STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Annual survey from 08/20/24 through 08/22/24.	D 000		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents had a completed care plan signed by the Primary Care Provider (PCP) within 15 days of the resident being assessed (Resident #5). The findings are: Review of Resident #5's current FL2 dated 05/29/24 revealed diagnoses of repeated falls, abnormal weight loss, lower back pain and constipation. Review of Resident #5's Resident Register revealed an admission date of 02/05/21. Review of Resident #5's Care Plan dated 05/28/24 revealed there was no PCP signature documented.	D 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 263	Continued From page 1 Interview with the Resident Care Director (RCD) on 08/22/24 at 3:22pm revealed: -She was responsible for faxing care plans to the PCP for a signature after the care plan had been completed. -She could not locate a signature page for Resident #5's care plan dated 05/28/24. -She did not know Resident #5's 05/28/24 care plan had not been signed by the PCP. -There was no process in place to ensure care plans were signed by the PCP. Interview with the Administrator on 08/22/24 at 3:45pm revealed: -She did not know Resident #5's 05/28/24 care plan had not been signed by the PCP. -The Assistant RCD was responsible for completing care plans and obtaining the PCP's signature. -The care plans were to be completed upon admission to the facility, annually and if there was a significant change in a resident's condition. -Once Resident #5's care plan had been completed, the care plan should have been faxed or emailed to the PCP within 15 days for review and to be signed.	D 263		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 2	D 358		

and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #2) related to not administering a medication used to treat anxiety related to dementia.

The findings are:

Review of Resident #2's current FL2 dated 05/06/24 revealed:
-Diagnoses included Alzheimer's disease and anxiety disorder.
-Resident #2 was constantly disoriented.
-Level of care was Special Care Unit (SCU).
-There was an order for quetiapine (a medication used to treat anxiety related to dementia) 50mg by mouth at bedtime.

Review of Resident #2's Resident Register revealed an admission date of 05/19/16.

Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for quetiapine 50mg by mouth at bedtime.
-Quetiapine 50mg by mouth at bedtime was documented as being administered from 06/01/24 through 06/12/24 at 8:00pm.
-There was documentation of "D/C'd" (discontinued) entered on the eMAR from 06/13/24 through 06/30/24.

Review of Resident #2's July 2024 and August 2024 eMAR revealed there was no entry for quetiapine 50mg by mouth at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 3 Observation of Resident #2's medications on hand on 08/22/24 at 11:12am revealed quetiapine 50mg by mouth at bedtime was not available on the medication cart. Review of Resident #2's record on 08/21/24 revealed there was no order to discontinue quetiapine 50mg. Review of Resident #2's behavioral health Nurse Practitioner's (NP) visit note dated 06/11/24 revealed there was an order to continue quetiapine 50mg by mouth at bedtime. Telephone interview with the facility's contracted Pharmacy on 08/21/24 at 11:13am revealed: -The pharmacy had received Resident #2's mental health NP's visit note dated 06/11/24 with the order to continue quetiapine 50mg by mouth at bedtime. -The pharmacy had overlooked Resident #2's quetiapine order and discontinued the medication on 06/12/24. -The pharmacy sends an electronic message through the eMAR system to the facility to approve or decline all medication orders. -The facility is responsible for reviewing all medication orders entered by the pharmacy. -The facility must enter approve or decline for all medication orders sent by the pharmacy. -The facility approved to discontinue Resident #2's quetiapine 50mg by mouth at bedtime. -The pharmacy did not receive any communication from the facility related to Resident #2's quetiapine after 06/12/24. Telephone interview with Resident #2's behavioral health NP on 08/21/24 at 11:28am revealed: -She was made aware upon her visit with	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 4	D 358		

Resident #2 on 07/18/24 that Resident #2's quetiapine 50mg by mouth at bedtime had been discontinued.
-She assumed that Resident #2's Primary Care Provider (PCP) had discontinued Resident #2's bedtime dose of quetiapine but did not verify this with the PCP.
-If Resident #2 did not receive scheduled dose of quetiapine, she could experience unsteadiness, agitation, and combativeness with care.
-She expected the facility to follow all provider orders.

Interview with the medication aide (MA) on 06/22/24 at 11:14am revealed she was not aware that Resident #2 had an order for quetiapine 50mg by mouth at bedtime.

Interview with the Special Care Coordinator (SCC) on 08/22/24 at 2:54pm revealed:
-She and the Resident Care Director (RCD) had access to approve or decline medication orders that were sent from the facility's contracted pharmacy.
-She did know Resident #2's had not been receiving quetiapine 50mg by mouth at bedtime because she had approved to discontinue the order sent from the pharmacy.
-She did not verify Resident #2's quetiapine 50mg by mouth at bedtime medication order prior to approving to discontinue the medication.
-She did not review Resident #2's behavioral health NP progress note from 06/11/24.

