STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey and complaint investigation on May 17, 2022 to May 20, 2022.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 4 sampled staff (Staff D, and E) were competency validated for Licensed Health Professional Support (LHPS) tasks including oxygen administration and monitoring. The findings are: 1. Review of Staff D's, medication aide (MA), staff record revealed: -Staff D was an agency MA hired by the facility. -Staff D did not have a staff record. -There was no documentation of a LHPS competency validation.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 161	Continued From page 1 Interview with Staff D on 05/18/22 at 9:31am revealed: -She was an agency MA and was hired by the facility to work in the Special Care Unit (SCU). -She was checked off for her LHPS tasks by the LHPS Registered nurse (RN) at the staffing agency. -She did not know the resident was on continuous oxygen. Interview with Resident #3 on 05/18/22 at 12:15pm revealed: -The power had been out at the facility earlier in the day for "awhile." -He did not realize his concentrator was not turned on after the power came back on. -No staff had looked at his concentrator to make sure it was turned on. -He felt "very tired" and "didn't know why he felt so tired today." Refer to the interview with the Business Office Manager on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 2. Review of Staff E's, MA personnel record revealed: -She was an agency MA and was hired by the facility to work in the Special Care Unit (SCU). -Staff E did not have a staff record. -There was no documentation of a LHPS competency validation. -She was checked off for her LHPS tasks by the LHPS Registered nurse (RN) at the agency. -She did not know the resident was on continuous oxygen. Interview with Staff E on 05/17/22 at 9:19am	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 161	Continued From page 2 revealed: -She was an agency MA and was hired by the facility to work in the Special Care Unit (SCU). -She was checked off for her LHPS tasks by the LHPS Registered nurse (RN) at the staffing agency. -She did not know the resident was on continuous oxygen. Refer to interview with the BOM on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. _____ Interview with the BOM on 05/18/22 at 4:00pm revealed: -It was her responsibility to maintain the staff records. -She thought staffing agency was responsible for providing LHPS competency validation for their staff. -She did not request documentation of the LHPS for the agency staff. -She was told, by the contracted staffing agency they made sure all agency staff were certified nursing assistants (NAs) and MAs and did not need anything. -She did not notify the facility's Regional Nurse about the agency staff. -She was not aware she needed to have proof of the LHPS tasks, competency validations prior to the agency staff starting to work at the facility. Interview with the Administrator on 05/18/22 at 4:24pm revealed: -The BOM was responsible for maintaining the staff records. -She did not know the staff working the SCU did not have any documentation of LHPS	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 161	Continued From page 3 competency validations. -The staffing agency was responsible for the orientation and onboarding of their staff. -She had not audited the staff records since the Resident Service Director (RSD) left the facility on 04/08/22 to determine if all SCU staff had their required LHPS competency validations. The LHPS competency validation form signed by a qualified licensed health professional had not been received for Staff D and E prior to exit on 05/20/22.	D 161		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to adequately supervise 3 of 5 residents (#2, #3, & #4) resulting in physical and verbal altercations between these residents. The findings are: Review of facility policy regarding Community Rounds dated 06/08/21 revealed: -Special Care staff will ensure resident safety with awareness of where their assigned residents are	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 4	D 270		

throughout the day.
-A systematic approach for resident monitoring will be provided with routine staff rounds.
-Community rounds will be made every hour per staff assignments.
-Shift overlap time or "change of shift" time will include additional accounting of all residents.
-The Special Care Director or designee will assign appropriate staff for rounds.
-All residents will be physically visited to account for whereabouts.
-Any unsafe conditions will be corrected immediately and reported to the supervisor.
-Any unusual situations will be brought to the supervisor's attention.
-Any resident wandering aimlessly will be re-directed toward the ongoing activity program or monitored closely if resident prefers to wander or walk about.
-Any resident appearing not engaged or isolated will be encouraged and re-directed to participate in ongoing activity program.
-Any resident unaccounted for will be reported to the supervisor at once.
-If a resident is missing, the Missing Person Elopement policy and procedure will be enacted immediately.

1. Review of Resident #3's current FL-2 dated 02/21/22 revealed:
-Diagnoses included dementia, metastic colon cancer, heart failure, COVID19, and chronic obstructive, pulmonary disease.
-Resident #3 required special care unit level of care.
-He was semi-ambulatory and intermittently disoriented.

Review of Resident #3's record revealed there was no care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 5 Review of Resident #3's Licensed Health Professional Support Tasks assessment completed 03/17/22 revealed he required assistance with ambulation with assistive devices and with oxygen administration and monitoring. Review of Resident #3's hospice assessment completed 05/05/22 revealed: -He was independent with toileting and eating and required extensive assistance with dressing and bathing. -Resident #3 exhibited agitation/restlessness, anxiety, confusion, dyspnea, impaired mobility, memory loss, pain, and weakness/fatigue. Review of Resident #3's hospice visit note dated 05/06/22 revealed: -A staff member reported that Resident #3 was "dating" another resident and it had been chaotic as they were "always arguing." -The resident's Responsible Party (RP) stated she was "concerned with his agitation" and that he had "become more agitated with her and facility staff and residents," and him "yelling, cursing, and screaming at others." Review of Resident #3's progress notes revealed: -On 04/30/22, Resident #3 told Resident #2 that she needed psychiatric help and that "none of the staff are treating her right," Resident #3 was making Resident #2 anxious and agitated. -On 05/13/22, Resident #3 was found in Resident #2's room throughout the day, he dictates Resident #2's actions and demanding that she follows what he dictates. -On 05/10/22, Resident #3 was found in Resident #2's room before breakfast, a shattered glass cup was found on the ground by residents and both	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 6	D 270		

residents stated they did not know how the cup was broken. - Resident #3 was being aggressive towards Resident #2 in the morning and ordering her around, and he became angry when staff told him to sit elsewhere.
-On 05/05/22, a female resident was observed showering in Resident #3's room.
-On 05/05/22, Resident #3 was observed yelling at a resident and other staff members that he needed to leave the facility.

Telephone interview with Resident #3's RP on 05/16/22 at 6:01pm revealed:
-She was aware that Resident #3 had developed a "friendship" with a female resident at the facility.
-She was not aware of the extent of Resident #3 relationship with Resident #2, and because of her relationship to Resident #3, she did not want to know any details of the relationship.
-She was aware he could become agitated with staff and residents at times.
-She usually visited the facility a couple times per week.
-Recently, Resident #3's demeanor when she visited was relaxed and content.

Observation on 5/17/22 at 12:45pm revealed:
-Resident #3 was sitting in his wheelchair in the common area, telling Resident #2 to push him to his room, in a loud demanding voice.
-A staff member intervened and pushed Resident #3 to his room.

Observation on 05/18/22 between 3:00 - 3:30pm revealed:
-Resident #2 was in Resident #3's room without supervision.
-No staff returned to the room to check on Residents #2 and #3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 7	D 270		

Review of Resident #2's current FL-2 dated 10/19/21 revealed:
-Diagnoses included hyperthyroidism, depression, gait disorder, and major neurocognitive disorder.
-Resident #2 required special care unit level of care.
-She was ambulatory, and constantly disoriented.

Review of Resident #2's unsigned care plan, dated 10/13/21, revealed she was independent with all activities of daily living.

Review of Resident #2's progress notes revealed:
-On 04/30/22 Resident #2 stated she and Resident #3 are together and no one can do anything about it.
-On 05/06/22, Resident #2 was agitated and instigating fights with another resident during breakfast.

Observation on 5/17/22 at 12:45pm revealed:
-Resident #3 was sitting in his wheelchair in the common area, telling Resident #2 to push him to his room, in a loud demanding voice.
-A staff member intervened and pushed Resident #3 to his room.

Observation on 05/18/22 between 3:00 - 3:30pm revealed:
-Resident #2 was in Resident #3's room without supervision.
-No staff returned to the room to check on Residents #2 and #3.

Telephone Interview with Resident #2's RP on 05/19/22 at 6:15pm revealed:
-He visited the facility at least once per week.
-Resident #2 had told her that she had a "boyfriend" at the facility awhile ago.
-He did not know much about the extent of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 8	D 270		

Resident #2 and Resident #3's relationship and was not interested in knowing the details.
-Resident #3 had come into Resident #2's room when he was there for a visit one day, which was awkward.
-He finally cut the visit short because Resident #3 did not leave the room.
-He had not observed any concerning behavior between Resident #2 and Resident #3 while he was visiting.

Refer to interview with personal care aide (PCA) on 05/18/22 at 11:15am.

Refer to interview with a second PCA on 05/18/22 at 3:45pm.

Refer to interview with a medication aide (MA) on 05/18/22 at 4:00pm.

Refer to telephone interview with a former MA on 05/19/22 at 2:23pm.

Refer to telephone interview with former special care coordinator (SCC) on 05/19/22 at 2:39pm.

Refer to interview with resident care coordinator (RCC) on 05/18/22 at 3:10pm

Refer to interview with administrator on 05/18/22 at 3:30pm and 05/19/22 at 3:05pm.

2.) Review of Resident #4's current FL-2 dated 05/03/22 revealed included diagnoses included anxiety disorder, dementia without behavioral disturbance, left femur fracture and hypertension.

Review of Resident #4's record revealed no completed care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 9 Review of Resident #4's record revealed no accidents or incident reports. Review of Resident #4's progress notes revealed no documentation regarding altercation between Resident #3 and Resident #4. Attempted telephone interview with Resident #4's Power of Attorney (POA) on 05/20/22 at 11:03am and 12:09pm was unsuccessful. Refer to interview with PCA on 05/18/22 at 11:15am. Refer to interview with a second PCA on 05/18/22 at 3:45pm. Refer to interview with a MA on 05/18/22 at 4:00pm. Refer to telephone interview with a former MA on 05/19/22 at 2:23pm. Refer to telephone interview with former SCC on 05/19/22 at 2:39pm. Refer to interview with RCC on 05/18/22 at 3:10pm. Refer to interview with administrator on 05/18/22 at 3:30pm and 05/19/22 at 3:05pm. _____ Interview with a PCA on 05/18/22 at 11:15am revealed: -She only worked in the special care unit (SCU) a few times, she usually worked on the assisted living unit. -Resident #3 could sometimes be "sweet," but he could also be challenging, becoming upset and yelling at other residents and staff.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 10 -Resident #3 thought Resident #2 was his wife and would often try to take her to his room. -She recalled once Resident #2 was not feeling well, and Resident #3 insisted she go to bed. -Resident #3 would not leave her room. -She went into Resident #2's room later and convinced Resident #3 to leave her alone so she could rest. Interview with a PCA on 05/18/22 at 3:45pm revealed: -She worked for an agency and today was her first day working in the facility. -She did not know any of the residents' names. -No one had informed her of any resident behaviors of which she needed to be aware. Interview with a Medication Aide (MA) on 05/18/22 at 4:00pm revealed: -She worked for an agency and had only worked in the facility once before today. -Today was her first day in the SCU. -She was using a list of residents clothing and the pictures on the medication administration records (MARs) to identify residents. -No one told her about any resident behaviors of which she needed to be aware. Telephone interview on 05/19/22 at 2:23pm with a former MA revealed: -Resident #3 frequently became upset and would shout and yell at other residents and staff. -Resident #3 was much more coherent than Resident #2. -Resident #3 would often upset Resident #2, telling her that staff "didn't want them to be together." -She would try to tell Resident #3 not to take Resident #2 into his room, but he would do so anyway.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 11	D 270		

-Resident #2 did not understand that Resident #3 was not her husband.
-She observed Resident #3 bossing Resident #2 around, telling her to push his wheelchair and to make his bed.
-Resident #3 would also become aggressive when Resident #4 would wander into his room.
-She recalled one time when Resident #4 wandered into Resident #3's room she attempted to intervene when Resident #3 became upset with Resident #4.
-Resident #2 was nearby when the altercation occurred and hit the MA a walker when she saw that Resident #3 was involved.
-Resident #3's dementia was very mild compared to most of the residents in the SCU and he became very agitated and frustrated because of the other residents wandering behaviors and confusion.
-The SCC had told staff to "redirect" Resident #4 when she began wandering toward Resident #3's room, and to either redirect Resident #2 and Resident #3 when they were together, or to "leave them be" because separating them was a trigger for both of them and could cause additional behaviors.

