:
-Resident #4 required assistance with walking and toileting upon admission.
-Some days were understaffed which caused several residents on SCU to go overlooked and not receive the care they needed; staff had to prioritize care based on what was immediately needed at that moment.
-He arrived for his shift on 11/30/21 after Resident #4's fall at 11:00pm.
-The previous shift on 11/30/21 from 3:00pm to 11:00pm was understaffed upon his arrival which would have made it difficult to supervise and care for residents according to their needs.

Interview with a second MA on 12/15/21 at 11:42am revealed:
-She was working on the SCU on 11/30/21 from 3:00pm to 11:00pm when Resident #4 fell.
-The SCU was understaffed on 11/30/21 during her shift; there should have been 2 MAs and 3-4 PCAs present to care for all the residents that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22	D 270		

were on SCU that evening.
-She was the only scheduled staff member for SCU that showed up for her shift on 11/30/21, so a PCA from the AL side came to help her on SCU totaling 2 staff members to care for the 31 residents present on SCU that evening.
-She knew Resident #4 required increased supervision because another MA had notified her that he was a high fall risk, but there was no specific supervision plan in place or communicated to the staff to prevent him from injuring himself.
-It was difficult to provide care and administer all resident medications that night due to short staffing, but she tried to help with resident care in between administering medications.
-It was difficult to supervise Resident #4 on 11/30/21 as appropriate due to being short staffed and trying to care for other residents; there was another resident that night experiencing wandering and destructive behaviors that the staff were trying to supervise and deal with.
-When Resident #4 fell on 11/30/21, she had been off the unit to take something to her car leaving one PCA on the SCU alone with all the residents.
-When she left the unit to go to her car, Resident #4 had been parked in the hallway in his wheelchair with 4 other residents who had not been put to bed yet due to being short staffed.
-When she returned to the unit, Resident #4 had fallen and was lying in a pool of blood on the floor; he had probably been lying there for 5-10 minutes at that point.
-Upon seeing Resident #4 on the floor, she sat him up, his skin from his head was hanging in front of his face, and she had to push the skin back up then wrapped his head with a towel and laid him back down on the floor.
-She had the PCA call for help to include 911

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 23	D 270		

along with the Resident Service Coordinator (RSC) and RSD.
-The RSD and the Administrator arrived at the facility at the same time as the ambulance arrived at the facility.
-She was told that evening, 11/30/21, by the RSC that she was not short staffed on that night.

Telephone interview with a former third MA on 12/16/21 at 10:43am revealed:
-He had worked at the facility for 4 years but quit his job on 11/29/21, the day before Resident #4 fell.
-During the 4 years he worked at the facility, the SCU had always been understaffed on 2nd and 3rd shifts making it difficult to care for and supervise residents according to their needs.
-Resident falls that happened on the SCU were often related to being understaffed and being unable to supervise resident as needed.
-SCU staff were expected to perform safety rounds on residents every two hours but they were routinely unable to do so on 2nd shift due to short staffing.
-There was no specific instructions regarding a safety and supervision plan communicated to him on the day Resident #4 was admitted to the facility to keep him safe.

Interview with the SCC on 12/15/21 at 3:25pm revealed:
-She was told that Resident #4 was a high fall risk and required activity of daily living (ADL) and toileting assistance upon admission.
-Resident #4's wheelchair that was in use at the time of his fall on 11/30/21 was a factor to his fall because it was very lightweight and not sturdy as he was a big man.
-She expected all high fall risk residents on the SCU to be supervised with safety checks and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24	D 270		

incontinence care every 1-2 hours, but safety and supervision rounds were not documented anywhere within the facility, she did not know why.
-It was the facility's policy to call 911 and send the resident to the hospital for evaluation if they hit their head and to report all falls to the resident's primary care provider (PCP); all staff were trained to do this upon hire.
-The facility had been down in staffing recently but that had begun to improve within the last two weeks.

Telephone interview with the previous SCD on 12/15/21 at 1:36pm revealed:
-On the night of 11/30/21, the SCU only had 1 PCA and 1 MA providing resident care in the SCU; there should have been 2 PCAs and 2 MAs according to the residents' needs.
-Upon admission, the family had made the facility aware that Resident #4 was a high fall risk, but no fall reduction interventions had been put in place because she was waiting on management approval to implement them.
-She had requested that general fall prevention interventions be put in place prior to Resident #4's fall from the Resident Service Director (RSD) such as a fall mat, low bed, and bed alarm, but they were never approved.
-There were no fall prevention interventions or increased supervision implemented for Resident #4 upon his admission, she did not know why.
-Resident #4 had a foldable travel wheelchair upon his admission to the facility.
-The hospice provider ordered the resident with a medical grade wheelchair, but it had not come in yet.
-After Resident #4's fall, she met with the resident's family members and suggested a 24/7 sitter to prevent further falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25 -After suggesting a sitter to Resident #4's family, she had been reprimanded by the RSD and the Administrator for suggesting that intervention, she did not know why. Interview with the RSC on 12/16/21 at 1:44pm revealed: -Resident #4 did not have a medical grade wheelchair upon admission because it had not come in yet. -Resident #4 had not received PT services because he was a hospice patient. -She left the facility on 11/30/21 around 6:00pm; prior to leaving, the MA on the SCU reported to her that she was the only employee for the 3:00pm to 11:00pm shift, so she instructed PCA from the AL to go to the SCU to assist with the staffing shortage. -She was notified on 11/30/21 around 10:00pm that Resident #4 had fallen and had sustained injuries. -She was unaware that the MA on the night of Resident #4's fall had left the unit leaving the PCA alone with all of the residents on SCU during the fall. -She expected staff to call someone from AL unit to come assist with supervision and care of residents on SCU if a staff member needed to leave the unit at any time. -If a staff member from AL was unable to come to the SCU to assist while another staff member left the unit, the SCU staff should have called her, the RSD, or the Administrator to come assist instead of leaving the PCA alone. -One staff member on SCU was unable to safely supervise and care for all 31 residents on SCU. -On the night of Resident #4's fall, all residents were normally in bed by 10:00pm, but were not all residents were in bed yet that night, 11/30/21, due to the short staffing on the SCU.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 26 Interview with the RSD on 12/14/21 at 4:03pm revealed: -Resident #4 stayed at the facility for a total of 8 days. -On his second day at the facility, 11/30/21, he tipped his wheelchair, rolled sideways, and hit his scalp on a door hinge in the SCU hallway. -The resident sustained a large laceration to the head that had profuse bleeding and was sent to the ER for treatment and stitches. -The family hired a 24/7 sitter after the accident, then pulled him out of the facility on 12/10/21 and took him back home. Second interview with the RSD on 12/16/21 at 2:41pm revealed: -She was unaware that there was only one staff member on the SCU the night that Resident #4 fell on 11/30/21. -It was concerning that only one scheduled person showed up to work that shift on that night (11/30/21), and that was not enough staff to care for all the residents on the SCU. -She was aware the facility had short staffing issues mostly on second shift (3:00pm-11:00pm), but she was not aware the staffing deficit was creating a safety issue for residents. -Short staffing had contributed to the staff's ability to supervise residents according to their needs and may have contributed to Resident #4's fall on 11/30/21. -If staff needed help on any shift, she expected them to ask each other, the supervisor in charge, or call her, the Administrator, or the RSC to come help them so they could provide safe care as needed; she was not sure why this process had not been followed. -She arrived at the facility on 11/30/21 after Resident #4 fell because the staff called her for	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27	D 270		

help.
-She was not aware that the unit was inadequately staffed on 11/30/21 from 3:00pm-11:00pm until she arrived on the unit sometime between 9:30pm and 10:30pm.
-If she had known that the SCU was short from 3:00pm-11:00pm on 11/30/201, she would have found someone to come in and help them or stayed and helped them herself.
-Emergency Medical Services (EMS) was already at the facility upon her arrival providing treatment to Resident #4 after his fall.
-Not having a medical grade wheelchair contributed to Resident #4's fall because it was safer, and he should have had the medical grade wheelchair upon admission to the facility.
-If Resident #4 had been in bed at the normal time (between 9:00pm and 10:00pm), he may not have fallen.
-There was not a chair alarm in place for Resident #4 at the time of his fall on 11/30/21, she was not sure why.
-The fall risk assessment and fall interventions were not in place upon Resident #4's admission per facility policy assessed needs because she was overwhelmed with other tasks and had not gotten to it yet.
-There was no increased supervision expectation communicated to staff upon Resident #4's admission, she did not know why except that she had not gotten to it yet.

Interview with the Administrator on 12/16/21 at 3:34pm revealed:
-He was not aware that Resident #4 did not have a medical grade wheelchair in place upon his admission on 11/29/21.
-He expected residents to have all durable medical equipment such as a hospital grade wheelchair in place prior to or upon admission to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 28	D 270		

the facility.
-If Resident #4 had a hospital grade wheelchair in place, it would have been sturdier and provided more support for the resident.
-He expected residents with a high fall risk to receive safety checks every two hours for supervision.
-He expected fall prevention interventions to be in place for residents with a high fall risk per facility policy and according to the resident's assessed needs.
-He expected the PCP to be made aware of every fall a resident sustained.
-He was not aware that there was only one staff member was scheduled showed up for work on the SCU on 11/30/21 from 3:00pm-11:00pm to care for the 31 residents present.
-The facility was frequently short staffed on the SCU from 7:00pm-11:00pm.
-He expected staff to call for help if they were short staff and unable to provide care as expected due to staffing shortages.
-He received a phone call on 11/30/21 after Resident #4 fell and arrived on the unit shortly thereafter.
-EMS was onsite at the facility when he arrived on 11/30/21 treating Resident #4 who had a skin tear to his right forearm and a head laceration.
-Upon his arrival, there were 3 residents still awake and not in bed.
-There should have been more than one staff member on the unit to provide care and supervise residents in the SCU on 11/30/21; one person cannot supervise and care for 31 residents.
-He was not sure why fall risk interventions and increased supervision had not been implemented for Resident #4 upon admission according to facility policy and his assessed needs.

