Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060160	B. WING		C 11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	ΓΕ, ZIP CODE	,
CADENCE	E HUNTERSVILLE	250 COM	MERCE CENTER	RDRIVE	
OADLINOL	HOWIEROVIELE	HUNTER	RSVILLE, NC 280	78	
(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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 000	Initial Comments		D 000		
	_	sure Section conducted a in survey on November 13, per 15, 2024.			
D 273	10A NCAC 13F .0902	(b) Health Care	D 273		
		Health Care assure referral and follow-up ad acute health care needs			
	This Rule is not met a TYPE A1 VIOLATION				
	interviews, the facility received appropriate residents (#4) related	ns, record reviews, and failed to ensure residents care for 1 of 5 sampled to a resident who was not when she had a swollen			
	The findings are:				
	policy dated 05/11/22 -Staff had the responseach resident and surwhen the resident had -When there was an ability to function the be immediately notified -A significant change ability to use one's had	sibility to provide care to mmon medical attention d a change in status. actual change in status or resident's physician should ed. included a change in the ends to grasp small objects.			
	***	4's current FL-2 dated gnoses included dementia, xiety.			
	Paview of Pasident #	1's Pesident Pegister			

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

TITLE (X6) DATE

Division of Health Service Regulation

DIVISION	of Health Service Regu	lation	_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
					C	
		HAL060160	B. WING		11/15/2024	
NAME OF B	20//DED OD 01/DD1/ED	OTDEETAN	DDE00 01TV 0TA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CADENCE	HUNTERSVILLE	250 COM	MERCE CENTE	R DRIVE		
CADLING	TIONIERSVILLE	HUNTER	SVILLE, NC 280	078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE	
				DEFICIENCY)		
D 070	0 " 15		D 070			
D 273	Continued From page	9 1	D 273			
	revealed Resident #4	was admitted on 05/19/21.				
	TOVOLIOU TRODIGOTIL // T	Was damitted on 00/10/21.				
	Pavious of Pacidont #	4's hospital admission notes				
		4 S Hospital admission hotes				
	revealed:	d for a con 00/00/04 to 00/00/04				
		d from 09/23/24 to 09/26/24.				
		e emergency room with a				
	swollen right hand/arr					
	•	sibly swollen, red and hot to				
	the touch.					
	-There was documen	tation her right hand and				
	arm was edematous ((swollen), erythema				
	(redness), warm and	tenderness to palpation.				
	-On 09/23/24, an X-ra	ay of the right hand revealed				
	diffuse edema of the					
		nitted to the hospital due to				
		s, erysipelas (a bacterial				
	•					
		trauma, gout/inflammatory				
		mination revealed significant				
		levated C-Reactive Protein				
	•	nich measures inflammation				
	in he body) .					
		nous (IV) antibiotics, IV				
	steroids, and oral anti	ibiotics.				
	a. Review of Residen	t #4's progress note dated				
	09/24/24 revealed:					
	-A late entry for 09/18	3/24, the Resident Care				
		nented Resident #4's hand				
	was slightly swollen.					
		9/24, the RCD documented				
	Resident #4's hand w					
		Services removed the rings				
	from Resident #4's fir					
		•				
		0/24, the RCD documented				
		as still swollen, notified				
	Resident #4's PCP ar	nd a Xray was ordered.				
	Review of Resident #	4's record revealed there				
	were no Accident/Inci	dent reports completed on				

Division of Health Service Regulation

09/18/24 and 09/19/24.

STATE FORM R35K11 If continuation sheet 2 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL060160	B. WING		C 11/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CADENCE	LUNTEDOVILLE	250 COMM	ERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE	HUNTERS	/ILLE, NC 280	78		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	2	D 273			
	the RCD dated 09/21The subject line titled	Resident #4's PCP from /24 at 12:11pm revealed: d was Resident #4's name. il included, "hey, this is her ent.				
	hand provided by Res (POA) dated 09/21/24 -Resident #4's right h the size of the left har -The swelling extended -The color of the right	ed up into the forearm area. hand was red and shiny. er revealed an indention ad been and a small				
	hand provided by Res 09/22/24 at 12:00pm -Resident #4's right h it had been in the pict -Swelling extended up than it had been in the -The right sleeve of the wearing was tighter a sleeve of the left hand -Resident #4's right h -The right pointer fing from where the ring h abrasion above the right middle fing abrasion on the section finger and the middle	and was swollen more than ture dated 09/21/24. To into the forearm area more the picture dated 09/21/24. The sweater Resident #4 was round her hand than the distributed and wrist area was redient revealed an indention and been and a small the ing indentation. The sweater Resident #4 was round her hand than the distributed her hand than the distributed has redient and a small than indentation. The sweater Resident #4 was round her hand than the distributed has redient her has redient has redient her has redient has redient her has redient her has redient her has redient has redient her has redient				
	#4's PCP dated 09/23	o the RCD from Resident B/24 at 8:10am revealed: titled Resident #4's name.				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 3 of 37

Division of Health Service Regulation

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		A. BUILDING: _		_		
HAL060160		B. WING		C 11/15/2024		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIR CODE	1	
NAME OF T	NOVIDEN ON GOLL FIELD		MERCE CENTER			
CADENCE	HUNTERSVILLE		SVILLE, NC 280			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 3	D 273			
		il included, "oh goodness", sent out", and "how is it				
	the RCD dated 09/23 -There were two phot hand.	Resident #4's PCP from /24 at 8:26am revealed: os of Resident #4's right ill included, "this is her hand				
	· ·	Desident #4's right hand				
	Review of a photo of Resident #4's right hand provided by Resident #4's POA dated 09/23/24 at 7:04pm revealed: -Resident #4's right hand was still swollenThe swelling extended up into the forearm area -The color of the right hand and wrist area was redThe right pointer finger revealed an indention from where the ring had been and a small abrasion above the ring indentationThe right middle finger revealed a small skin abrasion on the section between the base of the finger and the middle joint.					
	dated 09/23/24 at 7:2	Resident #4's PCP office				
	-Resident #4's POA in Resident #4's right haweek. -On 09/18/24, Reside the local fire departm -Staff at the facility to ordered and should b	enformed the provider that and had been swollen for a sent #4's rings were cut off by ent. Id the POA that X-rays were back by today (09/23/24). Ed Resident #4's office				
	record and there was	no documentation of having			1	

Division of Health Service Regulation

any workup related to Resident #4's hand.

STATE FORM R35K11 If continuation sheet 4 of 37

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		
		1141 000400	B. WING		C	
		HAL060160			11/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		250 COM	MERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE	HUNTERS	VILLE, NC 280	78		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ı,	PROVIDER'S PLAN OF CORRECTION	(VE)	_
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(* /	E
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	
				DEFICIENCY)		
D 273	Continued From page	<u> </u>	D 273			
-	. •					
		e PCP would be seeing				
	Resident #4 on Tueso	day, 09/24/24.				
		4's history and physical				
	dated 09/23/24 at 8:3	•				
		plan was completed by				
	Resident #4's PCP.	Decident #41a DOA				
	-The PCP spoke with					
	and reviewed on 09/2	nd was received by email				
		ident #4 was sent to the				
	emergency room for e					
		the impression that an X-ray				
		er, it was not as of 09/23/24.				
	was ordered, noweve	1, It was not as of 09/23/24.				
	Interview with a repre	sentative from the local fire				
		24 at 5:15pm revealed on				
	•	re fighters responded to a				
	•	assist cutting rings off of				
	Resident #4's fingers	0 0				
	J	ŭ				
	Interview with the RC	D on 11/14/24 at 9:52am				
	revealed:					
	-On 09/17/24, staff in	formed her that Resident				
	#4's right hand was s	wollen.				
	-She found Resident	#4's right hand to be slightly				
	swollen so she told th	ne staff to keep it elevated.				
		ent #4's hand was very				
		aking to the Special Care				
	, ,	ney concluded the rings on				
	•	ngers were possibly causing				
	the fingers and hand					
		hand and fingers were so				
		ked like the were cutting off				
		fingers due to their slight				
	blue tinged color.					
		fire department to come and				
	cut the rings off of Re					
	-She did not contact [Resident #/I's PCP hecause	1			

