STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 conducted a follow-up survey and complaint investigation on 11/01/22 - 11/02/22.	D 000		
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: FOLLOW-UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 4 residents (#6, #7, #8) observed during the medication passes including errors with an antipsychotic (#6); a topical medication for pain and inflammation (#7); and medications for enlarged prostate and arthritis (#8); and for 1 of 5 sampled residents (#1) for record review related to a medication used to treat pain, fever, headache, inflammation and to reduce the risk of heart attack. The findings are: 1. The medication error rate was 14% as evidenced by the observation of 4 errors out of 28	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 1	D 358		

opportunities during the 8:00am medication passes on 11/01/22 and 11/02/22.

a. Review of Resident #6's current FL-2 dated 10/10/22 revealed:
-Diagnoses included dementia, hypertension, congestive heart failure, and chronic obstructive pulmonary disease.
-There was an order for Olanzapine 2.5mg 1 tablet twice a day at 8:00am and 2:00pm. (Olanzapine is an antipsychotic 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.

Review of Resident #6's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Olanzapine 2.5mg take 1 tablet twice daily at 8:00am and 2:00pm for behaviors.
-Olanzapine was scheduled for administration at 8:00am and 2:00pm.

Observation of the 8:00am medication pass on 11/01/22 revealed:
-The medication aide (MA) administered Olanzapine 2.5mg to Resident #6 at 9:44am.
-Olanzapine was administered late, 44 minutes beyond the allowed time frame, with the next dose due at 2:00pm. (For medications with multiple administrations, consistent time intervals are necessary to prevent side effects and adverse reactions.]

Interview with the MA on 11/01/22 at 1:41pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 2	D 358		

-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 because she got to work late 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 medications scheduled for 8:00am should be administered by 9:00am.
-She was not aware of any issues delaying 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 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 care provider (PCP) dated 11/01/22 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 3	D 358		

-The facility notified the PCP that Resident #6's Olanzapine was administered late that morning, 11/01/22.
-The PCP instructed the facility staff to administer the 2:00pm dose that day, 11/01/22, closer to 3:00pm.

Interview with Resident #6' PCP on 11/02/22 at 1:24pm revealed:
-The facility notified him yesterday, 11/01/22, that the resident's 8:00am dose of Olanzapine was administered late.
-Administering doses of Olanzapine too close together could increase the resident's risk for falls.

b. Review of Resident #7's current FL-2 dated 07/26/22 revealed diagnoses included dementia and Vitamin D deficiency.

Review of Resident #7's physician's order dated 08/17/22 revealed an order for Diclofenac Gel 1% apply 2 grams to knees twice daily. (Diclofenac Gel is a topical medication used to treat pain and inflammation.)

Review of Resident #7's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Diclofenac Gel 1% spread 2 gm topically to knees twice daily.
-Diclofenac Gel was scheduled for administration at 8:00am and 8:00pm.

Observation of the 8:00am medication pass on 11/02/22 revealed:
-The medication aide (MA) opened Resident #7's tube of Diclofenac Gel 1% and squeezed a quarter-sized amount and applied it with a gloved hand to the resident's knees at 8:26am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 4	D 358		

-The MA did not use a measuring device to measure a 2gm dose.

Observation of Resident #7's medications on hand on 11/02/22 at 10:02am revealed:
-There was a supply of Diclofenac Gel 1% dispensed on 08/18/22 with instructions to spread 2gm topically to knees twice daily.
-There was a flat plastic dosing card in the box with the Diclofenac Gel that was marked for a 2gm dose and a 4gm dose.

Interview with the MA on 11/02/22 at 10:03am revealed:
-There was a plastic measuring dose card in the box with the Diclofenac Gel.
-She did not use the plastic dose card to measure 2gm of Diclofenac Gel because she just "eyeballed" it and used what she thought was close to 2gm.
-The resident complained of pain in her knees at times.

Interview with Resident #7 on 11/02/22 at 3:50pm revealed:
-The MAs usually put medication on both her knees, but she was unsure how much.
-Her left knee hurt at times.

