<u>Division o</u>	of Health Service Regu	lation					
	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE S COMPL		
	z	HAL09214	B, WING		R- 11/0	C 2/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREETADE	RESS, CITY, STA	ATE, ZIP CODE			
CADENCE	NORTH RALEIGH	5219 OLD RALEIGH,	WAKE FORES NC 27609	ST RD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIÊNCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DE	CAS) COMPLETE DATE	
0 000	Initial Comments		D 000				ļ
		sure Section conducted a complaint investigation on	19 18		1		
D 358	10A NCAC 13F .1004 Administration	l(a) Medication	D 358			12/17/22	
	(a) An adult care hor preparation and admit prescription and non-by staff are in accordant (1) orders by a licens which are maintained	sed prescribing practitioner In the resident's record; and on and the facility's policies		nedication passe for 3 weeks to en proper medication administration proce	5 Surl V	19133	OF.
Shirk-law of Clark	FOLLOW-UP TO TYPE The Type B Violation Non-compliance conton Based on observation reviews, the facility farmedications as order #7, #8) observed durinctuding errors with a topical medications for and medications for arthritis (#8); and for (#1) for record review used to treat pain, for and to reduce the rist The findings are: 1. The medication errors with a collection of the observed by the observed.	was abated. inues. Ins, interviews, and record alled to administer ed for 3 of 4 residents (#6, ing the medication passes an antipsychotic (#6); a pain and inflammation (#7); anlarged prostate and 1 of 5 sampled residents or related to a medication wer, headache, inflammation is of heart attack.		medication Technic RSD will document findings of medication Technic pass. 2. RSD will educate medication on implementation new order and refreshments and refreshments are medication practices.	on idian of	12/11/23 11/12/23	OT
Division of He LABORATORY STATE FORM		SUPPLIER REPRESENTATIVE'S SIGNATURE	Execu	tive Director P14F11	19/13/1 -19/13/1 05)	(XS) CLATE	/17/2002 5
34 3 1	1 2						

Reviewed and Aknowledged.
WW 12/28/22

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING: ___ R-C HAL09214 B. WING 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5219 OLD WAKE FOREST RD CADENCE NORTH RALEIGH RALEIGH, NC 27609 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 Continued From page 1 D 358 3. RJD or designee will opportunities during the 8:00am medication passes on 11/01/22 and 11/02/22. complete final check of new orders to ensure a. Review of Resident #6's current FL-2 dated 10/10/22 rovealed: -Diagnoses included dementia, hyperansion, congestive heart failure, and chronic costructive accuracy and completion. pulmonary disease. -There was an order for Olanzapine 2.5mg 1 tablet twice a day at 8:00am and 2:00pm. 4. RSD or designee will 12/17/22 (Olanzapine is an antipsycholic used to treat psychosis and mood disorders.) audit three charts Review of Resident #6's physician's orders dated a week to ensure medications on hand 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 match physician orders, electronic medication administration record (eMAR) revealed: -There was an entry for Olanzapine 2.5mg take 1 tablet twice dally at 8:00am and 2:00pm for behavlors. 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:

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Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING: _ COMPLETED R-C HAL09214 B. WING 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE CADENCE NORTH RALEIGH 5219 OLD WAKE FOREST RD RALEIGH, NC 27609 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION LEACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION] DAT TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 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 moming because she got to work late that morning, 11/01/22. -She started the medication pass about 7:45am that moming, 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 revoaled: The MAs had 1 hour before and 1 hour after the scheduled time to administer medications. The medications scheduled for 8:00ain 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 moming 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:

Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING: COMPLETED R-C HAL09214 B. WING_ 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5219 OLD WAKE FOREST RD CADENCE NORTH RALEIGH RALEIGH, NC 27600 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID IO PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX (XS) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LEC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 3 D 358 -The facility notified the PCP that Resident #6's Olanzapine was administered late that morning, -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 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 Dictofenac Gel 1% spread 2 gm topically to knees twice dally. 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 Diciolenac Gel 1% and squeezed a quarter-sized amount and applied it with a gloved hand to the resident's knees at 8:26am.