Telephone interview with Resident #4's Primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 29	D 270		

Care Provider (PCP) on 12/16/21 at 1:00pm revealed:
-She had not yet seen or evaluated Resident #4 upon his admission prior to his fall on 11/30/21 or by his discharge on 12/10/21.
-She was not notified of Resident #4's fall until she requested a time to see him as a new resident but would have followed up with him immediately after to evaluate him and order additional fall prevention interventions if she had been notified.
-She expected Resident #4 to have a medical grade wheelchair at the facility upon admission and that should have been easy for the facility to obtain.
-She expected Resident #4 to have increased supervision, hourly safety rounding, and an order for weekly physical therapy (PT) upon admission due to his high fall risk assessment.

Refer to telephone interview with the previous SCD on 12/15/21 at 1:36pm.

Refer to interview with the RSC on 12/16/21 at 1:44pm.

Refer to interview with the RSD on 12/16/21 at 2:41pm.

Refer to interview with the Administrator on 12/16/21 at 3:34pm.

2. Review of Resident #7's current FL-2 dated 09/27/21 revealed:
-Diagnoses of Alzheimer's disease, neuropathy, transient ischemic attack, and urinary incontinence.
-She was intermittently disoriented and semi-ambulatory.
-She was incontinent of bladder and bowel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 30	D 270		

Review of Resident #7's Resident Register dated 09/28/21 revealed:
-There was no admission date for the resident documented.
-She had significant memory loss and required direction.
-She required assistance with toileting, bathing, getting in and out of bed, and ambulation (walking).

Review of Resident #7's progress notes dated 10/04/21 revealed she was admitted to the facility on that day, 10/04/21.

Review of Resident #7's current assessment and care plan dated 11/12/21 revealed:
-She had wandering behaviors.
-She required limited assistance with a walker to ambulate but needed reminders to use her walker.
-She was sometimes disoriented and had significant memory loss requiring direction.
-She required extensive assistance with toileting and bathing and needed hands on assistance with all tasks and incontinence care.

Review of Resident #7's Morse Fall Scale Results dated 10/04/21 revealed:
-She scored a 55 out of 150 with factors that may contribute to falls including secondary diagnoses, use of a walker to ambulate, having a weak gait, and forgetfulness of her limitations.
-A fall score of 55 placed the resident at high risk of falling and implementation of high fall risk prevention interventions were recommended.

Review of Resident #7's Service Plan dated 11/10/21 revealed:
-The resident was independent with mobility but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 31	D 270		

may require hands on assistance in addition to the use of her walker.
-The resident required moderate physical assistance with transferring, dressing, and grooming.
-The resident required extensive physical assistance with bathing and toileting tasks.
-The resident required a secure environment with door alarms, wander guards, and frequent checks by the facility staff.
-The resident may require escorts, prompts, and cues to use her assistive device.
-The resident had a moderate potential for falls and would require safety awareness, clear pathways, and reminders to use her walker.
-Any changes in the resident's condition were to be reported to her primary care provider (PCP).
-The resident had moderate impairment of orientation and required supervision and oversight for safety.

Review of Resident #7's Licensed Health Professional Support (LHPS) report dated 10/28/21 revealed the resident had a fall without injury on 10/02/21; two days prior to her admission.

Review of Resident #7's progress notes dated 10/12/21 revealed the resident was getting up to go to the bathroom and fell to the floor with no injury.

Review of Resident #7's primary care provider (PCP) visit note dated 10/26/21 revealed:
-The resident was seen to establish care and assessment as a new patient.
-There was documentation the resident had occasional episodes of aggressive behaviors and refusals to take medications, but there was no documentation that the provider was made aware

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 32	D 270		

of any history of falls.
-There was an order to provide a safe and secure environment for the resident and to report any behavior or wandering issues.

Review of Resident #7's progress notes dated 10/27/21 revealed:
-The resident was found on the floor lying flat on her back.
-She had a laceration to her right ear and stated she was coming out of the bathroom when she lost her balance and fell.
-She did not have her walker near her.
-The resident's PCP and family were notified, and she was to be sent to the emergency room (ER) via ambulance.

Review of Resident #7's Incident and Accident report dated 10/27/21 at 1:15pm revealed:
-The resident stated she was coming out of the bathroom when she lost her balance and fell to the floor.
-The resident hit her ear and split it open.
-The resident's walker was not with her and was on the other side of the room.
-The resident's PCP was notified of the fall.
-Emergency Medical Services (EMS) was called and she was sent to the ER for a right ear laceration.
-The resident was placed on alert charting for frequent checks on 10/28/21 at 10:40am.
-The resident was referred for unknown therapies on 10/28/21 at 10:41am.
-The resident's safety of environment was reviewed (obstacles removed from path) on 10/27/21 at 1:41pm.

Review of Resident #7's ER records dated 10/27/21 revealed:
-She was seen for a fall on the way from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 33	D 270		

bathroom that resulted in a complex right ear laceration requiring repair with stitches and a follow up with an ear, nose, and throat (ENT) specialist in six days.
-During the ear laceration repair, it was noted that the laceration penetrated through the ear cartilage.
-The resident had bruising around the area that was dressed in a pressure bandage after stitches were used to repair the area.

Review of Resident #7's progress notes dated 11/15/21 revealed:
-The resident was found on the floor in the bathroom on her buttocks stating she lost her balance.
-There were no observed injuries noted at that time.
-The resident's family and PCP were notified of the fall.

Review of Resident #7's PCP visit note dated 11/15/21 revealed:
-The facility had reported that the resident fell in the shower.
-Upon assessing the resident, she did not remember the event.
-A physical assessment was performed on the resident, but the resident was not able to communicate effectively due to cognitive impairment making reliable sources of information limited.
-The resident and facility staff were educated on fall prevention strategies and there was an order to provide the resident with a safe and secure environment.

Review of Resident #7's progress notes dated 11/25/21 revealed:
-The resident was found at her bedside sitting on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 34	D 270		

the floor stating she lost her balance.
-There were no observed injuries notes at that time.
-Her vital signs were obtained, and her family and PCP were notified of the fall.

Review of Resident #7's Incident and Accident report dated 11/25/21 at 8:00am revealed:
-The resident stated she was getting out of bed and lost her balance.
-There were no obvious injuries or wounds.
-The resident was referred for therapy on 12/07/21 at 10:57am.
-The resident's safety of environment was reviewed (obstacles removed from path and staff educated) on 11/25/21 at 10:57am.

Review of Resident #7's PCP visit note dated 11/29/21 revealed:
-The resident was seen for hypertension, Alzheimer's disease, fall, gait instability and PT/OT orders.
-It was reported that the resident had an unwitnessed fall on 11/25/21 and a physical assessment was performed on the resident, but the resident was not able to communicate effectively due to cognitive impairment making reliable sources of information limited.
-The resident and staff were educated on fall prevention strategies with instructions to ensure the resident always used her walker.
-There was an order for PT/OT services and to provide the resident with a safe and secure environment.

Review of Resident #7's Incident and Accident report dated 11/29/21 at 4:30pm revealed:
-The resident was observed on the floor in her bedroom and stated that she was taking a bath and fell.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 35	D 270		

-She had a small skin tear on her left elbow and a small knot on the right side of her forehead.
-The staff placed a cool cloth on her forehead and cleaned and dressed her skin tear.
-The resident's family was notified and told staff to watch for any changes.
-911 was to be called and the family would meet the resident at the hospital.
-The resident was referred for unknown therapies on 12/07/21 at 11:01am.
-The resident's safety of environment was reviewed (obstacles removed from path and staff educated) on 11/29/21 at 7:01pm.

Review of a text message on the Special Care Coordinator's (SCC) phone from Resident #7's family member revealed:
-She had been notified of Resident #7's fall on 11/29/21 and came to see her at the facility.
-Upon arrival to the facility, she approved the facility to not call EMS or have the resident sent to the ER.

Review of Resident #7's family member's typed notes with the SCC's handwritten notes dated 12/01/21 revealed:
-The family member met with the SCC and provided written documentation of her concerns about the resident's falls at the facility on 12/01/21.
-She requested a health assessment of the resident; the SCC's handwritten note notated that the resident was a fall risk and she would request an order.
-The family notated that the resident had fallen four times since her admission on 10/04/21 to include: 10/27/21 in which she required stitches in the ER, 11/15/21 with no injury, 11/25/21 in which she sustained a huge bruise on her right lower back and the family member was only notified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 36	D 270		

when she picked the resident up to take her home for the Thanksgiving holiday, and lastly on 11/29/21 in which she sustained a bump on her forehead and a skin tear on her elbow while trying to take a shower.
-The family member requested a plan for safety in the resident's movement around the bathroom and bedroom to include a bed alarm, furniture cushions, toileting schedule and assistance, an order for physical therapy (PT), addressing incontinence and hygiene, periodic testing for urinary tract infections, and a plan to be routinely updated on Resident #7's needs and condition; the SCC's handwritten notes notated she would request an order and discuss interventions with the Resident Service Director (RSD).

Review of a communication log dated 12/02/21 revealed a urinary analysis was obtained on Resident #7 to rule out a urinary tract infection (UTI) which may cause the resident to be off balance.

Review of a physician's order for Resident #7 dated 12/03/21 revealed and order for daily blood pressure checks and a monthly urinalysis.

Review of Resident #7's December 2021 electronic medication administration record (eMAR) revealed the resident began receiving daily blood pressure checks on 12/07/21.

Review of a communication log dated 12/06/21 revealed a bed alarm and furniture cushioning was brought in by the daughter for fall prevention measures.

