STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 08/01/2019

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CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

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E 000	Initial Comments An unannounced Recertification survey was conducted on 07/29/19 through 08/01/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #W5VE11..	E 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		8/29/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/22/2019

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F 585	Continued From page 1	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

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F 585	Continued From page 2 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a grievance investigation and resolution was provided in writing to 1 of 1 residents/family member reviewed for grievances. (Resident #64) The findings included: Resident #64 was originally admitted to the facility on 6/21/19 with diagnoses including Dementia, Atrial Fibrillation, Cerebrovascular Accident, Epileptic Syndrome, Osteoarthritis and Difficulty Walking. According to the most recent Annual Minimum Data Set dated 6/28/19, Resident #64's cognition was impaired. He required limited	F 585	F 585 Grievances 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #64 is no longer a resident at this facility as of July 13, 2019 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The IDT team have completed interviews with current residents and/or resident representative to identify any grievances	

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F 585	Continued From page 3 assistance with most areas of activities of daily living, except he required extensive assistance with dressing and supervision for eating and bathing. During an interview on 7/31/19 at 8:12 AM, NA#1 revealed Resident #64's family member was concerned that the nurses took too long giving Resident #64's medication. During an interview on 7/31/19 at 9:12 AM, Nurse #1 revealed Resident #64's family member was concerned about his falls and his medication not being on time. During an interview on 7/31/19 at 4:09 PM, the facility Social Worker stated she could not recall Resident #64 or his family voicing any concerns about resident care. She stated a couple of meetings were held with Resident #64's family, but she still could not recall any complaints that were voiced. Review of facility grievances from 5/3/19 through 7/25/19 revealed there were no complaints filed regarding Resident #64's care. During an interview on 7/31/19 at 4:15 PM, the Director of Nursing (DON) revealed she talked to Resident #64's family member for over an hour when he was ready to be discharged about his medication and his bed linen being soiled. The DON said grievances were followed up on during morning meetings. She revealed if a family member had a complaint, it needed to be taken care of. She stated the grievance would go to the department that could resolve it and staff were educated. The DON revealed in order for the	F 585	that need follow up by the facility. This was completed on 8/20/19 and any identified grievances have been investigated, resolved and written notification sent to the resident and RR as of 8/29/19. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Any employee of the facility can obtain or assist resident or resident representative in completing a grievance form. At the time a grievance is obtained by a staff member, it will be given to facility Social Services Director or Facility Administrator for recording. The Social Services Director will then distribute the grievance form to the appropriate departments for resolution. Once resolved, the department head will return the grievance form back to the Director of Social Services, who will then notify the originator of the grievance of the resolution. Facility Staff Development Coordinator and/or Social Services Director have completed re-training of current facility staff to ensure they understand regulation F585, including timeliness of receiving resident/resident representative grievance, reporting, and resolution. This re-training will be completed by 8/29/19. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Facility Administrator will complete a	

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F 585	Continued From page 4 written grievance to be resolved, the grievance would be discussed with the family member and signed by them or she would talk with the family member by phone. She stated the resolution would be written and mailed to the family member by the Social Worker. The DON stated Resident #64's grievance required a lot of education of staff. She stated she considered her talk with Resident #64's family member a grievance and she thought she had written up something, but she said she also thought she had resolved the issue since Resident #64 was not coming back to the facility. The DON revealed she always taught staff to make sure that grievances were in writing. She stated her expectation was for the grievance to be written on paper and the Social Worker would make a copy of it and send a letter to the family member.	F 585	review of the facility grievances & logs weekly for 4 weeks, then monthly for 12 months to ensure timely completion. A summary of monitoring efforts will be completed by the facility administrator and/or Social Services Director and presented to the facility QAPI meeting monthly.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set assessment accurately for 1 of 17 residents (Resident #3) reviewed for assessments. The findings included: Resident #3 was admitted to the facility on 6/12/2015 with diagnoses to include atrial fibrillation, congestive heart failure and hypertension.	F 641	F-641 Accuracy of Assessments 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3's MDS assessment and Medical Record was reassessed by the MDS Coordinator on 7/16/19. MDS for resident #3 has been updated to include use of anticoagulant medication during the look back period per RAI (Resident Assessment Interview) guidelines and	8/29/19

