Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		
		HAL09214	B. WING		R-C 11/02/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E. ZIP CODE	
			D WAKE FOREST		
CADENCE	NORTH RALEIGH	RALEIG	H, NC 27609		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 000	Initial Comments		D 000		
	_	sure Section conducted a complaint investigation on			
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	(a) An adult care hor preparation and admi prescription and non-by staff are in accorda(1) orders by a licens which are maintained	ed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:			
	The Type B Violation Non-compliance cont				
	reviews, the facility farmedications as ordered #7, #8) observed duri including errors with a topical medication for and medications for earthritis (#8); and for (#1) for record review	ed for 3 of 4 residents (#6, ng the medication passes an antipsychotic (#6); a pain and inflammation (#7); enlarged prostate and 1 of 5 sampled residents related to a medication ver, headache, inflammation			
	The findings are:				
	The medication errevidenced by the obs	or rate was 14% as ervation of 4 errors out of 28			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R-C
HAL09214		B. WING		11/02/2022	
NAME OF D		CTDEET ADE	RESS, CITY, STA	TE 7/D 00DE	
NAME OF P	ROVIDER OR SUPPLIER		, ,	,	
CADENCE	NORTH RALEIGH		WAKE FORES	IRD	
		NC 27609			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358 Continued From page 1		D 358			
	opportunities during t passes on 11/01/22 a	he 8:00am medication ind 11/02/22.			
	10/10/22 revealed:	t #6's current FL-2 dated dementia, hypertension,			
		re, and chronic obstructive			
		for Olanzapine 2.5mg 1			
tablet twice a day at 8:00am and 2:00pm.					
		ipsychotic used to treat			
	psychosis and mood	disorders.)			
	Review of Resident #6's physician's orders dated 10/19/22 revealed an order for Olanzapine 2.5mg 1 tablet twice a day at 8:00am and 2:00pm for behaviors.				
	(eMAR) revealed: -There was an entry f	administration record for Olanzapine 2.5mg take 1			
	behaviors.	:00am and 2:00pm for			
	-Olanzapine was school 8:00am and 2:00pm.	eduled for administration at			
	11/01/22 revealed: -The medication aide Olanzapine 2.5mg to -Olanzapine was adm beyond the allowed ti dose due at 2:00pm.	Resident #6 at 9:44am. hinistered late, 44 minutes me frame, with the next (For medications with hs, consistent time intervals			
	Interview with the MA	on 11/01/22 at 1:41pm			

Division of Health Service Regulation

revealed:

STATE FORM 6899 P14F11 If continuation sheet 2 of 13

Division of Health Service Regulation

D 358 Continued From page 2 She usually started the morning medication pass at 7:30am and the time she finished varied depending on residents' behaviors and moods. She was running behind with the medication pass that morning, 11/01/22. She started the medication pass about 7:45am that morning, 11/01/22. She started the medication pass about 7:45am that morning, which caused her to run late with administering the 8:00am medications. Interview with the Special Care Coordinator (SCC) on 11/01/22 at 1:47pm revealed: The MAs had 1 hour before and 1 hour after the scheduled time to administer medications. The medication pass that morning, 11/01/22. The MA should notify her if the MA was running late with administering the morning medications. Resident #6 should have received the Olanzapine by 9:00am because she had another dose scheduled at 2:00pm that could be administered as early as 1:00pm. Interview with the Resident Services Director (RSD) on 11/01/22 at 1:56pm revealed: There was usually one MA administering medications on first shift in the special care unit (SCU). The administration times were staggered for the morning medications so they could be administered within 1 hour before and 1 hour	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
CADENCE NORTH RALEIGH (P4) ID PRETIX TAG (P4) ID PROTICE TAG (P4) ID PRETIX TAG			HAL09214	B. WING		1	
CA4 ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
PREFIX TAG COMPACTOR LSC IDENTIFYING INFORMATION) D 358 Continued From page 2 -She usually started the morning medication pass at 7:30am and the time she finished varied depending on residents' behaviors and moodsShe was running behind with the medication pass that morning because she got to work late that morning, 11/01/22She started the medication pass about 7:45am that morning, which caused her to run late with administering the 8:00am medications. Interview with the Special Care Coordinator (SCC) on 11/01/22 at 1:47pm revealed: -The MAs had 1 hour before and 1 hour after the scheduled time to administer medicationsThe medications scheduled for 8:00am should be administered by 9:00amShe was not aware of any issues delaying the medication pass that morning, 11/01/22The MA should notify her if the MA was running late with administering the morning medicationsResident #6 should have received the Olanzapine by 9:00am because she had another dose scheduled at 2:00pm that could be administered as early as 1:00pm. Interview with the Resident Services Director (RSD) on 11/01/22 at 1:56pm revealed: -There was usually one MA administering medications on first shift in the special care unit (SCU)The administration times were staggered for the morning medications so they could be administeried within 1 hour before and 1 hour	CADENCE NORTH RALEIGH			T RD			
-She usually started the morning medication pass at 7:30am and the time she finished varied depending on residents' behaviors and moodsShe was running behind with the medication pass that morning because she got to work late that morning, 11/01/22She started the medication pass about 7:45am that morning, which caused her to run late with administering the 8:00am medications. Interview with the Special Care Coordinator (SCC) on 11/01/22 at 1:47pm revealed: -The MAs had 1 hour before and 1 hour after the scheduled time to administer medicationsThe medications scheduled for 8:00am should be administered by 9:00amShe was not aware of any issues delaying the medication pass that morning, 11/01/22The MA should notify her if the MA was running late with administering the morning medicationsResident #6 should have received the Olanzapine by 9:00am because she had another dose scheduled at 2:00pm that could be administered as aerly as 1:00pm. Interview with the Resident Services Director (RSD) on 11/01/22 at 1:56pm revealed: -There was usually one MA administering medications on first shift in the special care unit (SCU)The administration times were staggered for the morning medications so they could be administered within 1 hour before and 1 hour	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
after the scheduled time. -If a MA was running late with the mediation pass, the MA should notify her, the SCC or the Resident Care Coordinator (RCC). Review of an email from Resident #6's primary	D 358	-She usually started to at 7:30am and the time depending on resider. She was running bethat morning, 11/01/2. She started the med that morning, which conditions administering the 8:00 linterview with the Spe (SCC) on 11/01/22 at 1-The MAs had 1 hour scheduled time to administered by 9. She was not aware of medication pass that 1-The MA should notify late with administering 1-Resident #6 should holanzapine by 9:00ardose scheduled at 2:1 administered as early linterview with the Resident #6 should rotify late with administering 1-There was usually of medications on first section. The administration timorning medications administered within 1 after the scheduled time 1-If a MA was running the MA should notify Care Coordinator (RCC).	the morning medication pass the she finished varied this behaviors and moods. In this behaviors and moods thind with the medication cause she got to work late 2. It is is is is is in the cause she got to work late 2. It is is is is is in the cause she got to work late 2. It is is is is in the cause she got to work late 2. It is is is is is in the cause she got to work late 2. It is is is is is in the cause she had another is in the cause she had another is in the cause she had another is is is is is is is in the special care unit is in the special care unit is is in the so they could be hour before and 1 hour me. Is is in the so they could be hour before and 1 hour me. Is is in the so the so they could be hour before and 1 hour me. Is is in the so the	D 358	DELINITY (

Division of Health Service Regulation

care provider (PCP) dated 11/01/22 revealed:

STATE FORM 6899 P14F11 If continuation sheet 3 of 13

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
HAL09214		B. WING		R-C 11/02/2	022	
	ROVIDER OR SUPPLIER		DRESS, CITY, STA WAKE FORES NC 27609			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 358	Olanzapine was admin 11/01/22. -The PCP instructed to the 2:00pm dose that 3:00pm. Interview with Reside 1:24pm revealed: -The facility notified how the resident's 8:00am administered lateAdministering doses together could increase falls. b. Review of Residen 07/26/22 revealed dia and Vitamin D deficient was an entry for a series of the view of Resident #08/17/22 revealed and apply 2 grams to kneed Gel is a topical medicinflammation.) Review of Resident #electronic medication (eMAR) revealed: -There was an entry for spread 2 gm topically policlofenac Gel was seat 8:00am and 8:00pm. Observation of the 8:01/1/02/22 revealed: -The medication aide tube of Diclofenac Gel	the PCP that Resident #6's inistered late that morning, the facility staff to administer day, 11/01/22, closer to Int #6' PCP on 11/02/22 at im yesterday, 11/01/22, that dose of Olanzapine was of Olanzapine too close se the resident's risk for It #7's current FL-2 dated agnoses included dementia ncy. T's physician's order dated order for Diclofenac Gel 1% es twice daily. (Diclofenac ation used to treat pain and T's November 2022 administration record for Diclofenac Gel 1% to knees twice daily. (Scheduled for administration m.) Doam medication pass on (MA) opened Resident #7's	D 358			

Division of Health Service Regulation

hand to the resident's knees at 8:26am.