Interview with the RCD on 08/21/24 at 11:04am and on 08/22/24 at 3:19pm revealed:
-She did not know Resident #2's quetiapine 50mg by mouth at bedtime had been discontinued without a physician's order.
-Medication orders were emailed or faxed to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 5 facility and the facility was responsible for faxing all medication orders to the pharmacy. -She did not know the pharmacy had received Resident #2's behavioral health NP visit note from 06/11/24. -She did not review Resident #2's provider progress note because the progress notes were usually emailed two to three days after the provider visits. -She and the SCC had access to approve or decline medication orders that were sent from the facility's contracted pharmacy. -Prior to approving any medication orders, she or the SCC were to verify all medication orders. Interview with the Administrator on 08/22/24 at 9:00am and at 3:46pm revealed: -She did not know Resident #2's quetiapine 50mg by mouth at bedtime had been discontinued without a physician's orders. -The SCC and the RCD were responsible for verifying all medication orders prior to approving medication orders sent from the pharmacy. -She expected the SCC and/or RCD to verify all medication orders prior to approving any medications orders sent from the pharmacy.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 6	D 367		

or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records (eMAR) was accurate for 1 of 5 sampled residents (Resident #4) related to a medication used to treat high blood sugar levels.

The findings are:

Review of Resident #4's current FL2 dated 04/15/24 revealed:
-Diagnoses included hypertension, type 2 diabetes mellitus and chronic kidney disease stage 4.
-Resident #4 had an order for finger stick blood sugars (FSBS) two times a day, at 6:30am and 8:00pm.

Review of Resident #4's Primary Care Provider's (PCP) orders dated 04/15/24 revealed orders to check FSBS twice daily and notify the PCP for blood sugars less than 90.

Review of Resident #4's June 2024 eMAR revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 7	D 367		

-There was an entry to check FSBS twice daily at 6:00am and 8:00pm.
-There was no documentation for a FSBS on 06/08/24 at 6:30am.
-There was no documentation for a FSBS on 06/12/24 at 8:00pm.
-There was no documentation for a FSBS on 06/19/24 at 6:30am.
-There was no documentation for a FSBS on 06/23/24 at 6:30am.
-There was no documentation for a FSBS on 06/25/24 at 8:00pm.

Review of Resident #4's July 2024 eMAR revealed:
-There was an entry to check FSBS twice daily at 6:00am and 8:00pm.
-There was no documentation for a FSBS on 07/09/24 at 6:30am.
-There was no documentation for a FSBS on 07/15/27 at 6:30am.
-There was no documentation for a FSBS on 07/16/24 at 6:30am.

Review of Resident #4's August 2024 eMAR revealed:
-There was an entry to check FSBS twice daily at 6:00am and 8:00pm.
-There was no documentation for a FSBS on 08/05/24 at 6:30am.
-There was no documentation for a FSBS on 08/07/24 at 6:30am.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/22/24 at 10:45am revealed:
-Resident #4 had an order dated 04/15/24 for FSBS twice daily.
-The Pharmacist visited the facility quarterly to audit 10-20% of residents' records to review the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 8	D 367		

residents' PCP orders.
-The facility should be using their missed medication review as the pharmacy staff did not check the eMARs for missed medication or FSBS.

Interview with a medication aide (MA) on 08/22/24 at 11:23am revealed:
-She was not aware there were areas on the eMAR with no documentation of a FSBS completed.
-She always made sure Resident #4 had her FSBS done.
-She could have entered the FSBS as completed but did not realize it was not entered because the eMAR program was recently changed.
-She was her initials but could not see the FSBS once it was put in.
-She thought chart audits were completed by the Resident Care Coordinator (RCC) but was not sure.

Telephone interview with Resident #4's PCP on 08/22/24 at 11:50am revealed:
-She was not sure if she was made aware of the missed FSBS in June, July, and August 2024.
-She checked the eMAR and the FSBS charting each time she visited Resident #4.
-She ordered the FSBS to determine if the resident needed changes made to her insulin dose.

Interview with the RCC on 08/22/24 at 10:05am revealed:
-The RCC was responsible for checking orders on the eMARs.
-She was not aware there was missing documentation on the June, July, and August 2024 eMARs.
-Chart and medication cart audits were done as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 9	D 367		

team by the RCC, SCC, Regional Health and Wellness Nurse and Administrator with the goal of doing them quarterly and whenever needed.
-The Pharmacy completed a quarterly audit but did not look for missed documentation on the eMAR.