Telephone interview with former SCC on 05/19/22 at 2:39pm revealed:
-Resident #3 was often upset at other residents and staff and would frequently sit in the hallway and yell and curse at staff and residents.
-Resident #3 and Resident #2 were frequently together.
-Staff observed them to be found in Resident #2's bed in the morning often and sometimes Resident #2 would not be wearing any underwear.
-She was concerned about the relationship between Resident #2 and Resident #3 because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 12	D 270		

Resident #3 was more coherent than Resident #2.
-Resident #3 would tell Resident #2 to make his bed.
-Resident #3 would often want Resident #2 in his room, but sometimes he would become frustrated because of her dementia and would demand she leave.
-Sometimes staff would have to intervene to get Resident #2 out of his room.
-When this occurred, Resident #2 would become upset because she did not understand what she had done to cause Resident #3 to want her out of his room.
-Often, later in the same day, Resident #3 would again want Resident #2 back in his room.
-She had raised concerns regarding the relationship and behaviors between Resident #2 and Resident #3 to the administrator on several occasions, to which the administrator would respond that the residents "had rights" and that nothing could be done regarding their relationship.
-There was never any discussion of redirection or room changes, since their rooms were close together.
-Resident #3 would also become very aggravated toward Resident #4.
-She never observed Resident #4 to wander into Resident #3's room, but she heard Resident #3 mocking Resident #4 saying "she's crazy! Here she comes!" and observed Resident #3 to try to block her path with his wheelchair when Resident #4 would wander down the hallway to look out to door near his room.

Interview with the RCC on 05/18/22 at 3:10pm revealed:
-She worked in the facility for about 2 weeks.
-She worked mostly in assisted living and was still

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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	D 270		

learning the residents in the special care unit.
-She tried to make sure that there was always at least one facility staff member working in the SCU with the agency staff so that at least one staff member would be familiar with the residents and could guide the agency staff regarding residents' needs.
-She was not aware that the facility staff member who was working in the SCU today had only worked in SCU a few times and was not familiar with most of the residents in the SCU.
-She was not aware of any residents in the SCU that were on any increased supervision measures currently.
-If there were residents needing increased supervision, this would be communicated at shift change.

Interview with Administrator on 05/18/22 at 3:30pm and on 05/19/22 at 3:05pm revealed:
-She was aware that Resident #3 and Resident #2 were often together in the SCU.
-Resident #2 would exhibit behaviors if staff tried to intervene and remove her from Resident #3's room.
-Resident #2 often looked to Resident #3 for direction when someone else was trying to tell her what to do.
-Resident #2 had been found in Resident #3's bed on at least one occasion.
-The staff member attempted to remove her from the bed, which resulted in Resident #2 becoming combative.
-Resident #4 often needed to be redirected away from the end of the hallway that Resident #3's room was on because she would wander down that way and sometimes go into his room or close his door which would upset him.
-The facility had been without a SCC for a few weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 -She was in the process of working with the activity director regarding developing an activity schedule that would separate residents in the SCU according to their cognitive status. -If residents were separated in this way, Resident #4 and Resident #3 not be around one another as much and there would be less opportunities for altercations between them. -Since the facility had been without an SCC, she and the RCC had been taking turns spending time in the SCU to assure residents were receiving adequate supervision and care until a new SCC was in place. -She usually spent time the SCU in the mornings to see how things were going and the RCC would spend time there in the afternoons. -She was aware that Resident #2 and Resident #3 were on different cognitive levels. -Although Resident #2's dementia had progressed more than Resident #3's, Resident #2 could still tell you about how she and Resident #3's "relationship" started and what she liked about him and how he was different than her husband. -She had spoke with Resident #2's responsible party and he was already aware that Resident #2 was "in a relationship" with another resident. -She had informed staff to do "continual safety rounds" every 15 minutes to check on Resident #3 if Resident #2 is with him. -If Resident #2 was not with him, they did not have to conduct the 15-minute checks. -Resident #3 could sometimes become agitated and would become loud when this occurred. -Staff had been directed to immediately go and see what was going on if they ever heard Resident #3 becoming loud. -Staff had been directed to try to encourage Resident #2 to "give him some space" if he became agitated.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 15 -Staff were aware that they could call Resident #2's responsible party if they needed his assistance in redirecting her away from Resident #3. -Staff had been directed to address both residents when they go into one of their rooms as it had been identified to be a trigger for Resident #2 if staff only addressed her or him. _____ The facility failed to provide supervision of Residents #2, #3, and #4, resulting in physical altercations with injuries to Resident #2 of unknown origin. The failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 20, 2022 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 5, 2022.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 276	Continued From page 16 Based on interviews and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#1) related to follow-up appointment and lab work after a resident was found lethargic. The findings are: Review of Resident #1's current FL2 dated 07/26/21 revealed diagnoses included dementia and hypothyroidism. Review of Resident #1's Physician Communication sheet dated 04/05/22 revealed: -Resident #1 was very lethargic. -Resident #1's Primary Care Physician's (PCP) reply was as follows, would it be possible to bring Resident #1 to the PCP's office on 04/06/22 at 11:00am. -Confirm by calling the PCP's office. -If Resident #1 worsened take Resident #1 to the emergency department for evaluation. -Try to get a urine sample, complete blood count (CBC), complete metabolic panel (CMP), and a thyroid stimulated hormone (TSH) level. -Can do the lab work in the PCP's office on 05/06/22. Review of Resident #1's Progress Notes revealed: -On 04/04/22, Resident #1 was lethargic, found in another resident's room and complaining of not feeling well. -On 04/06/22, Resident #1 vomited multiple times after dinner. -On 04/07/22, Resident vomited after drinking coffee. -On 04/08/22, Resident #1 slid out of her wheelchair.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 276	Continued From page 17 Telephone interview with Resident #1's PCP on 05/19/22 at 10:10am revealed: -On 04/05/22, she received an email from staff at the facility stating Resident #1 was lethargic. -On 04/05/22, she returned an email requesting the facility staff contact her office about an appointment on 04/06/22 at 11:00am. -On 04/05/22, in the email she requested the facility staff complete the lab work if Resident #1 could not come to her office on 04/06/22. -She did not receive communication from the facility staff after that email was sent. -On 04/06/22, she called the facility staff to inquire about the lab work that she ordered on 04/05/22 and she was told the former Health and Wellness Director (HWD), who was a Registered Nurse (RN) would call her back. -On 04/06/22, she did not receive a call back from the facility. -On 04/07/22, she called the facility to check on Resident #1's condition and left a message for the former HWD to return her call. -On 04/08/22, her staff called the facility and notified the staff, she would be in to see Resident #1 at the facility and to have a urine sample ready and labs. -On 04/08/22, when she arrived at the facility, there were no labs completed or a urine sample acquired. -She asked the former HWD about the lack of responses related to Resident #1 being seen and was given excuses. -On 04/08/22, she ordered an antibiotic for Resident #1 due to a urinary tract infection based on symptoms and a urine sample and blood work was obtained and sent to the lab. -On 08/13/22, she changed the antibiotic she ordered for Resident #1's UTI because there was a bacterial resistance to the previous antibiotic according to the urine culture obtained.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 276	Continued From page 18 -This follow-up was very important because an untreated UTI could cause pyelonephritis (infection of the kidneys) and sepsis (a life-threatening condition caused by the body's response to an infection). Interview with the lead medication aide (MA) on 05/19/22 at 3:00pm revealed: -Prior to 04/08/22, the Resident Service Director (RSD) was responsible for processing the orders, notification to the lab and transportation. -The RSD was no longer at the facility on 04/08/22. -After 04/09/22, she was responsible for processing the orders, notification to the lab and transportation. -She was not aware of Resident #1's order dated 04/05/22 for the follow-up visit, urine sample and lab work. Interview with the Resident Care Coordinator (RCC) on 05/20/22 at 11:34am revealed: -The signed Physician Communication sheet was considered an order and any response from the physician was to be considered a physician's order. -On 04/05/22, the lead MA would have been responsible for processing the order written by Resident #1's PCP to complete lab work, urine and for the appointment on 04/06/22. -The Lead MA was responsible for notifying transportation to make arrangements for Resident #1 to be transported to the PCP office. -The Lead MA was responsible for notifying the lab for a lab draw visit. -The transportation aide was responsible for transportation of Resident #1 to the PCP office. -The contracted lab after receiving the orders was responsible for obtaining the blood work at the facility.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 276	Continued From page 19 Interview with an Administrator from sister facility on 05/20/22 at 12:04pm revealed: -She was the Administrator from another community temporally filling in. -The signed Physician Communication sheet was considered a physician's order. -During the last 6 months, the Regional Nurse/Resident Care Coordinator (RCC)/Administrator were responsible for processing the orders. -One of the above staff was responsible for notifying the lab and transportation for Resident #1 ' s appointments. -On 04/05/22 to present, the lead MA was responsible for processing the orders, notifying the lab and transportation. Interview with the Administrator on 05/19/22 at 2:57pm revealed: -Prior to until 04/08/22, the RSD was responsible for processing all orders and notification to the lab and transportation. -From 04/09/22 to 04/26/22, the lead MA was responsible. -From 04/26/22 to 05/10/22 the SCD was responsible. -From 05/10/22 she was responsible until the RCC was trained. -She did not know the blood work or urine sample was not obtained when ordered by the physician and the physician completed it during the visit with Resident #1. Based on observations and record reviews, Resident #1 was not interviewable. _____ The facility failed to ensure the resident attended a follow-up appointment with primary care provider after an episode of lethargy resulting in a	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 276	Continued From page 20 3-day delay in diagnoses and treatment of a UTI. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 20, 2022 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 5, 2022.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the rights of a resident were guaranteed for 1 of 5 residents (Resident #1) as evidence by a resident in the Special Care Unit (SCU) not receiving her hearing aids, dentures and glasses on a daily basis. The finding are: Review of Resident #1's current FL2 dated 07/26/21 revealed diagnoses included dementia and hypothyroidism. Review of Resident #1's Licensed Health Professional Support (LHPS) tasks dated 02/02/22 revealed a task for the application and removal of prosthetic device.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 338	Continued From page 21 Observation of Resident #1 during the medication pass on 05/17/22 at 9:46am revealed: -Resident #1 was in her wheelchair in the day room. -Resident #1 did not have on her hearing aids, glasses or her dentures were not in her mouth. -Resident #1's hearing aids were not in their containers in the medication cart. Interview with the medication aide (MA) on 05/17/22 at 9:46am revealed: -On 05/17/22, she was responsible for administering medications to the residents in the SCU. -Resident #1 had hearing aide containers in the medication cart which did not contain the hearing aids. -She would have put the hearing aids in Resident #1's ear if they were in the containers. Observation of the medication cart on 05/18/22 at 9:31am revealed there were no hearing aids in their containers in the medication cart. Observation of Resident #1's bathroom on 05/18/22 at 9:32am revealed Resident #1's dentures were in her bathroom in the denture cup. Observation of Resident #1 on 05/18/22 at 9:38am revealed: -Resident #1 was sitting in her wheelchair in the day room. -She was not wearing her hearing aids, glasses or dentures. Observation of Resident #1's bathroom on 05/19/22 at 9:00am revealed Resident #1's dentures were in her bathroom in the denture	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 338	Continued From page 22 cup. Observation of the medication cart on 05/19/22 at 9:05am revealed there were no hearing aids in their containers in the medication cart. Observation of Resident #1 on 05/19/22 at 9:08am revealed: -Resident #1 was sitting in her wheelchair in the day room. -She was not wearing her hearing aids, glasses or dentures. Observation of Resident #1's bathroom on 05/20/22 at 9:00am revealed Resident #1's dentures were in her bathroom in the denture cup. Observation of the medication cart on 05/20/22 at 9:02am revealed there were no hearing aids in their containers in the medication cart. Observation of Resident #1 on 05/20/22 at 9:05am revealed: -Resident #1 was sitting in her wheelchair in the day room. -She was not wearing her hearing aids, glasses or dentures. Telephone interview with Resident #1's Power of Attorney (POA) on 05/18/22 at 4:47pm revealed: -Resident #1 was considered deaf and required hearing aids in order to communicate and follow direction. -Resident #1's hearing aids have been lost many times and replaced two times by her. -Resident #1 has an eye condition which required her to wear glasses in order to see. -When Resident #1 does not have her glasses on or hearing aids in she cannot her or see and that	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 338	Continued From page 23	D 338		

greatly decreases her quality of life.
-The facility failed to put Resident #1's dentures in many times which caused Resident #1 to develop sores in her mouth when the staff did put her dentures in because they did not use a denture adhesive.
-She took Resident #1 and the dentures to the dentist the beginning of March 2022, to be resized and informed the staff to put the dentures in every day and use a denture adhesive.
-There was a family friend who came to the facility every day and checks on Resident #1 and Resident #1 had not been wearing the dentures, hearing aids or glasses since the first of March 2022.
-She informed the previous Resident Care Director the beginning of March 2022 and nothing was done about it.
-She called the Administrator in March 2022 and informed her Resident #1's hearing aids were missing again, and the staff were not putting Resident #1's dentures in or glasses on.
-During the phone call to the Administrator in March 2022, she informed the Administrator Resident #1 was not able to communicate effectively because Resident #1 could not hear without the hearing aids, see without the glasses or effectively eat without the dentures.
-When she tried to talk to Resident #1 over the phone Resident #1 could not hear her and even with the family friend there trying to help Resident #1 communicate was impossible because Resident #1 could not hear them.
-She received a call from Resident #1's primary care physician (PCP) on 04/08/22 after a visit asking about Resident #1's hearing aids and Resident #1 not being able to hear what she was saying.
-She was told when Resident #1 was admitted to the SCU, the staff was responsible for putting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 338	Continued From page 24 Resident #1's hearing aids in, glass on and dentures in her mouth but no one had done that. Telephone interview with Resident #1's PCP on 05/19/22 at 10:10am revealed: -Resident #1 was last seen by her at the facility on 04/08/22 after being found unresponsive on 04/05/22. -Resident #1 was not wearing glasses or hearing aids which made it very difficult to communicate with Resident #1. -Resident #1 could not hear her at all so questions were not answered. -She diagnosed Resident #1 with a urinary tract infection during that visit and was concerned because if Resident #1 had any other complaints then she could not communicate that to the staff. -She considered the fact Resident #1 did not have the hearing aids in, glasses on or wearing her dentures a critical impact on Resident #1's quality of life because of the lack of communication. Interview with the Administrator on 05/18/22 at 4:24pm revealed: -She received a report from the Resident Service Director in November 2021 Resident #1 lost her hearing aids. -The family replaced them in November 2021, and she did not hear anything more about it. -The medication aides (MAs) were responsible for putting Resident #1's hearing aids in in the morning and taking them out and placing the hearing aids in their containers back in the medication cart every evening. -The personal care aides (PCAs) were responsible for putting Resident #1's dentures in every morning before breakfast and take them out at night before bed. -The PCAs were also responsible for putting	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 338	Continued From page 25 Resident #1's glasses on in the morning and off at night.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#4) who was prescribed medications for insomnia and constipation. The findings are: Review of the facility's undated Medication Policies and Procedures revealed: -Medication orders will be verified by staff with a prescribing practitioner when orders received where not clear or incomplete. -Clarification would be documented in the resident's record.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 26	D 344		

Review of Resident #4's current FL-2 dated 05/03/22 revealed included diagnoses included anxiety disorder, dementia without behavioral disturbance, left femur fracture and hypertension.