Review of Resident #7's progress notes dated 12/06/21 revealed that a family member brought the resident a bed alarm for fall prevention, but it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 37 was not working properly. Review of Resident #7's physical therapy visit note report dated 12/07/21 revealed: -The resident was seen and assessed for an initial admission visit to physical therapy from a referral that had been received on 12/06/21. -The resident had a history of 2 or more falls with injury in the last 12 months. -The resident had 2 or more hospitalizations within that last 6 months. -The resident had 2 or more ER visits within that last 6 months. -The resident had a decline in mental, emotional, or behavioral status within that last 3 months. -She required considerable assistance in routine situations, was not alert and oriented, and was unable to shift attention and recall directions more than half the time. -She required consistent reminders and cues due to being easily distracted. -She had memory deficits with failure to recognize familiar persons/places, inability to recall events within that last 24 hours, and significant memory loss that required supervision. -She had impaired decision making with the inability to perform ADLs, inability to appropriately stop activities, and jeopardized her safety through actions. -She had bruising on the lower side of her back and around her nose. -The resident was identified as being at risk of falls and required a safety plan. -She had decreased strength and was unable to safely transfer, ambulate, or perform ADLs independently. -She had noted deficits in function, mobility, strength, reaction time, balance, gait technique, and safety that could contribute to falls. -The focus of her physical therapy would be fall	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 38	D 270		

prevention, gait training, and activity tolerance.

Review of Resident #7's record revealed:
-The resident sustained five falls, two with injuries, from 10/04/21-11/29/21 and there were no documented fall prevention interventions put into place by the facility until 12/06/21 when a family member requested a meeting with the facility to discuss the falls and to implement fall prevention interventions.
-There was no documentation of increased supervision or a toileting schedule per facility policy and Resident #7's assessed needs.

Interview with a personal care aide (PCA) on 12/16/21 at 11:10am revealed:
-She helped assist Resident #7 on 11/29/21 after a fall where the resident was found in the bathroom floor and stated she was trying to "take a bath".
-Resident #7 required assistance with toileting and bathing and she had not gotten to her soon enough.
-Short staffing was an issue on SCU and contributed to resident falls because it prohibited the staff from being able to complete safety rounds and assist residents as needed.
-There had been nothing communicated with her regarding Resident #7 needing increased supervision; she tried to check on residents every 2 hours.

Interview with a medication aide (MA) on 12/16/21 at 10:43am revealed:
-He had worked at the facility for 4 years but had quit his job on 11/29/21.
-During the 4 years he worked at the facility, the SCU had always been understaffed on 2nd and 3rd shifts and there were only 2 staff members on 2nd shift from August 2021 to 11/29/21 at least

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 39	D 270		

twice weekly.
-Resident falls that happened on SCU were often related to being understaffed and being unable to supervise residents as needed.
-SCU staff were expected to perform safety rounds on residents every two hours but they were routinely unable to do so on 2nd shift due to short staffing.
-Resident #7 required increased supervision to be frequently reminded to use her walker.
-He was not present for Resident #7's fall on 10/12/21.
-He was working on 10/27/21 when Resident #7 fell; the resident had just gone back to her room after lunch when a PCA notified him the resident had fallen, he provided first aid to her and called 911.
-There were no fall interventions put into place after Resident #7's fall on 10/27/21, he did not know why, but he felt the resident needed more assistance because she was a high fall risk who required frequent redirection and supervision.
-The facility did not increase safety checks for Resident #7, move her room closer to the staff desk, or try to keep her in her common areas for closer monitoring, as he thought they should have, he did not know why.
-He was working on 11/15/21 when Resident #7 tried to go to the bathroom by herself; she had been educated to call for help to go to the bathroom, but she was unable to remember to follow instructions, and she fell.
-The PCA should have assisted Resident #7 to the bathroom on 11/15/21 during the every 2-hour safety checks, but he was unsure if this was done that day because the facility did not document safety checks anywhere, he did not know why; the fall happened between 10:30am and 11:30am when the PCAs usually took their breaks.
-He was working on 11/25/21 when Resident #7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 40	D 270		

was getting ready for breakfast while he was administering medications to the other SCU residents; the staff went to get Resident #7 for breakfast and found her on the floor after she had tried to independently get out of bed.
-There were only three staff working on 11/25/21 instead of four staff when Resident #7 fell; a PCA should have assisted her out of bed to prevent her from falling.

Interview with the SCC on 12/15/21 at 3:25pm revealed:
-She expected all high fall risk residents on the SCU to be supervised with safety checks and incontinence care every 1-2 hours, but safety and supervision rounds were not documented anywhere within the facility, she did not know why.
-Resident #7 had fallen approximately 2-3 times in the last month; one fall resulted in a bruise on her flank, another fall sent her to the hospital to get stitches in her ear, and another fall caused a cut on her forehead.
-It was the facility's policy to call 911 and send the resident to the hospital for evaluation if they hit their head and to report all falls to the resident's primary care provider (PCP); all staff were trained to do this upon hire.
-There had been interventions put in place after the last fall to help reduce the risk of Resident #7 falling and becoming injured per her family member's request to include increased blood pressure checks, padded edges of furniture in the resident's room, a higher commode seat in the bathroom, and she had ordered a bed alarm, but there had not officially been increased supervision put into place, she did not know why.

Telephone interview with the previous Special Care Director (SCD) on 12/15/21 at 1:36pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 41	D 270		

revealed:
-She had requested that general fall prevention interventions be put in place prior to Resident #7's falls, but they were never approved by upper management, she did not know why.
-Resident #7 had fallen approximately 4 times during her employment at the facility; there were never any post-fall interventions or meetings or reviews about the resident's falls like the facility policy indicated there should be, she did not know why.

Interview with the Resident Service Coordinator (RSC) on 12/16/21 at 1:44pm revealed:
-Resident #7 required a lot of redirection and supervision but she was unsure of what interventions had been put into place for the resident.
-She expected staff to provide Resident #7 increased supervision and toileting assistance every 1-2 hours.
-It was the facility policy to send a resident to the emergency room (ER) if a resident fell and hit their head.
-If Resident #7 hit her head on 11/29/21, the facility staff should have sent her to the ER.
-The facility did call 911 when Resident #7 fell and hit her head on 11/29/21, but when the ambulance arrived, the resident declined treatment with her power of attorney's approval and the facility allowed her to do so; so she did not go to the ER that day.

Interview with the Resident Service Director (RSD) on 12/16/21 at 2:41pm revealed:
-She was aware that Resident #7 had frequent falls.
-There should have been interventions put into place to prevent further falls for Resident #7 after her first fall with new intervention after every fall

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 42	D 270		

thereafter; she was unsure why that had not happened.
-Resident #7's PCP should have been notified after every fall the resident experienced which may have contributed to interventions being put into place after each fall; she was unsure why that had not happened.
-It was the facility policy that any resident who hit their head in a fall should go to the ER for evaluation.
-When EMS arrived on 11/29/21 after Resident #7's fall in which she hit her head, the resident declined services and did not go to the hospital for evaluation; Resident #7 was unable to independently decline EMS services, but she thought the resident's power of attorney (POA) had been contacted to approve the decision.

Interview with the Administrator on 12/16/21 at 3:34pm revealed:
-He was aware that Resident #7 had experienced frequent falls.
-He was unsure if there were any other interventions that should have been in place for Resident #7, he did not know why.

Telephone interview with Resident #7's PCP on 12/16/21 at 1:00pm revealed:
-She was aware that Resident #7 was a high fall risk but had only been made aware of 3 of the 5 falls the resident had sustained since 10/12/21 and was notified of only one fall in which the resident had been injured.
-She expected to be notified of all residents falls so she could assess the resident and the reason why they fell.
-When reviewing resident records at the facility, documentation lacked, and staff frequently forgot to report falls which prevented her from knowing the details of falls in which she could evaluate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 43	D 270		

and provide interventions to residents as appropriate.
-If she had been aware of all of Resident #7's falls, she would have implemented physical and occupational therapy (PT/OT), evaluated her to assess why she was falling, assessed if her level of care was appropriate, rule out a urinary tract infection (UTI), and provided orders to have her in public areas for increased supervision of at least a safety check every hour, as well as orders for a fall mat, signage to remind the resident not to get up without assistance, hourly safety rounding, and toileting and needs assistance every 1-2 hours.
-She expected the facility to have provided Resident #7 with increased supervision due to the amount of falls she had and to have been proactive in requesting and implementing fall prevention interventions.

Attempted telephone interview with Resident #7's family member on 12/16/21 at 10:15am and 3:30pm was unsuccessful.

Attempted telephone interview with a second PCA on 12/16/21 at 11:08am was unsuccessful.

Attempted telephone interview with a third PCA on 12/16/21 at 11:28am was unsuccessful.

Refer to telephone interview with the previous SCD on 12/15/21 at 1:36pm.

Refer to interview with the RSC on 12/16/21 at 1:44pm.

Refer to interview with the RSD on 12/16/21 at 2:41pm.

