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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation was conducted from 7/13/20 to 7/14/20. Event #TDLH11. Five of the twenty allegations were substantiated.	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.	F 563		7/30/20

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

Electronically Signed | 08/04/2020

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 563	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, family, staff, and physician interview the facility failed to allow an immediate family member to visit for compassionate care in accordance with CMS memo Covid-19 QSO 20-14-NH and the facility Covid-19 Policy/Plan for one (Resident #1) of three residents reviewed for visitation rights. Findings included: The facility Covid-19 Policy/Plan last updated on 5/6/20, stated, "At this time and until further notice, no visitors, volunteers, or other persons are permitted to enter the facility with the exception of end of life or other compassionate circumstances ...." Resident #1 was admitted to the facility on 1/10/20 with the diagnoses of Alzheimer's disease, hypertension, anemia, dementia, muscle wasting, cachexia, and adult failure to thrive. An immediate family member was listed as the resident's responsible party and health care power of attorney in the resident's medical record. Documentation on the most recent MDS assessment dated 6/11/20 coded Resident #1 as cognitively impaired, dependent on staff for bed mobility, toilet use, and personal hygiene but requiring extensive assistance with eating. Documentation on the care plan dated as initiated on 3/16/20 revealed Resident #1 was at risk for alteration in psychosocial wellbeing related to restriction on visitation due to Covid-19. One of the interventions was to encourage alternative communication with visitors.	F 563	1. F563 – Right to Receive/Deny Visitors Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Resident #1 deceased prior to the survey on 6/23/2020 b. The Social Worker and Nurse #6 were re-educated on 7/15/2020 by the Administrator about the facility allowing an immediate family member to visit for compassionate care in accordance with CMS memo COVID-19 QSO 20-14-NH and the facility COVID-19 Policy/Plan. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: c. On 7/15/2020, 100% of current hospice residents were identified and the responsible party was contacted by the Social Worker via phone to ensure the immediate family member was allowed visitation for compassionate care in accordance with CMS memo COVID-19 QSO 20-14-NH and the facility COVID-19 Policy/Plan. If the immediate family member was not previously allowed visitation, the Social Worker notified the immediate family of the CMS memo COVID-19 QSO 20-14-NH and the facility COVID-19 Policy/Plan and offered them visitation. d. On 07/15/2020, the Social Worker	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 563	Continued From page 2 Documentation in a social service progress note dated 6/17/20 stated, "[Family member] came to facility yesterday evening and filled out the DNR (Do not Resuscitate) consent for [Resident #1]." Record Review revealed a physician's order dated 6/17/20 for a Hospice consult and for Hospice to evaluate and treat Resident #1. Documentation on a Hospice visit note dated 6/18/20 revealed, "92-year-old female, [family member] not present at admission due to facility restrictions for Covid-19. Paper notes signed by [family member]. Hospice philosophy explained, [family member] POA (power of attorney), she is seeking no further aggressive measures, she wants comfort for [Resident #1] that is rapidly declining with Alzheimer's disease. .....Pt (patient) has had a weight loss since March, from 110 [pounds] to 92, thin frail appearance. She frequently refuses meals or consumes less than 25 %. Observed Pt eating, mechanical soft diet, pocketing notes, two bites consumed and then refused." Documentation in the nursing notes for Resident #1 on dated 6/23/20 at 7:51 AM revealed, "Nurse was called to resident room. Resident noted with no pulse or breath sounds. Skin was cool to touch. Community Hospice was called and notified." Documentation in the nursing notes on 6/23/20 at 1:01 PM revealed, "Resident remains picked up by funeral home." An interview was conducted on 7/13/20 at 1:00 PM with the family member of Resident #1 who was the health care power of attorney and responsible party. The family member revealed that she visited Resident #1 weekly to view her	F 563	and Administrator started re-education to 100% of current licensed nurses regarding the facility allowing an immediate family member to visit for compassionate care in accordance with CMS memo COVID-19 QSO 20-14-NH and the facility COVID-19 Policy/Plan. Education will be completed on July 30, 2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: e. On 07/15/2020, Social Worker/or designee will complete a weekly Hospice Visitation audit to include offering an immediate family member to visit resident in the facility. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: f. Administrator will review the hospice visitation audit documentation weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, of the hospice patients for and will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: July 30, 2020	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 563	Continued From page 3	F 563		