Review of resident's record revealed that Resident #4 was admitted on 03/29/22.

Review of Resident #4's subsequent physicians dated 05/12/22 revealed a discontinue order for melatonin 3mg every night.

Review of Resident #4's March 2022 electric Medication Administration Record (eMAR) revealed:
-There was an entry for melatonin 3mg every night scheduled at 8:00pm.
-The Melatonin 3mg every night was not documented as administered 03/29/22 to 03/31/22 due to awaiting new medications and prescription.

Review of Resident #4's April 2022 eMAR on revealed:
-There was an entry for melatonin 3mg every night at bedtime hard copy prescription (Rx) required ** suspended 04/21/22 to 05/15/22: hold/meds for discontinue (D/C) order**.
-The melatonin 3mg was documented as, "awaiting Rx delivery" on 04/01/22, 04/04/22, 04/05/22, 04/06/22, 04/07/22, 04/08/22, 04/12/22, 04/13/22 and 04/14/22, "not on cart" on 04/19/22,"awaiting Rx" on 04/09/22, 04/10/22 and 04/15/22, "resident refused" on 04/16/22, "needed a new script" on 04/17/22, "withheld" on 04/18/22, and "awaiting pharmacy" on 04/20/22.
-The melatonin 3mg every night at bedtime was documented as administered on 04/11/22.
-The melatonin 3mg every night at bedtime was documented as on hold from 04/21/22 to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 27 04/30/22. Review of Resident #4's May 2022 eMAR revealed: -There was an entry for melatonin 3mg every night at bedtime hard copy Rx required ** suspended 04/21/22 to 05/15/22: hold/meds for D/C order**. -The melatonin 3mg every night at bedtime was documented as on hold from 05/01/22 to 05/14/22. -The melatonin 3mg every night at bedtime was documented as administered on 05/15/22. Telephone interview with Resident #4's contracted pharmacy technician on 05/18/22 at 11:49am revealed: -The facility was responsible for faxing all orders to the pharmacy. -The pharmacy was responsible for entering all orders on to the eMAR. -The pharmacy received an unsigned order for melatonin 3mg every night at bedtime to be dispensed. -All orders received at the pharmacy required a physician signature. -Because there were no signed physician orders, there was an entry on the eMAR requiring a prescription before the pharmacy could dispense the medication. Interview with lead MA on 05/19/22 at 10:48am and 3:10pm revealed: -She expected the MAs to report to her if there needs to be a clarification of orders with the physician or pharmacy. -The MAs are responsible for contacting the pharmacy and the PCP to reorder or clarify medication orders. -The MAs are responsible for obtaining	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 28	D 344		

prescriptions from the resident's PCP.
-The MAs are responsible for sending any new orders or prescriptions to the pharmacy.
-It was her responsibility to complete a weekly cart audit but was unable to complete audit last week.
-She did not know Resident #4 did not have melatonin on the cart.
-She was responsible for notifying the Resident Care Coordinator (RCC) of any missed medications.
-She does not remember anyone notifying her of any medications for Resident #4 that required clarification.

Interview with the RCC on 05/19/22 at 11:23am revealed:
-She expected the MAs to report to the lead MA if there needs to be a clarification of orders with the physician or pharmacy.
-The MAs are responsible for completing a form to send to pharmacy to reorder or clarify medication orders.
-The MAs are responsible for obtaining prescriptions from the resident's PCP.
-The MAs are responsible for sending any new orders or prescriptions to the pharmacy.
-She did not know Resident #4 did not have melatonin on the cart.

Interview with the Administer on 05/19/22 at 3:30pm revealed:
-Lead MA was to notify Administer of any missing medications.
-Lead MA was responsible for notifying the pharmacy or PCP to reorder or clarify medication orders.
-She did not know Resident #4 did not have melatonin.
-She expected the staff to administer medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 29 as prescribed by the PCP. Interview with Resident #4's PCP on 05/19/55 at 11:45am revealed: -She did not know Resident #4 did not have her medications. -She had not received notification from the facility that Resident #4 did not have a signed physician order for the melatonin. -If facility had contacted her to notify her that the orders did not have the physician signature, she would have sent new signed orders immediately. b. Review of Resident #4's current FL-2 dated 05/03/22 revealed an order for polyethylene glycol 3350, 17gm daily. Review of Resident #4's March 2022 eMAR revealed: -The was an entry for polyethylene glycol 3350, 17gm daily scheduled at 9:00am. -The polyethylene glycol 3350, 17gm daily was not documented as administered 03/29/22 to 03/31/22 due to awaiting new medications and prescription. Review of Resident #4's April 2022 eMAR on revealed: -There was an entry for polyethylene glycol 3350, 17gm daily hard copy Rx required **suspended 04/21/22 to 05/15/22: hold/meds for D/C order**. -The polyethylene glycol 3350, 17gm daily was documented, "awaiting delivery" on 04/01/22, 04/06/22, 04/07/22, 04/08/22, 04/11/22, 04/14/22, 04/15/22 and 04/17/22, "not on cart" on 04/02/22, 04/03/22, 04/04/22, 04/12/22 and 04/13/22, "unable to take" on 04/05/22, 04/18/22, 04/19/22 and 04/20/22, "waiting for Rx/order" on 04/09/22, 04/10/22 and 04/16/22 and, "awaiting pharmacy" on 04/21/22.	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 30	D 344		

-The polyethylene glycol 3350, 17gm daily was documented as on hold from 04/22/22 to 04/30/22.

Review of Resident #4's May 2022 eMAR on 03/18/22 revealed:
--There was an electronic entry for polyethylene glycol 3350, 17gm daily hard copy Rx required **suspended 04/21/22 to 05/15/22: hold/meds for D/C order**.
-There was documentation on the MAR of polyethylene glycol 3350, 17gm daily on hold from 05/01/22 to 05/15/22.
-There was documentation on the MAR that polyethylene glycol 3350, 17gm administered 05/16/22.
-There was a circle around the MA's initials documented beside polyethylene glycol 3350, 17gm daily with electronic note stating, "medication not on cart" on 05/17/22.

Observation of Resident #4's medications on hand on 05/18/22 at 10:50am revealed there was no polyethylene glycol 3350, 17gm daily on the medication cart.

Telephone interview with Resident #4's contracted pharmacy technician on 05/18/22 at 11:49am revealed:
-The facility was responsible for faxing all orders to the pharmacy.
-The pharmacy was responsible for entering all orders on to the eMAR.
-The pharmacy received an unsigned order for polyethylene glycol 3350, 17gm daily to be dispensed.
-All orders received at the pharmacy required a physician signature.
-Because there were no signed physician orders, there was an entry on the eMAR requiring a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 31	D 344		

prescription for polyethylene glycol before the pharmacy could dispense the medication.

Interview with lead MA on 05/19/22 at 10:48am and 3:10pm revealed:
-She expected the MAs to report to her if there needs to be a clarification of orders with the physician or pharmacy.
-The MAs are responsible for contacting the pharmacy and the PCP to reorder or clarify medication orders.
-The MAs are responsible for obtaining prescriptions from the resident's PCP.
-The MAs are responsible for sending any new orders or prescriptions to the pharmacy.
-It was her responsibility to complete a weekly cart audit but was unable to complete audit last week.
-She did not know Resident #4 did not have polyethylene glycol on the cart.
-She was responsible for notifying the Resident Care Coordinator (RCC) of any missed medications.
-She does not remember anyone notifying her of any medications for Resident #4 that required clarification.

Interview with the RCC on 05/19/22 at 11:23am revealed:
-She expected the MAs to report to the lead MA if there needs to be a clarification of orders with the physician or pharmacy.
-The MAs are responsible for completing a form to send to pharmacy to reorder or clarify medication orders.
-The MAs are responsible for obtaining prescriptions from the resident's PCP.
-The MAs are responsible for sending any new orders or prescriptions to the pharmacy.
-She did not know Resident #4 did not have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 344	Continued From page 32 polyethylene glycol on the cart. Interview with the Administer on 05/19/22 at 3:30pm revealed: -Lead MA was to notify Administer of any missing medications. -Lead MA was responsible for notifying the pharmacy or PCP to reorder or clarify medication orders. -She did not know Resident #4 did not have polyethylene glycol. -She expected the staff to administer medications as prescribed by the PCP. Interview with Resident #4's PCP on 05/19/55 at 11:45am revealed: -She did not know Resident #4 did not have her medications. -She had not received notification from the facility that Resident #4 did not have a signed physician order for the polyethylene glycol. -If facility had contacted her to notify her that the orders did not have the physician signature, she would have sent new signed orders immediately.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 33 TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents related to nebulizer treatments and oxygen used to treat breathing problems (Resident # 3) and a medication used to treat thyroid problems (Resident #1). The findings are: Review of the facility's Medication Administration Policy and Procedure dated 09/18/19 revealed: -The medications were to be administered as ordered by the physician. -The medications were to be administered and documented on the electronic Medication Administration Record (eMAR). -The medications were to be refilled in a timely manner to ensure residents had all physician medications available. 1. Review of Resident #3's current FL-2 dated 02/21/22 revealed: -Diagnoses included dementia, metastic colon cancer, heart failure, COVID19, and chronic obstructive pulmonary disease (COPD). -Resident #3 required special care unit (SCU) level of care, he was semi-ambulatory, and was intermittently disoriented. -Resident #3 had an order for 4 liters of continuous oxygen. -An order for budesonide 0.5mg per 2ml nebulization twice daily (used to prevent breathing difficulties, chest tightness, wheezing, and coughing caused by respiratory disorders, such as asthma and COPD). -An order for formoterol, 20mcg/2ml 20mcg nebulization every 12 hours (long-acting	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 34	D 358		

bronchodilator used as a long-term maintenance treatment to prevent or decrease wheezing and trouble breathing caused by asthma or ongoing lung disease such as COPD);
-An order for revefenacin (yupelri) 175mcg/2ml inhalation solution nebulized daily (long-term medication used to treat an ongoing lung disease, COPD, used regularly to reduce and prevent symptoms such as shortness of breath, cough, and wheezing).

Review of Resident #3's physician's orders revealed:
-An order dated 03/21/22 for Duoneb inhale via nebulizer BID (every 12 hours) (used to treat and prevent symptoms (wheezing and shortness of breath) caused by ongoing lung disease (COPD) which includes bronchitis and emphysema.

Review of hospital discharge documentation revealed Resident #3 was initially discharged from the hospital to the facility on 02/21/22.