Refer to interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 44 12/16/21 at 3:34pm. _____ Telephone interview with the previous SCD on 12/15/21 at 1:36pm revealed: -She was employed as the SCD for the SCU at the facility from 10/2021-12/10/21. -Everyday had staffing issues in the SCU while she was employed there, and it was not uncommon to only have one staff member for 2nd or 3rd shift making it difficult to provide care and supervision according to residents' needs. -The facility frequently relied on staff members to stay late or come in early to help ease the burden of inadequate staffing issues; and she frequently stayed late to assist the 2nd shift with resident care. -She expected high fall risk residents to have increased supervision to include keeping those residents in common areas when possible and providing safety checks on the resident every hour; this was often not able to be done as expected on 2nd and 3rd shifts due to severe staffing shortages. Interview with the RSC on 12/16/21 at 1:44pm revealed: -She expected staff to implement fall precautions and supervision for high fall risk residents per the facility policy and assessed needs, then evaluate reasons residents might have fallen to correct the issue, she was not sure why this had not happened. -She expected SCU staff to perform safety rounds on residents every 1-2 hours and to call for assistance if they were unable to do so. -Staff had previously reported to her that they were struggling to complete their work and care for residents due to short staffing. -She tried to assist as needed on all shifts with resident care when staffing was short.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 45 Interview with the RSD on 12/16/21 at 2:41pm revealed: -She was aware the facility had short staffing issues mostly on second shift (3:00pm-11:00pm), but she was not aware the staffing deficit was creating a safety issue for residents. -Short staffing had contributed to the staff's ability to supervise residents according to their needs. -If staff needed help on any shift, she expected them to ask each other, the supervisor in charge, or call her, the Administrator, or the RSC to come help them so they could provide safe care as needed; she was not sure why this process had not been followed. Interview with the Administrator on 12/16/21 at 3:34pm revealed: -He expected residents with a high fall risk to receive safety checks every two hours for supervision per facility policy and assessed needs. -He expected fall prevention interventions to be in place for residents with a high fall risk per facility policy and according to the resident's assessed needs upon admission and after every fall by the SCD and RSD. -He expected the PCP to be made aware of every fall a resident sustained and was not aware that had not happened as expected. -The facility was frequently short staffed on the SCU from 7:00pm-11:00pm. -He expected staff to call for help if they were short staff and unable to provide care as expected due to staffing shortages. Refer to Tag D0465 10A NCAC 13F .1308(a) (Type A2 Violation) The facility failed to ensure supervision for 2 of 6	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 270	Continued From page 46 sampled residents (#4 and #7) in accordance with the facility's policies and procedures and each resident's assessed needs which resulted in a resident (#4) with a history of falls sustaining a severe head injury on his second day of admission at the facility from an unwitnessed and unsupervised fall on 11/30/21 in which the PCP was not made aware and Resident #7 with a know history of falls at the facility sustaining head injuries, lacerations, skin tears, and bruises from five unwitnessed falls between 10/12/21-11/29/21 in which the PCP was not always made aware and no fall prevention interventions or increased supervision were put into place upon admission or after each fall for either resident until requested by family members when they expressed their concerns to the facility or their family member discharged the resident from the facility due to their concerns. The facility's failure resulted in serious physical harm and neglect to each resident which constitutes a TYPE A1 VIOLATION. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 12/15/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JANUARY 15, 2022.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 47	D 273		

Based on interviews and record review, the facility failed to ensure referral and follow-up for 1 of 5 sampled residents (#2) with a compression device that was used without an order.

The findings are:

Review of Resident #2's current FL-2 dated 11/02/21 revealed diagnoses included hypertension, osteoarthritis, hypothyroidism, depressions, anxiety, osteoporosis, diverticulosis, anemia, neurogenic bladder, glaucoma and gastroesophageal reflux disease.

Review of Resident #2's Resident Register revealed:
-She was admitted to the facility on 11/03/21.
-She required assistance using her Lymphapress. (A Lymphapress is a pneumatic sequential compression device used to treat edema.)

Review of Resident #2's current care plan dated 11/04/21 revealed there was no information regarding the use of a compression device.

Review of Resident #2's Licensed Health Professional Support (LHPS) dated 12/06/21 revealed Resident #2 required staff assistance with application of the Lymphapress device three times per week.

Review of Resident #2's record revealed there was no order for a Lymphapress device.

Interview with Resident #2 on 12/15/21 at 3:14pm revealed:
-The Lymphapress device was a full body suit used to treat her lymphedema.
-She required staff assistance to zip her into the suit and turn on the device and unzip her after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 48	D 273		

each use.
-She used the compression device for 45 minutes, three times per week.
-She began using the Lymphapress device prior to being admitted to the facility and brought it with her at move in.

Interview with a medication aide (MA) on 12/16/21 at 11:30am revealed:
-Resident #2 came to facility with the compression device.
-The compression suit covered Resident #2's legs and extended to cover her chest.
-Resident #2 used the device every morning but would sometimes refuse.
-Staff assisted Resident #2 with getting the compression suit on and off when she used the device.
-Staff turned the machine on for use for 45 minutes each time.
-Resident #2 had given her instructions on how to assist with the compression device.
-She had not received instruction or education from physical therapy, a nurse or management.

Interview with the Resident Service Coordinator (RSC) on 12/15/21 at 3:42pm revealed:
-Resident #2 brought the compression device with her when she moved into the facility.
-Resident #2 used the compression device three times per week per the LHPS task.
-Staff assisted Resident #2 with zipping and unzipping the compression suit.
-Use of the device was not documented and there was no physician's order for the device.
-She did not see the use of the device as a treatment that needed an order.
-She thought that staff assistance with zipping and unzipping was comparable to assisting with dressing instead of a treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 49 -She thought Physical Therapy had initiated the treatment and educated the staff. Interview with the Resident Service Director (RSD) on 12/16/21 at 10:53am revealed: -There was no order for the compression device to be used for Resident #2. -Staff assisted Resident #2 with zipping and unzipping the device when it was used. -She thought that staff assistance with zipping and unzipping was comparable to assisting with dressing instead of a treatment. -She was not aware how often or for how long the device was used. A second interview with the RSD on 12/16/21 at 3:00pm revealed: -Resident #2 instructed staff on use of the compression device. -She did not see the use of the device as a treatment that needed an order. Interview with Physical Therapy (PT) staff contracted by the facility on 12/16/21 at 4:10pm revealed: -Resident #2's Lymphapress treatment was not initiated by PT at the facility. -The Lymphapress is a treatment used to assist with fluid mobilization and brought in by Resident #2 when she moved into the facility. -There should be an order in place for the compression device to be used at the facility. -He was not aware of an order for Resident #2 to use the compression device. -He was not aware of PT completing education on the use of the compression device with staff. Interview with the Primary Care Provider (PCP) for Resident #2 on 12/16/21 at 1:00pm revealed: -Resident #2 came to the facility with the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 273	Continued From page 50 compression device. -She did not know if Resident #2 used the device at the facility. -There should have been an order for use of the device at the facility. -The facility had not contacted her for an order to use the device.	D 273		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication administration records were accurate and complete for 1 of 5 residents reviewed (#1) and 1	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 51	D 367		

of 3 residents during the medication pass (#6) including medications for pain (#1) and reflux disease (#6).

The findings are:

1. Review of Resident #1's current FL-2 dated 08/04/21 revealed diagnoses included dementia, glaucoma, and osteoarthritis.

Review of Resident #1's physician order dated 11/30/21 revealed there was an order for Tramadol 50mg, one tablet every 6 hours as needed for pain. (Tramadol is a controlled substance used to treat pain.)

Review of Resident #1's controlled substance (CS) log for Tramadol 50mg starting 11/21/21 revealed:
-Tramadol was documented as administered on 12/06/21 at 5:45am.
-Tramadol was documented as administered on 12/10/21 at 5:00am.
-Tramadol was documented as administered on 12/11/21 at 5:00am.
-Tramadol was documented as administered on 12/13/21 at 6:00am.

Review of Resident #1's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Tramadol 50mg, take one tablet every 6 hours as needed for pain.
-Tramadol was not documented as administered on 12/06/21 at 5:45am.
-Tramadol was not documented as administered on 12/10/21 at 5:00am.
-Tramadol was not documented as administered on 12/11/21 at 5:00am.
-Tramadol was not documented as administered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 52	D 367		

on 12/13/21 at 6:00am.

Observation of Resident #1's medications on hand on 12/14/21 at 3:29pm revealed there were 7 tablets of Tramadol 50mg remaining in the package dispensed 11/02/21 which accurately matched the CS log.

Telephone interview with a medication aide (MA) on 12/15/21 at 9:54am revealed:
-The eMAR should match the medications administered and the CS log.
-Resident #1's Tramadol order recently changed from scheduled four times a day, to as needed.
-He forgot to sign the medication on the eMAR after documenting on the CS log for some of the doses he administered Resident #1.

Refer to interview with the Special Care Unit Manager on 12/15/21 at 3:40pm.

Refer to interview with the Resident Services Coordinator on 12/16/21 at 1:45pm.

Refer to interview with the Resident Services Director on 12/16/21 at 3:00pm.

Refer to interview with the Administrator on 12/16/21 at 3:30pm.

Refer to telephone interview with the facility's primary care provider (PCP) on 12/16/21 at 1:01pm.

2. Review of Resident #6's current FL-2 dated 11/21/21 revealed:
-Diagnoses included dementia and osteoarthritis.
-There was an order for Pantoprazole 40mg, give one tablet daily before breakfast. (Pantoprazole is a medication used to treat stomach ulcers and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 53	D 367		

reflux disease. Pantoprazole should be administered on an empty stomach according to manufacturer's recommendations.)

Observation of the 9:00am medication pass in the Special Care Unit (SCU) on 12/14/21 revealed Resident #6 swallowed her morning medications including her Pantoprazole 40mg capsule at 9:02am.

Review of Resident #6's December 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Pantoprazole 40 mg, with instructions to take one tablet every day before breakfast, scheduled for administration at 7:30am.
-Pantoprazole 40mg was documented as administered on 12/14/21 at 7:30am.

Interview with Resident #6 on 12/14/21 at 9:15am revealed she ate breakfast earlier this morning in her room before staff brought her to the television room where she received her morning medications.

Interview with the MA on 12/14/21 at 4:50pm revealed:
-The eMAR should match the time the medication was administered.
-Resident #6 ate her breakfast before she was able to administer her Pantoprazole this morning (12/14/21).

Refer to interview with the Special Care Unit Manager on 12/15/21 at 3:40pm.