through the window and called the facility daily for updates regarding the condition of Resident #1 since the facility went into lockdown for Covid-19 in March 2020. The family member stated she could see through the window that Resident #1 was not doing well in May 2020 and the nursing staff were notifying her that Resident #1 was not eating very much. The family member stated that Resident #1 was put on Hospice and an order for her to not be resuscitated was made on 6/17/20. The family member lamented that she was not allowed to see Resident #1 and had to hand the paperwork for approval of Hospice services and the DNR (do not resuscitate) order through the door on 6/17/20. The family member indicated she was very regretful she was unable to sit and be with Resident #1 during her last days. The family member stated, "I could see the life going out of her, but they wouldn't let me go in [to the facility]."

An interview was conducted with the facility social worker on 7/13/20 at 1:30 PM. The social worker revealed she set up a video conference and gave weekly updates to the family member of Resident #1. The social worker stated that the facility did not offer, and the family member did not ask to come into the facility to see Resident #1 prior to her death. The social worker indicated that unless a resident was actively dying the family members of residents were not allowed into the facility at that time.

Nurse #5 was interviewed on 7/13/20 at 2:40 PM. Nurse #5 stated that he did not see much of a change in Resident #1, but she was in a gradual decline. Nurse #5 confirmed that the family member for Resident #1 called him daily in the evening for updates on Resident #1. Nurse #5

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 563	Continued From page 4	F 563		

remembered that the last two times before Resident #1 died, the family member stood in the pouring rain for hours looking at Resident #1 through the window. Nurse #5 reiterated that he did not see much of change in Resident #1 but within 48 hours of being put on Hospice services, Resident #1 passed away.

Nurse #6 was interviewed on 7/13/20 at 10:54 PM. Nurse #6 stated that the family member called her at least two times a week on the morning shift for updates on Resident #1. Nurse #6 stated that the medical director was aware of the decline in health for Resident #1. Nurse #6 stated that Resident #1 was not eating and only drank liquid supplement. Nurse #6 confessed that she did not notify the medical director or the family member when she observed the weight of Resident #1 dropped to 89 pounds on 6/19/20. Nurse #6 stated that the physician and the family member both knew that Resident #1 had a major decline and she was placed on Hospice.

An interview was conducted with the facility Administrator on 7/14/20 at 10:40 AM. The Administrator explained that Resident #1 was not actively dying and therefore the family member was not invited into the facility. The Administrator acknowledged the family member was in constant communication with the facility, but family members were not allowed in the building at that time unless the resident was actively dying. The Administrator explained that she relied on the clinical judgement of the facility nurses, administrative nurses, and the medical director to make the determination if a resident was actively dying.

The facility medical director was interviewed on

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 563	Continued From page 5 7/14/20 at 12:47 PM. The medical director acknowledged that Resident #1 was physically declining, and he agreed that Hospice services were warranted at the time he wrote the order on 6/17/20. He stated that he did not know that the death of Resident #1 was imminent. The Medical Director stated that he was under the impression that the family member of Resident #1 was allowed into the building when she brought the signed paperwork for the resident to be put on Hospice. The Medical Director denied that he was the one that made any decision about when a family member could come into the building for comfort care at the end of life for a resident. The Medical Director stated, "I don't make those policies."	F 563		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		7/30/20