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F 641	Continued From page 5 A review of Resident #3's Medication Administration Record (MAR) for July 2019 revealed Coumadin (an anticoagulant was administered daily from 7/1/2019 thru 7/30/2019. Resident #3's quarterly Minimum Data Set (MDS) assessment dated 7/16/2019 revealed his cognition was severely impaired, and he received extensive assist from staff for activities of daily living. He was not coded on the MDS as receiving anticoagulants during the 7 day look back period. On 7/31/2019 at 10:48 AM, an interview was conducted with the MDS nurse, who stated Resident #3 had received an anticoagulant daily during the month of July. The MDS nurse stated the anticoagulant should have been coded on the MDS assessment and she would modify the assessment. On 8/1/2019 at 10:11 AM, an interview was conducted with the Administrator who stated he expected the MDS assessments to be coded accurately.	F 641	submitted 7/24/2019. 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An MDS audit was conducted utilizing an MDS Audit Tool on 8/17/2019 by the MDS Coordinator and Regional MDS Consultant. The tool was used to review section for these identified residents for use of anticoagulants to ensure accuracy. All residents were found to have current accurate information. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: In-services of completing the MDS including Section of N of the MDS, was immediately provided on 7/31/19 for the MDS Nurses by the Regional MDS consultant. An MDS Audit Tool was created to monitor accuracy of coding, including Anticoagulant medication (Section N) of the MDS. This audit tool will be utilized by the IDT team, M-F at the morning team meeting to complete a random review of an MDS assessment. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: MDS Coordinator will perform random audits of 5 MDS assessments weekly for 3 months then quarterly for 12 months to ensure continued compliance. MDS Coordinator will complete a summary of audit results and present at facility	

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F 641	Continued From page 6	F 641	Monthly Quality Assurance Performance Improvement meeting.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to recommend a Level 2 Pre-Admission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident #16) reviewed for PASRR. The findings included: A review of Resident #16 Pre-Admission Screening and Resident Review (PASRR) dated 11/24/2014 revealed she received a level 1 category.	F 644	F-644 Coordination of PASARR and Assessments 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #16 was referred for Preadmission Screening and Resident Review (PASARR) on 8/19/19 by Director of Social Services. 2) Address how the facility will identify	8/29/19

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F 644	Continued From page 7 Resident #16 was admitted to the facility on 1/20/2015 with diagnoses to include stroke and psychosis. On 8/14/2018 an additional diagnosis was entered as paranoid schizophrenia. Resident #16's annual Minimum Data Set (MDS) assessment dated 12/5/2018 revealed her cognition to be moderately impaired and she required extensive assistance from staff for activities of daily living. Her diagnoses included schizophrenia and her PASRR was coded as a level 1. Resident #16's care plan, last revised on 4/11/2019 revealed psychotropic medication use related to the diagnoses of dementia, psychosis, and paranoid schizophrenia. On 7/31/2019 at 10:43 AM, an interview was conducted with the MDS nurse who stated she had started her employment at the facility within the last 3 months. The MDS nurse stated the process of adding diagnoses to existing residents' assessments included notifying the Social Worker (SW) so a determination could be made if a rescreening to the PASRR level was needed. The MDS nurse did not know if that process had been followed prior to her employment when Resident #16's new diagnoses was added. On 7/31/2019 at 10:22 AM, an interview was conducted with the SW who stated she had started her employment at the facility in 11/2018. The SW reviewed online records and stated Resident #16's only PASRR was dated for 2014 and another PASRR had not been applied for. The SW stated if she had been employed at the facility when Resident #16's additional diagnosis	F 644	other residents having the potential to be affected by the same deficient practice: The Director of Nursing and/or Administrative nurses have completed an audit of current resident diagnosis, including pharmacy recommendations and psychological consultations to identify any resident with a new, severe mental illness diagnosis. Any resident identified with new diagnosis of severe mental illness will then have PASAAR audit completed by Director of Social Services to ensure that referral for PASAAR Level II has been completed. Any resident identified as not having been referred for PASAAR Level II as required will be referred as of 8/29/19. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: New diagnosis of mental illness will be reviewed by the Interdisciplinary Team as a part of the Clinical meeting and determination made as to need for referral for PASAAR Level II. If need for referral for PASAAR Level II is identified; Director of Social Services will complete the referral. Interdisciplinary team will receive training and education for PASAAR Level II referral for new diagnosis of severe mental illness. Regional Director of Clinical Services will provide education to DON and UM by 8/29/19, who will then provide education and training to the Interdisciplinary team. 4) Indicate how the facility plans to	