Refer to interview with the Resident Services Coordinator on 12/16/21 at 1:45pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 367	Continued From page 54 Refer to interview with the Resident Services Director on 12/16/21 at 3:00pm. Refer to interview with the Administrator on 12/16/21 at 3:30pm. Refer to telephone interview with the facility's primary care provider (PCP) on 12/16/21 at 1:01pm. Interview with the Special Care Unit Manager on 12/16/21 at 3:40pm revealed: -The electronic medication administration record (eMAR) should match the medication administered including the accurate time the medication was administered. -It was the medication aide's (MA) responsibility to ensure medication administration was documented accurately. Interview with the Resident Services Coordinator (RSC) on 12/16/21 at pm revealed: -She expected eMAR to be complete and accurate. -There was no audit process done currently on the eMAR to ensure it was complete and accurate. -The eMAR should be accurate and complete because the primary care providers review them to ensure treatment was appropriate. Interview with the Resident Services Director (RSD) on 12/16/21 at 3:00pm revealed she expected the eMAR to be complete and accurate. Interview with the Administrator on 12/16/21 at 3:30pm revealed he expected the eMAR to be complete and accurate. Telephone interview with the facility's PCP on	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 55 12/16/21 at 1:01pm revealed: -She expected the eMAR to be complete and accurate. -She reviewed the eMAR frequently to ensure that residents were receiving the appropriate treatment and it was important the eMAR accurately reflected the medications administered and the accurate time the medication was administered.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass on 12/14/21 by a medication aide observed on the Special Care Unit (SCU) who administered medication that had fallen onto a dirty surface and touched medications with her bare hand. The findings are: The facility's policy for Infection Control related to Medication Administration was requested on 12/14/21 at 4:15pm and was not provided prior to survey exit.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 371	Continued From page 56 Observation of the Special Care Unit (SCU) hallway on 12/14/21 from 8:35am to 8:55am revealed: -There was a resident that walked down the hallway and stopped at the medication cart. -The resident had a mask pulled down under her mouth while standing at the medication cart. -The resident picked up the cranberry juice on top of the medication cart and moved other items around on top of the medication cart. -The medication aide (MA) came up to the medication cart and redirected the resident to the television room at 8:53am. Observation of the 9:00am medication administration pass on 12/14/21 revealed: -The MA sanitized her hands at 8:55am. -The MA did not clean or wipe down the medication cart with sanitizer. -The MA began preparing medications for a second resident. -The MA popped a medication out of a single pill package and the pill landed on the medication cart. -The MA picked up the medication with her bare hand and placed it in the medication cup with the other medications. -There was an additional medication that was stuck to the adhesive on the back of a single medication package. -The MA removed the stuck medication pill with her bare hands and placed it in the medication cup with other medications. -The MA administered the second resident her medications in the television room at 9:02am. -The MA sanitized her hands after she returned to the medication cart from administering the second resident her medications at 9:05am. Interview with the Special Care Unit Manager	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 371	Continued From page 57 (SCUM) on 12/14/21 at 9:35am revealed: -The resident standing at the medication cart prior to the MA administering medications to the second resident tested positive for COVID-19. -The second resident that was observed receiving her medications in the television room tested negative for COVID-19. Interview with the MA on 12/14/21 at 4:15pm revealed: -She was aware that she should have discarded the medication when it dropped on the medication cart. -She was nervous during the medication pass observation and that was why she did not discard of the medication when it dropped on the medication cart. -She was aware that she should not have touched the medication that was stuck to the medication packet with her bare hand. -She normally wiped down the medication cart prior to administering medications but did not remember to this morning (12/14/21). -The resident that was observed standing at the medication cart, who tested positive for COVID-19, was known to touch items on the medication cart throughout the day. Second interview with the SCUM on 12/15/21 at 3:40pm revealed: -She expected staff to follow proper infection control principles during medication administration. -Staff should not handle medications with their bare hands and if a medication fell onto an unclean surface staff should throw the medication away. Interview with the Resident Services Coordinator (RSC) 12/16/21 at 1:45pm revealed:	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 371	Continued From page 58 -She expected staff to follow proper infection control principles during medication administration. -She would have expected staff to discard the medication that fell on the medication cart rather than pick it up with an ungloved hand and administer it. -She expected staff to wear a glove when handling oral medication. -She was concerned with cross contamination if a resident was given medication that was handled with bare hands or given a medication that fell on a dirty surface such as a medication cart. Interview with the Resident Services Director (RSD) 12/14/21 at 3:50pm revealed: -She expected the MAs to adhere to proper infection control guidelines during medication administration. -She expected when the MA dropped the pill on the medication cart that she would have discarded the medication. -She expected when the medication tablet was stuck to the medication pack that the MA would have donned a glove and removed the medication, not using her ungloved hand to remove the medication. Interview with the Administrator on 12/16/21 at 3:30pm revealed he expected staff to follow proper infection control practice during medication administration including not touching oral medications with ungloved hands. Telephone interview with the facility's Primary Care Provider (PCP) on 12/16/21 at 1:01pm revealed: -She expected staff to follow basic infection control practice during medication administration especially with the current COVID-19 outbreak on	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 371	Continued From page 59 the SCU. -If staff was not following basic infection control practice during medication administration, they were placing the residents that were COVID-19 negative at greater risk to get the COVID-19 virus. _____ The facility failed to ensure infection control measures were adhered to during medication administration while the Special Care Unit (SCU) was in a COVID-19 outbreak placing the residents at increased risk of disease transmission. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 12/16/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 30, 2022.	D 371		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 451	Continued From page 60	D 451		

facility failed to notify the county Department of Social Services (DSS) of incidents resulting in injury requiring emergency medical evaluation treatment for 2 of 4 sampled residents (#3, #7).

The findings are:

1.Review of Resident #7's currently FL-2 dated 09/27/21 revealed:
-Diagnoses of Alzheimer's, neuropathy, transient ischemic attack, and urinary incontinence.
-She was intermittently disoriented and semi-ambulatory.
-She was incontinent of bladder and bowel.
-Her level of care was documented as assisted living - memory care.

a.Review of Resident #7's progress note dated 10/27/21 revealed:
-The resident was found on the floor coming out of the bathroom.
-She had a laceration (cut) to her right ear.
-She did not have her walker with her.
-She was sent to the emergency room (ER) for evaluation.

Review of the an Incident and Accident Report for Resident #7 dated 10/27/21 revealed:
-The resident fell to the floor coming out of the bathroom, hitting her ear and splitting it open.
-She did not have her walker by her side; it was on the other side of the room.
-Emergency Medical Services (EMS) was called to transport the resident to the ER.
-The resident's primary care provider and responsible party were notified.
-There was no documentation that local Department of Social Services (DSS) Social Worker/Adult Home Specialist was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 451	Continued From page 61	D 451		

Review of Resident #7's ER report dated 10/27/21 revealed:
-The resident was treated for a right ear laceration after a fall after using the toilet and hit the bathroom sink.
-The resident required a complex procedure requiring 7 sutures to repair her ear and a follow up to an ear, nose, and throat specialist on 11/02/21.

Telephone interview with the local DSS Social Worker/Adult Home Specialist on 12/15/21 at 2:29pm revealed she had not received any incident reports dated 10/27/21 for Resident #7.

Interview with the Resident Care Director (RSD) on 12/16/21 at 2:41pm revealed:
-It was her responsibility to complete Incident and Accident Reports when a resident was sent to the ER or required emergency medical evaluation more than basic first aide.
-She forgot to notify the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 10/27/21.

Interview with the Administrator on 12/16/21 at 3:34pm revealed:
-It was the RSD's responsibility to notify the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 10/27/21.
-He was not aware that reporting to the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 10/27/21 had been forgotten or overlooked.
-He expected all incidents requiring DSS notification to be sent to the local DSS Social Worker/Adult Home Specialist.

b. Review of an Incident and Accident Report for Resident #7 dated 11/29/21 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 62 -The resident was observed on the floor in her bedroom and stated she fell trying to take a bath. -The resident had a small skin tear to her right elbow and a small knot on the right side of her head. -The responsible party was notified and was to meet the resident at the emergency room (ER) after the facility called 911 for an ambulance. -There was no documentation that the primary care provider (PCP) or local Department of Social Services (DSS) Social Worker/Adult Home Specialist was notified. Interview with the Resident Service Coordinator (RSC) on 12/16/21 at 1:44pm revealed: -It was facility policy to send any resident who fell and hit their head to the ER for further emergency medical evaluation. -Resident #7 did not go to the ER on 11/29/21 after falling and hitting her head, but emergency medical services (EMS) were called and came to the facility; the resident and her responsible party declined transportation to the ER at that time. Telephone interview with the local DSS Social Worker/Adult Home Specialist on 12/15/21 at 2:29pm revealed she had not received any incident reports dated 11/29/21 for Resident #7. Interview with the Resident Service Director (RSD) on 12/16/21 at 2:41pm revealed: -It was her responsibility to complete Incident and Accident Reports when a resident was sent to the ER or required emergency medical evaluation more than basic first aide and report the incident to the local DSS Social Worker/Adult Home Specialist. -She forgot to notify the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 11/29/21.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 451	Continued From page 63 Interview with the Administrator on 12/16/21 at 3:34pm revealed: -It was the RSD's responsibility to notify the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 11/29/21. -He was not aware that reporting to the local DSS Social Worker/Adult Home Specialist of Resident #7's fall on 11/29/21 had been forgotten or overlooked. -He expected all incidents requiring DSS notification to be sent to the local DSS Social Worker/Adult Home Specialist. 2. Review of Resident #3's current FL-2 dated 10/2/21 revealed diagnoses included Parkinson's Disease and dementia. a. Review of an electronic progress note dated 09/22/21 at 9:28pm for Resident #3 revealed: -The resident started making noises when the medication aide (MA) was assisting him to bed. -The MA noticed the resident was choking and called for assistance from another MA. -He was sent to the emergency room (ER) for evaluation. Attempted review of Resident #3's Incident and Accident Reports on 12/14/21 at 11:00am revealed the report was unavailable because the facility did not complete an Incident and Accident Report for 09/22/21. Telephone interview with the local Department of Social Services (DSS) Social Worker/Adult Home Specialist on 12/15/21 at 3:34pm revealed she had not received incident reports dated 09/22/21 for Resident #3. Interview with the Resident Care Director (RCD)	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 64	D 451		

on 12/16/21 at 3:00pm revealed:
-She did not know why staff had not completed an Incident and Accident Report when Resident #3 was sent to the ER on 09/22/21 and 10/12/21.
-It was her responsibility to complete Incident and Accident Reports when a resident was sent to the ER.
-She forgot to complete an Incident and Accident Report for Resident #3 when he was sent to the ER on 09/22/21.