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 580	Continued From page 6 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and family interviews the facility failed to notify the resident's responsible party of a change of condition for 1 of 3 residents (Resident # 3) reviewed for notification. The findings included: Resident #3 was admitted to the facility on	F 580	2. F580 – Notify of Changes (Injury/Decline/Room, etc.) Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Resident #3 discharged prior to the	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 580	Continued From page 7 12/8/2019 with diagnoses to include acute respiratory failure, pneumonia, dementia, congestive heart failure, diabetes, and coronary artery disease. A review of Resident #3's admission minimum data (MDS) set assessment dated 12/19/19 revealed his cognition to be moderately impaired, required extensive assistance from staff for activities of daily living, and had no pressures sores. A review of a Physician follow up visit dated 1/21/20, revealed Resident #3 developed a left posterior thigh abscess, and was started on Clindamycin (an antibiotic). A review of Resident #3's Medication Administration Record (MAR) for January 2020 revealed Clindamycin was administered three times per day (TID) from 1/14/20 through 1/24/20 for left gluteal thigh fold abscess. A review of Resident #3's MAR for February and March 2020 revealed Bactrim DS (an antibiotic) was administered two times per day (BID) from 2/27/20 through 3/7/20 for wound infection. On 7/14/20 at 9:06 AM, an interview was conducted with the MDS nurse. The MDS nurses stated she was the wound nurse at the time of Resident #3's admission at the facility. The MDS nurse stated Resident #3 had an abscess on his left posterior gluteal fold and the Physician had seen it and referred him to general surgery to have it lanced. The nurse stated she was unable to remember if a culture had been done on the abscess and she was unable to find any record of culture results, but stated the resident was on	F 580	survey on 4/9/2020 b. The MDS Nurse and Nurse #3 were re-educated on 7/15/2020 by the Administrator on the facility's policy for notifying the resident's responsible party of a change of condition. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: c. On 7/15/2020, Current residents with wounds and those on isolation were audited by the minimum data set nurse (MDS) to ensure the resident and responsible party were notified of any changes in the resident's condition. No identified concerns were noted in this audit. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: d. The licensed nursing staff were educated on 7/15/20 by Administrator regarding notification of resident, physician and responsible party regarding a change of condition in a resident's status. This education will be a part of licensed nurses orientation. e. On 07/15/2020, the MDS Nurse/or Director of Nursing will complete a weekly times 4 weeks, bi weekly times 2 and monthly times, Notification of Change of Condition audit to ensure the resident, physician and responsible party of residents with wounds or that require	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 580	Continued From page 8 contact precautions for the wound abscess while at the facility. The MDS nurse stated the infection control nurse was no longer working at the facility and she was unable to find records of a culture report. The MDS nurse stated if Resident #3 had an infection in his wound, and it looked like he did because he was on antibiotics a second time, the responsible party (RP) would have been notified by her, but she was unable to find a report of notification in the medical record. On 7/14/20 at 10:07 AM, an interview was conducted with the nurse (#3) who frequently cared for Resident #3. The nurse stated Resident #3 was on isolation for Methicillin-resistant Staphylococcus Aureus (MRSA) (a bacterium causing infection) from a sore on his back thigh. The nurse stated there was a sign on the resident's door along with the appropriate personal protective equipment (PPE). The nurse stated the (RP) would have seen the isolation sign and PPE but would've been called also. The nurse stated it was the nurse's responsibility to call the RP, but she could not remember if anyone had called her. On 7/14/20 at 11:36 AM, an interview was conducted with Resident #3's RP. The RP stated she visited the resident and saw a bag on the door with PPE but no one had called to tell her the resident was in isolation or that he had MRSA in his wound. On 7/14/20 at 1:06 PM, an interview was conducted with the Administrator, who stated she was not aware Resident #3's RP was not notified of his change of condition as she did not start working at the facility until after he had been cleared of isolation.	F 580	isolation were notified of any changes and this is documented in the medical record. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: f. Starting the week of 7/15/20 Administrator will review the Notification of Change in Condition audit documentation weekly times 4 weeks, bi-weekly times two , and monthly times 1 month, of residents with wounds and those requiring isolation and will report audit findings monthly to the QAPI team for review times 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: July 30, 2020	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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 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 observations, record review and staff	F 690	3. F690 – Bowel/Bladder Incontinence,	7/30/20