Interview with the Resident Services Director (RSD) on 11/02/22 at 10:15am revealed:
-The MAs should follow the instructions on the eMARs and administer medications as ordered.
-The MA should have used the plastic dosing card to measure 2gm of Diclofenac Gel for Resident #7.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 5	D 358		

the correct dosage of Diclofenac Gel to Resident #7's knees.
-Underdosing the Diclofenac Gel could cause the resident's pain not to be managed effectively.
-Too much of the Diclofenac Gel could put the resident at risk of possible side effects to the kidneys if the resident had underlying kidney disease.

c. Review of Resident #8's current FL-2 dated 01/05/22 revealed:
-Diagnoses included dementia and prostatic hypertrophy (enlarge prostate).
-There was an order for Finasteride 5mg 1 tablet once a day. (Finasteride is used to treat enlarged prostate. According to the manufacturer, Finasteride should not be swallowed whole and not crushed.)

Review of Resident #8's standing orders dated 09/07/22 revealed:
-There was an order for may crush medications and/or place in apple sauce\pudding, or juice if not contraindicated by pharmacy.
-Refer to Do Not Crush (DNC) List.

Review of Resident #8's physician's orders dated 10/12/22 revealed an order for Finasteride 5mg take 1 tablet daily **Do Not Crush**.

Observation of the 8:00am medication pass on 11/02/22 revealed:
-The medication aide (MA) prepared morning medications for Resident #8, including one Finasteride 5mg tablet.
-The MA crushed Resident #8's oral medications, including the Finasteride 5mg tablet, mixed them in applesauce and administered the medications to the resident at 8:34am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 6	D 358		

Review of Resident #8's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Finasteride 5mg take 1 tablet daily, **DO NOT CRUSH**.
-Finasteride was scheduled for administration at 8:00am.

Observation of Resident #8's medications on hand on 11/02/22 at 10:06am revealed:
-There was a supply of Finasteride 5mg tablets dispensed on 10/03/22.
-The instructions included, "DO NOT CRUSH".

Interview with the MA on 11/02/22 at 10:03am revealed:
-She usually crushed Resident #8's medications because she was not sure the resident could swallow the medications whole because of swallowing problems.
-If a medication could not be crushed, it would be noted on the medication package.
-The facility did not have a DNC list to her knowledge.
-She did not see the instructions on the eMAR and the medication label that Finasteride should not be crushed.

Interview with the Resident Care Coordinator (RCC) on 11/02/22 at 10:15am revealed:
-There should be a DNC list kept on the medication cart.
-The MAs should follow instructions on the eMAR and the medication label.
-If a medication could not be crushed, the MA should contact the physician to see if the medication could be changed or check with her or the Resident Services Director (RSD).
-She thought Resident #8 should be able to swallow his medications whole.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 7	D 358		

Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable.

Interview with Resident #8's primary care provider (PCP) on 11/02/22 at 1:24pm revealed:
-If a medication should not be crushed, the MA should contact the pharmacy or the provider to see if there were alternative medications that could be taken.
-Some medications lose their potency when crushed.

d. Review of Resident #8's physician's orders dated 10/12/22 revealed an order for Arthrotec 75mg/200mcg take 1 tablet twice daily at breakfast and dinner *Do Not Crush*. (Arthrotec is a combination medication used to treat arthritis. Arthrotec has one medication used to treat arthritis and the other medication protects the lining of the gastrointestinal tract from irritation by the arthritis medication. Arthrotec is a delayed-release tablet and should not be crushed.)

Review of Resident #8's standing orders dated 09/07/22 revealed:
-There was an order for may crush medications and/or place in apple sauce\pudding, or juice if not contraindicated by pharmacy.
-Refer to Do Not Crush (DNC) List.

Observation of the 8:00am medication pass on 11/02/22 revealed:
-The medication aide (MA) prepared morning medications for Resident #8, including one Arthrotec 75mg/200mcg tablet.
-The MA crushed Resident #8's oral medications, including the Arthrotec 75mg/200mcg tablet,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 8	D 358		

mixed them in applesauce and administered the medications to the resident at 8:34am.
-The resident was served breakfast at 9:05am.
-Arthrotec was administered on an empty stomach instead of at breakfast as ordered.

Review of Resident #8's November 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Arthrotec 75mg/200mcg take 1 tablet twice a day at breakfast and dinner, *DO NOT CRUSH*.
-Arthrotec was scheduled for administration at 8:00am and 5:00pm.

Observation of Resident #8's medications on hand on 11/02/22 at 10:06am revealed:
-There was a supply of Arthrotec 75mg/200mcg tablets dispensed on 10/03/22.
-The instructions were to take 1 tablet twice a day at breakfast and dinner, *DO NOT CRUSH*.
-There was an auxiliary sticker on the package with "do not chew or crush, swallow whole".