Interview with the Administrator on 12/16/21 at 3:37pm revealed:
-He was not aware that staff had not completed an Incident and Accident Report when Resident #3 was sent to the ER on 09/22/21.
-He expected staff to send all Incident and Accident Reports to DSS Social Worker/Adult Home Specialist.

b. Review of an electronic progress note dated 10/12/21 at 3:37pm revealed:
-The MA heard a loud noise and found the resident on the floor in front of the bathroom door.
-The resident told the MA he hit his head and the MA observed a skin tear on his left arm.
-He was sent to the ER for evaluation.

Attempted review of Resident #3's Incident and Accident Reports on 12/14/21 at 11:00am revealed the report was unavailable because the facility did not complete an Incident and Accident Report for 10/12/21.

Telephone interview with the local Department of Social Services (DSS) Social Worker/Adult Home Specialist on 12/15/21 at 3:34pm revealed she had not received incident reports dated 10/12/21 for Resident #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	Continued From page 65 Interview with the RCD on 12/16/21 at 3:00pm revealed: -It was her responsibility to complete Incident and Accident Reports when a resident was sent to the ER. -She forgot to complete an Incident and Accident Report for Resident #3 when he was sent to the ER on 10/12/21. Interview with the Administrator on 12/16/21 at 3:37pm revealed: -He was not aware that staff had not completed an Incident and Accident Report when Resident #3 was sent to the ER on 10/12/21. -He expected staff to send all Incident and Accident Reports to DSS Social Worker/Adult Home Specialist.	D 451		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 465	Continued From page 66 (SCU) for 4 of 9 shifts sampled from 11/30/21 to 12/10/21. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 96 beds including a special care unit (SCU) with a capacity of 36 beds. Review of the facility's resident census report dated 11/30/21 revealed there was an SCU census of 31 residents, which required 31 staff hours on second shift and 24.8 hours on third shift. Review of the employee timecards dated 11/30/21 revealed there was a total of 26.75 staff hours provided on second shift in the SCU with a shortage of 4.25 hours. Review of the employee timecards dated 11/30/21 revealed there was a total of 19.25 staff hours provided on third shift in the SCU with a shortage of 5.55 hours. Review of the facility's resident census report dated 12/06/21 revealed there was an SCU census of 31 residents, which required 31 staff hours on second shift. Review of the employee timecards dated 12/06/21 revealed there was a total of 28.5 staff hours provided on second shift in the SCU with a shortage of 2.5 hours. Review of the facility's resident census report dated 12/10/21 revealed there was an SCU census of 30 residents, which required 30 staff hours on second shift.	D 465		

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D 465	Continued From page 67 Review of the employee timecards dated 12/10/21 revealed there was a total of 28.5 staff hours provided on second shift in the SCU with a shortage of 1.5 hours. Telephone interview with a resident's family member on 12/15/21 at 8:50am revealed: -She was told by facility staff that there were only two staff members on the SCU on 11/30/21 when their family member fell. -She was told by a staff member that they were understaffed and that they could not properly provide the residents with the supervision they required. Review of an Incident and Accident Report dated 11/30/21 at 10:15pm revealed: -A resident was observed lying in the floor outside of another resident's room with his wheelchair next to him. -He suffered a large laceration to his scalp with bleeding that required repair and 911 was called. -Assistance and first aid were provided to the resident while awaiting EMS arrival, no vital signs were obtained. -The resident's responsible party was notified via phone call on 11/30/21 at 11:00pm. Confidential interview with a former staff member revealed: -The facility was constantly short staffed which caused safety issues on the SCU. -Residents were not able to be supervised appropriately. -The evening of 11/30/21 when a resident fell there was only 1 medication aide (MA) and 1 personal care aide (PCA), when there should have been 2 MAs and 2 PCAs. -She was not aware of a time when the Resident	D 465		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 465	Continued From page 68	D 465		

Services Coordinator (RSC), Resident Services Director (RSD), or the Administrator worked on the floor to assist staff when the facility was short staffed.

Interview with a PCA on 12/14/21 at 9:18am revealed:
-There were two residents on the SCU that require two-person assistance with incontinence care and transfer.
-He was often asked to stay over to help cover the second shift.
-The residents in the SCU required supervision and frequent redirection because there were residents who wandered and sometimes went into other residents' rooms.

Telephone interview with a MA on 12/15/21 at 9:54am revealed:
-There were some nights when he was the only MA for the entire facility which meant he had to split his time between the assisted living (AL) side and the SCU.
-On nights when the facility was understaffed, there was some resident care that was overlooked and some resident care that had to be re-prioritized for a later time.

Telephone interview with a second MA on 12/15/21 at 11:45am revealed:
-When she was the only MA on the SCU she was not able to assist residents with their personal care needs such as toileting and feeding assistance.
-Staffing had been an issue since she was hired 6 months ago.
-Safety was a concern due to staffing.
-There were several residents with behaviors and she was unable to supervise them adequately.

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D 465	Continued From page 69 Interview with a third MA on 12/15/21 at 3:35pm revealed: -Staffing on the SCU was a safety issue because staff were not able to supervise the residents like they needed to when there were only two staff on the unit. -Staff from first shift was often asked to stay over onto second shift and, if they did not, then there was only one staff member on the SCU. -The Special Care Unit Manager (SCUM) would stay over and help on the floor for a few hours if she was able. -The RSC was aware that there was sometimes a gap in staffing from about 6:00pm until 9:00pm when there was only one staff member on the SCU when someone calls out. -There were at least two residents on the SCU that required two-person assistance. Interview with the SCUM on 12/15/21 at 3:25pm revealed: -Staffing on the SCU had improved in the last two weeks but she was aware it had been an issue in the past. -She was not made aware when staff called out. -She was often asked to stay over her shift to help cover some of second shift. -She did not expect only one or two staff members to be left on the SCU. -The residents of the SCU required increased supervision because they were at risk for falls and other injuries. A second interview with the SCUM on 12/16/21 at 11:10am revealed she was not notified by staff or the Resident Services Coordinator when there was only one staff member on the SCU such as the evening of 11/30/21 from 6:00pm to 9:00pm. Interview with the RSC on 12/16/21 at 1:45pm	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 465	Continued From page 70	D 465		

revealed:
-She was aware that there was sometimes only one MA for the entire building.
-Staff had brought it to her attention that they needed help in the SCU in order to properly supervise the residents.
-The RSD and Administrator were called in because of a fall on 11/30/21, not to staff the facility.
-She was working the AL side of the facility the afternoon of 11/30/21 until around 6:00pm.
-When she found out that there was only one staff member on the SCU on 11/30/21 on second shift, she instructed a PCA to go over to the SCU side from the AL side around 6:00pm.
-She was not aware that the PCA did not go over to the SCU until 9:00pm that evening.
-She was responsible for making the schedule and assignments for the facility.
-If staff were not able to work a scheduled shift, they were to call the facility and let the lead MA on shift know, who then would work on finding coverage.
-If the lead MA on shift could not find coverage, they were to make her aware so that she could find coverage.
-She was often not aware of staff not showing up until the next day, for example when there was a call out for second or third shift.
-She was aware that the facility was short staffed and that it was mainly for second shift when staff from first shift could not extend or staff from third shift were not able to come in early.

Interview with the RCD on 12/16/21 at 3:00pm revealed:
-She was not aware of the SCU being short staffed until after the fact, such as the next morning.
-It was the responsibility of the RSC to alert her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 465	Continued From page 71	D 465		

and the Administrator if she was not able to cover the facility's staffing shortage.
-One staff could not properly supervise all of the SCU residents.
-She was not aware that there was only one staff present on the SCU the evening of 11/30/21 when a resident fell, resulting in serious injury.

Interview with the Administrator on 12/16/21 at 3:30pm revealed:
-He aided taking two or three residents to the bathroom on the evening of 11/30/21 which was why he counted himself in the staffing hours from 10:15pm until 2:15am.
-He was not aware that the SCU was short on 11/30/21 until he arrived to the facility because of a resident fall that resulted in serious injury.
-He did not clock in when he provided resident care if the facility was short.
-He was never told by any residents or residents' families that they felt like the facility was unsafely staffed.
-He did not expect one staff member to be able to supervise all of the SCU residents.
-He was not aware that there were times only one staff member present on the SCU.
-He was not told by the RSC or RSD that staffing was short in the SCU on 11/30/21, 12/06/21, or 12/10/21.
-Staff would bring the fact that they were short staffed up to him after the shift, but if he was aware that they were short staffed, he or the RSD would come in and worked the floor.

Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).

_____

The facility failed to ensure there was enough staff on the Special Care Unit (SCU) to meet the

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 465	Continued From page 72 required staffing hours and the needs of the residents. There were not enough staff members present on the unit to properly supervise residents that were at high fall risks including the evening of 11/30/21, which resulted in a resident falling and receiving a serious head injury. The facility's failure resulted in a substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 12/15/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 15, 2022.	D 465		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.	D 612		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 73 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding proper use of personal protective equipment (PPE) when caring for COVID-19 positive residents including face shield, gown, and gloves, proper use of face masks by staff, dedicated staff to care for COVID-19 positive residents, staff screening, and social distancing of residents during activities and dining. The findings are: Review of North Carolina Department of Health and Human Services (NC DHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 11/19/21 revealed: -All staff should be screened for symptoms prior to every shift, all residents should be screened for symptoms daily and all visitors should be screened for symptoms prior to entering the facility. -During an outbreak, testing should continue on affected unit(s) or facility wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated or partially vaccinated residents, until there are no new cases for 14 days. Review of CDC Guidance Interim Infection	D 612		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 74 Prevention and Control Recommendations to COVID-19 spread in Nursing Homes & Long-Term Care Facilities dated 09/10/21 revealed: -Identify healthcare personnel (HCP) who will be assigned to work only on the COVID-19 care unit when it is in use. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift. -The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection. -HCP caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator). -Ideally, a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending. -In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway. -If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or	D 612		

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 75	D 612		

symptoms concerning for COVID-19, residents should remain in their current location pending return of test results.

