Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: B. WING HAL060159 02/29/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5601 MARGARET WALLACE ROAD CADENCE SENIOR LIVING AT MINT HILL MATTHEWS, NC 28105 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) D 000 **Initial Comments** D 000 The Adult Care Licensure Section and the Mecklenburg County DSS conducted an Annual survey and a Complaint Investigation on February 27 - 29, 2024. D 014 10A NCAC 13F .0206 Capacity D 014 Executive Director, Regional Director of Health 10A NCAC 13F .0206 Capacity and Wellness, and Vice President of Operations reviewed community licence and capacity. (a) The licensed capacity of adult care homes licensed pursuant to this Subchapter is seven or By April 15, Executive Director or designee will more residents. apply for new license to accurately represent (b) The total number of residents shall not capacity of Assisted Living beds verses Memory Care beds. exceed the number shown on the license. (c) A facility shall be licensed for no more beds than the number for which the required physical space and other required facilities in the building are available. (d) The bed capacity and services shall be in compliance with G.S. 131E, Article 9, regarding the certificate of need. This Rule is not met as evidenced by: Based on observation, and interviews, the facility failed to maintain their bed capacity and services for rooms that were previously licensed for Special Care Unit (SCU) beds. Review of the facility's license effective 01/01/24 revealed the facility was licensed for a bed capacity of 84 beds with 48 beds assigned as SCU beds, and 36 beds assigned as Assisted Living (AL) beds. Observation of the facility during the tour on 02/27/24 from 8:15am to 9:30am revealed: STATE FORM

Reviews of a acknowledged on

4/10/24. by DMS. -The census was 36 residents in the facility.

(X6) DATE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
*****************	HAL060159		B. WING		02	02/29/2024	
	ROVIDER OR SUPPLIER E SENIOR LIVING AT MIN	IT HILL 5601 MA	ADDRESS, CITY, STATE ARGARET WALLAC EWS, NC 28105	MANAGES VIOLENCES			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 014	residentsHallway B contained residentsHallway C contained residentsHallway D contained residentsHallway D contained residentsInterview with a medi 8:34am revealed: -Hallways B and C w-Hallways B and C w-Hallway B was remoconverted into private -There were 8 residents cognitively impaired a beds. Interview with a personal properties of the residents of the resident of the residents of the residentsHallway B used to be remodeled back in June AL residentsHallway B contains presidentsAll of the residents of assistance to minimal interview with the Add 1:05pm revealed: -The SCU used to count of the residentsThe SCU used to count of the residents.	14 beds assigned to AL 8 beds assigned to AL 13 beds assigned to SCU 8 beds assigned to AL cation aide on 02/27/24 at ere dedicated as the SCUs. deled in July 2023 and e AL rooms. Ints residing on hallway B on hallway B were not and did not qualify for SCU conal care aide (PCA) on evealed hallways A, B and D ts. sident Service Director 13:42pm revealed: 19 the SCU but was 19 2023 and began admitting crivate rooms for 12 AL In hallway B required no I assistance with ADLs. ministrator on 02/28/24 at mprise of two hallways, B	D 014				

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STATEMENT OF DETICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HAL060159		A. BUILDING:	PRANCE -	02/29/2024	
		B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	
CADENCE	SENIOR LIVING AT MI	NT HILL 5601 MA	RGARET WALL	ACE ROAD	
			WS, NC 28105		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL ELSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 014	She and the Regional Chief of Operations (COO) decided to take the 24 SCU beds on Hallway B and convert then into 12 private AL beds. -Around the middle of July was when Hallway B was opened to allow residents to move in. -It was her understanding that the Regional COO spoke with construction and handled all of the licensure information. -She did not speak to construction about the plan for the renovation. -She did not speak to the licensure section about the change in licensure. -She did not receive a letter from Raleigh about a new license. Attempted telephone interview with the COO on 02/29/24 at 11:20am and 1:31pm were unsuccessful. 2 10A NCAC 13F .0802 (d) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (d) The assessor shall sign the care plan upon its completion. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 4 of 5 sampled residents had an accurate care plans that were signed by the assessor upon completion (#2, #3, #4 and #5). 1. Review of Resident #2's current FL2 dated 12/20/23 revealed: -Diagnoses included asthma, depression, heart murmur, hypertension, and a pacemaker. -Resident #2 was admitted to the Assisted Living (AL) on 12/10/20.		D 014		
D 262			D 262	Resident Services Director reviewed all identified initial care plans that were not signed. Each identified initial care was out of compliance was signed by	plan that
				Resident Services Director and Execu Director completed audit of current resident charts to ensure signatures at present. Any discrepancies were correinmediately. Beginning 4/1/24, Resident Services Executive Director, or designee will comonthly audits to ensure continued co of signatures on care plans for 6 mont team will determine if continued auditin necessary following 6 months.	re ected Director, onduct ompliance hs. QI

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	HAL060159				02	02/29/2024
NAME OF P	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CADENC	E SENIOR LIVING AT N	IN I HILL	ARGARET WALLAC EWS, NC 28105	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 262	Continued From page 3		D 262			
U 202	Review of Resident #2's Care Plan dated 01/25/24 revealed: -Resident #2 was independent with eating, toileting, dressing and groomingResident #2 required limited assistance with ambulation, bathing, and transfersThe care plan was not signed by the assessor. Refer to the interview with the Resident Service Director (RSD) on 02/29/24 at 9:30am. Refer to the interview with the Administrator on 02/29/24 at 10:06am. 2. Review of Resident #3's current FL2 dated 05/23/23 revealed: -Diagnoses included atrial fibrillation, sleep apnea, and heart failure (condition in which the heart cannot pump blood as well as it should)Resident #3 was admitted to the facility on 08/31/21.					
	05/04/23 revealed: -Resident #3 was in toileting, dressing, g -Resident #3 requir ambulationThe care plan was Refer to the intervie at 9:30am. Refer to the intervie 02/29/24 at 10:06ar	#3's Care Plan dated adependent with eating, grooming and transfers. ed supervision with not signed by the assessor. www.with the RSD on 02/29/24 www.with the Administrator on m. ent #4's current FL2 dated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL060159		B. WING		02		
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
CADENCE	E SENIOR LIVING AT MI	IIVI TIILL	ARGARET WALLAC	EROAD			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 262	Continued From page 5		D 262				
	Refer to the interview with the RSD on 02/29/24 at 9:30am.						
	Refer to the interview with the Administrator on 02/29/24 at 10:06am.						
	revealed:	SD on 02/29/24 at 9:30am					
	-She was responsible for completing and signing the care plansShe did not sign the care plans because she						
	completed the care plans in the computer and thought that was enough.						
	Interview with the Administrator on 02/29/24 at 10:06am revealed:						
	-The assessor was to sign the care plansThe RSD was responsible for completing the care plan assessments and signing themCare plans were supposed to be completed during the initial assessment for new residents and then annually or with significant changes in						
	conditionShe was not aware signed by the assess	the care plans were not					
	, , , , , , , , , , , , , , , , , , , ,						