Review of Resident #3's hospital discharge summary dated 04/19/22 revealed:
-Resident #3 was admitted to the hospital from 04/07/22 - 04/19/22.
-The "chief complaint" was documented as increasing shortness of breath.
-Resident #3 had a history of COPD, required continuous oxygen, had a history of congestive heart failure, dementia, and colon cancer with metastasis to the liver, and also atrial fibrillation.
-At admission, Resident #3 had developed shortness of breath overnight and was found to be running a fever of 103.5.
-His heart rate was as high as 159 and his blood pressure was 114/61.
-A computed tomography (CT) pulmonary angiogram revealed no pulmonary embolisms but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 35 bibasilar atelectasis (complete or partial collapse of lower lung) and consolidation with right basilar mucous plugging. Review of Resident #3's emergency department visit note dated 04/07/22 revealed: -Resident #3 presented with concerns for shortness of breath, reporting progressive shortness of breath throughout the night. -Upon arrival, Resident#3 was "satting at 60% on 3 liters of oxygen." -Resident #3 was administered albuterol by improvement of symptoms and placed on BiPAP (a mode of ventilation developed for full ventilatory support in intensive care settings). -Resident #3 presented with concerns of shortness of breath, likely secondary to COVID-19 pneumonia with community-acquired pneumonia, and had significant hypoxia as well as tachycardia. a.) Review of Resident #3's electronic medication administration records (eMAR) from February 2022 through May 2022 revealed no entry for oxygen, 4 liters, continuous. Review of Resident #3's progress note dated 05/05/22 revealed: -Resident was having trouble breathing this morning; oxygen saturation was 83 and after oxygen cord was detangled, oxygen saturation was 96. -Resident continuously thinks his oxygen is connected when it is not. Review of Resident #3's documentation from hospice progress report dated 05/11/22 revealed he had dyspnea (shortness of breath) with minimal exertion and had a wet cough.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 36 Review of documentation from hospice progress report dated 05/16/22 revealed: -Upon arrival Resident #3 was wheeling himself down the hallway. -Assisted Resident #3 with connecting nasal cannula to oxygen concentrator. Review of documentation from hospice progress report dated 05/05/22 revealed: -At arrival, Resident #3 was sitting in the hallway in his wheelchair. -He had his oxygen cords present; however, there was no oxygen tank in sight. -Resident #3 reported he sometimes had pain in his lungs and stated it "feels like something is sticking in my lungs." Observation of Resident #3 on 05/18/22 at 12:15pm revealed: -Resident #3 was sitting in his wheelchair in his room, with his nasal cannula in place, which was attached to his concentrator, however, the concentrator was not turned on. -Resident #3 appeared pale in color. -Resident #3 turned the concentrator on at 12:20pm. -Resident #3's checked his oxygen saturation at 12:25pm was 94%. Interview with Resident #3 on 05/18/22 at 12:15pm revealed: -The power had been out at the facility earlier in the day for "awhile." -He did not realize his concentrator was not turned on after the power came back on. -No staff had looked at his concentrator to make sure it was turned on. -He felt "very tired" and "didn't know why he felt so tired today."	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 37 Interview with MA on 05/18/22 at 12:25pm revealed: -She worked for an agency and today was her first day working in the special care unit (SCU). -The power had been out at the facility today from about 7:45am to 10:30am. -She was not very familiar with the residents or their needs. -She was utilizing a list another staff member had made her to help her identify residents by what they were wearing today, along with the pictures of them in the medication administration record (MAR) system. -She was not aware that Resident #3 did not have an oxygen canister in place during the power outage this morning. -She was not aware that Resident #3's concentrator was not turned back on after the power was restored around 10:30am this morning. -She had not noticed the concentrator was not turned on when she went to his room earlier to administer his nebulizer medications after the power had been restored. -She did not recall if oxygen was listed on Resident #3's MAR. Observation of Resident #3 on 05/18/22 at 2:45pm revealed: -Resident #3 was in the common area, with oxygen canister attached via nasal cannula and was assisted back to his room by a staff member. -The staff member did not assist Resident #3 with switching from the oxygen canister to his oxygen concentrator. -Resident #3 asked for assistance in switching to his concentrator after staff member left his room because he "didn't have the wrench" necessary to turn the canister off. -After prompting, the MA assisted in switching	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 38 him to the concentrator. Interview with the MA on 05/18/22 at 2:55pm revealed: -She had the wrench required to turn the oxygen concentrator off for Resident #3. -No staff informed her that Resident #3 needed assistance switching from his oxygen canister to his concentrator. Observation of the SCU on 05/19/22 at 9:10am revealed: -Resident #3 was ambulating in his wheelchair down the hallway from his room toward the dining room, with no oxygen in place. -Resident #3 checked his oxygen level and it was 90% and his heart rate was 104 at 9:12am. -Resident #3 made his way to the dining room, continuing without oxygen in place at 9:18am. -The MA working in the SCU was observed to be at the medication cart in an alcove across from the dining room, using her phone for several minutes. -Resident #3 was sitting at the table eating his breakfast at 9:24am, continuing without oxygen in place. - Resident #3 checked his oxygen level and it was 88% and his heart rate was 80 at 9:24am. -Resident #3 had a lot of congestion in his chest with a productive cough and appeared pale and dusky. -At 9:27am, Resident #3 checked his oxygen and it was 83% and his heart rate was 101. -At 9:27am, the MA was prompted to check on Resident #3 because he was not wearing his oxygen in the dining room. -The MA replied she "be there in a few minutes" and that she was "getting his medications ready." -At 9:29am the MA was prompted a second time to check on Resident #3.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 39	D 358		

-At 9:31am, the MA brought an oxygen canister to the dining room and used a wrench tool to turn the canister on.
-At 9:33am, Resident #3's checked his oxygen and it was 93% and his heart rate was 70.
-At 9:35am, Resident #3's checked his oxygen level was 97% and his heart rate was 61.
-Medication aide was observed telling Resident #3 that "he knew he could not leave his room without his oxygen" and that he "needed to make sure he always had it with him."

Interview with Resident #3 on 05/19/22 at 9:10am revealed:
-Resident #3 stated his fingers were cool to touch.
-Resident #3 stated it was sometimes hard to catch his breath while trying to eat.

Observation of Resident #3 on 05/19/22 at 2pm revealed:
-Resident #3 was sitting in his room in his wheelchair, attached to two portable tanks.
-The dials on both of the portable tanks were in the red zone, reflecting they were empty.
-At 2:01pm, Resident #3 checked his oxygen and was 88% and his pulse was 65.
-At 2:03pm MA was prompted to assist Resident #3 in switching to his concentrator from the portable tanks.
-At 2:06pm the MA went to Resident #3's room and used a wrench tool to turn off the oxygen tanks and switched him back to his concentrator.
-Resident #3 was connected via nasal cannula to his oxygen concentrator at 2:09pm.
-At 2:14pm, Resident #3 checked his oxygen and it was 96.

Interview with Resident #3 at 2:00pm revealed:
-Staff had pushed him back to his room after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 40	D 358		

lunch over an hour ago but did not switch the oxygen from the portable tanks to the concentrator.
-He was not aware the tanks he was currently using were both empty and that he was not receiving any oxygen through his nasal cannula.
-He depended on staff to switch him to and from the canisters when he left and returned to his room because he did not have a wrench tool required to turn off the oxygen tanks when he needed to switched to his concentrator, or to switch to the tanks when he wanted to leave his room.
-He was currently feeling "really tired" and was short of breath.

Interview with MA on 05/19/22 at 2:09pm revealed:
-When she assisted Resident #3 in switching to the concentrator from the tanks, she observed the tanks he was connected to were both empty.
-She was at lunch when Resident #3 was in the dining room, and she did not know if someone had assisted him back to his room after lunch.
-She had not conducted rounds to check on residents since returning from her lunch break.
-The MA had the wrench required to turn the oxygen canisters on and off when Resident #3 was leaving, or returning to, his room.
-Resident #3 was not able to turn the canisters off or on when leaving or returning to his room, without assistance from the MA.
-Resident #3 would often leave his room without his oxygen and she would remind him frequently that he needed to be sure he had his oxygen with him.
-Resident #3 resided in the SCU.

Interview with a PCA on 05/19/22 at 2:15pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 41	D 358		

-She assisted Resident #3 back to his room after lunch today.
-She thought Resident #3 was able to manage his oxygen himself, and she did not realize he needed assistance switching back to the oxygen concentrator after lunch.
-She had not checked the canisters when she assisted him back to his room to see how much oxygen was left in the tanks.
-She did not know his portable tanks would not last very long since he received 4 liters of oxygen, continuous.
-She did not usually work in the SCU and was not very familiar with the residents and their needs.

Interview with Resident Care Coordinator (RCC) on 05/18/22 at 3:10pm revealed:
-She worked in the facility for about 2 weeks and had mostly worked in the assisted living side of the facility.
-She was not aware that this morning, when the power was out, that Resident #3 was without oxygen for the duration of the power outage, and for more than an hour afterwards.
-The facility had a backup generator and there were red outlets throughout the facility where an oxygen concentrator could be plugged in, in the event of a power outage, if there were no oxygen canisters available.
-When Resident #3 was out of his room, staff should make sure he was using oxygen via portable canisters and if in his room, he should be attached to the oxygen concentrator.

Interview with former SCC on 05/19/22 at 2:39pm revealed:
-Resident #3 had an order for 4 liters of continuous oxygen.
-Resident #3 had a portable oxygen concentrator, but it had broken shortly before she stopped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 42	D 358		

working at the facility.
-Resident #3 would sometimes get nervous about making sure his oxygen was in place.
-After his portable concentrator broke, he had to use portable canisters when he was out of his room.
-The MA would assist Resident #3 with changing to and from the canisters because facility staff would have the wrench required to turn the canister on and off.

Interview with Administrator on 05/18/22 at 3:20pm and 05/19/22 at 3:09pm revealed:
-If there was power outage in the facility, residents who required continuous oxygen should be switched to a portable canister immediately if the resident had canisters available.
-If there were no canisters available, the resident should be moved with their concentrator, to one of the red outlets throughout the facility so the concentrator could be plugged in on generator power, for the duration of the power outage.
-When the power went out this morning, she had walked around the facility and checked on several residents who required as needed and continuous oxygen.
-She told the facility's PCA who was working in the SCU to check on Resident #3.
-She had not followed up to see if Resident #3's oxygen was in place during the power outage.
-The facility was currently without a SCC, so the facility PCA who was working in the SCU this morning would have the most knowledge about the residents' needs.
-Swas made aware by staff that Resident #3 had been observed hooked up to two empty canisters in his room that afternoon (05/19/22).
-Staff were responsible for ensuring Resident #3's oxygen was in place at all times.
-Staff should be checking to see if Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 43	D 358		

was wearing the nasal cannula, looking to see what his tubing was connected to, assessing if there was oxygen in the canister if he was using them at the time, and they should also be actually feeling the air coming out of his nasal cannula.

Interview with Resident #3's physician's assistant on 05/19/22 at 1:05pm revealed:
-Resident #3 had several health conditions, including COPD, cancer and heart failure.
-Resident #3 had an order for continuous oxygen, 4 liters.
-Resident #3 was hospitalized in April 2022 due to breathing difficulties and other symptoms.
-If Resident #3 was not receiving oxygen as ordered, this could have contributed to the hospitalization.
-Not wearing his oxygen as ordered could be detrimental to Resident #3's health and could lead to complications with his disease.
-Her expectation was for the facility staff to ensure Resident #3 was wearing his oxygen, as ordered, at all times, to help decrease the risk of exacerbation of his COPD symptoms, which with his diagnoses would be detrimental to his health.

b.) Review of Resident #3's February 2022 (02/23/22 - 02/28/22) eMAR revealed:
-An entry for budesonide sus 0.5mg/2 "inhale 1 vial via nebulizer twice a day."
-Beginning on 02/23/22, budesonide was not documented as administered on 6 occasions of 48 opportunities between 02/23/22 and 02/28/22.
-The MAR documented a reason of "physical unable to take" on 02/25/22 at 12:51pm, 02/26/22 at 8:28am, 2/26/22 at 6:16pm, 2/27/22 at 8:11am, 2/28/22 at 9:04am, and 2/28/22 at 7:52pm.