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 690	Continued From page 10 interviews the facility failed to keep a urinary catheter bag from coming into contact with the floor for 1 of 3 residents (Resident #6) reviewed for catheter care. The findings included: Resident #6 was admitted to the facility on 2/5/2017 with diagnoses to include neuromuscular dysfunction of the bladder, and aphasia. Review of Resident #6's most recent Minimum Data Set assessment dated 6/1/2020 revealed her cognition to be severely impaired and she required total assistance from staff for activities of daily living. The resident was assessed to have an indwelling catheter. Review of Resident #6's care plan dated as revised on 4/16/2020 revealed the resident was care planned for an indwelling catheter with potential for complications associated with catheter use. The interventions included to check catheter tubing for kinks each shift, position the drainage bag below the level of bladder, provide catheter care every shift, and monitor and report to the Physician any signs and symptoms of infection. During an observation on 7/13/2020 at 6:53 AM, the catheter bag and tubing were attached to the bed rail and both were dragging on the floor. The bed appeared in the lowest position. During an observation on 7/13/2020 at 4:12 PM, the catheter bag was attached to the bottom rail of the bed and the lower half of the bag was lying flat on the floor, appeared empty. The bed was in	F 690	Catheter, UTI Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. On 7/13/2020, NA #8 removed Resident #6's urinary catheter bag from the floor. b. On 7/14/2020, the NA #8 and Nurse #7 were re-educated by the Administrator on the facility policy regarding catheter care, particularly to keep a urinary catheter bag from coming into contact with the floor. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: c. On 7/15/2020, 100% of current residents with urinary catheters were reviewed by the MDS Nurse for catheter care to ensure their catheter bags were not in contact with the floor. If there was any deficiency, the MDS Nurse corrected immediately. d. On 07/15/2020, MDS Nurse and Administrator started re-education to 100% of current licensed nurses and nursing assistants regarding the facility policy on bowel/bladder incontinence, catheter care, and UTIs. Education will be completed on July 30, 2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 690	Continued From page 11 the lowest position. On 7/13/20 at 4:13 PM, an interview was conducted with Nursing Assistant (NA) #8 who was in the room and caring for the roommate of Resident #6. The NA stated the catheter bag was on the floor because the bed was in the lowest position, but it should not be on the floor. The NA stated she did not realize it was on the floor and proceeded to raise the bed until the catheter bag was off the floor. On 7/13/20 at 4:28 PM, an interview was conducted with Nurse #7 who stated she had not noticed the catheter bag was on the floor when she made rounds. The nurse stated the bed needed to be raised a little, so the catheter bag was not on the floor as that was an infection control issue. An interview was conducted on 7/14/2020 at 1:06 PM, with the Administrator who stated she expected staff to keep resident's urinary catheter bags from contacting the floor.	F 690	recur: e. On 07/15/2020, the MDS Nurse/or designee will complete a weekly Catheter Bag audit to ensure residents with urinary catheters had their catheter bags positioned so they were not in contact with the floor. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: f. Administrator will review the Catheter Bag audit weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, of residents with urinary catheters and will report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: July 30, 2020	
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		7/30/20

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 727	Continued From page 12 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have Registered Nurse (RN) coverage for at least 8 consecutive hours per day for 3 out of 17 days reviewed for staffing (7/5/20, 7/9/20 and 7/11/20). The findings included: On 7/13/20 at 3:58 PM an interview was conducted with the interim Director of Nursing (DON) who stated she was working as the facility's interim DON until the facility could hire someone for the position. The DON stated around the 3rd week of June 2020 the DON, Staff Development Coordinator (SDC), unit manager, and another Registered Nurse (RN) quit working at the facility. The DON stated she was put in the position of interim DON because she was the only regular staff RN still working at the facility. On 7/14/20 at 12:18 PM, an interview was conducted with the facility's staff scheduler, who stated most of the time she tried to have an RN on duty for 8 hours a day. The scheduler stated last month when all the RN's left, she had to move the current DON to that position, but also still had to schedule her to work as a floor nurse. The scheduler stated she had 2 "as needed" (PRN) RN's to help, but the facility did not use agency staff. A review of the daily staff schedule with the scheduler revealed the facility had no RN coverage on 7/9/20 and 7/11/20 and only 4 hours of RN coverage on 7/5/20. The scheduler	F 727	4. F727 – RN 8 Hrs./7 days/Wk., Full Time DON Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. On 7/15/2020 the Interim Director of Nursing and Scheduler were re-educated by the Administrator on the policy to have Registered Nurse (RN) coverage for a least 8 consecutive hours, not including the DON, per day. b. A new Unit Manager (RN) was hired and started on 7/8/2020; a new Evening/Weekend Supervisor (RN) was hired and started on 7/29/2020. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: c. On 7/15/2020, the Scheduler and Administrator did a 100% review of the schedule for the upcoming 2-week period to ensure there was at least 8 consecutive hours of Registered Nurse (RN) coverage, not including the DON, per day. If facility RN staff were unable to provide the daily coverage, an agency staffing company was contacted to fill the need of a RN.	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 727	Continued From page 13 confirmed the interim DON did not work on the dates of 7/9/20 and 7/11/20 and a PRN RN was not working on those dates. The scheduler confirmed the interim DON worked only 4 hours on 7/5/20 and a PRN RN was not working on that day. On 7/14/2020 at 12:50 PM an interview was conducted with the Administrator, who stated she moved the interim DON to that position on 6/20/20. The Administrator stated she would have liked to have RN coverage every day of the week but knew there were some dates an RN was not available since 6/20/20. The Administrator stated she did not look into using an agency RN because she had another RN that she thought could help cover.	F 727	Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: d. On 07/15/2020, the Scheduler/or designee will complete a weekly Schedule audit for the upcoming week to ensure the facility has Registered Nurse (RN) coverage for a least 8 consecutive hours, not including the DON, per day. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: e. Administrator will review the weekly Schedule audit weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, the to ensure RN coverage at least 8 hours per day and report audit findings monthly to the QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: July 30, 2020	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		8/7/20