Division of Health Service Regulation

she thought the rings were causing the fingers

STATE FORM 6899 R35K11 If continuation sheet 5 of 37

Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C C	:D	
	COMPLETED	
HAL060160 B. WING 11/15/20	2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
250 COMMERCE CENTER DRIVE		
CADENCE HUNTERSVILLE HUNTERSVILLE, NC 28078		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION SHOULD BE CORRECTION (EACH CORRECTION SHOULD BE CORRECT	(X5) COMPLETE DATE	
D 273 Continued From page 5 and hands to swell. -On 09/19/24, the swelling had gone down some in Resident #4's hand and fingers. -On 09/20/24, Besident #4's hand and fingers were swollen more so she called the PCP. -When she called the PCP, she informed the PCP about another resident needing an xray of the hand and then she told the PCP about Resident #4 and the PCP said she would order the X-ray. -She was under the understanding an X-ray was ordered for two residents hands which included Resident #4. Telephone interview with Resident #4's POA on 11/14/24 at 10:06am revealed: -On 09/18/24, a family member called him and told him Resident #4 shand was swollen and the staff needed permission to cut trings off. -On 09/18/24, he went to the facility to check on Resident #4 and the RCD asked for permission to cut the rings off of Resident #4 was not sent out to the emergency room because the RCD thought the swelling was because of the rings and the fire department could cut them off. -On 09/18/24, he was shocked to find Resident #4's hand and forearm were swollen more than on 09/18/24, here after the rings were cut off. -The RCD stated the PCP was aware and an X-ray was ordered and they were waiting on the results. Telephone interview with Resident #4's Primary Care Provider (PCP) on 11/14/24 at 12:01pm revealed: -On Friday 09/20/24, the RCD called her about another resident with a hand and foot injury from a fall.		

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 6 of 37

Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
					С
		HAL060160	B. WING		
		HALU6U16U	1		11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		250 COM	IERCE CENTE	R DRIVE	
CADENCE	HUNTERSVILLE	HUNTERS	VILLE, NC 280	78	
0(1) 15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION	0/5
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE
				DEFICIENCY)	
D 273	Continued From page	e 6	D 273		
-	. •				
		ntioned but at that time it was			
	_	esident #4 was mentioned.			
	-She did not an X-ray				
		that Resident #4's hand			
		3/24 and required Resident			
	#4's rings to be cut of	f by the local fire			
	department.	- · · · · · · · · · · · · · · · · · · ·			
		Resident #4 needed an			
	X-ray until 09/23/24 b				
		h the RCD on 09/20/24.			
		nentation in Resident #4's			
		to an X-ray of Resident #4's			
	•	elling until 09/23/23 when			
		alled to inquire about the			
	results of a hand X-ra	· -			
		n 09/18/24, when staff s hand was swollen and they			
		nent to cut rings off because			
	of the swelling then s	•			
		al visit or had Resident #4			
	sent out to be evaluat				
		ble antibiotics could have			
	been ordered on the				
	boon ordered on the	00/10/21.			
	Refer to telephone int	terview with the			
	Administrator on 11/1				
	b. Review of Residen	t #4's progress note dated			
		ate entry for 09/20/24, the			
	RCD documented Re	sident #4's hand was still			
	swollen, notified Resi	dent #4's PCP and an X-ray			
	was ordered.	,			
	Review of Resident #	4's record revealed there			
	were no physician's o	order dated 09/20/24 for an			
	X-ray of the hand.				
	Review of Resident #	4's progress note dated			
	09/24/24 revealed:				

Division of Health Service Regulation

-A late entry for 09/21/24, the RCD documented

STATE FORM 6899 R35K11 If continuation sheet 7 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
HAL060160		B. WING		C 11/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
CARENCE	· IIIINTEDOVII I E	250 COMN	IERCE CENTE	R DRIVE	
CADENCE	HUNTERSVILLE	HUNTERS	VILLE, NC 280	78	
0//0 15	STIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 7	D 273		
	handShe spoke with Resi that an X-ray was ord received from the PC -On 09/21/24 she call the X-ray and a nurse X-ray ordered or foun recordShe emailed a pictur would follow-up with I -Resident #4 showed movement of the righ Interview with the RC revealed: -On 09/20/24, she wa an X-ray was ordered which included Resid completedOn 09/21/24, She ca inquired about the X-l because staff notified inquiring about the re Resident #4's hand w -She called the PCP's nurse there was not a Resident #4 in Reside -She did not ask to sp to inform them about hand and arm or to as -She sent an email to that day and would ju	dent #4's POA and told him lered but no results were P office. led the PCP's office about a told her that there was no ad in Resident #4's office le of Resident #4's hand and PCP on Monday, 09/23/24. signs of pain with thand. D on 11/14/24 at 9:52am les under the understanding I for two resident's hands ent #4 and they were alled to the PCP's office and ray for Resident #4's POA was sults of the X-ray and ras still swollen. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen order in for an X-ray for ent #4 office record. It is office and was told by a sen orde			
	at 9:21am revealed:	cation aide (MA) on 11/14/24			

Division of Health Service Regulation

swollen and she informed the Special Care

STATE FORM R35K11 If continuation sheet 8 of 37

Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
HAL060160			B. WING		C	
		HAL060160			11/15/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
		250 COMN	IERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE	HUNTERS	VILLE, NC 280	78		
040.1=	CLIMMADY CT		· ·	PROVIDER'S PLAN OF CORRECTION	1 000	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(/	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		
			1	DEFICIENCY)		
D 273	Continued From page	. 8	D 273			
D 210	Continued From page	5 0	5276			
	Coordinator (SCC).					
	-	the RCD to keep Resident				
	#4's hand elevated.					
	•	, someone outside of the				
	-	ff of Resident #4's fingers.				
	-Over the next few da	ays Resident #4 hand				
	continued to swell.					
		ent #4's POA was upset over				
		44's hand and forearm had				
	-	s were cut off instead of				
	getting better.					
		and was told that the PCP				
		ch was not resulted yet.				
		PCP because the RCD was				
	taking care of it.					
	Talambana intensiass.	with Decident #415 DOA on				
	•	with Resident #4's POA on				
	11/14/24 at 10:06am					
		ent #4's right hand was 9/18/24, even after the rings				
	were cut off.	9/10/24, even alter the migs				
	-The hand and forear	m area were swollen				
		and was red and shiny.				
		ention's from where the rings				
		n on her pointer finger.				
		out the X-ray and was told				
	that the RCD said the					
	resulted yet.	, , , , , , , , , , , , , , , , , , ,				
		ent #4's swelling was the				
		ncerned that nothing was				
	being done so he ask	•				
	_	t the RCD said they were				
	waiting on the X-ray r					
		g Resident #4 to the ER but				
		result should be back in the				
	morning (09/23/24).					
		:30pm, he called Resident				
		spoke to another provider.				
		old him no X-ray order or any				
	•	cerning Resident #4's				

