STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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
E 000	Initial Comments An unannounced Recertification survey was conducted 2/15/2021 through 2/19/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# BBNY11.	E 000		
F 000	INITIAL COMMENTS A recert and complaint survey was conducted 2/15/2021 through 2/19/2021. Event ID #BBNY11 0 of the 10 complaint allegations were not substantiated.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		3/16/21

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

Electronically Signed | 03/04/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 584	Continued From page 1 and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff and resident interviews and observations the facility failed to provide a comfortable environment by failure to have an operable working bathroom faucet that produced hot water in 1 of 7 resident bathrooms (room #203, resident #12) reviewed for environment. Findings included: Resident #12 was admitted on 1/14/2019. A quarterly MDS assessment dated 2/12/21 coded the resident as being mildly cognitively impaired. On 2/15/21 at 9:26 AM the water temperature was checked in resident #12's bathroom room #203. The sink had a single handled faucet and was turned to the left to check the hot water temperature. The water was cold. The water continued to run and was checked again at 9:30	F 584	This plan of correction is submitted as required under Federal and State Regulation and statutes applicable to long term care providers. This plan of correction does not constitute an agreement by the facility and such liability is hereby specifically denied. The submission of the plan does not constitute an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are correctly applied. F584 1.The Faucet in R12 has been repaired on2/17/21 and water temperature will be at a comfortable level for R12 per her preference.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 584	Continued From page 2 AM and 9:32 AM and the water was cold and did not get warm. The faucet was missing the middle circle which shows red for hot on the left and blue for cold on the right. A second observation of the water temperature in room #203 was completed on 2/17/21 at 8:59 AM by turning the faucet to the left revealed the water was cold. The water continued to run and was checked at 9:04 AM and the water was cold. At 9:04 AM the faucet was turned to the right and the water was cold. At 9:06 AM the water was cold. At 9:08 AM the water was lukewarm. At 9:10 AM the water was warm. A review of the facility work orders were reviewed from September 2020 to February 2021 revealed no work orders were received for the water not getting hot in room #203. A review of the resident council minutes from November 2020 to February 2021 revealed no concerns related to water not getting hot in resident bathrooms. Resident #12 attended the resident council meeting on 2/15/21 at 3:00 PM during the survey and voiced her concern regarding the water temperature not getting hot in her room #203. An interview was completed with the resident #12 on 2/17/21 at 9: 10 AM who stated that the water had been cold since she had moved in. She had told numerous people such as nurses' aides, nurses but it has never gotten fixed. Resident #12 stated that Maintence came a few weeks ago to check it but never came back. Resident #12 stated that she had been told that due to her room being at the end of the hall it takes a long	F 584	2.All other residents have the potential to be affected. The Maintenance Director/ Designee will obtain the water temperature for resident rooms to ensure water is at a comfortable level for the residents. The faucets in the resident rooms of facility have been audited by the Maintenance Director to ensure cold water on the right and hot water on the left and was completed 3/5/2021. 3.Maintenance Staff to be educated by the Licensed Nursing Home Administrator on acceptable water temperature levels for resident care areas per State Regulation on 2/24/2021 Staff to be educated on Maintenance Work Order process on 3/4/21 by the Maintenance Director 4.The Maintenance Director/ designee will randomly test 5 water faucets weekly for one month to ensure a comfortable level for the residents and monitor hot water on left and cold water on right beginning on 3/16/2021. The faucets and water will the be audited in 5 random rooms monthly for two months (until June 2021). The Maintenance Director/ designee will bring work orders to Morning Meeting -Monday through Friday to ensure follow up beginning on 3/16/2021 Administrator to ensure compliance via verification of audit accuracy beginning 3/16/2021. Data obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 584	Continued From page 3	F 584		

time to get hot water. Resident #12 stated it is not pleasant to wash your face when you get up and the water is ice cold.

On 2/17/21 at 2:17 PM an observation round was completed with the Administrator, Maintence director, Nursing home consultant, Environment services (EVS) director and the regional EVS representative. An observation of the water temperature and faucet was completed in room #203. The water was turned to the left which is for hot water and then turned to the right which is for cold water. It was identified that the water got warm if turning the faucet handle to the right which is for cold water. The Maintence director stated that he had checked this before.

A phone interview was completed with Nursing Assistant #4 (NA) on 2/18/21 at 7:03 PM. She stated that she was aware of the water being cold in room #203. She will first turn on the faucet and then will get additional tasks completed for the resident until the water would get warm. NA #4 stated there is a work order book we can write down concerns but had not completed any work orders for this as she had only been here four months and it had always taken a long time for the water to get warm.