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 15 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to do hand sanitation according to facility policy in one out of five hallways in the facility. A nurse aide (NA #6) and a housekeeper (HK #1) failed to perform hand hygiene in-between residents in the quarantine unit. This occurred during a Covid-19 pandemic. Findings included: The handwashing/hand hygiene policy for the facility, dated August 2015, stated that alcohol-based hand rub or, alternately, soap and water should be used before and after assisting a resident with meals and after contact with objects in the immediate vicinity of the resident. 1.Continuous observations were made in the quarantine unit/300 hall on 7/13/20 beginning at 9:30 AM. Nurse aide NA #6 was observed leaving	F 880	5. F880 – Infection Prevention & Control Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Nursing assistant #6 and Housekeeper #1 were reeducated by the Administrator on 7/14/2020 on the proper procedure for hand sanitation/hand hygiene including hand washing/ and donning/doffing PPE between residents and during meals in the quarantine unit according to facility policy. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: b. On 7/15/2020, current facility staff	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 16 room 308 at 9:30 AM with a breakfast tray from the resident in that room. The breakfast tray was put on a dining cart in the hallway by NA #6 who then went directly into Room 304. NA #6 came out of Room 304 at 9:35 AM with the breakfast tray from the resident in that room, put the breakfast tray on the dining cart in the hallway, and went directly to answer a call light in Room 315 without doing any hand sanitation. NA # 6 was observed to touch the tray table and reposition the resident in Room 315 as she spoke to the resident. NA #6 was observed to grab a pair of gloves and enter the bathroom in Room 315 to wash her hands. The door to Room 315 was closed by NA #6 and NA #6 left Room 315 at 9:42 AM. NA #6 went directly into Room 316, picked up the breakfast tray of the resident in the room, and put on the dining cart in the hallway. NA #6 went into Rooms 314, 312, 309, and 306 repeating the process of picking up breakfast trays and putting them on the dining cart in the hallway without doing any hand sanitation in between rooms. NA #6 was not observed to wear a plastic gown at any time during the observations beginning at 9:30 AM. An interview was conducted with NA #6 on 7/13/20 at 9:51 AM. NA #6 confirmed that she did not do any hand sanitation except for washing her hands prior to assisting the resident in Room 304 and prior to and after assisting the Resident in Room 315, after she closed the door. NA #6 confirmed she did not put on a gown since she started picking up the breakfast trays. NA #6 stated that she was expected to wash her hands after picking up every third resident food tray or every third room. NA #6 said she wore a plastic gown, did hand sanitation, and put on gloves in the quarantine unit when she was providing care	F 880	working on the quarantine unit were visually observed by the MDS Nurse and Medical Records Manager (LPN) for proper hand sanitation/hand hygiene and donning/doffing PPE between residents and during meals. If there was any deficiency, the MDS Nurse or Medical Records Manager (LPN) educated the staff member immediately. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: c. On 07/15/2020, the Administrator started re-education to of the current facility staff on hand sanitation/hand hygiene using the CMS recommended “Clean Hands” YouTube video and demonstration competency of hand washing/ and donning/doffing PPE. The Director of Nursing will continue the education which will be completed 8/4/2020. This education will be a part of new staff orientation d. On 07/15/2020, the MDS Nurse/or Director of Nursing will complete a visually observation audit daily times 5 days, weekly times 3 weeks, bi weekly times 2 and monthly times 1 of Hand Sanitation/PPE to ensure facility staff are performing proper hand sanitation/hand hygiene including hand washing/ and donning/doffing PPE. This Hand Sanitation/PPE audit will cover observing facility staff for proper hand sanitation with hand washing and donning/doffing PPE	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 17 but not when she was picking up meal trays. NA #6 stated that the gowns were hanging on the back of the resident door in each room. Nurse #3 was interviewed on 7/13/20 at 10:20 AM. Nurse #3 stated that she had spoken with NA #6 regarding hand washing about a month ago. Nurse #3 added the information that NA #6 did not usually work in the quarantine unit. Nurse #3 explained that it was important to wear the gown as directed and do proper hand sanitation in the quarantine unit because although the residents were tested for Covid-19 multiple times, the dialysis patient was coming and going. Nurse #3 explained that the staff were expected to wear a gown while in each resident room. Nurse #3 further explained that the gown was not necessary in the hallway, but on the back of each resident's door was a gown to be used while in the room with a resident. An interview was conducted with the Director of Nursing (DON) on 7/14/20 at 10:45 AM. The DON denied that she was the person responsible for the infection control policies and procedures. She stated that she was unable to provide what the expectations were for infection control in the facility and she was not involved with any monitoring or tracking of infections within the facility. An interview was conducted with the facility Executive Director/Administrator on 7/14/20 at 11:36 AM. The Executive Director/Administrator stated that the DON was the person responsible for the infection control policies and procedures and the expectation was that the staff follow the infection control policies and procedures.	F 880	as demonstrated by 10 employees across all three shifts which include day, evening and night shifts. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: e. Administrator will review the results of the visual observations audits daily times 5 days, weekly times 3 weeks, bi weekly times 2 and monthly times 1 of Hand Sanitation/PPE the to ensure proper hand sanitation/hand hygiene and report audit findings monthly to the QAPI team for review times 3 months. The Quality Assurance and Performance Improvement Committee can modify this plan to ensure the facility remains in compliance. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: DPOC will be submitted and completed by: August 7, 2020	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 18	F 880		

