STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 02/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow an order to obtain a blood pressure reading prior to administration of an antihypertensive medication for 1 of 4 sampled residents (Resident #2). The findings included: Resident #2 was readmitted to the facility on 8/1/19 with medical diagnoses inclusive of unspecified dementia with behavioral disturbance, chronic obstructive pulmonary disease, and hypertension. Resident #2's last quarterly Minimum Data Set (MDS) dated 1/27/2020 revealed he had mildly impaired cognition. Section E - Behavior: did not identify rejection of care. A review of Resident #2's orders revealed Cozaar (antihypertensive) 100mg (milligrams) by mouth one time a day, check BP (blood pressure) prior to administration with a start date of 8/3/19. A review of Resident #2's medication administration record (MAR), vital signs and	F 684		

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

Electronically Signed

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nursing progress notes revealed documentation that resident had last refused Cozaar 100mg by mouth on February 6, 7, 12, 13, 14, and 15, 2020. Documentation of Resident #2 refusing vital signs was last recorded on February 15, 2020. Last recorded blood pressure for Resident #2 was November 22, 2019.

An observation on 2/18/2020 at 8:41 AM, Nurse #1 approached Resident #2 to inquire if he wanted to take his medications at that time and he agreed. Nurse #1 administered Cozaar 100mg along with another antihypertensive and a narcotic. Nurse #1 did not attempt to take Resident #2's blood pressure prior to administration of Cozaar 100mg.

An interview was conducted on 2/19/2020 at 12:30 PM with Nurse #1. During the interview, she reported Resident #2 had a history of refusing to have his blood pressure taken by nursing staff and it was her understanding the doctor had discontinued the order to check Resident #2's blood pressure before administration of Cozaar. Nurse #1 stated she should have followed the order and requested from Resident #2 that she obtain a blood pressure reading prior to the administration of Cozaar.

The Director of Nursing (DON) was interviewed on 2/19/2020 at 12:22 PM. The DON identified the process for obtaining a blood pressure reading by either the nurse aide assigned to the resident and the nurse confirming the blood pressure reading with the nurse aide or the nurse to take the resident's blood pressure prior to administration of medication as ordered by the provider. The DON stated Nurse #1 was

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F 684	Continued From page 2 expected to follow the order by attempting to take or confirming with the nurse aide an attempt had been made to take Resident #2's blood pressure prior to administration of Cozaar. On 2/19/19 at 4:18 PM, a phone interview was conducted with the Nurse Practitioner (NP). The NP stated the nurse administering medications to Resident #2 should have followed the order to take his blood pressure before administration of Cozaar.	F 684		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a resident interview and staff interviews, the facility failed to complete a resident request for a transfer to a skilled nursing facility for 1 of 3 sampled residents reviewed for admissions, transfers and discharges (Resident #1). The findings included: Resident #1 was originally admitted to the facility 2/4/12 and readmitted 2/8/20. A Minimum Data Set assessment dated 1/16/20 assessed his speech as clear, able to understand and be understood, adequate hearing, moderately impaired vision, intact cognition, required supervision to limited assistance with activities of daily living, able to ambulate without	F 745		

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mobility devices and no current discharge plans.

Resident #1's care plan, revised 1/22/20 indicated that he was a long-term care resident due to personal care needs. Interventions included staff to assist with care needs.

On 2/18/20 Resident #1 was interviewed at 8:30 AM. During the interview he stated that he spoke to the Social Worker (SW) several times requesting a transfer to a skilled nursing facility (SNF) (facility #2) to be closer to his family. He further stated that he had not received any follow up regarding this request, but that he missed being closer to his family, especially his mother. He stated the last time he spoke to the SW regarding this request was over a month ago and then stated, "I want to be with my family and my mother."

The SW was interviewed on 2/19/20 at 4:35 PM. During the interview, the SW stated that towards the end of 2019 Resident #1 requested a transfer to facility #2 that was closer to home. The SW further stated that she completed the paperwork for the transfer and provided the paperwork to Administrator #1, per the Administrator's request. The SW also stated that a response was not received from facility #2, so she called facility #2 around November 2019 to follow up, left a voice message for Administrator #2, but did hear anything back. The SW said she told Resident #1 before he went home for the holidays that she would continue to work on his request to transfer to facility #2, but that she honestly forgot and that she did not continue to follow up.

On 2/18/20 Administrator #1 was interviewed at 12:20 PM and stated that it was brought to his

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attention in June 2019 that Resident #1 requested to be transferred to facility #2. Administrator #1 stated that he sent an email to Administrator #2 and included the necessary paperwork, but that he did not get a response regarding the transfer request. Administrator #1 also stated that he thought he spoke to Administrator #2 in September 2019 during a corporate meeting regarding the transfer, but that he was not certain of the date. He then stated that he was not sure why the referral was not processed and the transfer completed.

Administrator #1 provided documentation for review of an email communication to Administrator #2 of facility #2. The communication was dated 6/17/19 and recorded that Resident #1 would like to move closer to home for family support and requested follow up by the Admission Coordinator.

On 2/18/20 Administrator #2 was interviewed via phone at 4:06 PM. Administrator #2 stated that she was the Administrator of facility #2 in June 2019 where Resident #1 requested to transfer to, but at that time she was preparing to transfer to another facility within the corporation. She stated that she did recall a discussion with Administrator #1 regarding the transfer for Resident #1 to facility #2, but could not explain why the transfer was not completed. She stated, "It is possible that the request just slipped through the cracks."

The Admissions Coordinator for facility #2 was interviewed via phone on 2/19/20 at 9:13 AM. The interview revealed there was no record of a referral or receipt of paperwork for a referral to facility #2 for Resident #1. The Admissions Coordinator stated that if a referral request had

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F 745	Continued From page 5 been received and processed it would have been reflected in their computer system. She did not have any record of receiving a request for Resident #1 to transfer to facility #2 and did not recall any phone calls or voice messages regarding this request.	F 745		