Review of Resident #3's March 2022 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 44 -An entry for budesonide sus 0.5mg/2 "inhale 1 vial via nebulizer twice a day." -Budesonide was not documented as not administered on 52 occasions of 62 opportunities between 03/01/22 and 03/31/22. -The MAR documented a reason of "physically unable to take" on 03/01/22 at 8:11am, 03/01/22 at 10:36pm, 03/02/22 at 8:41pm, 03/02/22 at 8:41pm, 03/20/22 at 8:14pm, 03/28/22 at 8:33pm, 03/29/22 at 8:45pm, 03/30/22 at 10:16am, and 03/30/22 at 9:38pm. Review of Resident #3's April 2022 eMAR revealed: -An entry for budesonide sus 0.5mg/2 "inhale 1 vial via nebulizer twice a day." -Budesonide was not documented as administered on 32 occasions of 60 opportunities between 04/01/22 and 04/30/22. -The MARs documented Resident #3 was in the hospital from 04/07/22 to 04/20/22. -The MAR documented a reason of "out of facility" on 04/07/22 at 9:55am, 04/07/22 at 7:16pm, 04/08/22 at 9:26am, 04/08/22 at 7:39pm, 04/09/22 at 7:33am, 04/09/22 at 8:14pm, 04/10/22 at 7:34am, 04/10/22 at 6:45pm, 04/11/22 at 9:21am, 04/11/22 at 6:48pm, 04/12/22 at 9:12am, 04/12/22 at 8:02pm, 04/13/22 at 8:23am, 04/13/22 at 7:00pm, 04/14/22 8:04am, 04/14/22 at 7:02pm, and 04/15/22 at 7:38am. -The resident was removed from the eMAR system for one dose on 04/15/22, and two doses on 04/16/22, 04/17/22, 04/18/22, and 04/19/22. -The MAR documented a reason of "resident refused" on 04/25/22 at 8:35pm and 04/26/22 at 9:27pm. Review of Resident #3's May 2022 eMAR (05/01/22 - 05/17/22) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 45 -An entry for budesonide sus 0.5mg/2 "inhale 1 vial via nebulizer twice a day." -Budesonide was not documented as administered on 7 occasions of 33 opportunities between 05/01/22 and 05/17/22. -The MAR documented a reason of "resident refused" on 05/01/22 at 8:30pm, 05/06/22 at 9:07am, 05/06/22 at 9:04pm, 05/10/22 at 9:26am, 05/12/22 at 8:27am, 05/14/22 at 9:27am, and 05/16/22 at 8:12pm. Observation of Resident #3's medications on 05/19/22 at 12:10pm revealed: -Resident #3 had a box of budesonide labeled "2 of 2" with instructions "inhale 1 vial via nebulizer twice a day *rinse mouth after use*" and a dispense date of 02/23/22. -The box was labeled that it contained a total of 30 unit-dose vials of budesonide. -There were 8 vials of budesonide remaining in the box. -There were no other boxes of budesonide on the medication cart for Resident #3. -Based on the dispense date, and medication administration records, Resident #3 should have completed all doses in the box on 04/01/22. Interview with lead MA on 05/19/22 at 12:10pm revealed: -She was the lead medication aide and conducted cart audits on a weekly basis, comparing the medications listed on residents' MARs with the medications that were on the cart. -She had not noticed that several of Resident #3's nebulizer treatments had not been refilled since they were originally ordered in February 2022 until today (05/19/22). -She "had no idea" how there were so many vials of Resident #3's nebulizer treatments left based on the dispense dates on the boxes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 46 -This morning she administered all four of Resident #3's scheduled breathing medications to him, including budesonide, ipratropium/albuterol (Duoneb), formoterol, and yuliperi. Interview with Resident #3's Physician's Assistant on 05/19/22 at 1:05pm revealed: -Resident #3's nebulizer treatments were important because they helped relax the diaphragm so that he could more easily move air through his lungs. -If Resident #3 was not getting his scheduled nebulizer treatments as ordered, there was concern it could cause exacerbation of his COPD. -While she could not say for certain that not getting his nebulizer treatments as scheduled could have caused him to develop shortness of breath and require hospitalization on 04/07/22, not getting his nebulizer treatments could cause exacerbations of breathing, which was detrimental to his COPD and other diagnoses. -Her expectation was that facility staff would make sure Resident #3 was receiving all medications, including nebulizer treatments as ordered to reduce his risk of exacerbations in breathing. Telephone interview with former MA on 05/19/22 at 2:23pm revealed: -She recalled Resident #3 received several nebulizer treatments a day, and there were several boxes of his medication treatments in the medication cart. -She did not know how there were so many treatments left if the medications had only been ordered once or twice based on the frequency, he received medications. -Resident #3 would sometimes refuse nebulizer treatments but she always documented this as a	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 47 refusal and not as administered. Telephone interview with the former special care corrdinator (SCC) on 05/19/22 at 2:39pm revealed: -Resident #3 received many nebulizer treatments a day. -Resident #3 would sometimes refuse his nebulizer treatments but she always documented this as a refusal and not that it was administered. Telephone call with Resident #3's pharmacy on 05/19/22 at 10:05am and 5/19/22 at 2:54pm revealed: -Budesonide is an airway steroid which helps keep inflammation down. -Missing doses of budesonide could result in increased inflammation in the airway and constricted breathing. -Resident #3 had an order dated 02/22/22 for budesonide administered twice daily. -A 30-day supply (60 vials) was last dispensed on 02/23/22 for Resident #3. -There had not been a request for a refill of budesonide for Resident #3 as of today (05/19/22). Interview with the Administrator on 05/19/22 at 3:05pm revealed: -She was not aware that several of Resident #3's scheduled daily nebulizer treatments had never been refilled since they were first filled when he was admitted to the facility in February 2022. -She was aware that Resident #3 sometimes refused his nebulizer treatments, but staff should be documenting refusals accordingly and not as "administered." -She was unsure how Resident #3 would still have doses available of nebulizer treatments from the original 30-day supply, filled in February 2022.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 48 -Her expectation was that staff would administer all medications, including nebulizer treatments as ordered by residents' physicians. Refer to interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:58pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. Refer to interview with the lead MA on 05/19/22 at 12:10pm. Refer to telephone interview with the former SCC on 05/19/22 at 2:39pm. c.) Review of Resident #3's February 2022 eMAR (02/23/22 - 02/28/22) revealed: -An entry for formoterol neb 20/2ml with instructions "inhale 1 vial via nebulizer every 12 hours." -Beginning on 02/23/22, formoterol was not documented as administered on 6 occasions of 12 opportunities between 02/23/22 and 02/28/22. -The MAR documented a reason of "physically unable to take" on 02/25/22 at 12:51pm, 02/26/22 at 8:28am, 02/26/22 at 6:16pm, 02/27/22 at 8:11am, 02/28/22 at 9:04am, and 02/28/22 at 7:52pm Review of Resident #3's March 2022 MAR revealed: -An entry for formoterol neb 20/2ml with instructions "inhale 1 vial via nebulizer every 12 hours." -Formoterol was documented as not administered on 9 occasions of 62 opportunities between 03/01/22 and 03/31/22. -The MAR documented a reason of "physically unable to take" on 03/01/22 at 8:11am, 03/01/22	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 49	D 358		

at 10:36pm and 03/02/22 at 8:41am.
-The MAR documented a reason of "awaiting prescription delivery" on 03/02/22 at 8:41pm.
-The MAR documented a reason of "resident refused" on 03/20/22 at 8:14pm, 03/28/22 at 8:34pm, 03/29/22 at 8:45pm, 03/30/22 at 10:16am, and 03/30/22 at 9:38pm.

Review of Resident #3's April 2022 MAR revealed:
-An entry for formoterol neb 20/2ml with instructions "inhale 1 vial via nebulizer every 12 hours."
-Formoterol was not documented as administered on 28 occasions of 60 opportunities between 04/01/22 and 04/30/22.
-The MARs documented Resident #3 was in the hospital from 04/07/22 to 04/20/22.
-The MAR documented a reason of "out of facility" on 04/07/22 at 9:55am, 04/07/22 at 7:16pm, 04/08/22 at 9:26am, 04/08/22 at 7:39pm, 04/09/22 at 7:33am, 04/09/22 at 8:14pm, 04/10/22 at 7:34am, 04/10/22 at 6:45pm, 04/11/22 at 9:21am, 04/11/22 at 6:48pm, 04/12/22 at 9:12am, 04/12/22 at 8:02pm, 04/13/22 at 8:23am, 04/13/22 at 7:00pm, 04/14/22 8:04am, 04/14/22 at 7:02pm, and 04/15/22 at 7:38am.
-The resident was removed from the eMAR system for one dose on 04/15/22, and two doses on 04/16/22, 04/17/22, 04/18/22, and 04/19/22.
-The MAR documented a reason of "refused" on 04/25/22 at 8:35pm and on 04/26/22 at 9:27pm.

Review of Resident #3's May 2022 MAR (05/01/22 - 05/17/22) revealed:
-An entry for formoterol neb 20/2ml with instructions "inhale 1 vial via nebulizer every 12 hours."
-Formoterol 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
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 50 on 8 occasions of 33 opportunities between 05/01/22 and 05/17/22. -The MAR documented a reason of "resident refused" on 05/01/22 at 8:30pm, 05/06/22 at 9:07am, 05/06/22 at 9:04pm, 05/10/22 at 9:26am, 05/12/22 at 8:27am, 05/14/22 at 9:27am, and 05/16/22 at 8:12pm. -The MAR documented a reason of "awaiting prescription deliver" on 05/11/22 at 8:04pm. Observation of Resident #3's medications on 05/19/22 at 12:10pm revealed: -Resident #3 had a box of formoterol neb 20/2ml labeled "1 of 1" with instructions "inhale 1 vial via nebulizer every 12 hours" with a dispense date of 02/23/22. -The box was labeled that it contained 60 individually wrapped doses of formoterol, which was a 30-day supply for Resident #3. -There were 26 vials of formoterol remaining in the box. -There were no other boxes of formoterol on the medication cart for Resident #3. -Based on the dispense date, and the medication admiration records, Resident #3 should have completed the box of formoterol on 04/01/22. Interview with lead MA on 05/19/22 at 12:10pm revealed: -She had not noticed that several of Resident #3's nebulizer treatments had not been refilled since they were originally ordered in February 2022 until today (05/19/22). -She "had no idea" how there were so many vials of Resident #3's nebulizer treatments left based on the dispense dates on the boxes. -This morning she administered all four of Resident #3's scheduled breathing medications to him, including budesonide, ipratropium/albuterol (Duoneb), formoterol, and yuliperi.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 51 Interview with Resident #3's Physician's Assistant on 05/19/22 at 1:05pm revealed: -Resident #3's nebulizer treatments were important because they helped relax the diaphragm so that he could more easily move air through his lungs. -If Resident #3 was not getting his scheduled nebulizer treatments as ordered, there was concern it could cause exacerbation of his COPD. -While she could not say for certain that not getting his nebulizer treatments as scheduled could have caused him to develop shortness of breath and require hospitalization on 04/07/22, not getting his nebulizer treatments could cause exacerbations of breathing, which was detrimental to his COPD and other diagnoses. -Her expectation was that facility staff would make sure Resident #3 was receiving all medications, including nebulizer treatments as ordered to reduce his risk of exacerbations in breathing. Telephone interview with former MA on 05/19/22 at 2:23pm revealed: -She recalled Resident #3 received several nebulizer treatments a day, and there were several boxes of his medication treatments in the medication cart. -She did not know how there were so many treatments left if the medications had only been ordered once or twice based on the frequency, he received medications. -Resident #3 would sometimes refuse nebulizer treatments but she always documented this as a refusal and not as administered. Telephone interview with the former SCC on 05/19/22 at 2:39pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 52	D 358		

-Resident #3 received many nebulizer treatments a day.
-Resident #3 would sometimes refuse his nebulizer treatments but she always documented this as a refusal and not that it was administered.

Telephone call with Resident #3's pharmacy on 05/19/22 at 10:05am and 5/19/22 at 2:54pm revealed:
-Formoterol is an airway opener and missing doses could result in increased inflammation and increased constriction.
-Resident #3 had an order dated 02/22/22 for formoterol, administered twice daily.
-A 30-day supply (60 vials) was last dispensed on 02/23/22 for Resident #3.
-There had not been a request for a refill of formoterol for Resident #3 as of today (05/19/22).

Interview with the Administrator on 05/19/22 at 3:05pm revealed:
-She was not aware that several of Resident #3's scheduled daily nebulizer treatments had never been refilled since they were first filled when he was admitted to the facility in February 2022.
-She was aware that Resident #3 sometimes refused his nebulizer treatments, but staff should be documenting refusals accordingly and not as "administered."
-She was unsure how Resident #3 would still have doses available of nebulizer treatments from the original 30-day supply, filled in February 2022.
-Her expectation was that staff would administer all medications, including nebulizer treatments as ordered by residents' physicians.

Refer to interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:58pm.

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
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 53 05/18/22 at 4:24pm. Refer to interview with the lead MA on 05/19/22 at 12:10pm. Refer to telephone interview with the former SCC on 05/19/22 at 2:39pm. d.) Review of Resident #3's April 2022 eMAR revealed: -An entry for ipratropium/sol albuterol (Duoneb) dated 03/31/22, with instructions "inhale 1 vial via nebulizer by mouth every 12 hours." -Ipratropium/sol albuterol (Duoneb) was not documented as administered on 28 occasions of 60 opportunities between 04/01/22 and 04/30/22. -The MARs documented Resident #3 was in the hospital from 04/07/22 to 04/20/22. -The MARs documented a reason of "out of facility" on 04/07/22 at 9:55am, 04/07/22 at 7:16pm, 04/08/22 at 9:26am, 04/08/22 at 7:39pm, 04/09/22 at 7:33am, 04/09/22 at 8:14pm, 04/10/22 at 7:34am, 04/10/22 at 6:45pm, 04/11/22 at 9:21am, 04/11/22 at 6:48pm, 04/12/22 at 9:12am, 04/12/22 at 8:02pm, 04/13/22 at 8:23am, 04/13/22 at 7pm, 04/14/22 at 8:04am, and 04/14/22 at 7:02pm. -The MARs documented a reason of "physically unable to take" on 04/15/22 at 7:38am. -The MARs documented a reason of "resident refused" on 04/25/22 at 8:35pm and 04/26/22 at 9:27pm. -The resident was removed from the eMAR system for one dose on 04/15/22, and two doses on 04/16/22, 04/17/22, 04/18/22, and 04/19/22. Review of Resident #3's May 2022 eMAR (05/01/22 - 05/17/22) revealed: -An entry for ipratropium/sol albuterol (Duoneb) with instructions "inhale 1 vial via nebulizer by	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 54	D 358		

mouth every 12 hours."
-Ipratropium/sol albuterol (Duoneb) was not documented as administered on 5 occasions of 33 opportunities between 05/01/22 and 05/17/22.
-The MAR documented a reason of "resident refused" on 05/01/22 at 8:30pm, 05/06/22 at 9:07am, 05/06/22 at 9:04pm, 05/10/22 at 9:26am, and 05/16/22 at 8:12pm.