Interview with the Administrator on 08/22/24 at 10:15am revealed:
-She was not aware of the missed documentation on Resident #4's June, July, and August 2024 eMARs.
-It was the responsibility of the RCC to check all orders on the eMARs.
-The Pharmacy did a quarterly audit, but she did not think they checked for missing documentation on the eMARs.

2. Review of Resident #3's current FL2 dated 03/04/24 revealed:
-Diagnoses included dementia, aphasia, depression, and insomnia.
-Resident #3's level of care was Special Care Unit (SCU).

Review of Resident #3's record on 08/21/24 revealed there was not an order for hydrocodone-acetaminophen 5mg-325mg by mouth every four hours.

Review of Resident #3's 2024 August eMAR revealed:
-There was an entry for hydrocodone-acetaminophen 5mg-325mg by mouth every four hours.
-Hydrocodone-acetaminophen 5mg-325mg every four hours was documented as administered eight times on 08/01/24 through 08/03/24.

Telephone interview with the contracted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 10 pharmacy for the facility on 08/22/24 at 1:40pm revealed: -The pharmacy did not receive an order for hydrocodone-acetaminophen 5mg-325mg by mouth every four hours. -The pharmacy did not enter an order for hydrocodone-acetaminophen 5mg-325mg by mouth every four hours on Resident #3's eMAR. -The facility did have access to add, change or discontinue medication orders in the eMAR system and more than likely entered Resident #3's order incorrectly. Interview with the RCD (Resident Care Director) on 08/20/24 at 3:22pm and on 08/22/24 at 3:19pm revealed: -She, the Administrator, the SCC and the RCC had access to add, change or discontinue medication orders in the eMAR system. -She entered Resident #3's hydrocodone-acetaminophen 5mg-325mg order. -Prior to approving any medication orders, she or the SCC were to verify all medication orders, but this order had been missed. -She trained MAs to review the eMAR and compare it to the medications on the cart before administering. Interview with the Administrator on 08/22/24 at 3:46pm revealed: -She expected the MAs to verify medication labels to the eMAR prior to administering medications. -It was the responsibility of the RCD and RCC to verify all orders on the eMARs.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 11 (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure there was an accurate accounting for the receipt, administration, and disposition of controlled medications for 1 of 4 sampled residents (Resident #3) related to medications to treat pain. The findings are: Review of Resident #3's current FL2 dated 08/28/23 revealed: -Diagnoses included dementia, aphasia, depression, and insomnia. -Resident #3's level of care was Special Care Unit (SCU). Review of Resident #3's Resident Register revealed an admission date of 08/28/23. Review of Resident #3's record on 08/20/24 revealed he was admitted under Hospice services on 07/23/24. Review of Resident #3's physician order dated 07/30/24 revealed: -There was an order for hydrocodone-acetaminophen (used to treat moderate to moderately severe pain) 10mg-325mg every eight hours. -There was an order to start hydrocodone-acetaminophen 10mg-325mg by	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 12	D 392		

mouth every four hours, as needed.

Review of Resident #3's 2024 July electronic medication administration record (eMAR) revealed:
-There was an entry for hydrocodone-acetaminophen 10mg-325mg by mouth every eight hours.
-The hydrocodone-acetaminophen 10mg-325mg every eight hours was documented as administered 4 times from 07/30/24 through 07/31/24.
-There was an entry for hydrocodone-acetaminophen 10mg-325mg by mouth every four hours as needed.
-The hydrocodone-acetaminophen 10mg-325mg every four hours as needed was not documented as being administered.

Review of Resident #3's July 2024 Controlled Substance Control Sheets (CSCS) revealed:
-There was a CSCS with resident's name, hydrocodone-acetaminophen take one tablet by mouth every eight hours with documentation of hydrocodone-acetaminophen 10mg-325mg every eight hours as being administered 3 out of 4 opportunities from 07/30/24 through 07/31/24.
-There were no CSCS available prior to exit with documentation for administration of hydrocodone-acetaminophen 10mg-325mg every four hours as needed was not documented as being administered.

Review of Resident #3's physician orders dated 08/01/24 revealed:
-There was an order to discontinue hydrocodone-acetaminophen 10mg-325mg by mouth every eight hours.
-There was an order to start hydrocodone-acetaminophen 10mg-325mg by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 13	D 392		

mouth every four hours.

Review of Resident #3's physician orders dated 08/02/24 revealed there was an order to discontinue hydrocodone-acetaminophen 10mg-325mg by mouth every four hours, as needed.

Review of Resident #3's August 2024 eMAR revealed:
-There was an entry for hydrocodone-acetaminophen 10mg-325mg by mouth every eight hours.
-Hydrocodone-acetaminophen every eight hours was documented as administered one time on 08/01/24.
-There was an entry for hydrocodone-acetaminophen 10mg-325mg by mouth every four hours.
-Hydrocodone-acetaminophen every four hours was documented as administered 100 times from 08/03/24 through 08/20/24.
-There was an entry for hydrocodone-acetaminophen 10mg-325mg by mouth every four hours as needed.
-Hydrocodone-acetaminophen every four hours as needed was not documented as being administered.