2. Continuous observations were made in the quarantine unit/300 hall on 7/13/20 of housekeeper (HK) #1 beginning at 10:43 AM. HK #1 was observed to be wearing gloves when she entered Room 305. HK #1 was observed to exit and reenter room 305 multiple times with garbage bags, toilet brush, cleaning spray, and cloth wipes. HK #1 was observed to enter room 306, with the same gloves on, repeating the same process of cleaning the room as she had for room 305. At 10:53 AM nurse aide (NA) #7 stood in the doorway to Room 305 and requested that HK #1 retrieve a towel from the clean linen cart. HK #1, with the same gloves on, took a towel off the clean linen cart and handed to NA #7, who reentered room 305. NA #7 was interviewed on 7/13/20 at 11:00 AM. NA #7 stated that she needed HK #1 to retrieve a clean towel for her from the clean linen cart because there were no other staff members on the hallway, and she did not want to remove her gown to retrieve linen for the resident in room 305. HK #1 was observed to grab a wet mop head, attach it to the mop, and clean the floor of room 306. Upon completion of cleaning the floor of room 306, HK #1 disposed of the wet mop head and put another wet mop head on the mop, repeating the process of cleaning the floor in room 305. HK #1 continued to keep the same gloves on. HK #1 then proceeded to clean the hand rails, wipe down the fire extinguisher, wipe down the hand sanitizer dispensers, and move dirty linen barrels out of the way without changing her gloves. HK #1 then, with the same gloves on, began to clean room 308, completing garbage removal, bathroom cleaning, and wiping down surfaces with cleaning spray in the room. HK #1 mopped the floor in room 308 by putting a wet mop head on a mop and wiping down the floors with the mop. At 11:23 AM Nurse #3 told