STATE FORM 6899 P14F11 If continuation sheet 4 of 13

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL09214	B. WING		R-C 11/02/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CARENCE	NORTH DATEION	5219 OLD	WAKE FORES	T RD		
CADENCE NORTH RALEIGH RALEIGH		, NC 27609				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 4	D 358			
	-The MA did not use a measure a 2gm dose					
	hand on 11/02/22 at 1 -There was a supply of dispensed on 08/18/2 2gm topically to knee -There was a flat plas with the Diclofenac G 2gm dose and a 4gm	of Diclofenac Gel 1% 22 with instructions to spread s twice daily. Stic dosing card in the box el that was marked for a				
	revealed: -There was a plastic r box with the Diclofena -She did not use the p 2gm of Diclofenac Ge "eyeballed" it and use close to 2gm.	measuring dose card in the ac Gel. blastic dose card to measure				
	revealed:					
	(RSD) on 11/02/22 at -The MAs should follo eMARs and administe	ow the instructions on the er medications as ordered. used the plastic dosing				

Division of Health Service Regulation

Interview with Resident #7's primary care provider (PCP) on 11/02/22 at 1:24pm revealed:
-The MAs should follow the order and measure

STATE FORM 6899 P14F11 If continuation sheet 5 of 13

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
HAL09214		B. WING		R-C 11/02/2022	
NAME OF PROVIDER OR SUPPLIER CADENCE NORTH RALEIGH	5219 OLD	DRESS, CITY, STA WAKE FORES , NC 27609	,		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
#7's kneesUnderdosing the Dick resident's pain not to be Too much of the Dick resident at risk of possident at risk of possidents at risk of possidents at risk of possidents of the resident disease. c. Review of Resident 01/05/22 revealed: -Diagnoses included do hypertrophy (enlarge particle) -There was an order for once a day. (Finasteri prostate. According to Finasteride should not not crushed.) Review of Resident #8 09/07/22 revealed: -There was an order for and/or place in apple is not contraindicated by -Refer to Do Not Crush Review of Resident #8 10/12/22 revealed and take 1 tablet daily **Documents of the 8:0 11/02/22 revealed: -The medication of the 8:0 11/02/22 revealed: -The medication aide (medications for Reside Finasteride 5mg tablet) -The MA crushed Residency including the Finasterial	Diclofenac Gel to Resident ofenac Gel could cause the ofenac Gel could put the sible side effects to the had underlying kidney #8's current FL-2 dated dementia and prostatic orostate). or Finasteride 5mg 1 tablet ide is used to treat enlarged to the manufacturer, to be swallowed whole and B's standing orders dated or may crush medications sauce\pudding, or juice if orpharmacy. h (DNC) List. B's physician's orders dated order for Finasteride 5mg to Not Crush**. Oam medication pass on (MA) prepared morning ent #8, including one to ident #8's oral medications, de 5mg tablet, mixed them ministered the medications	D 358			

Division of Health Service Regulation

STATE FORM 6899 P14F11 If continuation sheet 6 of 13

Division of Health Service Regulation

Division	of Health Service Regu	lation	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
P. WING			R-C			
		HAL09214	B. WING		11/02/2022	
NAME OF D	ROVIDER OR SUPPLIER	STDEET AF	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF FI	NOVIDER OR SUFFLIER					
CADENCE	NORTH RALEIGH	5219 OLD	WAKE FORES	TRD		
0,152.102		RALEIGH	, NC 27609			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
				DEFICIENCY)		
D 050	0 " 15	•	D 050			
D 358	Continued From page	e 6	D 358			
	Review of Resident #	8's November 2022				
	electronic medication	administration record				
	(eMAR) revealed:					
		or Finasteride 5mg take 1				
	tablet daily, **DO NO	T CRUSH**.				
	-Finasteride was sche	eduled for administration at				
	8:00am.					
	Observation of Resid	ent #8's medications on				
	hand on 11/02/22 at 1					
		of Finasteride 5mg tablets				
	dispensed on 10/03/2					
	-The instructions inclu	ıded, "DO NOT CRUSH".				
	Interview with the MA	on 11/02/22 at 10:03am				
	revealed:					
	-She usually crushed	Resident #8's medications				
	•	sure the resident could				
	swallow the medication					
	swallowing problems.					
		not be crushed, it would be				
	noted on the medicati	. 0				
	-The facility did not ha	ave a DNC list to her				
	knowledge.					
	-She did not see the i	nstructions on the eMAR				
	and the medication la	bel that Finasteride should				
	not be crushed.					
	Interview with the Res	sident Care Coordinator				
	(RCC) on 11/02/22 at					
	-There should be a D					
	medication cart.	140 hat Ropt on the				
		our in atmosphisms are the supplemental and the supplemental and the supplemental area.				
		ow instructions on the eMAR				
	and the medication la					
		not be crushed, the MA				
	should contact the ph	ysician to see if the				
		changed or check with her or				
	the Resident Services	_	1			
		nt #8 should be able to				
	Silo alougin resider	it ii o oi iodid bo abio to	1		1	

Division of Health Service Regulation

swallow his medications whole.