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F 644	Continued From page 8 of paranoid schizophrenia came through; the diagnosis would have triggered for her to submit for another PASRR screening. On 8/1/2019 at 10:09 AM, an interview was conducted with the Administrator, who stated he was new to the facility. The Administrator stated he would have expected Resident #16 to be submitted for an additional PASRR screening when her 8/2018 diagnosis of paranoid schizophrenia was added to her record.	F 644	monitor its performance to make sure that solutions are sustained: An audit of new diagnosis of severe mental illness will be completed weekly for four weeks and then monthly to ensure that referral for Preadmission Screening and Resident Review (PASAAR) have been completed, by Director of Nursing Services and/or Administrative Nurses Social Services Director will complete a summary of monitoring results and present to the monthly Quality Assurance and Performance Improvement (QAPI) meeting for review. Any issues identified will be addressed by the QAPI committee and the	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		8/29/19

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F 657	Continued From page 9 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to update a resident ' s care plan upon re-admission to the facility with orders for continuous oxygen for 1 of 1 resident reviewed for oxygen therapy (Resident #4). The findings included: Resident #4 was admitted to the facility on 8/8/17 and had a diagnosis of cerebrovascular accident (stroke) and atherosclerotic heart disease. Review of the Care Plan for Resident #4 revealed an entry dated 3/26/19 that noted the resident had a potential for difficulty breathing due to a history of respiratory failure and to monitor for signs and symptoms of difficulty breathing. There was no information on the care plan the resident received oxygen therapy. The most recent Minimum Data Set (MDS) assessment dated 4/26/19 revealed the resident was cognitively intact and required extensive to total assistance with all activities of daily living. The MDS revealed the resident received oxygen therapy. Review of the medical record revealed Resident #4 was re-admitted to the facility from the hospital on 5/23/19. There was a current physician ' s order dated 5/23/19 for oxygen therapy 3 liters	F 657	F-657 Care Plan Timing and Revision 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #4's care plan was reviewed and updated to include orders for continuous oxygen by the MDS Nurse on 7/31/19 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit has been completed by the IDT of resident care plan to ensure residents with orders for oxygen have a care plan in place. This audit was completed by MDS Coordinator on 7/31/19 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS Coordinator will perform random audits of 5 resident Care Plans monthly to ensure that care plans have been updated per RAI guidelines. Regional Reimbursement Specialist completed training with MDS Coordinators & IDT on 7/31/19 related to care planning	

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F 657	Continued From page 10 per minute continuously. On 7/29/19 at 3:30 PM Resident #4 was observed lying in bed and was receiving nasal oxygen at 3 liters per minute. On 7/31/19 at 3:50 PM an interview was conducted with MDS Nurse #1 and the facility ' s Corporate MDS Consultant. The MDS Nurse was observed to review the resident ' s Care Plan and stated there was not a care plan for oxygen therapy. The MDS Nurse stated when a resident returned from the hospital, the Care Plan should be updated as soon as possible, for example if the resident was re-admitted on the weekend the Care Plan should be updated either on Monday or Tuesday. The MDS Consultant stated the Care Plan was not updated and was missed. The MDS Nurse could not explain why the Care Plan was not updated to reflect the oxygen therapy. On 7/31/19 at 4:51 PM an interview was conducted with the Staff Development Coordinator (SDC) who was also the interim Director of Nursing (DON). The SDC/DON stated the resident was re-admitted and was probably why it was missed on the Care Plan but she would expect oxygen to be included in the resident ' s Care Plan.	F 657	process, including timing and revision of care plans. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained MDS Coordinator and Regional Reimbursement Specialist will be completing random audits on 5 resident care plans monthly for 3 months, then quarterly. The MDS Coordinator and Administrator will complete a summary of monitoring efforts and present at the monthly QAPI meeting to ensure continued compliance.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		8/29/19

