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CADENCE HUNTERSVILLE	250 COMMERCE CENTER DRIVE HUNTERSVILLE, NC 28078

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a annual and follow up survey on March 17, 2026 through March 18, 2026.	D 000		
D 079	10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidenced by three oxygen tanks being stored in a free-standing, unsecured manner without stands or storage racks. Review of the facility's Assistance with Oxygen policy dated 06/01/24 revealed oxygen tanks must be secured at all times. Observation of a resident's room located on the second floor hall of the Assisted Living (AL) on	D 079		

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D 079	Continued From page 1 03/17/26 at 10:46am revealed: -The resident's door was closed. -There was no sign on the resident's room door warning that oxygen was in use. -The resident was sitting in a reclining chair in the far corner of the room. -Two personal care assistants (PCAs) entered the room, spoke to the resident and then walked from the room. -There were two unsecured, free-standing, full oxygen tanks sitting inside the resident's room, upright along the wall, approximately two feet to the right of the resident's door to her room. -There were no gauges on them. -There was tape around the valve posts indicating the tank had not been used since filled. -The resident had one oxygen cylinder properly stored in a portable stand just inside the room near the closet doors. Interview with a medication aide (MA) on 03/17/26 at 10:46am revealed: -She was one of the MAs on duty on the AL that day (03/17/26). -Oxygen tanks that were not in use in a portable stand were to be stored in a tank storage rack in the resident's closet. -She did not know why the resident did not have a tank storage rack in her closet. -She did not notice the tanks when she entered the resident's room that morning to administer her medications. Interview with the Resident Care Coordinator (RCC) on 03/18/26 at 2:55pm revealed: -If oxygen tanks were in a resident's room they were to be stored in a tank storage rack or in a wheeled cylinder stand. -Oxygen tanks were not to be left standing unsecured on the floor.	D 079		

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D 079	Continued From page 2 -She was aware the resident had unsecured oxygen tanks in her room. -She forgot to remove them from the resident's room and put them in the tank storage rack in her office. -She was unsure if MAs were trained on proper storage of oxygen tanks. Observation of a second residents room located in the Special Care Unit (SCU) of the facility on 03/17/26 at 3:00 pm revealed: -There was an oxygen sign visible on the door. -There were no residents present in the room. -There was one unsecured, free-standing, oxygen cylinder sitting upright in the closet beside a tank storage rack. -The closet had five other oxygen tanks stored properly in a tank storage rack. Interview with a MA on 03/17/26 at 2:15pm revealed: -She was the MA on duty that shift on the SCU. -She did not know how long the oxygen tank had been stored unsecured. -She had not seen oxygen tanks in the resident's room, unsecured. -She knew the oxygen tanks were to be stored in the closet but was not told how to store the oxygen tanks in the tank rack. Interview with the Special Care Unit Director (SCD) on 03/17/26 at 2:26pm revealed: -Oxygen tanks were to be stored in the tank racks inside the resident's closet. -MAs were trained how to store oxygen tanks through in-services, monthly meetings, and when there was a new oxygen order. -The oxygen tanks were not supposed to be unsecured. -She did not know how long the one oxygen tank	D 079		

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D 079	Continued From page 3 had been freestanding and unsecured. Telephone interview with a representative with the facility's durable medical equipment (DME) provider on 03/18/26 at 1:02pm and 2:35pm revealed: -Oxygen tanks were to be stored in a tank rack or in a tank stand. -If a oxygen tank fell it could become damaged and the oxygen could leak out or it could cause an injury. Interview with Health and Wellness Director (HWD) on 03/18/26 at 3:18pm revealed: -Oxygen tanks were to always be stored in a tank rack or a tank stand. -MAs and PCAs were trained during orientation and during monthly meetings how to properly store oxygen tanks. -The Maintenance Director helped educate staff during safety meetings on proper oxygen tank storage. -She expected staff to notify her, the RCC or a MA if they observed oxygen tanks not stored in a tank rack or tank stand. Interview with the Administrator on 03/18/26 at 3:55pm revealed: -Oxygen tanks were to be stored in tank racks or tank stands. -The HWD, RCC, SCD and MAs were all responsible for ensuring the oxygen tanks were stored properly. -The staff were educated on oxygen storage during new employee orientation. -The PCAs were trained on oxygen storage, but were expected to notify the MA, RCC, or HWD if a tank was not stored properly.	D 079		

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D 283	Continued From page 4	D 283		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure food items being stored and served to residents were labeled and dated and expired foods were disposed of. The findings are: Review of an undated facility policy titled Food Storage Policy revealed- The purpose of this policy is to ensure that all foods served at the (name of corporation) is stored safely and properly to maintain quality, prevent contamination, and comply with federal, state,	D 283		

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and local food safety regulations. Proper food storage protects residents, staff, and visitors while promoting operational efficiency.
-All food must be stored in a clean, safe and organized manner, following the First-in, First-Out (FIFO) principle.
-All foods must be labeled with the item name and date received or prepared.
-Any food items showing signs of spoilage, off-odor, discoloration, or damage must be discarded immediately.