Division of Health Service Regulation

STATE FORM 6899 R35K11 If continuation sheet 9 of 37

Division of Health Service Regulation

	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		COMPLETED	
			A. BUILDING: _			
				C		
		HAL060160	B. WING		11/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
			MERCE CENTE			
CADENCE	HUNTERSVILLE		SVILLE, NC 280			
040.15	CUMMADV CT			PROVIDER'S PLAN OF CORRECTION	MI 0/5	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	()	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE DATE	
				DEFICIENCY)		
D 273	Continued From page	9	D 273			
	_	d been documented in the				
	past week.					
		already requested the				
		ent #4 to the ER when he				
		ne PCP, who explained				
		rstanding with the RCD				
	_	rder for Resident #4's hand.				
		know about the condition of				
	until 09/23/24.	nd did not order an X-ray				
		oive any calle about the				
		eive any calls about the				
		the X-ray not being done for				
	over a six day span.	I the PCP knew about the				
	_	and the redness, but none				
	of the staff actually ch					
	Of the Stall actually Ci	lecked with the FCF.				
	Telephone interview v	vith a second MA on				
	11/15/24 at 10:27 rev					
		ent #4's POA was visiting				
	when Resident #4 co					
		and redness in Resident				
	#4's hand and forearr	n.				
	-She was not given a	report about Resident #4's				
	hand and arm so she	asked a personal care aide				
	(PCA).					
	-After speaking to the	PCA she called the RCD				
	and reported her findi					
		e was an X-ray completed				
	and they were just wa	_				
		at there were no results yet.				
		rned because the swelling				
		ld him that the PCP was				
	·	just waiting on the results				
	_	hould take Resident #4 to				
		should but she did not have				
	a reason to send Res					
		n by the PCP and tests were				
	ordered.	2021				
	ା -She did not call the F	PCP because she was told				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 10 of 37

Division of	of Health Service Regu	ılation			
AND DUAN OF CORRECTION IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL060160	B. WING		C 11/15/2024
		TALUGU 100			T1/13/2024
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STAT	ΓE, ZIP CODE	
CADENCE	E HUNTERSVILLE		MERCE CENTER		
		HUNTERS	VILLE, NC 280	78	<u>, </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY 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 273	Continued From page	e 10	D 273		
	to notify the RCD and physician or tell her to -She was directed to				
	1:31pm revealed:	with the SCC on 11/15/24 at			
	-On 09/18/24, about 5 about Resident #4's s	5:00pm, a PCA informed her			
		ent #4's swollen hand she			
	called the RCD.	311C// 1 G G 11 G 11 G 11 G 11 G 11 G 11			
		ssed Resident #4's hand, she			
		e fire department could cut			
		re department was called.			
	#4's right hand fingers	2 or 3 rings off of Resident			
		end out if an emergency, if			
	not notify RCD, then I	RCD would assess the			
	concern and determing notified or send the re	ne if the physician was to be esident out.			
		ng decreased a little bit after			
	the rings were cut off Thursday evening 09/	but began to swell more on 0/19/24.			
	-She informed the RC 09/20/24.				
		D told her the PCP ordered			
	an X-ray and would b				
		d not see the mobile X-ray			
	technician in the build 6:30pm.	ding before she left around			
		PCP because the RCD said			
	the PCP was aware a results.	and waiting on the X-ray			
	11/14/24 at 12:01pm				
		Resident #4 needed an and until 09/23/24 because of			
	_	with the RCD on 09/20/24.			

Division of Health Service Regulation

-There was no documentation in Resident #4's office records related to an X-ray of Resident #4's

STATE FORM 6899 R35K11 If continuation sheet 11 of 37

Division of Health Service Regulation

	r of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA	(VO) MULTIPLE	CONCEDITOR	(V2) DATE	CLIDVEV	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _				
						С	
		HAL060160	B. WING		11/	15/2024	
NAME OF D		OTDEET A	DDDEGG OITY OTA	TE 710 000E			
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA				
CADENCE	HUNTERSVILLE		IMERCE CENTER				
		HUNTER	SVILLE, NC 280	178			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COI		(X5)	
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLETE DATE	
IAG			IAG	DEFICIENCY)			
D 273	Continued From page	e 11	D 273				
	right hand due to swe	elling until 09/23/23 when					
	, •	alled inquiring about the					
	results of a hand X-ra	· · · · · · · · · · · · · · · · · · ·					
		lled the on-call service over					
		e there was not an X-ray					
	completed.	,					
	'						
	Refer to telephone in	terview with the					
	Administrator on 11/1						
		·					
	c. Review of Resident #4's Hospital Discharge						
	Summary dated 09/20	6/24 at 4:17pm revealed:					
	-An order for predniso	one (used to treat					
	inflammation) 20mg e	every day for 10 days, to					
	begin on 09/26/24.						
	-An order for tramado	ol (used to treat pain) 50mg,					
	_	0 days, to begin on 09/26/24.					
		allopurinol (used to treat					
	gout) 100mg every m						
		amlodipine besylate (used					
	to treat blood pressur	,					
		divalproex (used to treat					
	dementia) 125mg two						
		donepezil (used to treat					
	dementia) 10mg at be						
	dementia) 10mg at be	memantine (used to treat					
	dementia) romg at be	suline.					
	Review of Resident #	4's September 2024					
		Administration Record					
	(eMAR) revealed:						
		one 20mg every day, with a					
	start date of 09/29/24						
		ednisone was administered					
	on 09/27/24 and 09/2						
	-An entry for tramado	I 50mg two times a day, with					
	a start date of 03/01/2	•					
		amadol was administered on					
		nd 09/27/24 at 9:00am.					
		nol 100mg every day, with a					

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 12 of 37

Division of Health Service Regulation

Division	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					_	
			P WING		C	
		HAL060160	B. WING		11/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
TO UNIC OF T	NOVIDER OR GOLF EIER					
CADENCE	HUNTERSVILLE		IMERCE CENTE			
		HUNTER	SVILLE, NC 280	078		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IGIEROT)		
D 273	Continued From page	12	D 273			
	start dated of 03/01/2	4, and there was no				
	documentation the all	lopurinol was administered			ļ	
	on 09/27/24 at 9:00ar	m.				
	-An entry for amlodipi	ine besylate 10mg every				
	day, with a start date	of 03/01/24 and there was				
	no documentation the	e amlodipine was				
	administered on 09/2	•				
	-An entry for divalproex 125mg, two times a day					
	with a start date of 03/01/24 and there was no					
	documentation the divalproex was administered on 09/26/24 at 9:00pm and 09/28/24 at 9:00am. -An entry for donepezil 10mg at bedtime with a					
	start date of 03/01/24 and there was no					
		onepezil was administered				
	on 09/26/24 at 9:00pr	· ·				
		ine 10mg at bedtime with a				
	start date of 03/01/24	_				
		emantine was administered				
	on 09/26/24 at 9:00pr	11.				
	Intervious with the DC	D on 11/11/24 at 0.52am				
		D on 11/14/24 at 9:52am				
	revealed:					
	·	ent #4 returned from the				
		did not bring the discharge				
	paperwork with her.					
		discharge paperwork she				
	could not make the no					
		itions in the eMAR or fax the				
	changes/additions to					
		remained as "LOA", leave				
		IAR until 09/28/24 when the				
		discharge paperwork.				
		nospital for a copy of the				
	discharge paperwork	because in the past "that				
	never worked" and sh	ne did not call the PCP for				
	recommendations or	to see if their office could				
	get a copy or if they r	eceived a copy.				
	_ ,,	• •				
	Telephone interview v	with Resident #4's Primary				
		on 11/14/24 at 12:01pm			l	