Interview with the MA on 11/02/22 at 10:03am revealed:
-She usually crushed Resident #8's medications because she was not sure the resident could swallow the medications whole because of swallowing problems.
-If a medication could not be crushed, it would be noted on the medication package.
-The facility did not have a DNC list to her knowledge.
-She did not see the instructions on the eMAR and the medication label that Arthrotec should not be crushed.
-The resident was in the dining room when she administered the medications so she thought the resident's breakfast would be served soon.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 9 Interview with the Resident Care Coordinator (RCC) on 11/02/22 at 10:15am revealed: -There should be a DNC list kept on the medication cart. -The MAs should follow instructions on the eMAR and the medication label. -If a medication could not be crushed, the MA should contact the physician to see if the medication could be changed or check with her or the Resident Services Director (RSD). -She thought Resident #8 should be able to swallow his medications whole. -If a medication was ordered to be administered with a meal or at mealtimes, it should be administered as soon as the resident received their food. Based on observations, interviews, and record reviews, it was determined Resident #8 was not interviewable. Interview with Resident #8's primary care provider (PCP) on 11/02/22 at 1:24pm revealed: -If a medication should not be crushed, the MA should contact the pharmacy or the provider to see if there were alternative medications that could be taken. -Crushing Arthrotec could affect the absorption of the medication and prevent the medication from working effectively and appropriately and could increase the potential for stomach upset and gastrointestinal bleeding. 2. Review of Resident #1's current FL-2 dated 03/24/22 revealed diagnoses of restrictive pulmonary disease, hypertension, and type 2 diabetes. Review of Resident #1's signed physician's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 10	D 358		

consultation orders dated 05/25/22 revealed an order to discontinue Aspirin 81mg daily. (Aspirin is used to treat pain, fever, headache, and inflammation and to reduce the risk of heart attack).

Review of Resident #1's September 2022 electronic medication administration record (eMAR) on 11/01/22 at 1:32pm revealed:
-There was an entry for Aspirin 81mg to be administered daily at 8:00am.
-Aspirin 81mg tablet was documented as administered 09/11/22- 09/30/22.
-There was no entry after 05/25/22 to discontinue Aspirin 81mg.

Review of Resident #1's October 2022 eMAR on 11/01/22 at 1:32pm revealed:
-There was an entry for Aspirin 81mg to be administered daily at 8:00am.
-Aspirin 81mg tablet was documented as administered 10/01/22- 10/31/22.
-There was no entry after 05/25/22 to discontinue Aspirin 81mg.

Review of Resident #1's November 2022 eMAR on 11/01/22 at 1:32pm revealed:
-There was an entry for Aspirin 81mg to be administered daily at 8:00am.
-Aspirin 81mg tablet was documented as administered on 11/01/22.
-There was no entry after 05/25/22 to discontinue Aspirin 81mg.

Observation of Resident #1's medications available for administration on 11/02/22 at 9:27am revealed Aspirin 81mg tablet was in the medication cart.

Interview with the Resident Care Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 11	D 358		

(RCC) on 11/02/22 at 9:01am revealed:
-There was a new order system since the last survey.
-The nurse was responsible to fax new orders to the pharmacy.
-She was responsible to verify new orders were in the eMAR system.
-The new order system had not started in May 2022.

Interview with the Resident Services Director (RSD) on 11/02/22 at 9:09am revealed:
-The primary care provider (PCP) gave new orders to her.
-She would fax the new orders to the pharmacy.
-The RCC would document the new order in the resident's record and verify the order in the eMAR system.
-She did not know the process of receiving medication orders in May 2022 because she was not working in the facility.
-She was not aware Resident #1 had an order to discontinue Aspirin 81mg.
-She had not completed medication order review audits.

Interview with the PCP on 11/02/22 at 1:26pm revealed:
-It was his first day,11/02/22, providing care to the residents in the facility.
-He did not have any concerns regarding Resident #1 continuing the Aspirin 81mg after it was discontinued.
-The order for the Aspirin 81mg was discontinued because it had no benefits to Resident #1.

Interview with the Administrator on 07/27/22 at 10:06am revealed:
-He expected the facility to review medication orders and ensure the orders were accurate on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL09214	A. BUILDING: _____ B. WING _____	R-C 11/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE NORTH RALEIGH	5219 OLD WAKE FOREST RD RALEIGH, NC 27609

(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 12 the eMAR. -The RSD or designee were responsible to ensure the medications in the medication cart were removed when orders were discontinued.	D 358		