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F 690	Continued From page 11 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to secure an indwelling urinary catheter to prevent accidental pulling or dislodgement of the catheter for 1 of 1 resident reviewed for a urinary catheter (Resident #2). The findings included: The facility policy titled Catheter Care, Urinary, revised in September 2014 under the section	F 690	F-690 Bowel/Bladder Incontinence, Catheter, UTI 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #2's urinary catheter was immediately secured with an anchoring device by the Director of Nursing on	

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F 690	Continued From page 12 Changing Catheters read: "2. Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. (Note: Catheter tubing should be strapped to the resident ' s inner thigh.)" Resident #2 was admitted to the facility on 10/31/18 and had a diagnosis of cognitive communication deficit and neurogenic bladder. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 4/26/19 revealed the resident had moderate cognitive impairment, required total assistance with toileting and had an indwelling urinary catheter. The Care Plan for Resident #2 initiated on 12/5/18 and updated on 6/1/19 noted the resident had an indwelling urinary catheter related to neurogenic bladder and a history of urinary retention. The approaches for care included the following: Catheter care every shift. Change catheter and bag every 4 weeks and as needed. Irrigate catheter with 20 ccs (cubic centimeters) of normal saline every shift. Monitor output every shift. On 7/31/19 at 10:20 AM Resident #2 was observed to receive catheter care. The urinary catheter was not secured and was lying across the resident ' s thigh with the urine drainage bag hanging on the frame of the bed. On 7/31/19 at 11:45 AM, an interview was conducted with Nurse #1 who was assigned to Resident #2. Nurse #1 was questioned about the resident not having a urinary catheter strap. Nurse #1 stated she did not think she had ever seen a catheter strap used in the facility.	F 690	7/31/19 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The Director of Nursing and administrative nurses completed a visual audit of all residents with a catheter to ensure that an anchoring device was in place on 7/31/19 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Staff Development Coordinator completed training with the nursing staff on 8/26/19 regarding the importance of having an anchoring device in place with any resident with a urinary catheter. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The DON and/or administrative nurses will complete a visual audit of each resident with a urinary catheter 3 times weekly for 12 weeks, then quarterly for 2 quarters to ensure an anchoring device is in place. The DON will complete a summary of monitoring efforts and present at the monthly QAPI meeting to ensure continued compliance.	

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F 690	Continued From page 13 On 7/31/19 at 1:11 PM an interview was conducted with Unit Manager #1. The Unit Manager stated she was not aware of the staff using a catheter strap to secure an indwelling urinary catheter and stated Resident #2 did not have a catheter strap. On 7/31/19 at 4:57 PM an interview was conducted with the Staff Development Coordinator (SDC) who was also the interim Director of Nursing (DON). The SDC/DON stated the 2 nurses interviewed had only worked at the facility for a few months and there were only 2 residents in the facility with an indwelling urinary catheter. The SDC/DON stated the resident should have the catheter secured and was the policy of the facility that urinary catheters be secured. On 8/1/19 at 9:58 AM the SDC/DON was re-interviewed. The SDC/DON stated she covered urinary catheters in orientation for new employees but did not go over the need to secure the urinary catheters. The SDC/DON further stated they stocked a device in the facility to secure urinary catheters. The SDC/DON continued and stated she had started educating the staff on using the device to secure indwelling urinary catheters.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		8/29/19