Review of Resident #3's August 2024 Controlled Substance Control Sheets (CSCS) revealed:
-There was a CSCS with resident's name, hydrocodone-acetaminophen take one tablet by mouth every four hours for pain 90 tablets with the first entry on 08/03/24 hydrocodone-acetaminophen one dose administered at 6:30pm leaving a balance of 29 tablets with entries for one dose administered until the balance was zero for the last entry on 08/09/24 at 1:45pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 14 -There was a CSCS with resident's name, hydrocodone-acetaminophen take one tablet by mouth every four hours for pain 90 tablets with the first entry on 08/11/24 hydrocodone-acetaminophen one dose administered at 2:15am leaving a balance of 29 tablets with entries for one dose administered until the balance was zero for the last entry on 08/17/24 at 10:19am -There was a CSCS with resident's name, hydrocodone-acetaminophen take one tablet by mouth every four hours as needed for pain 90 tablets with the first entry on 08/09/24 hydrocodone-acetaminophen one dose administered at 5:50pm leaving a balance of 12 tablets with entries for one dose administered until the balance was zero for the last entry on 08/21/24 at 6:00am. -There was a CSCS with resident's name, hydrocodone-acetaminophen take one tablet by mouth every four hours as needed for pain 90 tablets with the first entry on 08/10/24 hydrocodone-acetaminophen one dose administered at 6:23pm leaving a balance of 28 tablets with entries for one dose administered until the balance was zero for the last entry on 08/21/24 at 6:00am. Telephone interview with a representative with the facility's contracted pharmacy on 08/21/24 at 1:40pm and at 4:08pm revealed: -The pharmacy received an order and dispensed 45 tablets of hydrocodone-acetaminophen 10mg-325mg by mouth every eight hours and on 07/30/24 and received an order to discontinue Resident #3's hydrocodone-acetaminophen 10mg-325mg by mouth every eight hours on 08/01/24. -The facility returned Resident #3's hydrocodone-acetaminophen 10mg-325mg by	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 15	D 392		

mouth every eight hours on 08/01/24.
-The pharmacy received and dispensed 90 tablets of hydrocodone-acetaminophen 10mg-325mg by mouth every four hours on 08/01/24.
-The pharmacy received an order and dispensed 90 tablets of hydrocodone-acetaminophen 10mg-325mg by mouth every four hours as needed on 07/30/24 and received an order to discontinue Resident #3's hydrocodone-acetaminophen 10mg-325mg by mouth every four hours as needed on 08/02/24.
-The facility should have returned Resident #3's discontinued hydrocodone-acetaminophen 10mg-325mg by mouth every four hours as needed or the facility should have relabeled the medication for hydrocodone-acetaminophen 10mg-325mg by mouth every four hours.

Interview with Resident #3's hospice nurse on 08/20/24 at 2:11pm revealed:
-She was responsible for handling Resident #3's hospice plan of care that included orders for hydrocodone-acetaminophen.
-The original order for hydrocodone-acetaminophen 10mg -325mg by mouth started on 07/30/24 and was discontinued on 08/01/24.
-The new order for hydrocodone-acetaminophen 10mg-325mg every 4 hours started on 08/01/24.
-After receiving a call from the pharmacy on 08/02/24, she clarified Resident #3's hydrocodone-acetaminophen 10mg-325mg every four hours, was to be scheduled.
-She expected facility staff to administer medications as ordered.

Interview with the RCD (Resident Care Director) on 08/20/24 at 3:22pm revealed:
-She received physician orders via email or on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049034	A. BUILDING: _____ B. WING _____	08/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADENCE MOORESVILLE	198 E WATERLYNN RD MOORESVILLE, NC 28117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 16 paper. -She approved and faxed orders to the appropriate pharmacy. -She trained medication aides (MA) to review the eMAR and compare it to the medications on the cart before administering. -Discontinued medications should be removed from the medication cart as soon as the discontinued order was received and to return the medication to the pharmacy. -She did not know the MAs were documenting scheduled hydrocodone on the as needed CSCS. -She expected MAs to triple check that their documentation was entered correctly on the CSCS. Interview with the Administrator on 08/22/24 at 3:45pm revealed: -The RCD was responsible for auditing the CSCS. -Discontinued medications should be removed from the cart, documented on CSCS, and returned to the pharmacy. -She did not know MAs were documenting scheduled hydrocodone on the as needed CSCS. -She expected MAs to match the eMAR, CSCS, and controlled substance medication on the cart.	D 392		