STATE FORM 6899 P14F11 If continuation sheet 7 of 13

Division of Health Service Regulation

Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
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		B. WING		R-		
		HAL09214	B. WING		11/0	2/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
			WAKE FORES	,		
CADENCE	NORTH RALEIGH			I KD		
		RALEIGH	, NC 27609			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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D 358	Continued From page	e 7	D 358			
	Danad on absorvation	ns, interviews, and record				
	interviewable.	nined Resident #8 was not				
	interviewable.					
	Indianal and a state					
		ent #8's primary care provider				
	(PCP) on 11/02/22 at					
		ld not be crushed, the MA				
	•	armacy or the provider to				
		rnative medications that				
	could be taken.					
		ose their potency when				
	crushed.					
		t #8's physician's orders				
	dated 10/12/22 revea	lled an order for Arthrotec				
	75mg/200mcg take 1	tablet twice daily at				
	breakfast and dinner	*Do Not Crush*. (Arthrotec				
	is a combination med	ication used to treat arthritis.				
	Arthrotec has one me	edication used to treat				
	arthritis and the other	medication protects the				
	lining of the gastrointe	estinal tract from irritation by				
	the arthritis medicatio	on. Arthrotec is a				
	delayed-release table	et and should not be				
	crushed.)					
	Review of Resident #	8's standing orders dated				
	09/07/22 revealed:	-				
	-There was an order f	for may crush medications				
		sauce\pudding, or juice if				
	not contraindicated by					
	-Refer to Do Not Crus					
	-	,				
	Observation of the 8:0	00am medication pass on				
	11/02/22 revealed:					
		(MA) prepared morning				
	medications for Resid	` ',				
	Arthrotec 75mg/200m					
		sident #8's oral medications,				
		c 75mg/200mcg tablet,				
	moduling the Artifole	o romgrzoomicy tablet,				

Division of Health Service Regulation

STATE FORM 6899 P14F11 If continuation sheet 8 of 13

Division of Health Service Regulation

Division of fleatin Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
				_		
		B. WING		R-C		
HAL09214			B. WING		11/02	/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			WAKE FORES	,		
CADENCE	NORTH RALEIGH		, NC 27609	i ND		
		RALEIGH	, NC 27609			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
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D 358	Continued From page	e 8	D 358			
	mixed them in apples	auce and administered the				
	medications to the res					
		rved breakfast at 9:05am.				
	-Arthrotec was admin					
	stomach instead of at	t breakfast as ordered.				
	Review of Resident #	Sia Navambar 2022				
		administration record				
	(eMAR) revealed:	==				
	_	for Arthrotec 75mg/200mcg				
		day at breakfast and dinner,				
	DO NOT CRUSH.					
		uled for administration at				
	8:00am and 5:00pm.					
	Observation of Reside	ent #8's medications on				
	hand on 11/02/22 at 1	10:06am revealed:				
	-There was a supply	of Arthrotec 75mg/200mcg				
	tablets dispensed on					
		e to take 1 tablet twice a day				
		er, *DO NOT CRUSH*.				
		ry sticker on the package				
		crush, swallow whole".				
		•				
	Interview with the MA	on 11/02/22 at 10:03am				
	revealed:					
	-She usually crushed	Resident #8's medications				
		sure the resident could				
		ons whole because of				
	swallowing problems.					
	• .	l not be crushed, it would be				
	noted on the medicati					
	-The facility did not ha					
	knowledge.					
	_	instructions on the eMAR				
		bel that Arthrotec should not				
	be crushed.	iso that Arthrotoc Should Hot				
		the dining room when she				
		dications so she thought the				
	aurillistered the Met	moduonio oo one mougin me	1			

Division of Health Service Regulation

resident's breakfast would be served soon.