Observation of the commercial refrigerator in the facility's kitchen on 03/17/25 at 9:23am revealed:
-There was a large plastic container which had pepperoni slices labeled "diced" prep date 03/07/26 use by 03/12/26.
-There were four opened gallon containers of salad dressing that was unlabeled and undated.
-There were two 4.5-pound containers of opened maraschino cherries that had ¼ left in the container that were unlabeled and undated.
-There was an opened plastic bag that had a label that was illegible, with dates unreadable of white chopped meat, the bag was tied by the plastic bag and had pink juice at the top of the bag.
-There was a vacuumed sealed bag of thawed meat patties that were red on the bottom and gray greenish on the sides, it was stamped freeze by 11/25/25, and was unlabeled and undated
-There was a second package of beef that was wrapped in saran wrap with a label that had no item name, preparation date was 02/23 and used by 02/25. There was no year listed on the label.

Interview with the cook on 03/17/26 at 9:11am revealed she and the Dietary Manager (DM) were responsible for labeling and dating food items in the refrigerator.

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D 283	Continued From page 6 Interview with the Dietary Manager (DM) on 03/17/26 at 9:30am revealed: -He or the cook were responsible for labeling and dating food items. -He wrote a delivery date on most items with a "D". -He was not aware the salad dressings were not stamped on the bottle by the manufacturer with an expiration date and only had a manufacturer date. -The ground beef was taken out last week and was pushed back on the tray and was overlooked when he went through the refrigerator to check for spoiled foods. -He checked the refrigerator weekly for spoiled foods and would take the blame for the spoiled items not being discarded. A second interview with the DM on 03/18/26 at 11:12am revealed: -He worked from 9:00am to 7:00pm and sometimes 6:30am to 7:00pm and works almost every day so his only cook can also have a day off. -He was aware that all food items should have an open or prepared date and a use by date. -He kept the food item for three days, however other items like deli meats and cheeses can be held up to seven days. Interview with the Administrator on 03/18/26 at 3:55pm revealed: -All food items in the refrigerator should be labeled with the date it was opened or prepared and a use by date. -Prior to food truck delivery, the refrigerator and freezer should be inspected for expired food and removed before adding the newly delivered items.	D 283		

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D 358	Continued From page 7	D 358		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 residents (#7) observed during the medication pass on 03/18/26 between 7:30am and 8:25am including an error for a medication to treat low vitamin D levels. The findings are: The medication error rate was 3.3% as evidenced by one error out of 30 opportunities during the 8:00am medication pass on 03/18/26. Review of Resident #7's FL2 dated 03/13/25 revealed: -Diagnoses included osteoporosis, osteoarthritis and depression. -There was an order for vitamin D3 (a supplement to treat low vitamin D levels) 2000units, one tablet daily. Review of Resident #7's physician's order dated 09/09/25 revealed there was an order for vitamin D3 2000units, one tablet once daily.	D 358		

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D 358	Continued From page 8	D 358		

Observation of the 8:00am medication pass on 03/18/26 at 7:35am revealed:
-The medication aide (MA) pulled a bottle of vitamin D3 1000units from the drawer of the medication cart.
-The bottle was an over the counter (OTC) bottle and the resident's last name was written on the label of the bottle.
-The MA held the bottle up to the electronic medication administration record (eMAR) on the computer screen and compared the label with the order.
-The MA poured one capsule of vitamin D3 1000units into the lid of the medication bottle and proceeded to pour the capsule into a medication cup containing seven other medications for Resident #7.
-The MA administered the medications to Resident #7.

Review of Resident #7's March eMAR revealed:
-There was an entry for vitamin D3 2000units, one capsule daily at 8:00am.
-There was documentation vitamin D3 2000units was administered to Resident #7 from 03/01/26 through 03/18/26.

Interview with the MA on 03/18/26 at 10:36am revealed:
-She was trained to compare medication labels with the order in the eMAR system before administering resident medications.
-Resident #7's vitamin D3 was an OTC medication and did not have a pharmacy label.
-She compared the label of Resident #7's vitamin D3 with the order in the eMAR system but missed the dosages did not match.