Observation of Resident #3's medications on 05/19/22 at 12:10pm revealed:
-Resident #3 had a box of ipratropium/sol albuterol (Duoneb) labeled "1 of 1" with instructions "inhale 1 vial via nebulizer by mouth every 12 hours" with a dispense date of 04/01/22.
-The box was labeled that it contained a total of 30 unit-dose vials.
-There were 19 vials of ipratropium/sol albuterol (Duoneb) remaining in the box.
-There were no other boxes of ipratropium/sol albuterol (Duoneb) on the medication cart for Resident #3.
-Based on the dispense date, and the medication administration records, Resident #3 should have completed the box of ipratropium/sol albuterol (Duoneb) on 04/29/22.

Interview with lead MA on 05/19/22 at 12:10pm revealed:
-She had not noticed that several of Resident #3's nebulizer treatments had not been refilled since they were originally ordered in February 2022 until today (05/19/22).
-She "had no idea" how there were so many vials of Resident #3's nebulizer treatments left based on the dispense dates on the boxes.
-This morning she administered all four of Resident #3's scheduled breathing medications to him, including budesonide, ipratropium/albuterol (Duoneb), formoterol, and yuliperi.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 55 Interview with Resident #3's Physician's Assistant on 05/19/22 at 1:05pm revealed: -Resident #3's nebulizer treatments were important because they helped relax the diaphragm so that he could more easily move air through his lungs. -If Resident #3 was not getting his scheduled nebulizer treatments as ordered, there was concern it could cause exacerbation of his COPD. -While she could not say for certain that not getting his nebulizer treatments as scheduled could have caused him to develop shortness of breath and require hospitalization on 04/07/22, not getting his nebulizer treatments could cause exacerbations of breathing, which was detrimental to his COPD and other diagnoses. -Her expectation was that facility staff would make sure Resident #3 was receiving all medications, including nebulizer treatments as ordered to reduce his risk of exacerbations in breathing. Telephone interview with former MA on 05/19/22 at 2:23pm revealed: -She recalled Resident #3 received several nebulizer treatments a day, and there were several boxes of his medication treatments in the medication cart. -She did not know how there were so many treatments left if the medications had only been ordered once or twice based on the frequency, he received medications. -Resident #3 would sometimes refuse nebulizer treatments but she always documented this as a refusal and not as administered. Telephone interview with the former SCC on 05/19/22 at 2:39pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 56 -Resident #3 received many nebulizer treatments a day. -Resident #3 would sometimes refuse his nebulizer treatments but she always documented this as a refusal and not that it was administered. Telephone call with Resident #3's pharmacy on 05/19/22 at 10:05am and 5/19/22 at 2:54pm revealed: -Ipratropium/albuterol (Duoneb) is a short-acting dilator, used to help with immediately opening the airways. Missed doses could result in breathing difficulties. -Resident #3 had an order dated 03/31/22 for ipratropium/albuterol (Duoneb) administered twice daily. -A 15-day supply (30 vials) was last dispensed on 04/01/22 for Resident #3. -There had not been a request for a refill of ipratropium/albuterol (Duoneb) for Resident #3 as of today (05/19/22). Interview with the Administrator on 05/19/22 at 3:05pm revealed: -She was not aware that several of Resident #3's scheduled daily nebulizer treatments had never been refilled since they were first filled when he was admitted to the facility in February 2022. -She was aware that Resident #3 sometimes refused his nebulizer treatments, but staff should be documenting refusals accordingly and not as "administered." -She was unsure how Resident #3 would still have doses available of nebulizer treatments from the original 30-day supply, filled in February 2022. -Her expectation was that staff would administer all medications, including nebulizer treatments as ordered by residents' physicians. Refer to interview with the Resident Care	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 57 Coordinator (RCC) on 05/18/22 at 3:58pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. Refer to interview with the lead MA on 05/19/22 at 12:10pm. Refer to telephone interview with the former SCC on 05/19/22 at 2:39pm. e.) Review of Resident #3's February 2022 eMAR (02/24/22 - 02/28/22) revealed: -An entry for yupelri 175mcg/3ml sol "inhale 1 vial via nebulizer every day." -Yupelri was not documented as administered on 4 occasions of 5 opportunities between 02/24/22 and 02/28/22. -The MAR documented a reason of "physically unable to take" on 02/25/22 at 12:51pm, 02/26/22 at 8:28am, 02/27/22 at 8:11am, and 02/28/22 at 9:04am. Review of Resident #3's March 2022 eMAR revealed: -An entry for yupelri 175mcg/3ml sol "inhale 1 vial via nebulizer every day." -Yupelri was not documented as administered on 3 occasions of 31 occasions between 03/01/22 and 03/31/22. -The MAR documented a reason of "physically unable to take" on 03/01/22 at 8:11am and 03/02/22 at 8:41am. -The MAR documented a reason of "resident refused" on 03/30/22 at 10:16am. Review of Resident #3's April 2022 eMAR revealed: -An entry for yupelri 175mcg/3ml sol "inhale 1 vial via nebulizer every day."	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 58	D 358		

-The MARs documented Resident #3 was in the hospital from 04/07/22 to 04/20/22.
-Yupelri was not documented as administered on 13 occasions of 30 opportunities between 04/01/22 and 04/30/22.
-The MARs documented a reason of "out of facility" on 04/07/22 at 9:55am, 04/08/22 at 9:26am, 04/09/22 at 7:33am, 04/10/22 at 7:34am, 04/11/22 at 9:21am, 04/12/22 at 9:12am, 04/13/22 at 8:23am, and 04/14/22 at 8:04am.
-The MARs documented a reason of "physically unable to take" on 04/15/22 at 7:38am.
-The resident was removed from the eMAR system for one dose on 04/16/22, 04/17/22, 04/18/22, and 04/19/22.

Review of Resident #3's May 2022 eMAR (05/01/22 - 05/17/22) revealed:
-An entry for yupelri 175mcg/3m. sol "inhale 1 vial nebulizer every day."
-Yupelri was not documented as administered on 2 occasions of 17 opportunities between 05/01/22 and 05/17/22.
-The MARs documented a reason of "resident refused" on 05/06/22 at 9:07am and on 05/10/22 at 9:26am.

Observation of Resident #3's medications on 05/19/22 at 12:10pm revealed:
-Resident #3 had 2 boxes revefenacin (yupelri) labeled "1 of 1" with instructions "inhale 1 vial via nebulizer every day"
-Each box was labeled that it contained a total of 30 unit-dose vials of revefenacin (yupelri).
-An open box with a dispense date of 02/22/22 contained 2 vials of revefenacin (yupelri).
-An open box with a dispense date of 04/01/22 contained 29 vials revenfenacin (yupelri).
-Based on the dispense date, and the medication administration records, Resident #3 should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 59 completed the first box of revenfenacin on 04/01/22. -Based on the dispense date, and the medication administration records, Resident #3 should have completed the second box of revenfenacin on 05/16/22. -There were no other boxes of revefenacin (yupelri) on the medication cart for Resident #3. Interview with lead MA on 05/19/22 at 12:10pm revealed: -She had not noticed that several of Resident #3's nebulizer treatments had not been refilled since they were originally ordered in February 2022 until today (05/19/22). -She "had no idea" how there were so many vials of Resident #3's nebulizer treatments left based on the dispense dates on the boxes. -This morning she administered all four of Resident #3's scheduled breathing medications to him, including budesonide, ipratropium/albuterol (Duoneb), formoterol, and yuliperi. Interview with Resident #3's Physician's Assistant on 05/19/22 at 1:05pm revealed: -Resident #3's nebulizer treatments were important because they helped relax the diaphragm so that he could more easily move air through his lungs. -If Resident #3 was not getting his scheduled nebulizer treatments as ordered, there was concern it could cause exacerbation of his COPD. -While she could not say for certain that not getting his nebulizer treatments as scheduled could have caused him to develop shortness of breath and require hospitalization on 04/07/22, not getting his nebulizer treatments could cause exacerbations of breathing, which was detrimental to his COPD and other diagnoses.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 60 -Her expectation was that facility staff would make sure Resident #3 was receiving all medications, including nebulizer treatments as ordered to reduce his risk of exacerbations in breathing. Telephone interview with former MA on 05/19/22 at 2:23pm revealed: -She recalled Resident #3 received several nebulizer treatments a day, and there were several boxes of his medication treatments in the medication cart. -She did not know how there were so many treatments left if the medications had only been ordered once or twice based on the frequency, he received medications. -Resident #3 would sometimes refuse nebulizer treatments but she always documented this as a refusal and not as administered. Telephone interview with the former SCC on 05/19/22 at 2:39pm revealed: -Resident #3 received many nebulizer treatments a day. -Resident #3 would sometimes refuse his nebulizer treatments but she always documented this as a refusal and not that it was administered. Telephone call with Resident #3's pharmacy on 05/19/22 at 10:05am and 5/19/22 at 2:54pm revealed: -Yupelri is a bronchdialator used to open the airway and is a long-acting medication. -Missing doses of yupelri could result in increased breathing difficulty. -Resident #3 had an order for yupelri administered once daily. -A 30-day supply (30 vials) was last dispensed on 02/23/22 and on 04/30/22 for Resident #3. -There had not been any other requests for refills	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 61	D 358		

other than the 04/30/22 request for Resident #3 as of today (05/19/22).

Interview with the Administrator on 05/19/22 at 3:05pm revealed:
-She was not aware that several of Resident #3's scheduled daily nebulizer treatments had never been refilled since they were first filled when he was admitted to the facility in February 2022.
-She was aware that Resident #3 sometimes refused his nebulizer treatments, but staff should be documenting refusals accordingly and not as "administered."
-She was unsure how Resident #3 would still have doses available of nebulizer treatments from the original 30-day supply, filled in February 2022.
-Her expectation was that staff would administer all medications, including nebulizer treatments as ordered by residents' physicians.

Refer to interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:58pm.

Refer to interview with the Administrator on 05/18/22 at 4:24pm.

Refer to interview with the lead MA on 05/19/22 at 12:10pm.

Refer to telephone interview with the former SCC on 05/19/22 at 2:39pm.