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STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (CONSTRUCTION	COLDAT	E SURVEY
		INCLUSION HOWOELD	A. BUILDING:			PLETED
		HAL09214	B. WING		4	R-C 1/02/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATI	E. ZIP CODE		IUZIZUZZ
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	• 2000000000000000000000000000000000000	RALEIG	H, NC 27609			
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D 358	Continued From pag	e 4	D 358			
	-The MA did not use	a measuring device to				
	measure a 2gm dosc	3.	1 [
	Obs					
1	hand on 11/02/22 at	lent #7's medications on				
	-There was a supply	of Diclofenac Gel 1%				
	dispensed on 08/18/2	22 with instructions to spread				9 9
	2gm topically to knee	s twice daily. stic dosing card in the box				
1	with the Diclofenac G	iel that was marked for a	6			1
ŀ	2gm dose and a 4gm	dose.		4		
1	i Intendeur seith III - B.B.A	, , , , , , , , , , , , , , , , , , ,		E		1
Ē:	revealed:	on 11/02/22 at 10:03am	83			
	-There was a plastic i	measuring dose card in the				
58	box with the Diclofen:	ac Gel.				
į	-She did not use the p	plastic dose card to measure	0			22
	2gm of Diclofenac Ge "eveballed" It and use	d what she thought was				
	close to 2gm.	≅				
	The resident complai	ned of pain in her knees at				
- 1	tlmes.					7.1
	Interview with Resider	nt #7 on 11/02/22 at 3:50pm				
[-	The MAs usually put	medication on both her				
	knees, but she was ur Her left knee hurt at t	isure how much,				
	: -) jei lek kiles lilik 9f (imes.				1
		Ident Services Director				
1	(RSD) on 11/02/22 at	10:15am revealed:				
	, I NO MAS Should Iollo MARs and administe	w the instructions on the r medications as ordered.				1
		used the plastic dosing				1 1
	card to measure 2gm : Resident #7.	of Diciofenac Gel for				
] !	tealectif #/ .					
Į į	nterview with Residen	t #7's primary care provider				1
10	PCP) on 11/02/22 at 1	1:24pm revealed;		**		, /
-	The MAs should follow	v the order and measure				i

Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING: COMPLETED R-C HAL09214 B. WING 11/02/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 21P CODE 5219 OLD WAKE FOREST RD CADENCE NORTH RALEIGH RALEIGH, NC 27609 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X5) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 358 Continued From page 5 D 358 the correct dosage of Dictofenac Gel to Resident #7's knees. -Underdosing the Dictofenac Gel could cause the resident's pain not to be managed effectively. -Too much of the Dictofenac 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 Finastéride 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.

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STATEMEN	of Health Service Red TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1	<u> </u>		RM APPROVE
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
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		HAL09214	B. WING			R-C 1/02/2022
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D 358	Continued From pag	ie 6	D 358			
	Review of Resident : electronic medication (eMAR) revoaled: -There was an entry tablet dally, **DO NO	#8's November 2022 n administration record for Finasteride 5mg take 1	D 358			
	Observation of Resident #8's medications on hand on 11/02/22 at 10:06am revealed: -There was a supply of Finasteride 5nig tablets dispensed on 10/03/22, -The instructions included, "DO NOT CRUSH".	10:06am revealed: of Finasteride 5nig tablets 22.		3		
II.	interview with the MA revealed:	on 11/02/22 at 10:03am				
	because she was not swallow the medicalic swallowing problems. If a medication could noted on the medication facility did not he knowledge. She did not see the intending the medication lates to crushed.	not be crushed, it would be on package, ave a DNC list to her nstructions on the eMAR bel that Finasteride should				
8	NCC) on 11/02/22 at There should be a Dinedication cart. The MAs should followed the medication later a medication could be cinedication could be cine Resident Services.	NC list kept on the winstructions on the eMAR pel. not be crushed, the MA reician to see if the hanged or check with her or Director (RSD). #8 should be able to				

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PRINTED: 11/21/2022 Division of Health Service Regulation FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING: _ COMPLETED R-C HAL09214 B. WING 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) 10 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX tD. PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG TAG 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 revoaled: alf 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 arthrilis and the other medication protects the fining of the gastrointestinal tract from imitation 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

Division of Health Service Regulation

11/02/22 revealed:

Arthrotec 75mg/200mcg tablet.