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 13 of 37

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 13 revealed: -She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24The facility staff were responsible for getting the discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	
NAME OF PROVIDER OR SUPPLIER CADENCE HUNTERSVILLE SUMMARY STATEMENT OF DEFICIENCIES HUNTERSVILLE, NC 28078 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 13 revealed: -She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24The facility staff were responsible for getting the discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once		
CADENCE HUNTERSVILLE (X4) ID PREFIX TAG D 273 Continued From page 13 revealed: -She did not know the facility did not receive Resident #4's discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once	NAME OF PROMPTS OF GUIDNIES	
CADENCE HUNTERSVILLE HUNTERSVILLE, NC 28078 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 13 revealed: -She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24The facility staff were responsible for getting the discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once	NAME OF PROVIDER OR SUPPLIER	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 13 revealed: -She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24The facility staff were responsible for getting the discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once	CADENCE HUNTERSVILLE	
revealed: -She did not know the facility did not receive Resident #4's discharge instructions dated 09/26/24The facility staff were responsible for getting the discharge instructions at the time of dischargeThe facility staff should have called the hospital for a copy of the discharge instructions once	PREFIX (EACH DEFICI	
Resident #4 returned to the facility and did not have the instructions. -The facility staff could have called her office for assistance in getting the discharge instructions because they may have had it in their system. -The purpose of the discharge instructions were to provide a plan of care for Resident #4 once she returned to the facility and without those instructions, staff would not know what to do and were responsible for notifying her if they could not get those instructions by the next morning. Refer to a telephone interview with the Administrator on 11/15/24 at 3:25pm. d. Review of Resident #4's Hospital Discharge Summary dated 09/26/24 at 4:17pm revealed: -An order for prednisone 20mg every day for 10 days, to begin on 09/26/24An order for tramadol 50mg, two times a day for 30 days, to begin on 09/26/24An order to continue allopurinol 100mg every morningAn order to continue amoldipine besylate 10mg every dayAn order to continue divalproex 125mg two times a dayAn order to continue donepezil 10mg at bedtimeAn order to continue memantine 10mg at bedtime.	revealed: -She did not know Resident #4's disc 09/26/24The facility staff with discharge instructions are the return have the instruction assistance in getting because they may and a plan of the state of the returned to the instructions, staff were responsible get those instructions. Refer to a telephonal Administrator on 1 d. Review of Residual Refer to a telephonal	

Division of Health Service Regulation

Review of Resident #4's September 2024

STATE FORM R35K11 If continuation sheet 14 of 37

Division of Health Service Regulation

DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			_			
			P WING		С	
		HAL060160	B. WING		11/15/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			ERCE CENTE			
CADENCE	HUNTERSVILLE		VILLE, NC 280			
			TILLE, NC 200			_
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(-)	_
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		•
IAO		,	IAG	DEFICIENCY)		
						\neg
D 273	Continued From page	e 14	D 273			
	electronic Medication	Administration Record				
	(eMAR) revealed:					
	` '	one 20mg every day, with a				
	start date of 09/29/24					
		ednisone was administered				
	on 09/27/24 and 09/2	8/24 at 9:00am.				
	-An entry for tramado	I 50mg two times a day, with				
	a start date of 03/01/2	24, and there was no				
	documentation the tra	amadol was administered on				
	09/26/24 at 9:00pm and 09/27/24 at 9:00amAn entry for allopurinol 100mg every day, with a					
	start dated of 03/01/2	4, and there was no				
		opurinol was administered				
	on 09/27/24 at 9:00ar					
		ine besylate 10mg every				
	•	of 03/01/24 and there was				
	no documentation the	•				
	administered on 09/2					
		ex 125mg, two times a day				
		3/01/24 and there was no				
		valproex was administered				
		n and 09/28/24 at 9:00am.				
	-	zil 10mg at bedtime with a				
	start date of 03/01/24					
		onepezil was administered				
	on 09/26/24 at 9:00pr					
		ine 10mg at bedtime with a				
	start date of 03/01/24	emantine was administered				
	on 09/26/24 at 9:00pr	11.				
	Interview with the PC	D on 11/14/24 at 9:52am				
		call the Resident #4's PCP				
		ssed medications for 2 days,				
		e prednisone and tramadol.				
	copecially missing me	piculiisone and tramador.				
	Telephone interview v	vith Resident #4's Primary				
		on 11/14/24 at 12:01pm				
	revealed:	5				

Division of Health Service Regulation

-She did not know Resident #4 did not receive

STATE FORM R35K11 If continuation sheet 15 of 37

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE 10 PROVIDERS PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 15 discharge medications on 09/26/24 to 09/28/24. -She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or diyene orders to cover Resident #4 notil have an increase in inflammation and that was apart of her hospitalization diagnoses. -Her concerns with not getting the tramadol was, Resident #4 could have an increase in her blood pressure. -Her concerns with not getting the amoldipine was, Resident #4 could have an increase in her blood pressure. -Her concerns with not getting the advalproex was, Resident #4 could have an increase in her blood pressure. -Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. -Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the memantine was, Resident #4 sementia could get worse. -Her concerns with not getting the divalproex was resident was defined the memantine was resident #4 sementia could		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 250 COMMERCE CENTER DRIVE HUNTERSVILLE CADENCE HUNTERSVILLE SUMMARY STATEMENT OF DEFICIENCES HUNTERSVILLE, NC 28078 PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY PLLL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 15 discharge medications on 09/28/24 to 09/28/24, -She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnosesHer concerns with not getting the tramadol was, Resident #4 could have an increase in pain and that was apart of her hospitalization diagnosesHer concerns with not getting the alloquinol was, Resident #4 could have an increase in her blood pressureHer concerns with not getting the divalproex was, Resident #4 could have an increase in behaviorsHer concerns with not getting the divalproex was, Resident #4 could have an increase in behaviorsHer concerns with not getting the memantine was, Resident #4's dementia could get worseWhen medication were missed, it caused a delay in the treatment process. Refer to a telephone interview with the Administrator on 11/15/24 at 3.25pm.				A. BOILDING				
CADENCE HUNTERSVILLE (74) D PREFIX TAG (74) C PREFIX TAG (74) C PREFIX TAG (75) C PREFIX TAG (76) C PROVIDERS PLAN OF CORRECTION (C PREFIX TAG (76) C PROVIDERS PLAN OF CORRECTION (C PREFIX TAG (76) C PROVIDERS PLAN OF CORRECTION (C PREFIX TAG (76) C PREFIX TAG (76) C PROST-REFERNCE TO THE APPROPRIATE (76) C PREFIX TAG (76) C PREFIX TAG (76) C PREFIX TAG (76) C PROST-REFERNCE TO THE APPROPRIATE (76) C PREFIX TAG (76) C PROST-PROPRIATE (76) C			HAL060160	B. WING		1		
MUNITERSVILLE NC 28078 SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCES PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DMTE	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCES DEFICIENCES DEFICIENCES DEFICIENCES DEFICIENCY NUST BE PRECEDED BY FULL PREEX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREEX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY D 273 Continued From page 15 DEFICIENCES DEFICIENCY DEFICIENCY - She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 in the mean time. - Her concerns with not getting the prednisone was, Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnoses. - Her concerns with not getting the allopurinol was, Resident #4 could have an excerbation of gout. - Her concerns with not getting the allopurinol was, Resident #4 could have an increase in her blood pressure. - Her concerns with not getting the divalproex was, Resident #4 could have an increase in her blood pressure. - Her concerns with not getting the divalproex was, Resident #4 could have an increase in her blood pressure. - Her concerns with not getting the divalproex was, Resident #4 could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine was, Resident #4 sementia could get worse. - Her concerns with not getting the memantine Wash Wash	CADENCE HUNTEPSVILLE 250 COM			ERCE CENTER	R DRIVE			
EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Continued From page 15 discharge medications on 09/26/24 to 09/28/24. She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 in the mean time. Her concerns with not getting the prednisone was, Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnoses. Her concerns with not getting the amlodipine was, Resident #4 could have an increase in pain and that was apart of her hospitalization diagnoses. Her concerns with not getting the allopurinol was, Resident #4 could have an increase in her blood pressure. Her concerns with not getting the divalproex was, Resident #4 could have an increase in her blood pressure. Her concerns with not getting the divalproex was, Resident #4 could have an increase in her blood pressure. Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. Her concerns with not getting the donepezil was, Resident #4's dementia could get worse. When medication were missed, it caused a delay in the treatment process. Refer to a telephone interview with the Administrator on 11/15/24 at 3.25pm.	CADENCE	HUNTERSVILLE	HUNTERS'	VILLE, NC 280	78			
discharge medications on 09/26/24 to 09/28/24. -She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 in the mean time. -Her concerns with not getting the prednisone was, Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnoses. -Her concerns with not getting the tramadol was, Resident #4 could have an increase in pain and that was apart of her hospitalization diagnoses. -Her concerns with not getting the allopurinol was, Resident #4 could have an exacerbation of gout. -Her concerns with not getting the allopurinol was, Resident #4 could have an exacerbation of gout. -Her concerns with not getting the allopurinol was, Resident #4 could have an increase in her blood pressure. -Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. -Her concerns with not getting the donepezil was, Resident #4's dementia could get worse. -Her concerns with not getting the memantine was, Resident #4's dementia could get worse. -Her concerns with not getting the memantine was, Resident #4's dementia could get worse. -When medication were missed, it caused a delay in the treatment process. Refer to a telephone interview with the Administrator on 11/15/24 at 3:25pm.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE	
-She expected the staff to call her and notify her that they did not have the discharge instructions dated 09/26/24 because she could have assisted in getting the instructions or given orders to cover Resident #4 in the mean time. -Her concerns with not getting the prednisone was, Resident #4 could have an increase in inflammation and that was apart of her hospitalization diagnoses. -Her concerns with not getting the tramadol was, Resident #4 could have an increase in pain and that was apart of her hospitalization diagnoses. -Her concerns with not getting the allopurinol was, Resident #4 could have an exacerbation of gout. -Her concerns with not getting the amlodipine was, Resident #4 could have an increase in her blood pressure. -Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. -Her concerns with not getting the divalproex was, Resident #4 could have an increase in behaviors. -Her concerns with not getting the donepezil was, Resident #4's dementia could get worse. -Her concerns with not getting the memantine was, Resident #4's dementia could get worse. -When medication were missed, it caused a delay in the treatment process. Refer to a telephone interview with the Administrator on 11/15/24 at 3:25pm.	D 273	Continued From page	2 15	D 273				
Telephone interview with the Administrator on 11/15/24 at 3:35pm revealed: -On 09/18/24 she knew that Resident #4's hand was swollen and the facility had to contact the local fire department to come cut the rings cut offShe was under the impression that the RCD was	D 273	discharge medication -She expected the stathat they did not have dated 09/26/24 becausin getting the instructing Resident #4 in the medication and thathat was apart of her concerns with not resident #4 could have that was apart of her concerns with not resident #4 could have the concerns wi	aff to call her and notify her the discharge instructions are she could have assisted ons or given orders to cover ean time. In the discharge instructions are she could have assisted ons or given orders to cover ean time. In the discharge instructions are she could have assisted ons or given orders to cover ean time. In the discharge in the diverse in the was apart of her asses. In the discharge in pain and thospitalization diagnoses. In the diverse in pain and thospitalization diagnoses. In the diverse in pain and thospitalization diagnoses. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in the diverse in the diverse in her allopurinol was, we an exacerbation of gout. In the diverse in t	D 273				