2. Review of Resident #1's current FL2 dated 07/26/21 revealed:
-Diagnoses included dementia and hypothyroidism.
-A order for levothyroxine (a medication used to treat hypothyroidism) 25mcg every Thursday morning.
-A order for levothyroxine 50mcg every Monday,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 62 Tuesday, Wednesday, Friday, Saturday and Sunday morning. Review of Resident #1's subsequent physician's order dated 04/10/22 revealed levothyroxine 50mcg every morning. a. Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed: -An entry for levothyroxine 25mcg once a week, scheduled to be administered on Thursday at 6:30am. -Levothyroxine 25mcg was documented as administered 03/03/22, 03/10/22, 03/17/22, 03/24/22 and 03/24/22. Review of Resident #1's April 2022 eMAR revealed: -An entry for levothyroxine 25mcg once a week, scheduled to be administered on Thursday at 6:30am. -Levothyroxine 25mcg was documented as administered 04/14/22, and 04/21/22. -The levothyroxine was not documented as administered on 04/07/22 and was not to be administered on 04/14/22 and 04/21/22. Review of Resident #1's May 2022 eMAR revealed: -An entry for levothyroxine 25mcg once a week, scheduled to be administered on Thursday at 6:30am. -Levothyroxine 25mcg was documented as administered 05/05/22 and 05/12/22. -The levothyroxine was not to be administered on 05/05/22 and 05/12/22. b. Review of Resident #1's March 2022 eMAR revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 63 -An entry for levothyroxine 50mcg six days a week, scheduled to be administered on Monday, Tuesday, Wednesday, Friday, Saturday and Sunday at 6:30am. -Levothyroxine 50mcg was not documented as administered on 03/27/22. -The levothyroxine was not documented as administered for 1 out of 31 opportunities. Review of Resident #1's April 2022 eMAR revealed: -An entry for levothyroxine 50mcg six days a week, scheduled to be administered on Monday, Tuesday, Wednesday, Friday, Saturday and Sunday at 6:30am. -Levothyroxine 50mcg was not documented as administered 04/06/22, 04/14/22, 04/15/22, 04/21/22, and 04/28/22. -The levothyroxine was not documented as administered for 5 out of 30 opportunities. Review of Resident #1's May 2022 eMAR revealed: -An entry for levothyroxine 50mcg six days a week, scheduled to be administered on Monday, Tuesday, Wednesday, Friday, Saturday and Sunday at 6:30am. -Levothyroxine 50mcg was not documented as administered 05/05/22, 05/12/22 and 05/17/22. -The levothyroxine was not documented as administered for 3 out of 17 opportunities. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/18/22 at 11:49am revealed: -There was an order dated 07/29/21 for levothyroxine 25mcg every Thursday morning and levothyroxine 50mcg every Monday, Tuesday, Wednesday, Friday, Saturday and Sunday morning.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 64 -Resident #1's pharmacy record did not reveal an order dated 04/10/22 for levothyroxine 50mcg every morning. -The facility was responsible for faxing new orders from the physician. -On 02/03/22, levothyroxine 50mcg, 26 tablets (26 doses) was dispensed to the facility. -On 03/10/22, levothyroxine 50mcg, 26 tablets (26 doses) was dispensed to the facility. -On 04/11/22, levothyroxine 50mcg, 26 tablets (26 doses) was dispensed to the facility. -On 05/13/22, levothyroxine 50mcg, 26 tablets (26 doses) was dispensed to the facility. -Levothyroxine 25mcg was not dispensed to the facility after 07/29/21. Observation of Resident #1's medications on hand on 05/18/22 at 9:01am revealed: -There was a medication card with levothyroxine 50mcg, with a fill date of 05/13/22 containing 23 out of 26 tablets. -Levothyroxine 50mcg six days a week was inscribed on the label. -Levothyroxine 25mcg one day a week was not available to be administered. Review of Resident #1's blood work dated 04/08/22 revealed: -A Thyroid Stimulating Hormone (TSH, a blood test used to measure the hormone) was documented as 7.780- high (normal 0.450-4.500). -There was a typed note on the TSH lab documented as "We'll increase to 50mcg daily". Telephone interview with Resident #1's primary care physician (PCP) on 05/19/22 at 10:10am revealed: -On 04/05/22, she received notification Resident #1 was lethargic and requested Resident #1 to be seen and lab work completed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 65 -Resident #1 was on 04/08/22 at the facility. -On 04/08/22, Resident #1's TSH was 7.780, which was considered high. -When the TSH was high, like with Resident #1, the high TSH levels caused other thyroid hormones to decrease and the pituitary gland compensated by increasing the TSH levels, putting Resident #1 in hypothyroidism. -Hypothyroidism can cause decreased heart rate with abnormal rhythm, feeling cold, irritability, lethargy (feeling tired), weakness osteoporosis, edema and coma. -She was not aware Resident #1 was not getting the levothyroxine as ordered. -Resident #1 was at an increased risk for developing coma or heart arrhythmia's. Refer to interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:58pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. Refer to interview with the lead MA on 05/19/22 at 12:10pm. Refer to telephone interview with the former SCC on 05/19/22 at 2:39pm. _____ Interview with the RCC on 05/18/22 at 3:58pm revealed: -She began work at the facility on 04/27/22. -She did not know who was responsible for medication cart audits which included comparing medications on the medication cart to the eMAR and orders. -She did not know who was responsible for receiving the orders and faxing them to the pharmacy to be entered into the resident's eMAR.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 66 Interview with the lead MA on 05/19/22 at 12:10pm revealed: -She was the lead medication aide and conducted cart audits on a weekly basis, comparing the medications listed on residents' MARs with the medications that were on the cart. -She did not look at dispense dates of medications when conducting cart audits; she only looked to ensure the medication was available. -She usually worked on the assisted living side of the facility and was not as familiar with the resident's medications in the special care unit (SCU). Telephone interview with the former SCC on 05/19/22 at 2:39pm revealed: -The lead medication aide conducted cart audits weekly to assure all medications were on the cart. -She was not sure if the lead medication aide ever looked at the dispense date of the medications when conducting a cart audit. Interview with the Administrator on 05/18/22 at 4:24pm revealed: -Prior to 04/26/22, the lead MA was responsible for obtaining orders and faxing them to the pharmacy for processing. -Prior to 04/26/22, the Resident Service Director (RSD) or the RCC was responsible for audits of the medication cart which included comparing the eMAR and orders to the medication on the medication cart for accuracy and completion. -After 04/26/22, the lead MA was responsible for weekly medication cart audits. -She and the Regional Nurse were responsible for checking behind the RSD/RCC/Lead MA to make sure all the audits were completed. -She did not know when the last medication cart	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 358	Continued From page 67 audit was completed prior to the RSD leaving on 04/08/22 and she did not check for completion of the audits after 04/08/22. _____ The facility failed to ensure medications were administered as order, resulting in a resident being hospitalized with breathing difficulties for 13 days after not receiving his 4 liters continuous oxygen, budesonide, fomoterol, ipratropium/albuterol, and yupelri nebulizer treatments, (Resident #3) and a resident not receiving her levothyroxine causing her to experience lethargy and weakness and increased risk of developing a heart arrhythmia and coma and requiring the PCP to complete an in facility appointment and an increase in her medication to treat the increased TSH levels (Resident #1). This failure resulted in serious risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 05/18/22. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED JULY 5, 2022.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior	D 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 68	D 366		

to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (Resident #1) for a medication to treat hyperthyroidism.

The findings are:

Review of Resident #1's current FL2 dated 07/26/21 revealed:
-Diagnoses included dementia and hypothyroidism.
-A order for levothyroxine (a medication used to treat hypothyroidism) 25mcg every Thursday morning.

Review of Resident #1's subsequent physician's order dated 04/10/22 revealed levothyroxine 50mcg every morning.

a. Review of Resident #1's March 2022 electronic Medication Administration Record (eMAR) revealed:
-An entry for levothyroxine 25mcg once a week, scheduled to be administered on Thursday at 6:30am.
-Levothyroxine 25mcg was documented as administered 03/03/22, 03/10/22, 03/17/22, 03/24/22 and 03/24/22.

Review of Resident #1's April 2022 eMAR revealed:
-An entry for levothyroxine 25mcg once a week, scheduled to be administered on Thursday at 6:30am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 69	D 366		

-There was no entry for levothyroxine 50mcg every morning beginning on 04/10/22.
-Levothyroxine 25mcg was documented as administered 04/14/22, and 04/21/22.
-The levothyroxine 25mcg was not documented as administered on 04/07/22 and was not to be administered on 04/14/22 and 04/21/22.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 05/18/22 at 11:49am revealed:
-There was an order dated 07/29/21 for levothyroxine 25mcg every Thursday morning.
-Resident #1's pharmacy record did not reveal an order dated 04/10/22 for levothyroxine 50mcg every morning.
-Levothyroxine 25mcg was dispensed to the facility on 07/29/21 with a quantity of 4 doses.
-Levothyroxine 25mcg was not dispensed to the facility after 07/29/21.

Observation of Resident #1's medications on hand on 05/18/22 at 9:01am revealed levothyroxine 25mcg one day a week was not available to be administered.

Refer to interview with the Resident Care Coordinator (RCC) on 05/18/22 at 3:58pm.

Refer to interview with the Administrator on 05/18/22 at 4:24pm.

Refer to interview with the lead MA on 05/19/22 at 12:10pm.

Interview with the RCC on 05/18/22 at 3:58pm revealed:
-She began working at the facility on 04/27/22.
-She did not know who was responsible for medication cart audits which included comparing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 70	D 366		

medications on the medication cart to the eMAR and orders.
-The MAs were responsible for accurate documentation of the medication administered to the resident.
-The MAs were responsible for re-ordering a medication that was out at the facility.

Interview with the lead MA on 05/19/22 at 12:10pm revealed:
-The MAs were responsible for documenting the medication that was administered.
-The MAs were responsible for notifying the pharmacy to re-order a medication that was out.
-She was the lead medication aide and conducted cart audits on a weekly basis, comparing the medications listed on residents' MARs with the medications that were on the cart.
-She did not look at the order for the medications when conducting cart audits; she only looked to ensure the medication was available according to the eMAR.
-She usually worked on the assisted living side of the facility and was not as familiar with the resident's medications in the special care unit (SCU).

Interview with the Administrator on 05/18/22 at 4:24pm revealed:
-The MAs were responsible for documenting the medication that was administered. And for notifying the pharmacy when a medication was not available for administration.
-Prior to 04/26/22, the lead MA was responsible for obtaining orders and faxing them to the pharmacy for processing.
-Prior to 04/26/22, the Resident Service Director (RSD) or the RCC was responsible for audits of the medication cart which included comparing the eMAR and orders to the medication on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 366	Continued From page 71 medication cart for accuracy and completion. -After 04/26/22, the lead MA was responsible for weekly medication cart audits. -She and the Regional Nurse were responsible for checking behind the RSD/RCC/Lead MA to make sure all the audits were completed. -She did not know when the last medication cart audit was completed prior to the RSD leaving on 04/08/22 and she did not check for completion of the audits after 04/08/22.	D 366		
D 433	10A NCAC 13F .1201(a) Resident Records 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter;	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 433	Continued From page 72 (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to maintain resident records in an orderly manner and readily available for review for 3 of 5 sampled residents (#2, #4, and #5). The findings are: 1. Review of Resident #4's current FL-2 dated 05/03/22 revealed: -Diagnoses included dementia without behavioral disturbance, anxiety disorder and left femur fracture. -The recommended level of care was the SCU. Review of Resident #4's record on 05/18/22 revealed: -There was not a completed care plan since admission. -There was not a completed resident assessment upon admission. Refer to interview with an Administrator on	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 433	Continued From page 73 05/20/22 at 10:50am. 2. Review of Resident #5's current FL-2 dated 03/08/22 revealed diagnoses included atrial fibrillation, dizziness and giddiness, dementia, hypokalemia and anxiety. Review of Resident #5's record on 05/18/22 revealed: -There was not a completed care plan since admission. -There was not a completed resident assessment upon admission. Refer to interview with an Administrator on 05/20/22 at 10:50am. 3. Review of Resident #2's current FL-2 dated 10/19/21 revealed a diagnoses included hyperthyroidism, depression, gait disorder, and major neurocognitive disorder. Review of Resident #2's record on 05/18/22 revealed: -An undated and unsigned resident assessment for Resident #2. -There was no care plan completed or signed by the physician. Interview with Administrator on 05/17/22 at 9:35am revealed: -Resident #2's record had been missing from the facility for several days. -She "had no idea" where Resident #2's record could be since it was not in the resident care director's (RCD) office where it was supposed to be, and it was not in the special care unit (SCU) where Resident #2 resided. -Staff had identified the record was missing on 05/13/22 when the complaint was initiated and	D 433		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 433	Continued From page 74 had been searching for it since then but had not yet found it. -Staff would continue to search for the record and she would see if she could gather some copies of documents that might be kept in Resident #2's business file or in a file in the SCU. Interview with Administrator on 05/18/22 at 10:20am revealed she had still not been able to locate Resident #2's record but was able to find a copy of her FL-2 from admission to the facility, her resident register completed upon admission, physician communication documentation, and recent incident reports. Refer to interview with an Administrator on 05/20/22 at 10:50am. _____ Interview with an Administrator on 05/20/22 at 10:50am revealed: -She was the Administer from another community temporary filling in due to the Administer not being present on 05/20/22. -The RSD was responsible for completing the care plan and assessment for PCP to sign but due to the facility not having an RSD, the Administer was responsible. -The regional RN also assisted with completion of care plans when requested.	D 433		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 463	Continued From page 75	D 463		

that the following requirements are met for admission to the special care unit:
(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.
(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.
(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 4 of 4 sampled residents residing in the Special Care Unit (SCU) had a pre-admission screening (Residents #1, #2, #3 and #4) and 4 out of 4 sampled residents did not have a disclosure statement (Residents #1, #2, #3, and #4).