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F 695	Continued From page 14 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to apply a humidification bottle to the oxygen concentrator to provide humidified oxygen for 1 of 1 resident reviewed for oxygen therapy (Resident #4). The findings included: The facility ' s policy titled Oxygen Administration Revised on October 2010 noted the purpose of the procedure was to provide guidelines for safe oxygen administration. The section, Steps in the Procedure, number 12 read: "Be sure there is water in the humidifying jar and that the water level is high enough that the water bubbles as oxygen flows through. 14. Periodically re-check water level in the humidifying jar." Resident #4 was originally admitted to the facility on 8/8/17 and had a diagnosis of cerebrovascular accident (stroke), diabetes and chronic kidney disease. The resident ' s Care Plan dated 3/26/18 noted the potential for difficulty breathing due to a history of respiratory failure. Monitor for signs and symptoms of respiratory difficulty. A Quarterly Minimum Data Set (MDS) Assessment dated 4/26/19 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living. The MDS noted the resident received oxygen therapy.	F 695	F-695 Respiratory/Tracheostomy Care and Suctioning 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The Director of Nursing applied a humidifier to the O2 concentrator for resident #4 on 7/31/19 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: An audit was completed by 7/31/19 to identify residents with O2 orders that included humidifier. If so, the resident was visually checked to see if the humidifier was in use. All residents are currently receiving O2 in accordance with physicians' orders. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: Residents with O2 concentrators will also have humidifiers in place. Per physicians' order. The facility Staff Development Coordinator completed training with nursing staff have received training related, F 695 including the use of humidifiers on 8/26/19.	

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F 695	Continued From page 15 Review of the clinical record revealed Resident #4 was re-admitted to the facility on 5/23/19 after a hospital stay. There were physician ' s orders dated 5/23/19 for oxygen at 3 liters per minute continuously and to change oxygen/nebulizer tubing/humidifier bottle every week. On 7/29/19 at 3:00 PM Resident #4 was observed lying in bed and oxygen was being administered via nasal cannula at 3 liters per minute. There was not a humidifying bottle attached to the oxygen concentrator to humidify the oxygen being administered to the resident. On 7/31/19 at 3:00 PM Resident #4 was observed lying in bed and oxygen was being administered via nasal cannula. There was not a humidifying bottle attached to the oxygen concentrator to humidify the oxygen being administered to the resident. On 7/31/19 at 3:15 an interview was conducted with Nurse #1 who was assigned to Resident #4. Nurse #1 stated Nursing Assistant (NA) #1 was the one who changed the humidifier and oxygen tubing every Wednesday. The Nurse stated there should be a humidification bottle on the oxygen concentrator and would put one on. On 7/31/19 at 3:17 PM an interview was conducted with NA #1. The NA stated she changed Resident #4 ' s oxygen tubing today but did not know why the resident did not have a humidification bottle on the oxygen concentrator but she would check. On 7/31/19 at 3:32 PM NA #1 stated before Resident #4 returned from the hospital he did not have a humidification bottle and when he	F 695	4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The DON and/or administrative nurses will visually inspect all resident receiving O2 for 3 x/week for 12 weeks, then quarterly for 2 quarters to ensure appropriate humidification of O2 DON will complete a summary of monitoring results and present at the facility monthly QAPI meeting.	

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F 695	Continued From page 16 returned there was a new order for the humidification bottle. The NA further stated she did not have access to the physician ' s orders and it was not communicated to her the resident should have a humidification bottle on the oxygen concentrator. On 7/31/19 at 4:51 PM an interview was conducted with the Staff Development Coordinator (SDC) who was also the acting Director of Nursing (DON). The SDC/DON stated if there was an order for the resident to have humidification then it should have been there.	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F 761		8/29/19

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F 761	Continued From page 17 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to maintain the temperature for 1 of 2 medication refrigerators reviewed (the Bottom medication refrigerator in the main medication room). The findings included: On 7/31/2019 at 3:29 PM, the medication refrigerators were reviewed with Nurse #1. The bottom medication refrigerator was observed not completely closed and with a temperature of 70 degrees Fahrenheit (F). Nurse #1 stated the temperature was not right and consulted with Unit Manager #1 immediately following the observation. On 7/31/2019 at 3:31 PM, an interview was conducted with Unit Manager #1 who stated the refrigerator should be in the range of 36 to 46 degrees F, as 70 degrees F was too hot, and the refrigerator was too full. The Unit Manager stated there were too many bags in the way and they were not letting the air circulate in the refrigerator. The Unit Manager stated she would have to look at the facility policy to see what to do about the medications in the refrigerator. Medications in the Bottom refrigerator included: 2- box of Avonex pens. The medication packaging indicated to store between 36-46 degrees F. 1-box Acetaminophen suppositories 650	F 761	F-761 Label/Store Drugs and Biologicals 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No residents were named related to this deficient practice 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All potential residents had a potential to be affected by this deficient practice The medication refrigerator in question was immediately corrected and the temperature came back into range within a short period of time. Pharmacy was contacted regarding medications stored in this refrigerator for replacement/destruction. 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: To ensure that facility refrigerators maintain the appropriate temperatures, temperatures in the medication refrigerators will be checked twice a day by the charge nurses and temperature and their initials will be placed on the temperature log. Instructions will be included on the temperature logs, which	