dates.

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 16 of 37

Division of Health Service Regulation

DIVISION	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			
			D 14//10			
		HAL060160	B. WING		11/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TO WILL OF T	NOVIBER OR GOLF EIER		, ,			
CADENCE	HUNTERSVILLE		MERCE CENTE			
		HUNTER	SVILLE, NC 280	78		1
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/112
				·		1
D 273	Continued From page	e 16	D 273			
	-The RCD should hav	ve notified Resident #4's				
	_	en hand which required the				
		cause there were to be no				
	_	nout the PCP's orders.				
		nsible for making sure an				
	· ·	om the PCP related to the				
	hand X-ray by calling					
		<u> </u>				
	department and verifying the order was received within a couple of hours. -The RCD was responsible to call the PCP back if					
	I					
	the order for the X-ray did not go throughThe RCD was responsible to follow-up with the					
	PCP after Resident #4's hand continued to swell					
	and when the X-ray w					
	_	her resident received their				
	X-ray.					
	_	nsible for contacting the				
	I	aking to an on call provider				
	when it was the week	•				
		nsible for processing the				
	I	on 09/26/24 when Resident				
		hospital within the same				
	day.	•				
	'	onsible for obtaining the				
		from the transport within the				
	same day.	·				
		nsible to call the hospital				
	I	he discharge paperwork if it				
		en a resident returned from				
	the hospital within the					
	-The RCD was respo	nsible for notifying the PCP				
	when there was a del					
		ssed medications due to no				
	discharge paperwork	after the resident returned				
	to the facility.					
	The facility failed to n	otify Resident #4's primary				
		days after the staff noticed				
		m was red and swollen				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 17 of 37

Division of Health Service Regulation

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL060160	B. WING		11	C / 15/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E. ZIP CODE		713/2024
			MERCE CENTER			
CADENCE	HUNTERSVILLE	HUNTER	SVILLE, NC 280	78		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	three days for celluliticantibiotics, intravenous antibiotics. The failure harm and constitutes The facility provided a accordance with G.S. this violation. THE CORRECTION	ent being hospitalized for s, requiring intravenous us steroids and oral e resulted in serious physical a Type A1 Violation.	D 273			
D 358	(a) An adult care hor preparation and admit prescription and nonby staff are in accord. (1) orders by a licens which are maintained (2) rules in this Secti and procedures. This Rule is not met Based on observation reviews, the facility fawere administered as residents (#4)) related	Medication Administration me shall assure that the nistration of medications, prescription, and treatments ance with: sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by: ns, interviews, and record illed to ensure medications ordered for 1 of 5 sampled ad to medications used to ain, gout, blood pressure,	D 358			
	-	4's FL-2 dated 01/11/24				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 18 of 37

PRINTED: 12/06/2024

Division (of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	ETED
		HAL060160	B. WING		11/1) 5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	TE, ZIP CODE		
CADENCE	E HUNTERSVILLE		MMERCE CENTER			
		HUNTER	RSVILLE, NC 280	78		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 18	D 358			
	revealed diagnoses in	neludad damantia				
	hypertension, and an					
	Review of Resident #4's Hospital Admission notes revealed: -Her hospitalization was from 09/23/24 to 09/26/24She presented to the emergency room with a swollen right hand/arm.					
	_	sibly swollen, red and hot to				
	the touch.	ntation her right hand and				
	arm noted edema, er	_				
	tenderness to palpati					
	_	of cellulitis, erysipelas (a				
	bacterial infection of	• • • • • • • • • • • • • • • • • • • •				
		thritis, physical examination erythema, pain and elevated				
	_	Resident #4 was admitted to				
	the hospital.					
	-She received intrave	enous (IV) antibiotics, IV				
	steroids, and oral ant					
	-A discharge time of	•				
	days, to begin on 09/	one 20mg every day for 10				
		ol 50mg, two times a day for				
	30 days, to begin on					
		allopurinol 100mg every				
	morning.					
		amlodipine besylate 10mg				
ı	every day. -An order to continue	divalproex 125mg two				

Division of Health Service Regulation

times a day.

(eMAR) revealed:

bedtime.