. The medication alde (MA) prepared morning medications for Resident #8, including one

-The MA crushed Resident #8's oral medications, including the Arthrotec 75mg/200mcg tablet,

	or riealth Service Reg	1		<u> </u>	FO	KIMAPPROVE
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY
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			AODRESS, CITY, STAT. -D WAKE FOREST			
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(X4) (D	SUMMARYST	ATEMENT OF DESIGNATION	10	DEDIROCOUR DI ALL		
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D 358	Continued From page	9 8	D 358		-	
	mixed thom in apples	auce and administered the				
8	medications to the re-	sident at 8:34am'	3			1
35	-The resident was se	rved breakfast at 9:05am.	2			
	-Arthrotec was admin	Istered on an empty				
	stomach instead of at	breakfast as ordered.				
3	Review of Resident #	8's November 2022				
	electronic medication	administration record				
	(eMAR) revealed:					
1	-There was an entry f	or Arthrotec 75mg/200mcg	1 1			
1	take 1 lablet twice a d	lay at breakfast and dinner,				Er.
- 1	*DO NOT CRUSH*.	a au la recent	5			
- 1	8:00am and 5:00pm.	uled for administration at	78,			
i	Observation of Reside	: ent #8's medications on				
ľ	tiand on 11/02/22 at 1	Orogan mosley.	1 1			1
	-There was a supply of	of Arthrotec 75mg/200mcg				ł
	'(ablets dispensed on 1	10/03/22.				
	-The instructions were	to take 1 tablet twice a day	l I			i
	at breakfast and dinne	r, *DO NOT CRUSH*.	76. 1			1
30	-There was an auxiliar	y sticker on the package	88			
	with "do not chew or c	rush, swallow whole*.	3			
59	Interview with the MA	on 11/02/22 at 10:03am				
	revoaled:					
ľ	-She usually crushed I	Resident #8's modications	1 1			
	bacause she was not s	sure the resident could				ls.
	swallow the medication	ns whole because of				
	swallowing problems.					
	en a medication could i	not be crushed, it would be				
	noted on the medication. The facility did not have	on package.	1			
	knowledgo.	AP 9 DIAC IIST IO UBL]			
		structions on the eMAR	1			
- 1.	and the medication lab	el that Arthrotec should not				
Į.	be crushed.					
	The resident was in th	e dining room when she	1 1			
	administered the medic	callons so she thought the	1 1			
l i	resident's breakfast wo	ould be served soon.				

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AND PLAN	T OF DEFICIENCIES OF CORRECTION	F CORRECTION IDENTIFICATION (X2) MULTI		CONSTRUCTION		E SURVEY
	6229			A. BUILDING:		PLETED
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,ADENGI	E NORTH RALEIGH		D WAKE FOREST H, NC 27609	RD		
(X4) ID	SUNMARY	STATEMENT OF DESICIENCIES	I ID T			
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D 358	Continued From page	go 9	D 358			
- 1		1				1
i	(PCC) on 14(02)22	esident Care Cool dinator	Programme (a)			
	-There should be a	at 10:15am revealed:				1
	medication cart.	orac use weht ou tue	th a			1
		low instructions on the eMAR				
\$	and the medication (abel.				
ľ	-If a medication coul	d not be crushed, the MA	1 1			
18	should contact the p	hysician to see if the				80
	medication could be	changed or check with her or				
	the Resident Service	es Director (RSD),				12.0
ŀ	swallow his medical	nt #8 should be able to				
- 1	if a medication was	ons whole. ordered to be administered				
	with a meal or at mea	altimes it should be	1			3
	administered as soor	as the resident received	1 1			
	heir food,	, , , , , , , , , , , , , , , , , , , ,				1
	Based on observation	ns, interviews, and record				
- 11	reviows, it was deten Interviewable.	mined Resident #8 was not				
	Interview with Reside	ent #8's primary care provider				
- 13	(PCP) on 11/02/22 at	1:24pm revealed:				
1.	If a medication shoul	d not be crushed. The MA				
5	should conlact the ph	armacy or the provider to	1			
	see if there were alter	mative medications that				es es
16	could be taken.	w				
	Crusning Arthrolec co	ould affect the absorption of event the medication from				
, i	vorkina effectivoly an	d appropriately and could				12
i	ncrease the potential	for stomach upset and	1 1			
g	astrointestinal bleedi	ing.				
2	. Review of Resident	#1's current FL-2 dated			3	
0	3/24/22 revealed dia	gnoses of restrictive	1 1			
p	ulmonary disease, hy	pertension, and type 2				
ļ.d	labetes.					
R	leview of Resident #1	's signed physician's			ļ	
of Health	Service Regulation	's signed physician's				