Review of the NC DHHS COVID-19 Post-Acute Care Setting Infection Control Assessment and Response (ICAR) Tool dated October 2021 revealed:
-All staff should be screened for symptoms prior to every shift, all residents should be screened for symptoms daily and all visitors should be screened for symptoms prior to entering the facility.
-Actively screen all staff for fever and respiratory symptoms before starting each shift; send them home if they are ill.

Review of an email from the LHD to the facility on 12/08/21 revealed reference material including NC DHHS COVID-19 Infection Prevention Guidance for Long-Term Care Facilities website link.

Review of the facility's COVID-19 Infection Control Measures for Community Team Members policy dated 12/12/20 revealed:
-This policy is a revision to an earlier policy dated April 2020. Any specific restrictions apply by county, state or regulatory agencies will be applied.
-All team members will complete the COVID-19 Screening Checklist to include recorded temperature check two times per shift (start and end of shift).
-During any identified COVID-19 positive case or cases within the community direct resident contact will be limited to assigned care personnel only except for emergency maintenance repair.
-Face masks are to be worn by all team members at all times when in the community unless the

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D 612	Continued From page 76	D 612		

person is on their meal break and in an area away from others.
-Gloves are to be worn at all times by all team members when in residential areas of the community. Upon entering a resident's room care staff will wear clean, disposable gloves. Remove and discard gloves when leaving the resident's room and immediately perform hand hygiene.
-Gowns will be worn by any team member entering or in the presence of a resident that was being isolated due to symptoms or new to the community and quarantined due to positive test of COVID-19 at all times.
-Any isolated or quarantined resident or outbreak identified within the community will require use of full PPE to include: N95 mask, gown, bouffant cap, booties, gloves, and face shield.
-All PPE is to be put on prior to entry but removed prior to exiting the apartment in a biohazard trash bag at the door.

Review of the facility's COVID-19 Introduction and Overview Training material dated 05/25/21 revealed:
-Follow state guidance for activities and dining.
-Avoid close contact between residents.
-No large group activities.
-Screening shall be completed by everyone who comes into the community including a temperature check. Staff shall screen at the start of every shift.

Review of the facility's COVID-19 Standard, Contact and Droplet Precautions Training material dated 05/25/21 revealed:
-Gloves shall be worn when you anticipate contact with residents on isolation.
-Contact and Droplet precautions shall be used when caring for residents with suspected or confirmed COVID-19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 77 -Residents on Contact and Droplet precautions should remain in his/her apartment, have limited people going in and out of apartment, and recommend placing a sign on the outside of the apartment. -PPE for Contact and Droplet precautions include gown, face mask, eye protection, and gloves. Review of the facility's COVID-19 PPE Training material dated 05/25/21 revealed: -For care of suspected or known COVID-19 residents PPE shall include gown, mask, eye protection and gloves. -Don PPE before resident contact, generally before entering the room, being careful to avoid contamination. -When wearing a mask, place it over the nose, mouth and chin. Review of the facility's COVID-19 Responding to Symptoms or Active Illness Training material dated 05/25/21 revealed: -If a resident has symptoms, isolate the resident. Ask the resident to stay in their apartment. Separate roommates or isolate together. -Report suspected cases to the LHD for further direction, help ensure appropriate testing, and determine what to do next. -For confirmed cases, follow direction from public health, stop all activities and group dining, limit any unnecessary contact, staff should wear a facemask at all times, and utilize full PPE during resident care. Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 96 beds including a special care unit (SCU) with a capacity of 36 beds. Review of the facility's resident census report	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 78 dated 12/14/21 revealed there was an SCU census of 30 residents. Review of the facility's COVID-19 Daily Facility Log on 12/14/21 revealed: -16 residents on the SCU tested positive for COVID-19 on 12/08/21. -1 staff member tested positive for COVID-19 on 12/09/21. -1 resident on the SCU tested positive for COVID-19 on 12/11/21. -2 staff members tested positive for COVID-19 on 12/13/21. -1 resident on the SCU tested positive for COVID-19 on 12/14/21. -There was a total of 18 residents that tested positive for COVID-19 and a total of 12 residents that tested negative for COVID-19 on the SCU. 1. a. Observation of a resident room on the Special Care Unit (SCU) on 12/14/21 from 8:30am to 8:35am revealed: -The Special Care Unit Manager (SCUM) entered a resident room wearing only a face mask. -One resident was sitting on the side of the bed. -The second resident was laying in the bed when the SCUM approached the resident and repositioned her. -The SCUM used a portable pulse oximetry device to check the resident's oxygen level. -The SCUM did not wear a gown, gloves, or face shield when providing the resident care. -The resident tested positive for COVID-19 on 12/08/21. Interview with the SCUM on 12/14/21 at 9:35am revealed: -Both residents in the room that she entered at 8:30am had tested positive for COVID-19. -She did not wear full personal protective	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 79	D 612		

equipment (PPE) including gown, face shield and gloves because they "were getting away from that" because the majority of the residents were testing positive for COVID-19.
-All staff should be wearing full PPE when caring for residents that tested positive for COVID-19 including the SCUM.

Observation of a medication aide (MA) on 12/14/21 at 9:10am revealed:
-She entered a resident room that was awaiting Emergency Medical Services due to testing positive for COVID-19 and being in respiratory distress.
-The MA wore a face mask to enter the room to take the resident's vital signs.
-She did not wear a gown, gloves, or face shield when providing the resident who tested positive for COVID-19 care.

Interview with the MA on 12/14/21 at 9:25am revealed:
-She started at the facility last week.
-She completed online training during orientation that talked about wearing PPE including a face mask, shield, gown and gloves during resident contact for those that tested positive for COVID-19.
-She was not familiar with what residents tested positive for COVID-19 but she knew that there was a list somewhere in the medication room that indicated who tested positive for COVID-19.
-There was no signage on the door that said which resident rooms contained residents that tested positive for COVID-19.
-She cared for residents that tested positive and negative for COVID-19 during her shift on the SCU.
-Staff did not wear full PPE when caring for the residents because there was an outbreak on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 612	Continued From page 80	D 612		

SCU and it was difficult to know who tested positive for COVID-19.

Telephone interview with a MA on 12/15/21 at 11:45am revealed:
-She wore full PPE including a face mask, shield, gown and gloves when caring for residents that tested positive for COVID-19.
-Other staff did not usually don gowns when performing patient care to the residents on SCU.
-She had noticed staff members on the SCU entering residents' rooms who tested positive for COVID-19 to perform resident care and they did not wear full PPE including a gown, gloves, and face shield.

Interview with a MA on 12/14/21 at 12:52pm revealed she did not wear full PPE when delivering food to residents, performing resident rounds or passing medications to residents that tested positive for COVID-19 because that was how she was trained during orientation.

A second interview with the SCUM on 12/14/21 at 12:35pm revealed full PPE should be worn when working with a resident that tested positive for COVID-19 but they did not unless they were bathing a resident because she "feels it was like family".

Observation of the facility's PPE on the SCU on 12/14/21 at 9:35am revealed there were 5 gowns in the medication room available for staff use and there was an additional supply of gowns located on the assisted living (AL) side of the facility.

Interview with the Resident Services Coordinator (RSC) on 12/16/21 at 1:45pm revealed:
-Staff on the SCU were expected to wear full PPE when providing resident care to residents that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 81	D 612		

tested positive for COVID-19.
-Staff were trained upon hire to wear full PPE when providing resident care to residents that tested positive for COVID-19.

Interview with the Resident Services Director (RSD) on 12/16/21 at 3:00pm revealed:
-The facility received COVID-19 guidance from the local health department.
-She was not aware that staff were not wearing full PPE when caring for residents that tested positive for COVID-19.

Interview with the Administrator on 12/14/21 at 11:42am revealed:
-Staff were expected to wear a N95 mask, gown, and gloves while performing resident care on residents that tested positive for COVID-19.
-Staff were expected to change PPE before going from a resident who tested positive for COVID-19 to a resident that tested negative for COVID-19.

Telephone interview with the facility's primary care provider (PCP) on 12/16/21 at 1:01pm revealed it was important for staff to adhere to CDC, NC DHHS, and LHD guidance including wearing of proper PPE when caring for residents that tested positive for COVID-19 to prevent further spread of the outbreak on the SCU.

Telephone interview with a communicable disease nurse at the LHD on 12/14/21 at 10:02am revealed:
-He provided the facility with NC DHHS Guidance for Long Term Care Facilities in an email on 12/08/21 which included wearing full PPE including a mask, face shield, gown and gloves when caring for residents that tested positive for COVID-19.
-It was important for staff to wear full PPE when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 612	Continued From page 82	D 612		

caring for residents that tested positive for COVID-19 to prevent further spread of COVID-19 on the SCU.

b. Observation of a housekeeper on the SCU unit on 12/14/21 at 4:14pm revealed she was wearing a face mask, but it was not covering her nose.

Observation of a maintenance worker in the hallway outside of the SCU unit on 12/14/21 at 4:16pm revealed he was wearing a face mask, but it was not covering his nose.

Observation of a medication aide (MA) on 12/14/21 at 12:35pm in the SCU hallway revealed she had her facemask pulled down under her chin.