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F 761	Continued From page 18 milligrams (mg). The medication packaging indicated to store between 59-86 degrees F. 13-individual Acetaminophen suppositories 650 mg in plastic bag with no directions for storage. 4-normal saline (NS) bags 250 milliliters (ml) with Vancomycin 1.75 grams (gm) with label attached to bag to refrigerate. 5-NS bags 500 ml with Vancomycin 1.75 gms with label attached to bag to refrigerate. 1-opened bottle Omeprazole oral suspension 150 ml with label to refrigerate. 1-humalog insulin vial 10 ml with label to refrigerate. 1-emergency drug box with label to refrigerate that contained: 1-lantus insulin, 1-levemir insulin flex pen, 1- 3 ml Humulin N insulin, 1- 3 ml Humulin R insulin, 1-novolog flex pen, 1-novolog mix 70/30 flex pen, 3- Phenergan suppository 25mg, 2-ativan 1ml vial. 1 Procrit opened vial, and 1 Procrit unopened vial with label to refrigerate-do not freeze 3-boxes with 10 vials each, 1 box with 6 vials Octreotide Acetated 1 ml. The medication packaging indicated to store at 36-46 degrees F. 4-glargine insulin pens unopened with label to keep in refrigerator do not freeze, refrigerate until opened. 5-tresiba flex insulin pens unopened with label to refrigerate. 5-novalog flex pen insulin unopened with label to refrigerate. 1-lantus Solostar insulin pen unopened with label to refrigerate. 4-humalog kwick pen insulin unopened with label to refrigerate. 2-levemir flex touch insulin pen with label to refrigerate. A review of the July 2019 Medication Refrigerator	F 761	will include the out of temperature range and to report immediately to the facility DON, Administrator and Maintenance Director for interventions. The temperature log will be visible on each refrigerator. The Licensed staff was educated by the Staff Development Coordinator by 8/29/19, regarding the monitoring of medication refrigerators temperatures, as well as, the distribution of IV bags within the refrigerator to allow for proper air flow to maintain refrigerator temperatures. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained The Director of Nursing (DON) or designee will check the temperature log 2X/week for 12 weeks, then weekly for 2 quarters to ensure that temperatures are being recorded and are within proper range. The results of the audits will be presented at the QAPI committee meetings for review and further recommendations for a minimum period of 3 months.	

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F 761	Continued From page 19 Temperature Log, labeled as Bottom, revealed the temperature on 7/30-31/2019 11:00 PM to 7:00 AM shift was 46 degrees F. On 7/31/2019 at 4:08 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the refrigerator was checked daily, but 70 degrees F was too warm. The DON stated she expected the temperature to be maintained at 36-46 degrees F by checking the refrigerator every shift. On 8/1/2019 at 10:13 AM, an interview was conducted with the Administrator who stated the delivery of medications on 7/31/2019 was approximately 7:30 AM and they were put in the bottom refrigerator at that time. The Administrator stated he expected the medication refrigerator to be checked by staff to maintain the proper temperature.	F 761		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population,	F 838		8/29/19

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F 838	Continued From page 20	F 838		

including, but not limited to,
(i) Both the number of residents and the facility's resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing

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F 838	Continued From page 21 information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to review and annually update the Facility assessment. The Findings included: A review of the facility assessment revealed it was last updated on 11/28/17 and failed to document the current Administrator and Director of Nursing. In an interview with the Administrator on 8/1/19 at 10:29 AM he stated the ownership of the building had changed on June 1, 20019 and he did not have an updated Facility assessment. He stated he looked at the plan, noted it was reviewed on 11/28/17 and he thought that was all that he needed.	F 838	F-838 Facility Assessment 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident was identified as being affected by this alleged deficient practice. 2) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All residents have the potential to be affected 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Facility Administrator and IDT team have met on 8/7/2019, to review the current facility assessment. Review and revision of the current facility assessment was approved by the QAPI Team on 8/29/19. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Facility Administrator and IDT team will incorporate the current facility assessment in the facility Quarterly QAPI	