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 880	Continued From page 19 HK #1 that she needed to change her plastic gown that she was wearing after she entered each room. HK #1 entered the room 303, designated as the nurse's station, and changed her plastic gown. HK #1 was not observed to change her gloves at that time. HK #1 was then observed to enter room 309, for the purposes of cleaning the room with a toilet brush and cloth towel in hand. HK #1 completed the cleaning process in room 309, removed her plastic gown, and hung it on the back of the door in room 309. At 11:47 AM HK #1, with the same pair of gloves, resumed wiping down the hall way railings, resident chairs, nursing equipment, and doors. HK # 1 was interviewed on 7/13/20 at 11:58 AM. HK #1 confirmed that she had not changed her gloves or did any hand hygiene since she started cleaning the resident rooms. HK #1 confirmed that she had training on procedures for cleaning in the quarantine unit but that she had just forgotten to change her gloves. The housekeeping supervisor was interviewed on 7/14/20 at 8:47 AM. The housekeeping supervisor stated that the housekeeper on the quarantine unit was supposed to hand sanitize and change gloves in between cleaning rooms in addition to changing her plastic gown going from room to room. The housekeeping supervisor confirmed HK #1 had been trained in the infection control procedures for the quarantine unit but that she had probably forgot.	F 880		
F 925 SS=F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and	F 925		7/30/20

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 925	Continued From page 20 rodents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews, the facility failed to maintain an effective pest control program to keep the facility free of American cockroaches and spiders for 5 of 5 resident hallways (hallways 100, 200, 300, 400, and 500), and the central nurse's station. The findings included: Review of the facility's contracted pest control company records revealed service was performed on the following dates: - 4/6/2020, the rooms serviced were 105, 106, 202, 204, 206, 207, 208, 209, 210, 307, 311, 403, 500, and 501. Interior rodent service was performed. - 5/12/2020, insecticide for cockroaches was applied to the interior areas of kitchen, office and side door-introduction point. Mice were baited in the exterior area. - 6/9/2020, insecticide for cockroaches was applied to the interior kitchen area. Mice were baited in the exterior area An observation was made on 7/13/20 at 6:15 AM of a large American cockroach crawling on the floor in front of the 100/200 nursing desk near the medication cart. Nurse Aide (NA # 1) was observed to obtain a paper towel and dispose of the cockroach. NA # 1 was interviewed at the time of the observations and indicated that it was not unusual to see cockroaches in the building. NA # 1 further indicated that it was documented in the computer system when a cockroach was	F 925	6. F925 – Maintains Effective Pest Control Program Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: a. Pest control treatment was performed on 7/14/2020 of the 200, 300, 400, and 500 Hall rooms and hallways, nursing desk, and exit hallways. b. Another pest control treatment was performed on 7/16/2020 of the exterior areas of the building. c. Another pest control treatment was performed on 7/27/2020 of the interior areas of the building. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: d. On 7/15/2020 the Maintenance Director completed a 100% audit of Hallways 100, 200, 300, 400, and 500 and the central nurse’s station to ensure compliance to the policy to maintain an effective pest control program. If any pests were found, the Maintenance Director addressed the problem immediately. e. On 07/13/2020, the Maintenance Director started re-education to 100% facility staff regarding the procedure for using the computer TELS system to notify	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 925	Continued From page 21 observed. An observation was made on 7/13/20 at 6:20 AM of a dead large American cockroach in the exit hallway between the 300 and 400 halls. Nurse # 1 was interviewed on 7/13/20 at 6:26 AM. Nurse #1 revealed that 3 hours prior to the interview the cockroaches were crawling around everywhere. Nurse #1 stated that last week she observed four cockroaches crawling up the wall of the resident in Room 401 B and inside the feeding tube syringe bag attached to the wall. Nurse #1 stated she tied off the feeding tube syringe bag and threw the bag away. Nurse #1 also observed cockroaches crawling all over the bed side table for the resident in Room 401 A. Nurse #1 stated that it did not do any good to notify anybody about the cockroaches. NA #3 was interviewed on 7/13/20 at 6:27 AM. NA #3 revealed that she went in Room 414 B to provide care to the resident on the 11:00 PM to 7:00 AM shift on 7/13/20 and observed a large cockroach crawling up the sleeve and covers of the resident. NA #3 stated she removed her slip-on shoe, brushed the cockroach off the resident, and killed the cockroach with her shoe. An observation was made on 7/13/20 at 6:34 AM of a large wolf spider crawling on the floor near the back nurse's station. A resident in a wheel chair was observed at the time of the observation of the spider to be sitting at the nurse's station in the back of the building. An observation was made on 7/13/20 at 7:10 AM of the dead wolf spider and multiple baby spiders crawling all over at the entrance to the 400	F 925	maintenance of any sightings of pests. Education will be completed on July 30, 2020. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: f. On 7/24/2020 the pest control company contract was updated to include an increased frequency of service and larger service area. g. The Maintenance Director/or designee will complete a Pest Control audit of all Hallways 100, 200, 300, 400, 500, nurse's station, and exit hallways each shift to ensure an effective pest control program 5 times a week, then weekly times one month, then monthly times three months. h. The Maintenance Director/or designee will complete an TELS audit of the computer TELS system to ensure staff are notifying maintenance of any sightings of pests and issues have been resolved 5 times a week, then weekly times one month, then monthly times three months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: i. Administrator will review the Pest Control and TELS audit tools weekly times 4 weeks, bi-weekly times 4 weeks, and monthly times 1 month, to ensure pest control reporting and treatment is effective and report audit findings monthly to the	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 925	Continued From page 22 hallway. Nurse #1 was interviewed at the time of the observation. Nurse #1 stated, "They stomped on the spider and baby spiders are crawling everywhere. We are trying to stomp on them too." An observation was made on 7/13/20 at 9:15 AM of two dead cockroaches in the hallway outside rooms 309 and 306. Record review revealed Resident #13 was assessed as alert and oriented on his most recent minimum data set (MDS) assessment dated 5/27/20. Resident #13 was interviewed on 7/13/20 at 8:28 AM. He stated in his room on the 400 hall he had seen cockroaches every evening and had seen them crawl across his bed. The Resident stated he had let the nurse know, and he stated maintenance and housekeeping had seen them also. Record review revealed Resident #9 was assessed as alert and oriented on his most recent MDS assessment dated 6/11/20. Resident #9 was interviewed on 7/13/20 at 9:15 AM. He stated in the past 14 days, while he was in the quarantine unit on the 300 hall, he had seen cockroaches in his room. He revealed that he was getting assistance from a nurse aide in getting dressed when he saw a large cockroach crawling in his room. He indicated the nurse aide killed the cockroach and threw it in the trash can. He stated that he had told the nurses and the nurse aides about the cockroaches and he indicated the staff were aware of the presence of cockroaches. Resident #9 added the information that he had run over two cockroaches with his wheel chair 2 days ago. Record review revealed Resident #10 was	F 925	QAPI team for review times 3 months. Documentation of the review will be kept by the Administrator in the QAPI Book. Include dates when the corrective action will be completed: July 30, 2020	