-An order to continue donepezil 10mg at bedtime. -An order to continue memantine 10mg at

Review of Resident #4's September 2024 electronic Medication Administration Record

STATE FORM R35K11 If continuation sheet 19 of 37

Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING		C	
		HAL060160	D. WING		11/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		250 COM	MERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE		SVILLE, NC 280			
040.15	QUMMADV QT	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N.	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
D 358	Continued From page	. 10	D 358			
D 000	Continued From page	5 19	2 000			1
		one 20mg every day, with a				1
	start date of 09/29/24, and there was no documentation the prednisone was administered					ı
						ı
	on 09/27/24 and 09/2	8/24 at 9:00am.				ı
	-An entry for tramado	l 50mg two times a day, with				1
	a start date of 03/01/2	24, and there was no				1
	documentation the tra	amadol was administered on				1
	09/26/24 at 9:00pm and 09/27/24 at 9:00am. -An entry for allopurinol 100mg every day, with a start dated of 03/01/24, and there was no					1
						1
						1
	documentation the all	lopurinol was administered				1
	on 09/27/24 at 9:00am.					I
	-An entry for amlodipi	ine besylate 10mg every				1
	day, with a start date	of 03/01/24 and there was				1
	no documentation the	e amlodipine was				I
	administered on 09/2	7/24 at 9:00am.				1
	-An entry for divalpro	ex 125mg, two times a day				I
	with a start date of 03	3/01/24 and there was no				1
	documentation the div	valproex was administered				1
	on 09/26/24 at 9:00pr	m and 09/28/24 at 9:00am.				1
	-An entry for donepez	zil 10mg at bedtime with a				1
	start date of 03/01/24	and there was no				I
	documentation the do	onepezil was administered				1
	on 09/26/24 at 9:00pr	m.				1
	-An entry for memant	ine 10mg at bedtime with a				1
	start date of 03/01/24	and there was no				1
	documentation the m	emantine was administered				I
	on 09/26/24 at 9:00pr	n.				1
						1
		sident Care Director (RCD)				1
	on 11/14/24 at 9:52ar					
	•	ent #4 returned from the				1
		y did not bring the discharge				
	paperwork with her.					
		discharge paperwork she				
	could not make the no					ı
		itions in the eMAR or fax the				
	changes/additions to					
	-Resident #4 remaine	ed as "LOA", leave of				l

Division of Health Service Regulation

absence on the eMAR until 09/28/24 when the

STATE FORM 6899 R35K11 If continuation sheet 20 of 37

Division of Health Service Regulation

DIVIDIOII C	n nealth Service Negu	iation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
					_	.]
		HALOGOIGO	B. WING		C	
		HAL060160	1		11/1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		250 COM	MERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE		VILLE, NC 280			
240.15	CLIMMADY CT				<u> </u>	0.45)
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
D 358	Continued From page	20	D 358			
D 330	Continued From page	2 20	D 336			
	family brought in the	discharge paperwork.				
	-Since Resident #4 re	emained as "LOA" the eMAR				
	would not have promi	pted the MAs to administer				
	the medications.	•				
	Telephone with a Pha	armacist from the facility's				
	contracted pharmacy	on 11/14/24 at 3:31pm				
	revealed: -On 09/27/24, the facility faxed over hospital discharge summary dated 09/26/24On 09/27/24, there was an order for prednisone 20mg every day for 10 days.					
	-The pharmacy dispe	nsed prednisone 20mg, 10				
	tablets, a 10 day supp					
		vas an order for tramadol				
	50mg two times a day					
	-The pharmacy dispe	nsed tramadol 50mg, 60				
	tablets, a 30 day supp	oly on 11/05/24.				
	-The allopurinol 100m	ng every day, amlodipine				
	-	day, divalproex 125mg, two				
		il 10mg at bedtime, and				
		pedtime were orders that				
	_	and the facility did not need				
	a fill yet.	and the lasting and her here				
	···· , - ··					
	Telephone interview v	with Resident #4's Primary				
		on 11/14/24 at 12:01pm				
	revealed:	- 1				
		about Resident #4 not				
		e because she could have				
		mation and swelling, and				
		hospitalization diagnoses.				
		about Resident #4 not				
		pecause she could have an				
	increase in pain and t					
	hospitalization diagno					
		about Resident #4 not				
		because she could have an				
	exacerbation of gout.					

Division of Health Service Regulation

-She was concerned about Resident #4 not

STATE FORM R35K11 If continuation sheet 21 of 37

Division of Health Service Regulation

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:			
			A. BOILDING.			
		HAL060160	B. WING		C 11/15/2	2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CADENCE	HUNTERSVILLE	250 COMM	ERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE	HUNTERS\	/ILLE, NC 280	78		
(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 ((X5) COMPLETE DATE
D 358	Continued From page	21	D 358			
	an increase in her blo -She was concerned a getting the divalproex an increase in behavi -She was concerned a getting the donepezil get worseShe was concerned a getting the memantine could get worseWhen medication we in the treatment proce Telephone interview w 11/15/24 at 3:35pm re -The RCD was respondischarge paperwork #4 returned from the b dayThe MAs were respondischarge paperwork same dayThe RCD was respondischarge paperwork same day.	about Resident #4 not because she could have ors. about Resident #4 not because her dementia could about Resident #4 not because her dementia about Resident #4 not because her dementia are missed, it caused a delay because. with the Administrator on bevealed: ansible for processing the on 09/26/24 when Resident anospital within the same ansible for obtaining the from the transport within the				
	-On 09/27/24, the RC did not have discharg	illable for administration. D reported that Resident #8 e instructions and that the family to bring back the				
D 433	10A NCAC 13F .1201	(a) Resident Records	D 433			
	resident in an orderly record in the adult car	Il be maintained on each manner in the resident's re home and made available ntatives of the Division of ation and county				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 22 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL060160	B. WING		C 11/1	; 5/2024
NAME OF PROVIDER OR SUPPLIER STREET ADI CADENCE HUNTERSVILLE 250 COMM		DRESS, CITY, STA MERCE CENTE VILLE, NC 280	R DRIVE	1 11/1	5/2024	
(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	(X5) COMPLETE DATE
D 433	form or hospital dischapplicable; (2) Resident Register (3) receipt for the follour of this Subchap (A) contract for service rates; (B) house rules as spoof this Subchapter; (C) Declaration of Re 131D-21); (D) the home's grieva (E) civil rights statemed (4) resident assessmed (5) contacts with the rephysician service or opposessional as require Subchapter; (6) orders or written to from a physician or of professional and their (7) documentation of influenza virus and president did not receive on this law; and (8) the Adult Care Howard Adult Care Home Hear resident is being or he waluation, records no evaluation such as Subchapters (1) the subchapter of	ins and the patient transfer arge summary, when it is powing as required in Rule offer: lees, accommodations and lecified in Rule .0704(a)(2) is sidents' Rights (G.S. lince procedures; and lent; leent and care plan; leesident's physician, other licensed health leed in Rule .0902 of this reatments or procedures ther licensed health liminglementation; limmunizations against licensed health leem licensed lic	D 433			
	Based on observation	as evidenced by: ns, record reviews and failed to ensure resident				

Division of Health Service Regulation

records were maintained in an orderly manner for

STATE FORM R35K11 If continuation sheet 23 of 37

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
					c	
		HAL060160	B. WING		11/15/	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CADENCE	LIINTEDOVII I E	250 COMM	ERCE CENTE	R DRIVE		
CADENCE	HUNTERSVILLE	HUNTERS	/ILLE, NC 280	78		
(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 433	Continued From page	23	D 433			
	3 of 5 sampled reside to accurate document resident's care plans.					
	The findings are:					
	02/01/24 revealed: -Diagnosis included of -Resident #2 was correlated was am -Resident's level of car (SCU). Review of Resident #	nstantly disoriented. bulatory. are was Special Care Unit 2's Resident Register				
	**	2's Accident and Incident revealed documentation				
		2's staff progress report led documentation that the it of her bed.				
	no was documented f within the past three r -Resident #2's fall risl low risk.	ent section for fall potential, for known history of fall months. k score was documented as				
	-She knew Resident #	•				

Division of Health Service Regulation

care plan for fall assessment.