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F 838	Continued From page 22	F 838	review to ensure this document is current and updated as needed. On 8/7/19, the Facility Assessment was reviewed by appropriate staff and deemed to be complete. The Facility Assessment will be reviewed annually and updated as needed going forward.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place. This failure was related to noncompliance at the regulatory grouping 483.21 on two consecutive annual recertification surveys. A deficiency at the regulatory grouping 483.21 was originally cited during the facility's 8/3/18 annual recertification survey and was recited on the current annual recertification survey dated 8/1/19. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag was cross referenced to the regulatory grouping 483.21 (F657).	F 867	F-867 QAPI/QAA Improvement Activities 1) Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No resident was identified affected by this alleged deficient practice 2) Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected 3) Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 8/15/19, Regional Director of Clinical Services, completed training members of	8/29/19

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CITADEL ELIZABETH CITY LLC	901 SOUTH HALSTEAD BOULEVARD ELIZABETH CITY, NC 27909

(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) COMPLETION DATE
F 867	Continued From page 23 F657 Based on observation, record review and staff interview the facility failed to update a resident's care plan upon re-admission to the facility with orders for continuous oxygen for 1 of 1 resident reviewed for oxygen therapy (Resident #4). The findings included: Resident #4 was admitted to the facility on 8/8/17 and had a diagnosis of cerebrovascular accident (stroke) and atherosclerotic heart disease. Review of the Care Plan for Resident #4 revealed an entry dated 3/26/19 that noted the resident had a potential for difficulty breathing due to a history of respiratory failure and to monitor for signs and symptoms of difficulty breathing. There was no information on the care plan the resident received oxygen therapy. The most recent Minimum Data Set (MDS) assessment dated 4/26/19 revealed the resident was cognitively intact and required extensive to total assistance with all activities of daily living. The MDS revealed the resident received oxygen therapy. Review of the medical record revealed Resident #4 was re-admitted to the facility from the hospital on 5/23/19. There was a current physician's order dated 5/23/19 for oxygen therapy 3 liters per minute continuously. On 7/29/19 at 3:30 PM Resident #4 was observed lying in bed and was receiving nasal oxygen at 3 liters per minute. On 7/31/19 at 3:50 PM an interview was conducted with MDS Nurse #1 and the facility's	F 867	the Quality Assurance Performance Improvement Committee Education about the purpose of the QA Committee, including development, modification and monitoring of QAPI plans. Administrator will review approaches to monitoring performance and outcomes and provide a summary of all monitoring efforts and present at the facility monthly QAPI committee. 4) Indicate how the facility plans to monitor its performance to make sure that solutions are sustained Administrator and QAPI Team Members will complete a summary of current QAPI plans, including implementation of plans & monitoring all performance of each plan. This will be completed weekly at their AM Team Meeting weekly for 3 months, then, quarterly for 4 quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345184	A. BUILDING _____ B. WING _____	C 08/01/2019

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F 867	Continued From page 24 Corporate MDS Consultant. The MDS Nurse was observed to review the resident's Care Plan and stated there was not a care plan for oxygen therapy. The MDS Nurse stated when a resident returned from the hospital, the Care Plan should be updated as soon as possible, for example if the resident was re-admitted on the weekend the Care Plan should be updated either on Monday or Tuesday. The MDS Consultant stated the Care Plan was not updated and was missed. The MDS Nurse and the Consultant could not explain why the Care Plan was not updated to reflect the oxygen therapy. On 7/31/19 at 4:51 PM an interview was conducted with the Staff Development Coordinator (SDC) who was also the interim Director of Nursing (DON). The SDC/DON stated the resident was re-admitted and was probably why it was missed on the Care Plan but she would expect oxygen to be included in the resident's Care Plan.	F 867		