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 925	Continued From page 23	F 925		

assessed as alert and oriented on her most recent admission MDS assessment dated 7/14/20. Resident #10 was interviewed on 7/13/20 at 10:15 AM. She stated she had been on the 300 hallway since her admission and she had seen a cockroach in her room crawling around on two different nights. She stated she woke up that morning and the cockroach was now "squashed" over by the trash can. The dead cockroach was observed on the floor next to her trash can at the time of the interview.

An interview was conducted with housekeeper #1 in the quarantine unit on 7/13/20 at 10:30 AM. Housekeeper #1 stated she had seen cockroaches in the facility on the 300 hallway. She indicated she kills them, sweeps them up, and disposes of them. She stated that nobody had told her to tell anybody.

On 7/13/2020 at 3:16 PM, an interview was conducted with the Maintenance Director who stated the facility had a computer TELS system in place for staff to notify him of sighting of bugs in the facility, and their location. The Director stated he and his assistants used a bug killer to spray inside the facility when bugs were reported to him. The Director reviewed the reported bug sightings in the facility with the surveyor and was as follows: 2 dates reported in April, 4 dates in May, 3 dates in June and 1 date in July. The Director stated of all the sightings of bugs noted on the morning of 7/13/20, he had not received one report in the TELS system to alert him for bug treatment needed. The Director stated the facility had a Pest Control Company contracted to come and treat the facility once per month, depending on what the issues were. The Director stated he thought the pest control company

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 07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 925	Continued From page 24 treated the exterior of the building in June for cockroaches. The Directed stated he and his staff had not made any rounds at night to observe for bugs, because no bug problems had been reported at night. The Director stated he expected the roach population be controlled to not come into the building. On 7/14/2020 at 1:06 PM, an interview was conducted with the Administrator who stated a bug problem had never been brought to her attention. The Administrator stated she expected that if staff saw a bug they would address it, and then notify maintenance through the TELS system and the Administrator to make sure the issue was addressed.	F 925		