Telephone interview with a representative with

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D 358	Continued From page 9 Resident #7's pharmacy on 03/18/26 at 1:27pm revealed: -Resident #7 and her family frequently purchased her medications through that pharmacy. -They did not have an order for Resident #7's vitamin D3 2000units, one tablet daily. -Vitamin D3 was an OTC medication and did not require a prescription. -If Resident #7 did not receive vitamin D3 as ordered, she could experience depression, bone pain and possible bone fractures. Interview with the Resident Care Coordinator (RCC) on 03/18/26 at 2:55pm revealed: -MAs were trained to compare the medication label with the order in the eMAR three times before administering a medication. -Resident #7's family provided her medications to the facility for administration. -Resident #7's vitamin D3 was an OTC medication and did not have a administration label specific to Resident #7's physician's order. -MAs were to inform her or the Health and Wellness Director (HWD) if a medication dosage did not match the dosage on the resident's eMAR. Interview with the HWD on 03/18/26 at 3:18pm revealed: -The MAs were responsible to administer medications according to the orders on the eMAR. -The MAs were responsible to notify her if a medication dosage or order did not match the order on the eMAR. -The RCC and lead MAs were responsible to do weekly medication audits of all residents to ensure the medication on the cart matched the order on the resident's eMAR. -She and the RCC were responsible for monthly	D 358		

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D 358	Continued From page 10 medication cart audits when the monthly cycle fill medications arrived from the pharmacy. Interview with the Administrator on 03/18/26 at 3:55pm revealed: -The MAs were responsible to verify the medication order and dosage on the medication label matched the order on the resident's eMAR when administering medications. -The MAs were responsible to notify the RCC or HWD if a resident's medication in the cart did not match the order in the resident's eMAR. -The Registered Nurse (RN) performed a medication administration skills check off on all MAs upon hire. -All MAs were shadowed by the RCC or a lead MA on each medication cart and observed passing medications from each cart before administering medications independently.	D 358		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure that medications were stored safely and securely for 1	D 378		

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D 378	Continued From page 11 of 1 resident (#8) who had a cough suppressant medication sitting on a stand next to her chair. The findings are: Review of the facility's Medication Services policy dated 12/05/25 revealed all medications for residents who receive assistance with their medications will be stored in a designated medication storage area. Review of Resident #8's current FL2 dated 02/20/26 revealed diagnoses included depression. Observation of Resident #8's room on 03/18/26 at 7:48am revealed: -Resident #8 was sitting in a chair in her room. -There was a bottle of Robitussin Nighttime Cough soft chews on the table next to her chair. -A medication aide (MA) and the Resident Care Coordinator (RCC) entered and exited Resident #8's room but did not appear to notice the medication bottle on the stand. Interview with the MA on 03/18/26 at 7:50am revealed she did not notice Resident #8 had a medication bottle on the stand next to her chair. Interview with the RCC on 03/18/26 at 7:50am revealed: -She did not see the medication bottle on the stand in Resident #8's room. -Resident #8 did not have a self-administration order for Robitussin soft chews. -She retrieved the medication bottle from Resident #8's room and explained to the resident that all medications must be stored in the medication cart.	D 378		

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D 378	Continued From page 12 Interviews with the RCC on 03/18/26 at 2:17pm and 2:55pm revealed: -Resident #8's Robitussin soft chews had 18 chews remaining of the 20 chews in a full bottle. -Residents were not permitted to keep medications in their rooms unless they had an order for self-administration. -If a staff member saw medications in a resident's room they were to notify the Health and Wellness Director (HWD) or the RCC. -She did not know if there were routine room observations of resident rooms looking for medications. -She was unsure if family members were educated on the process for bringing medications into the building. Interview with the HWD on 03/18/26 at 3:18pm revealed: -Residents were not allowed to have medications in their rooms without an physician's order. -With the ease of ordering/delivering over the counter (OTC) medications, family members did not always contact the facility when a resident asked a family member for an OTC medications, choosing to have the medication just sent to the resident at the facility. -All staff were responsible to observe for medications in resident rooms and report any medications found to her. Interview with the Administrator on 03/18/26 at 3:55am revealed: -Medications were not to be stored in resident rooms without a self-administration order and an order on the electronic medication administration record (eMAR). -Sometimes residents or family members did not understand medications could not be in resident rooms, even OTC medications.	D 378		

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D 378	Continued From page 13 -All staff were trained during staff meetings of items not allowed to be in resident rooms, including medications. -If a staff member observed medications in a resident's room, they were to notify any member of the management staff. -There were no routine room observations for medications in resident rooms, but all staff should be observing for medications when in resident rooms.	D 378		