Interview with the MA on 12/14/21 at 4:15pm revealed:
-She had her mask pulled down to catch her breath.
-She should not have removed her mask on the SCU because staff were always expected to have mask on to protect themselves, the residents, and other staff members.

Interview with the Resident Services Coordinator (RSC) on 12/16/21 at 1:45pm revealed:
-All staff members were expected to always wear facemasks properly including covering their nose and mouth.
-All staff were trained on how to properly wear facemasks upon hire.

Interview with the Resident Services Director (RSD) on 12/16/21 at 3:00pm revealed:
-The facility received COVID-19 guidance from the local health department.
-She was not aware that staff was not wearing

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 83 their facemasks properly. Interview with the Administrator on 12/14/21 at 11:42am revealed staff were expected to always wear their facemasks properly including covering their nose and mouths. Telephone interview with the facility's primary care provider (PCP) on 12/16/21 at 1:01pm revealed it was important for staff to adhere to CDC, NC DHHS, and LHD guidance including properly wearing facemask covering over their nose and mouth to prevent further spread of COVID-19. Telephone interview with a communicable disease nurse at the LHD on 12/14/21 at 10:02am revealed: -He provided the facility with NC DHHS Guidance for Long Term Care Facilities in an email on 12/08/21 which included properly wearing a facemask while in the facility. -It was important for staff to correctly wear facemasks over their mouth and nose to prevent further spread of COVID-19. 2. Review of the facility's census on 12/14/21 revealed there were at least 4 semi-private rooms that contained a resident that tested positive for COVID-19 and a resident that tested negative for COVID-19. Observation of the SCU on 12/14/21 from 8:30am to 9:25am revealed: -There were two medication aides (MA) on the Special Care Unit (SCU) providing care to the residents including medication administration and vital signs. -There were two personal care aides (PCA) on the SCU providing care to the residents. -The MAs and PCAs cared for both residents that	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

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D 612	Continued From page 84	D 612		

tested positive for COVID-19 and those who tested negative for COVID-19.
-There was not dedicated staff to care for the 18 residents that tested positive for COVID-19 and the 11 residents that tested negative for COVID-19.

Interview with a MA on 12/14/21 at 9:25am revealed staff were assigned residents based on location which meant they cared for residents that tested positive and negative for COVID-19 on the same shift.

Interview with the Resident Services Coordinator (RSC) on 12/16/21 at 1:45pm revealed:
-Staff was dedicated to the SCU or AL (assisted living) side of the facility each shift.
-She was aware that there were some instances that staff members had to share between SCU and AL since the COVID-19 outbreak on the SCU.

Interview with the Resident Services Director (RSD) on 12/14/21 at 11:40pm revealed:
-She received COVID-19 guidance from the local health department (LHD).
-The COVID-19 outbreak "snowballed" with positive tests.
-The regional infection control coordinator informed them on 12/13/21 to separate residents that tested positive for COVID-19 as much as possible but, with so many residents testing positive, it was not possible.

Interview with the Administrator on 12/14/21 at 12:04pm revealed:
-The regional infection control coordinator that contacted them on 12/13/21 to ensure that they had enough personal protective equipment (PPE) and did not inform them that they needed to have

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	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 85	D 612		

designated staff for residents that tested positive for COVID-19.
-He was not aware that there should be designated staff to care for residents that tested positive for COVID-19.

Telephone interview with a communicable disease nurse at the LHD on 12/14/21 at 10:02am revealed:
-He provided the facility with NC DHHS Guidance for Long Term Care Facilities in an email on 12/08/21 which included having designated staff for residents that tested positive for COVID-19 when possible.
-It was important to have designated staff for residents that tested positive for COVID-19 to prevent further spread of COVID-19.
-The facility did not specifically ask about separating residents that tested positive for COVID-19 but if they had, he would have suggested moving residents that tested positive for COVID-19 together.

Telephone interview with the regional infection control coordinator on 12/14/21 at 12:50pm revealed:
-She provided the facility with guidance about separating the residents that tested positive for COVID-19 as much as possible.
-The facility should adhere to LHD guidance regarding designating staff specifically to care for residents that tested positive for COVID-19.

3. Observation of the facility's front entrance lobby on 12/14/21 at 7:15am revealed:
-A medication aide (MA) was in the lobby at a COVID-19 screening table.
-The COVID-19 screening table included an electronic COVID-19 screening tool, a COVID-19 Antigen Rapid Self-Test kit, hand sanitizer and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 612	Continued From page 86	D 612		

KN95 masks.
-A housekeeper with the facility entered the facility and did not take her temperature or log into the electronic screening.

Interview with the housekeeper that was observed not screening at the front entrance on 12/16/21 at 10:00am revealed:
-She was trained during orientation one month ago that staff should screen at the entrance before starting their shift.
-She was familiar with how to perform a self screening including a temperature check.
-She did not want to get in the surveyor's way on 12/14/21 which was why she did not screen before starting her shift.
-She worked on the assisted living (AL) side of the facility and was not responsible for cleaning on the SCU.

Interview with the Resident Service Director (RSD) on 12/14/21 at 8:20am revealed all staff were trained upon hire that they were expected to complete the screening process including a temperature check before starting their shift.

A second interview with the RSD on 12/16/21 at 3:00pm revealed:
-She received guidance for the facility from the local health department (LHD).
-She was not aware that staff was entering the community without screening for symptoms of COVID-19 and a temperature check.

Interview with the Administrator on 12/14/21 at 11:42am revealed:
-He was not aware that there was staff that did not screen prior to entering the facility for their shift.
-Staff had expressed concern in the past about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 87 the time it took to complete screening, so he had the time clock moved to the facility entrance to prevent staff from being late. -He was responsible for reviewing the screening logs daily and would receive notification if there was an abnormal response to the screening questions. Telephone interview with a communicable disease nurse at the LHD on 12/14/21 at 10:02am revealed: -He provided the facility with NC DHHS Guidance for Long Term Care Facilities in an email on 12/08/21 which included staff screening for symptoms of COVID-19 and a temperature check at the start of each shift. -It was important to have staff screen prior to the start of each shift to prevent further spread of COVID-19. 4. Observation of the Special Care Unit (SCU) television room on 12/14/21 from 10:04am to 10:08am revealed: -There were 8 residents sitting less than 6 feet apart in distance from each other in the television room. -There were both residents who tested positive and negative for COVID-19 in the television room. -One resident did not have a face mask and one resident did not have their face mask pulled up over their nose. -There was one staff member that was wearing a mask. -The Special Care Unit Manager (SCUM) entered the television room and gave the staff member a large ball to have the residents toss. -The SCUM identified the residents to the surveyor and identified that five of the eight residents were positive for COVID-19.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 88 Observation of the SCU activity room on 12/14/21 at 12:35am revealed: -There were 4 residents seated less than 6 feet apart at a small table eating lunch. -There were no staff present. -The SCUM identified one of the residents at the table tested positive for COVID-19. Interview with the SCUM on 12/14/21 at 12:45pm revealed: -Residents that needed feeding assistance were seated in the dining room for meals. -There were 4 residents that enjoyed eating together in the activity room. -The residents that ate together in the activity room did not need feeding assistance. -It was hard to keep residents separated in the television room. -She tried encouraging creative movement such as 'kicking the ball'. -She tried to engage residents in "interactive activities rather than using touchable supplies". Interview with the Resident Services Director (RSD) on 12/15/21 at 9:00am revealed: -Residents on the SCU were to eat in their rooms unless they needed feeding assistance. -Residents should not be eating together in the activity room on the SCU. -Residents should remain socially distant when possible during activities and dining. Telephone interview with a communicable disease nurse at the LHD on 12/14/21 at 10:02am revealed: -He provided the facility with NC DHHS Guidance for Long Term Care Facilities in an email on 12/08/21 which included socially distancing for activities and social distancing for residents that needed feeding assistance.	D 612		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D 612	Continued From page 89 -It was important to socially distance during activities and dining to prevent further spread of COVID-19. _____ The failure of the facility to adhere to the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and local health department (LHD) recommendations and guidance regarding proper use of personal protective equipment including face shield, gown and gloves when caring for COVID-19 positive residents, proper wearing of face masks by staff, not dedicating staff to care for COVID-19 positive residents, staff screening including symptoms and temperature screening, and social distancing during dining and activities placed the residents in the Special Care Unit (SCU) at increased risk for transmission and infection from COVID-19. The facility's failure placed the residents at substantial risk of serious harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 12/14/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JANUARY 15, 2022.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

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D912	Continued From page 90 regulations. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Housekeeping and Furnishings and Medication Administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to the 29 residents including a paring knife left in an unlocked drawer in the dining room kitchen not monitored by staff. [Refer to Tag D0079 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations and interviews, the facility failed to ensure infection control measures were implemented during the morning medication pass on 12/14/21 by a medication aide observed on the Special Care Unit (SCU) who administered medication that had fallen onto a dirty surface and touched medications with her bare hand. [Refer to Tag D0371 10A NCAC 13F .1004(n) Medication Administration (Type B Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 4 of 9 shifts sampled from 11/30/21 to 12/10/21. [Refer to Tag D0465 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D912	Continued From page 91 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding proper use of personal protective equipment (PPE) when caring for COVID-19 positive residents including face shield, gown, and gloves, proper use of face masks by staff, dedicated staff to care for COVID-19 positive residents, staff screening, and social distancing of residents during activities and dining [Refer to Tag D0612 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision, Special Care Unit Staffing, and Infection Prevention and	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092213	A. BUILDING: _____ B. WING _____	R 12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE AT WAKE FOREST	3218 HERITAGE TRADE DR WAKE FOREST, NC 27587

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 92 Control Program. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision to 2 of 6 sampled residents (#4, #7) in accordance with their current diagnoses, assessed needs, and facility policy resulting in residents (#4, #7) having unwitnessed falls in which they were found on the floor sustaining head injuries and lacerations requiring emergency medical interventions. [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision. (Type A1 Violation)].	D914		