Division of I	lealth Scrvice Re				FO	RM APPROVE
STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
<u> </u>		HAL09214	B. WING		R-C	
IAME OF PROV	IDER OR SUPPLIER	STREETA	DORESS, CITY, SYATI	= 7/0 CODE	11	/02/2022
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D 358 .Co	ntinued From pag	je 10	D 358			
infl	lor lo discentinue ed to treat pain, fe	dated 05/25/22 reyoaled an Aspirin 81mg dally. (Aspirin is ever, headache, and reduce the risk of heart				
ele (eN -Th adn -As	ctronic medication IAR) on 11/01/22 lere was an entry ninistered daily at pirin 81mg tablet	was documented as				
-Th Asp	oirin 81mg,	after 05/25/22 to discontinue				
11/0 -The)1/22 at 1:32pm re	for Aspirin 81ma to be				
-Asş adm -The	pirin 81mg tablet v ninistered 10/01/2	vas documentad as				
on 1 -The adm -Asp	1/01/22 at 1:32pn ero was an entry fi Inistered daily at I Iirin 81mg tablet v	or Aspirin 81mg to be 9:00am. vas documented as				
-The	inistered on 11/01 are was no entry a arin 81mg.	1/22. Iter 05/25/22 to discontinue				
avall 9:27	able for administr	ent #1's medications ation on 11/02/22 at rin 81mg tablet was in the				
	view with the Res	ident Care Coordinator				

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY	
			A. BUILDING:			COMPLETED	
	·	HAL09214	8. WING		4237	R-C 11/02/2022	
IAME OF F	ROVIDER OR SUPPLIER	STREET	ODRESS, CITY, STATE	ZIP COOR	30	10212022	
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		RALEIG	H, NC 27609				
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DAT	REGULATORY OF	LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIVE ACTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE REAPPROPRIATE	COVIDE DATE	
D 358	Continued From pag	se 11	D 358				
	(RCC) on 11/02/22 a	st 9:01am revealed:	53			l.	
	-There was a new or	der system since;the last					
8	survey.	•					
	-Ine nurso was resp	onsible to fax new orders to	1 1				
	the pharmacy.	- 6				ii.	
	the eMAR system.	e to verify new orders were in					
4		em had not started in May					
Ī	2022.	The state of the s					
1	Interview with the De	sident Services Director					
	(RSD) on 11/02/22 al	3:09am revealed:				4	
	-The primary care pro	ovider (PCP) gave new				1	
Ī	orders to her,		1				
	-She would fax the no	aw orders to the pharmacy.				ı	
	-The RCC would doc	ument the new order in the	ř			1	
le.	resident's record and system,	verify the order in the eMAR					
		process of receiving	i i				
509	medication orders in t	May 2022 because she was				i	
	not working in the faci	ility.				8	
1	-She was not aware F	Resident #1 had an order to					
31	discontinue Asplrin 81	lmg.	1				
,	sne nao not complet gudits,	od medication order review	1				
	,		1			1	
	nterview with the PCI	P on 11/02/22 at 1:26pm	1 1				
	evealed;	Si					
	of was his lirst day, 11, residents in the facility	/02/22, providing care to the				10 10	
i i	He did not have any o		1 1				
	Resident #1 continuing	g the Aspirin 81mg after it					
	vas disconlinued.				i		
	The order for the Asp	irin 81mg was discontinued			8		
] <u>t</u>	ecause it had no ben	elils to Resident #1.	9				
Lí	nterview with the Adm	inistrator on 07/27/22 at					
[]	0:08am revealed:	modulo on onerize at					
13	He expected the facili	ly to review medication			l		
13	rdare and oncurs the	orders were accurate on	E 1		1		

P14F11

1413

PRINTED: 11/21/2022 FORM APPROVED

STATEMEN	of Health Service Rec TOF DEFICIENCIES	quiation			FO	RM APPROVE	
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2)MULTIPLE (CONSTRUCTION	(X3) DAT COM	E SURVEY PLETED	
		HAL09214	B. WING		R-C 11/02/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	Z. ZIP CODE			
CADENCE	NORTH RALEIGH	5219 OL	D WAKE FOREST				
(X4) ID	SIJUMARYE	TATEMENT OF DEFICIENCIES	H, NG 27609		<u> </u>		
PREFIX TAG	REGULATORY OR LSG IDENTIFYING INFORMATION)		ID PREFIX 7AG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE	TICN SHOULD BE COME		
D 358	Continued From pag	je 12	D 358				
ŀ	the eMAR.					8	
i	-The RSD or designs	ee were responsible to					
Ī	ensure the medication	ons in the medication cart					
- 1	were removed when	orders were discontinued.					
I							
ĺ						1	
1						6	
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