STATE FORM R35K11 If continuation sheet 24 of 37

Division of Health Service Regulation

DIVISION	n nealth Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLET	TED
					_	
			D WING		C	
		HAL060160	B. WING		11/15	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			MERCE CENTE			
CADENCE	HUNTERSVILLE					
		HUNTER	SVILLE, NC 280	0/8		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOLATORT OR L	ESCIDENTII TIIVG INI OKMATION)	TAG	DEFICIENCY)	NAIL	27112
				,		
D 433	Continued From page	e 24	D 433			
	1 0					
		sident Care Director (RCD)				
	on 11/15/24 at 3:07pr					
	-She know Resident #	#2 had a history of falls.				
	-She did not know Re	esident #2 had				
	documentation of no t	fall history within the				
	previous three months	S.				
	•					
	Telephone interview v	vith the Administrator on				
	11/15/24 at 3:28pm re					
		#2 had a history of falls.				
	-She did not know Re	•				
	documentation of no					
	previous three months					
	previous unee monus	5.				
	Defents a talanhana i	:				
		interview with the SCC on				
	11/15/24 at 1:32pm.					
		h the RCD on 11/15/24 at				
	3:07pm.					
	Refer to a telephone i					
	Administrator on 11/1	5/24 at 3:28pm.				
	2. Review of Residen	t #3's current FL2 dated				
	07/08/24 revealed:					
	-Diagnosis included c	erebral infarction, cognitive				
	communication deficit					
	hypertension.	-,				
	-Resident #3 was con	stantly disoriented				
	-Resident #3 was am					
		are was for Special Care				
		are was for opecial Care				
	Unit (SCU).					
	Deview of Deside 19	Ole Decident Decists				
	Review of Resident #	_				
	revealed an admissio	n date of 09/22/21.				
		3's Accident and Incident				
	report dated 11/00/2/	revealed documentation	I			

Division of Health Service Regulation

that the resident had a fall.

STATE FORM R35K11 If continuation sheet 25 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
				_	l c l
		HAL060160	B. WING		11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
CADENCE	HUNTERSVILLE	250 COMN	IERCE CENTE	R DRIVE	
CADENCE	HOWIERSVILLE	HUNTERS	VILLE, NC 280	78	
(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 COMPLETE
D 433	Continued From page	e 25	D 433		
	dated 11/09/24 reveal resident had a fall and Review of Resident # 11/15/24 revealed: -Under the assessment on was documented fivithin the past three re-Resident #3's fall risk low risk. Telephone interview with Coordinator (SCC) or revealed: -She completed Resident #3's fall risk low risk.	ent section for fall potential, for known history of fall months. It is score was documented as with the Special Care in 11/15/24 at 1:32pm dent #3's care plan. If it is a section on the in the special potent in the special care plan.			
	11/15/24 at 3:28pm re-She knew Resident #-She did not know Redocumentation of not previous three month Refer to a telephone 11/15/24 at 1:32pm. Refer to interview with 3:07pm.	#3 had a history of falls. esident #3 had fall history within the s. interview with the SCC on the the RCD on 11/15/24 at			
	Refer to a telephone Administrator on 11/1				
	3. Review of Residen 01/11/24 revealed:	t #4's current FL2 dated			

Division of Health Service Regulation

-Diagnosis included dementia.

STATE FORM R35K11 If continuation sheet 26 of 37

Division of Health Service Regulation

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		С	
		HAL060160	B. WING		11/15/2024	_
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CADENCE	HUNTERSVILLE		IERCE CENTEI VILLE, NC 280			
(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	<u> </u>
D 433	Continued From page	e 26	D 433			
	Unit (SCU).					
	revealed an admissio	<u> </u>				
	Review of Resident #4's Accident and Incident report dated 08/17/24 revealed documentation that the resident had an unwitnessed fall.					
		4's staff progress report led documentation that the tnessed fall.				
	Review of Resident #4's Care Plan dated 09/30/24 revealed: -Under the assessment section for fall potential, no was documented for known history of fall within the past three monthsResident #4's fall risk score was documented as low risk.					
		n 11/15/24 at 1:32pm dent #4's care plan. #4 had a history of falls. ere was a section on the				
	11/15/24 at 3:28pm re	#4 had a history of falls. esident #4 had fall history within the				

Division of Health Service Regulation

Refer to a telephone interview with the SCC on

STATE FORM R35K11 If continuation sheet 27 of 37

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	
					С
		HAL060160	B. WING		11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	E, ZIP CODE	
CADENCE	HUNTERSVILLE		IMERCE CENTER SVILLE, NC 2807		
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 433	Continued From page	e 27	D 433		
	11/15/24 at 1:32pm.				
	Refer to interview with 3:07pm.	h the RCD on 11/15/24 at			
	Refer to a telephone Administrator on 11/1				
	completed all residen completed care plans	on 11/15/24 at 1:32pm Director (RCD) normally t care plans, but she is if the RCD was out. ew all care plans prior to into the Primary Care			
	revealed: -She and the SCC we completing resident completing all care				
	11/15/24 at 3:28pm re -The RCD and SCC v completed resident ca -If the SCC completes care plan is reviewed the care plan to the P -She expected the ca -She only reviews res	were responsible for are plans. s a resident care plan, the by the RCD prior to sending			

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 28 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			_
		HAL060160	B. WING		11	C 1 /15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE		
			MERCE CENTER			
CADENCE	HUNTERSVILLE		SVILLE, NC 280			
0/10/15	STIMMADV ST.	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF C	ODDECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 28	D 451			
D 451	10A NCAC 13F .1212 and Incidents	2(a) Reporting of Accidents	D 451			
	10A NCAC 13F .1212 Incidents	Reporting of Accidents and				
		ne shall notify the county				
		services of any accident or				
	incident resulting in re	•				
	accident or incident resulting in injury to a					
resident requiring referral for emerge						
	evaluation, hospitalization, or medical treatment					
	other than first aid.					
	This Rule is not met	as evidenced bv:				
		ews and interviews, the				
		the County Department of				
	Social Services (DSS) of accident/incidents that				
	, ,	medical evaluation for 5 of 5				
	sampled residents (#	1, #2, #3, #4 and #5).				
	The findings are:					
	Paview of facility's las	cident Report and State				
	1	effective date of 06/08/21				
	revealed:	ellective date of 00/00/21				
		eport is completed by staff				
		ences, injury and incidents.				
		Director (RCD) or designated				
	staff completes the in	` ,				
	-Incidents are reporte					
		rty and physician with				
		date and time the report				
		lly/responsible party and				
	physician in the narra	<u> </u>				
		shall notify the county				
		services of any accident or				
	incident resulting in d	eath or any accident or				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 29 of 37

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
					c	
		HAL060160	B. WING		1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
CADENCE	HUNTERSVILLE	250 COM	MERCE CENTE	R DRIVE		
0,152,1101		HUNTER	SVILLE, NC 280	78		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 451	Continued From page	e 29	D 451			
	referral for emergence hospitalization or medifirst aide. -The report shall be sedepartment of social stelefacsimile, electror 48 hours of the initial staff of the accident of 1. Review of Residen 01/11/24 revealed: -Diagnosis included a and dementiaResident #1 was continued to the staff of the accident of the ac	dical treatment other than ubmitted to the county services by mail, nic mail, or in person within discovery or knowledge by or incident. t #1's current FL2 dated anxiety, Alzheimer's Disease,				
		1's emergency department 24/24 revealed Resident #1 fall with head injury.				
	10/24/24 revealed: -Resident #1 had a fainto another walkerResident #1 hit her had sent to the EDThe accident/incident	all while pushing her walker nead when she fell and was at report did not have an area of document notification to of social services.				
	Social Services (DSS (AHS) Supervisor on revealed DSS did not Resident #1's ED visi	receive notification of				

Division of Health Service Regulation

AHS Supervisor on 11/15/24 at 2:05pm.