STATE FORM 6899 P14F11 If continuation sheet 9 of 13

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
HAL09214		B. WING		R- 11/0	C 2/2022	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1	
5219 OLD		WAKE FORES				
CADENCE NORTH RALEIGH RALEIGH,		NC 27609				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	9	D 358			
	(RCC) on 11/02/22 at -There should be a D medication cartThe MAs should followed and the medication could should contact the phemedication could be of the Resident Services -She thought Resident swallow his medication was owith a meal or at mean administered as soon their food. Based on observation reviews, it was determine the with Reside (PCP) on 11/02/22 at -If a medication should should contact the phemedication and proposed in the residence of the medication and proving effectively an increase the potential gastrointestinal bleed.	ow instructions on the eMAR bel. not be crushed, the MA ysician to see if the changed or check with her or is Director (RSD). In #8 should be able to ons whole. Ordered to be administered altimes, it should be as the resident received In #8's primary care provider 1:24pm revealed: In not be crushed, the MA armacy or the provider to mative medications that Ould affect the absorption of revent the medication from in dappropriately and could for stomach upset and ing. It #1's current FL-2 dated				

Division of Health Service Regulation

Review of Resident #1's signed physician's

STATE FORM 6899 P14F11 If continuation sheet 10 of 13

Division of Health Service Regulation

DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL09214	B. WING		11/02/2022	
					•	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CADENCE	NORTH RALEIGH		WAKE FORES	T RD		
		RALEIGH,	NC 27609			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 10	D 358			
	order to discontinue Aused to treat pain, fev	educe the risk of heart				
	electronic medication (eMAR) on 11/01/22 a -There was an entry f administered daily at -Aspirin 81mg tablet v	at 1:32pm revealed: or Aspirin 81mg to be 8:00am.				
	administered 09/11/22					
	11/01/22 at 1:32pm re -There was an entry f administered daily at -Aspirin 81mg tablet v administered 10/01/2	or Aspirin 81mg to be 8:00am. was documented as				
	on 11/01/22 at 1:32pr -There was an entry f administered daily at -Aspirin 81mg tablet v administered on 11/0	or Aspirin 81mg to be 8:00am. was documented as				
	Observation of Reside available for administ 9:27am revealed Asp medication cart.					

Division of Health Service Regulation

Interview with the Resident Care Coordinator

STATE FORM 6899 P14F11 If continuation sheet 11 of 13

Division of Health Service Regu	ulation			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
HAL09214 B. WING		B. WING		R-C 11/02/2022
NAME OF PROVIDER OR SUPPLIER STREET A		DRESS, CITY, STAT	TE, ZIP CODE	-
5219 OLE		WAKE FOREST	T RD	
CADENCE NORTH RAI FIGH		, NC 27609		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
surveyThe nurse was responsible the pharmacyShe was responsible the eMAR systemThe new order syste 2022. Interview with the Re (RSD) on 11/02/22 a -The primary care proders to herShe would fax the n -The RCC would dooresident's record and systemShe did not know the medication orders in not working in the facture of the systemShe was not aware discontinue Aspirin 80 and the system and the s	at 9:01am revealed: der system since the last consible to fax new orders to e to verify new orders were in em had not started in May esident Services Director t 9:09am revealed: covider (PCP) gave new ew orders to the pharmacy. cument the new order in the d verify the order in the eMAR ee process of receiving May 2022 because she was cility. Resident #1 had an order to at mg. eted medication order review CP on 11/02/22 at 1:26pm 1/02/22, providing care to the ty.	D 358	DEFICIENCY)	

Division of Health Service Regulation

10:06am revealed:

Interview with the Administrator on 07/27/22 at

-He expected the facility to review medication orders and ensure the orders were accurate on

STATE FORM P14F11 If continuation sheet 12 of 13

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER CADENCE NORTH RALEIGH (X4) ID PREDIX REGULATORY OR ISC DENTIFYING INFORMATION) D 358 Continued From page 12 the eMARThe RSD or designee were responsible to ensure the medications in the medication cart were removed when orders were discontinued.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
CADENCE NORTH RALEIGH SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	1		HAL09214	B. WING		•	
(X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358 Continued From page 12 the eMAR. -The RSD or designee were responsible to ensure the medications in the medication cart	·						
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) D 358 Continued From page 12 the eMAR. -The RSD or designee were responsible to ensure the medications in the medication cart	I CADENCE NORTH RALEIGH						
the eMAR. -The RSD or designee were responsible to ensure the medications in the medication cart	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE COMPLETE	
	D 358	the eMARThe RSD or designe ensure the medication	e were responsible to ns in the medication cart	D 358			

Division of Health Service Regulation

STATE FORM 6899 P14F11 If continuation sheet 13 of 13