The findings are:

1. Review of Resident #3's current FL-2 dated 02/21/22 revealed:
-Diagnoses included dementia, metastic colon cancer, heart failure, COVID19, and chronic obstructive pulmonary disease.
-Resident #3 required secured unit level of care, was semi-ambulatory, and was intermittently disoriented.

a. Review of Resident #3's record revealed there was no pre-admission screening for the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 463	Continued From page 76 to evaluate the appropriateness of the resident's placement in the SCU. b. Review of Resident #3's record revealed there was no special care unit disclosure statement signed by Resident #3's responsible party. Refer to interview with Business Office Manager (BOM) on 05/20/22 at 10:35am Refer to interview with the Administrator on 05/20/22 at 10:50am. 2. Review of Resident #2's current FL-2 dated 10/19/21 revealed: -Diagnoses included hyperthyroidism, depression, gait disorder, and major neurocognitive disorder. -Resident #2 required special care unit level of care, was ambulatory, and constantly disoriented. a. Review of Resident #2's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. b. Review of Resident #2's record revealed there was no special care unit disclosure statement signed by Resident #2's responsible party. Refer to interview with BOM on 05/20/22 at 10:35am Refer to interview with the Administrator on 05/20/22 at 10:50am. 3. Review of Resident #1's current FL2 dated 07/26/21 revealed: -Diagnoses included dementia and hypothyroidism. -Resident #1 required secured unit level of care.	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 463	Continued From page 77 -Resident #1 was intermittently disoriented. a. Review of Resident #1's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. Telephone interview with Resident #1's Power of Attorney (POA) member on 05/18/22 at 4:47pm revealed she could not recall if the pre-admission screening was performed before Resident #1 was admitted to the SCU. b. Review of Resident #1's record revealed there was no special care unit disclosure statement signed by Resident #1's responsible party. Refer to interview with BOM on 05/20/22 at 10:35am Refer to interview with the Administrator on 05/20/22 at 10:50am. 4. Review of Resident #4's current FL-2 dated 05/03/22 revealed: -Diagnoses include dementia without behavioral disturbance, anxiety disorder and left femur fracture. -The recommended level of care was the SCU. a. Review of Resident #4's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. b. Review of Resident #4's record revealed there was no special care unit disclosure statement signed by Resident #4's responsible party. Refer to interview with BOM on 05/20/22 at	D 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 463	Continued From page 78 10:35am Refer to interview with the Administrator on 05/20/22 at 10:50am. _____ Interview with BOM on 05/20/22 at 10:35am revealed: -The Administrator was responsible for completing pre-admission screenings currently due to facility not having a Special Care Coordinator (SCC) or Resident Services Director (RSD). -The Marketing Director was responsible for giving an admission packet to the resident's family to complete which contains the resident disclosure. -The Marketing Director was responsible for ensuring the disclosure has been completed. -She did not keep SCU resident's pre-admission screens in the business office records but did keep resident disclosures in the business office records. Interview with an Administrator on 05/20/22 at 10:50am revealed: -She was the Administrator from another community temporally filling in due to Administrator not being present on 05/20/22. -She stated the Administrator was responsible for completing the pre-screening due to the facility not having an RSD. -Admission packets were given to the residents' family by the Marketing Director which was reviewed by the Administrator after family completed their packet, to ensure all paperwork has been completed.	D 463		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 464	Continued From page 79 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a Special Care Unit Resident Profile and Care Plan was completed was completed within 30 days of admission, and quarterly for 4 of 4 sampled residents (Resident #1, #2, #3 and #4) who did not have documentation of a care plan within 30 days of admission, quarterly profiles. The findings are: 1. Review of Resident #3's current FL-2 dated 02/21/22 revealed: -Diagnoses included dementia, metastic colon cancer, heart failure, COVID19, and chronic obstructive pulmonary disease.	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 464	Continued From page 80 -Resident #3 required secured unit level of care, was semi-ambulatory, and was intermittently disoriented. Review of Resident #3's record revealed: - Resident #3 had no completed special care unit quarterly profiles. - Resident #3 had no completed care plan. Refer to interview with an agency medication aide (MA) on 05/19/22 at 10:55am. Refer to interview with an agency personal care aide (PCA) on 05/19/22 at 11:00am. Refer to interview with the Business Office Manager (BOM) on 05/20/22 at 10:35am. Refer to interview with an Administrator on 05/20/22 at 10:650am. 2. Review of Resident #2's current FL-2 dated 10/19/21 revealed: -Diagnoses included hyperthyroidism, depression, gait disorder, and major neurocognitive disorder. -Resident #2 required special care unit level of care, was ambulatory, and constantly disoriented. Review of Resident #2's record revealed: - Resident #2 had no completed special care unit quarterly profiles. - Resident #2 had no care plan that had been signed by her physician. Refer to interview with an agency MA on 05/19/22 at 10:55am. Refer to interview with an agency PCA on 05/19/22 at 11:00am.	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 464	Continued From page 81 Refer to interview with the BOM on 05/20/22 at 10:35am. Refer to interview with an Administrator on 05/20/22 at 10:650am. 3. Review of Resident #1's current FL2 dated 07/26/21 revealed: -Diagnoses included dementia and hypothyroidism. -Resident #1 required secured unit level of care. Review of Resident #1's Resident Register revealed she was admitted to the SCU on 07/29/22. Review of Resident #1's Resident Profile revealed there was no SCU resident care plan and profile completed within 30 days of admission to the SCU. Review of Resident #1's current Care Plan dated 11/02/21 revealed: -She required supervision with eating and toileting. -She required limited assistance with ambulation, bathing, dressing, grooming and transfers. Refer to interview with an agency MA on 05/19/22 at 10:55am. Refer to interview with an agency PCA on 05/19/22 at 11:00am. Refer to interview with the BOM on 05/20/22 at 10:35am. Refer to interview with an Administrator on 05/20/22 at 10:650am.	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 464	Continued From page 82 4. Review of Resident #4's current FL2 dated 05/03/22 revealed: -Diagnoses included anxiety disorder, dementia without behavioral disturbances and left femur fracture. -The recommended level of care was the SCU. Review of Resident #4's record revealed there was no documented SCU Resident Profile and Care Plan completed within 30 days of admission. Refer to interview with an agency MA on 05/19/22 at 10:55am. Refer to interview with an agency PCA on 05/19/22 at 11:00am. Refer to interview with the BOM on 05/20/22 at 10:35am. Refer to interview with an Administrator on 05/20/22 at 10:650am. _____ Interview with agency SCU MA on 05/19/22 at 10:55am revealed no one had told her where any information was related to residents needs or behaviors. Interview with agency SCU PCA on 05/19/22 at 11:00am revealed: -That was her first day working on the SCU unit. -She was told there was a book on the unit if she had any questions related to the residents needs or behaviors. Interview with BOM on 05/20/22 at 10:35am revealed the Administer was currently responsible for ensuring a written resident profile and	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 464	Continued From page 83 assessments were completed due to facility not having a Special Care Coordinator (SCC) or Resident Services Director (RSD). Interview with an Administrator on 05/20/22 at 10:50am revealed: -She was an Administrator from another community temporary filling in due to the Administrator not being present on 05/20/22. -The RSD would normally be responsible for completing the resident profile and care plan for the PCP to sign but due to the facility not having an RSD, the Administrator was responsible. -The regional RN also assisted with completion of care plans when requested.	D 464		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 468	Continued From page 84	D 468		

responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure that 2 of 4 sampled staff (Staff B and D) completed six hours of dementia specific training within their first week of working in the Special Care Unit (SCU).

The findings are:

1. Review of Staff B's, personnel record revealed:
-There was no documentation of Special Care Unit (SCU) training completed for Staff B.
-Staff B was hired on 03/10/22.
-He worked as a personal care aide (PCA) on the SCU.

Interview with Staff B on 05/19/22 at 9:10am revealed:
-He was hired in March 2022 and worked as a PCA in the SCU.
-He did not receive any SCU training since he started work in the SCU in March 2022.

Attempted telephone interview with a representative from the facility's contracted staffing agency on 05/18/22 at 4:00pm was unsuccessful.

Refer to the interview with the Business Office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 468	Continued From page 85 Manager on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 04/18/22 at 4:24pm. 2. Review of Staff D's, personnel record revealed: -There was no documentation of SCU training completed for Staff B. -Staff D was an agency MA hired by the facility on 05/15/22. -She worked as a MA in the SCU. Interview with Staff D on 05/18/22 at 9:31am revealed: -She was employed by a staffing agency as a MA. -On 05/15/22, she started to work in the SCU. -She was not asked to provide documentation of previous SCU training to the facility. Attempted telephone interview with a representative from the facility's contracted staffing agency on 05/18/22 at 4:00pm was unsuccessful. Refer to the interview with the Business Office Manager on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 04/18/22 at 4:24pm. _____ Interview with Business Office Manager on 05/18/22 at 4:00pm revealed: -It was her responsibility to maintain the personnel records. -She did not request documentation of SCU training for the agency staff. -She thought the staffing agencies completed the SCU training and she did not need a copy of their training hours.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 468	Continued From page 86 -She did not complete an audit of the personnel records since the Resident Service Director (RSD) left the facility 04/08/22 because she was very busy with getting the new hires working. Interview with the Administrator on 05/18/22 at 4:24pm revealed: -The BOM was responsible for maintaining the staff records. -She did not know the staff working in the SCU did not have any documentation of SCU training. -The staffing agency was responsible for the orientation and onboarding of their staff. -She had not audited the staff records since the RSD left the facility on 04/08/22 to determine if all SCU staff had their required dementia training.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Personal Care and Supervision, Medication Aide Training and Competency and Health Care. The findings are:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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
D912	Continued From page 87 1. Based on observations, interviews, and record reviews, the facility failed to adequately supervise 3 of 5 residents (#2, #3, & #4) resulting in physical and verbal altercations between these residents. [Refer to tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff D, and E) who administered medications had completed the Medication Aide Training and completed the clinical skills evaluation prior to administering medications. [Refer to tag 0935, G.S. 131D-4.5B(b) ACH Medication Aide; Training and Competency (Type B Violation)]. 3. Based on interviews and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#1) related to follow-up appointment and lab work after a resident was found lethargic. [Refer to tag 0276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type B 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 interviews and record reviews, the facility failed to ensure all residents were free from neglect related to Medication Administration.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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 88 The finding are: 1. Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 sampled residents related to nebulizer treatments and oxygen used to treat breathing problems (Resident # 3) and a medication used to treat thyroid problems (Resident #1). [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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
D935	Continued From page 89 (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews, and record reviews the facility failed to ensure 2 of 3 sampled staff (Staff D, and E) who administered medications had completed the Medication Aide Training and completed the clinical skills evaluation prior to administering medications. The findings are: 1. Review of Staff D's, medication aide (MA) personnel record revealed: -Staff D was an agency MA and hired on 05/15/22. -There was documentation she passed the written MA exam on 01/04/08. -There was no documentation she completed the 5/10/15 hour training. -There was no documentation Staff D completed the medication clinical skills competency validation.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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
D935	Continued From page 90 Review of a resident's May 2022 electronic medication administration record (eMAR) revealed Staff D administered medications on 05/18/22. Refer to interview with the Business Office Manager (BOM) on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. 2. Review of Staff E's, MA personnel record revealed: -Staff E was and agency MA and hired on 05/15/22. -There was documentation she passed the written MA exam on 05/15/20. -There was no documentation she completed the 5/10/15 hour training. -There was no documentation Staff E completed the medication clinical skills competency. Review of a resident's May 2022 eMAR revealed Staff B documented administering medications on 05/17/22. Refer to interview with the BOM on 05/18/22 at 4:00pm. Refer to interview with the Administrator on 05/18/22 at 4:24pm. _____ Interview with the BOM on 05/18/22 at 4:00pm revealed: -She was aware the MAs required the 5/10/15 hour MA training and clinical skill check off to be completed prior to administering medications. -She was responsible for putting the pre-employment packet together which included	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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
D935	Continued From page 91 the staff's 5/10/15 hour MA training and give to the Regional Nurse for processing. -The Regional Nurse was responsible for getting the MAs clinical skills check off completed by a nurse. -After the 5/10/15 hour training and clinical skills were verified and completed then the Regional Nurse was to give her the staff file back for the final hiring process. -She was told, by the contracted staffing agency they made sure all agency staff were nursing assistants (NAs) and MAs and did not need anything. -She did not notify the Regional Nurse about the agency staff. -She was not aware she needed to have proof of the 5/10/15 hour MA training for the agency MAs or that the agency MA were required to have the clinical skills check off prior to administering medications. Interview with the Administrator on 05/18/22 at 4:24pm revealed: -The BOM was responsible for giving the MA staff records to the Regional Nurse for processing the 5/10/15 hour MA training and the clinical skills check off. -The Regional Nurse was responsible for all MA training and the clinical skills check off to show proficiency. -A MA could not administer medications until completion/verification of the 5/10/15 hour MA training and the clinical skill check off. -The BOM was responsible for collecting agency staff records to show proof of MA training and clinical skills check off from the agency prior to administering medications. -She did not know the agency MAs needed to have a nurse complete the clinical skill check off at the facility prior to administering medications.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060160	A. BUILDING: _____ B. WING _____	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

(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
D935	Continued From page 92 -She had not audited the staff records since the RSD left the facility on 04/08/22 to determine if all the MAs had their required MA training and their clinical skill check off completed. Refer to Tag D0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation). _____ The facility failed to ensure 2 of 3 sampled staff (Staff D, and E) who administered medications had completed the Medication Aide Training and had completed the clinical skills checklist prior to administering medications resulting in MAs who failed to administer oxygen to a resident who was on 4 liters continuous oxygen, and 4 different nebulizer treatments causing his blood oxygen saturation to drop and to be without oxygen for several hours. The facility's failure to ensure MAs met training requirements prior to the administration of medications resulted in medication errors which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 20, 2022 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 5, 2022.	D935		