STATE FORM R35K11 If continuation sheet 30 of 37

Division of Health Service Regulation

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BUILDING:				
		HAL060160	B. WING		C 11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
CADENCE	HUNTERSVILLE		MERCE CENTE		
			SVILLE, NC 280		
(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 APPROPF DEFICIENCY)	BE COMPLETE
D 451	Continued From page	÷ 30	D 451		
	Refer to the telephone interview with the Special Care Coordinator (SCC) on 11/15/24 at 1:32pm.				
	Refer to the interview Director (RCD) on 11	with the Resident Care /15/24 at 3:07pm.			
	Refer to the telephone interview with the Administrator on 11/15/24 at 3:28pm.				
	2. Review of Resident #5's current FL2 dated 09/26/24 revealed: -Diagnoses included cognitive impairment deficit, muscle weakness and depression. -Resident #5 was constantly disoriented. -Resident's level of care was Assisted Living (AL).				
	dated 09/06/24 revea	's hospital discharge report led Resident #5 was tal on 08/31/24 for altered			
	Review of Resident #5's late entry progress note dated 09/05/24 revealed the resident was sent to the emergency department (ED) on 08/31/24 for evaluation due to being lethargic (fatigue).				
	Review of Resident # was no incident repor hospitalization from 0				
	=	24 at 2:05pm revealed DSS ation of Resident #5's			
	Refer to the telephone AHS Supervisor on 1	e interview with the DSS 1/15/24 at 2:05pm.			
	Refer to the telephone	e interview with the Special			

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 31 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			7 ti BoileBiito.		С
		HAL060160	B. WING		11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
CADENCE	HUNTERSVILLE		IERCE CENTE		
		HUNTERS	VILLE, NC 280	178	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 451	Continued From page	e 31	D 451		
	Care Coordinator (SC	CC) on 11/15/24 at 1:32pm.			
	Refer to the interview Director (RCD) on 11	with the Resident Care /15/24 at 3:07pm.			
	Refer to the telephone Administrator on 11/1				
	02/01/24 revealed: -Diagnosis included d -Resident #2 was cor -Resident #2 was am	nstantly disoriented.			
	Review of Resident #2's emergency department (ED) report dated 06/05/24 revealed: -Resident #2 was evaluated due to altered mental status and Alzheimer's dementia with agitationResident #2 became agitated and pushed another resident.				
		2's record revealed there n that a Accident or Incident npleted.			
	dated 08/14/24 revea -Resident #2 fell in th and was bleedingThere was no docum being sent to the hosp -There was no docum responsible party noti -Under Treatment, no documentedThe accident/inciden	e spa bathroom on her face nentation of Resident #2 pital. nentation of family or			

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 32 of 37

Division of Health Service Regulation

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
			7 . BOILBING.		C	:
		HAL060160	B. WING		1	5/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE		
CADENCE HUNTERSVILLE 250 COMME			MERCE CENTE			
	T		SVILLE, NC 280			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 451	Continued From page	e 32	D 451			
	landed on the hard floral resident #2 had a srinner lip with mild swet to front tooth but not I resident #2 had an a her left arm. Resident #2 had four deep purple, almost gleg. Resident #2 to be adfall, contusion of face hyponatremia. Refer to the telephone Care Coordinator (SC Refer to the interview Director (RCD) on 11/1. Refer to the telephone Administrator on 11/1. 4. Review of Residen 07/08/24 revealed: Diagnosis included of communication deficit hypertension. Resident #3 was corresident #3 was am	unwitnessed fall where she por. mall laceration to her upper elling with a mild irregularity oose. abrasion and contusion to a separate contusions and greenish bruising to her right limited to the hospital due to a urinary tract infection and se interview with the DSS 1/15/24 at 2:05pm. The interview with the Special CC) on 11/15/24 at 1:32pm. With the Resident Care 1/15/24 at 3:07pm. With the Resident Care 1/15/24 at 3:28pm. The interview with the 5/24 at 3:28pm. The interview with the 5/24 at 3:28pm. The interview with the 5/24 at 3:28pm.				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 33 of 37

Division of Health Service Regulation

	of Health Service Regu			achier Puler I en	(A) DATE (1) (T)
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
					С
		HAL060160	B. WING		11/15/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
		250 CON	MERCE CENTER	R DRIVE	
CADENCE	HUNTERSVILLE	HUNTER	SVILLE, NC 280	78	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLET
D 451	Continued From page	e 33	D 451		
	summary dated 10/16 was admitted for six of uropathy (obstruction a suprapubic cathete nursing facility.	3's hospital discharge 6/24 revealed Resident #3 days due to obstructive to urine flow), placement of r and discharged to a skilled 3's record revealed there out dated 10/16/24.			
	•	24 at 2:05pm revealed DSS ation of Resident #3's			
	Refer to the telephon AHS Supervisor on 1	e interview with the DSS 1/15/24 at 2:05pm.			
		e interview with the Special CC) on 11/15/24 at 1:32pm.			
	Refer to the interview Director (RCD) on 11	with the Resident Care /15/24 at 3:07pm.			
	Refer to the telephon Administrator on 11/1				
	01/11/24 revealed: -Diagnosis included of -Resident #4 was cord-Resident #4 was nord-	nstantly disoriented.			
	dated 09/26/24 revea	tal on 09/23/24 for cellulitis			

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 34 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL060160	B. WING		C 11/15/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CADENCE	HUNTERSVILLE		ERCE CENTE			
		HUNTERS	/ILLE, NC 280	78		
(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 APPROPF DEFICIENCY)	BE COMPLI	ETE
D 451	Continued From page	e 34	D 451			
	dated 09/24/24 revea the emergency depar	4's late entry progress note led the resident was sent to tment (ED) on 09/23/24 for elling to the right hand and				
	Review of Resident # was no Incident Repo	4's record revealed there ort dated 09/23/24.				
	-	24 at 2:05pm revealed DSS ation of Resident #4's				
	Refer to the telephone AHS Supervisor on 1	e interview with the DSS 1/15/24 at 2:05pm.				
		e interview with the Special CC) on 11/15/24 at 1:32pm.				
	Refer to the interview Director (RCD) on 11/	with the Resident Care /15/24 at 3:07pm.				
	Refer to the telephone Administrator on 11/1					
	-The facility was respreports to the Departrany incidents that hap than first aidShe received one ac	vith the DSS AHS 24 at 2:05pm revealed: onsible for faxing incident ment of Social Services for opened which required more cident/incident report for ed residents since January				
	Telephone interview v Coordinator (SCC) or revealed: -Medication Aides (Ma					

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 35 of 37

Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	:TED
					l c	
		HAL060160	B. WING		1	5/2024
		070557.10		T. J.D 00D5		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
CADENCE	HUNTERSVILLE		MERCE CENTER			
			SVILLE, NC 280			
(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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 451	Continued From page	 e 35	D 451	,		
	who displayed behavi	ncident reports for residents iors and/or falls				
		oorts were to be turned into				
	the RCD as soon as					
		as responsible for sending				
	accident/incident repo	orts to the Department of				
	Social Services.					
		nen an accident/incident				
	•	to the Department of Social				
	Services.					
	Interview with the RC	CD on 11/15/24 at 3:07pm				
	revealed:	D 011 11/10/21 at 0.01 p				
		dent/incident reports and				
	she reviewed them.	·				
	_	the MA if there was an				
	accident/incident.					
	-MAs were only requi					
	accident/incident in a accident/incident repo	staff progress note, in an				
	communication form.					
		A to always fax a physician				
		to the Primary Care Provider				
	(PCP) when there wa	as an accident/incident.				
	· ·	ne Administrator were				
	•	ng accident/incident reports				
	to the Department of					
	-She sent accident/in	•				
	needed more than first	Services when a resident				
		st aldo.				
	Telephone interview v	with the Administrator on				
	11/15/24 at 3:28pm re	evealed:				
		report should be sent to the				
	I	Services within 24 hours of				
	a resident being sent					
		e Department of Social				
	reports.	n receiving accident/incident				
	roporto.					

Division of Health Service Regulation

-She expected the RCD to complete

STATE FORM 6899 R35K11 If continuation sheet 36 of 37

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE	(X3) DATE SURVEY COMPLETED	
						С	
		HAL060160	B. WING		11	/15/2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CADENCE HUNTERSVILLE 250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTIO		(X5) COMPLETE DATE			
D 451	Continued From page 36		D 451				
D 451	Continued From page accident/incident report Department of Social -The facility had not continued accident/incident report incident report r	orts and send to the Services. completed audits of	D 451				

Division of Health Service Regulation

STATE FORM R35K11 If continuation sheet 37 of 37