A phone interview was completed with Nursing Assistant #5 (NA) on 2/18/21 at 10:33 PM who stated she was aware of the water being cold in room #203. NA #5 stated she knew Maintence had worked on getting the water to get warm in the past and it was fixed, however, that end of the 200 hallway seems to take longer to get the water warm. NA #5 stated she must let the water run approximately five minutes before it gets warm. NA #5 stated there are work orders we can fill out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 584	Continued From page 4 for Maintence concerns. She stated I know they were working in room #203 during her shift on 2/18/21. A phone interview was completed with the Maintence director (MD) on 2/19/21 at 10:01 AM who stated the he had not received any work orders regarding the water in room #203 prior to the survey. A phone interview was completed with Nursing Assistant #6 (NA) on 2/19/21 at 10:29 AM who stated the water at the end of the 200 hallway takes time to get warm. NA #6 stated she had been told to just turn it on and let it run. NA #6 was aware of the clipboard at the nurse's station to identify concerns. During an interview conducted with the Administrator on 2/19/21 at 10:54 AM she stated she was not aware there were any water problems in room #203 and would have thought with resident council it would have been brought up. The Administrator reported it was her expectation that if anyone identified a problem, they would fill out a work order and when the work orders were completed, Maintence would write down what they did.	F 584		
F 641 SS=E	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 reviews, staff interviews, resident interviews and observations the facility	F 641	1.The following residents□ have had their individual Minimum Data Sets (MDS)	3/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 5 failed to correctly code Minimum Data Set (MDS) for 11 of 50 residents reviewed for MDS accuracy. Resident # 16 was incorrectly coded for Brief Interview for Mental Status (BIMS) on a quarterly MDS dated 01/21/2021. Resident # 45 was not coded correctly for tobacco use on the annual MDS dated 01/19/2021. Resident # 10 was not coded for current tobacco use on an annual MDS dated 08/24/2020. Resident # 65 was not coded for oxygen use on a quarterly MDS dated 02/02/2021. Resident # 73 was incorrectly coded for anticoagulant use on an annual MDS dated 02/05/2021. Resident # 75 was not coded correctly for discharge status on a discharge MDS dated 11/24/2020. Residents # 8, # 44, # 49, # 63 and # 68 were not coded correctly for level II PASSR (Preadmission Screening and Resident Review) on comprehensive MDSs. Findings included: 1. Resident #16 was admitted to the facility on 2/1/16 with a diagnosis of vascular dementia without behavioral disturbance, Type 1 diabetes mellitus. Resident #16, quarterly MDS assessment dated 1/20/21 did not assess the resident for section C 0100 through C 0500 for Brief Interview for Mental Status (BIMS). The staff assessment for mental status section C0700 through C1000 was completed. A review of previous MDS quarterly assessments 10/2/20 and 7/8/20 coded the resident as being cognitively intact. Review of the Social Service progress note for	F 641	reviewed and corrected on 2/23/2021 by the MDS Coordinator for R16 BIMS reassessed, R45 and R10 tobacco use clarified, R73 anticoagulants clarified, R8, R44, R49, R63, and R68 PASRR Level 2 coding corrected, R75 discharge information corrected. The MDS Coordinator reviewed and corrected R65 oxygen therapy on 3/3/21. 2.All other residents have the potential to be affected. The MDS has been review for residents with PASRR Level 2, Tobacco use, oxygen therapy, anticoagulants, discharge disposition information, and BIMS resident interview per RAI guidelines. The review of the past 3 months of MDS coding resulted in 9 corrections; 5 submitted on 2/23/2021, 3 on 3/3/2021, and 1 on 3/4/2021. All current resident records have been review and transmission completed 3/4/2021. 3.MDS Coordinator has been educated on the RAI guidelines for proper coding and information gathering by the Regional Reimbursement Consultant on 2/24/2021. SW#2 no longer works at the facility. SW#1 has been educated on the BIMS assessment process per the RAI manual and correct coding of PASRRs per the RAI manual by the Administrator on 3/5/2021. 4.The Director of Nursing/ designee will randomly review 3 completed MDS for accuracy, coding, and content weekly for 1 month. Then the MDS review will be completed 5 times monthly for 2 months. Administrator to ensure compliance via verification of audit accuracy. Data	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 6 Resident #16 dated 1/18/21; revealed the resident was on the isolation hall at this time. Staff assessment completed. He was alert and oriented to person, place and time. No noted behaviors currently. A phone interview with social worker #2 (SW) was conducted on 2/18/21 at 11:03 PM. The SW stated that Resident #16 was on the isolation hall when the interview should have been conducted and no additional staff other than nursing was allowed back on the COVID unit. SW explained that she just did the staff assessment with the nurse as his BIMS is typically very high and there were no changes. A phone interview was completed with the MDS nurse on 2/18/21 at 1:05 PM who stated that she was not aware of a directive not to go on the COVID unit. The MDS nurse stated that if a resident was on the COVID unit and needed a MDS assessment completed, staff would need to put on all personal protective equipment and complete all questions. The MDS nurse stated that she was the last person to review the MDS assessments and must have missed that his BIMS was not completed. A phone interview was completed with the Director of Nursing on 2/18/21 at 10:42 AM who stated if a resident was on the Covid unit any staff discipline that needed to see a resident who is on the Covid unit, they would complete this task at the end of the day. The Administrator was interviewed by phone on 2/18/2021 at 10:54 AM who stated there were alternate ways to complete the MDS if a resident was on the Covid unit such as over the phone,	F 641	obtained during audits will be analyzed for patterns and trends by the Administrator. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 7	F 641		

face time or at the end of the day, the staff would exit from the facility when finished completing the assessment. The Administrator reported their expectation was for the MDS to be completed accurately.

2. Resident #45 was admitted to the facility on 10/19/16 with diagnoses that included hypertension, dysphagia, depressive mood disorder, chronic kidney disease, aphasia, diabetes, hemiplegia, and hemiparesis.

Resident #45's annual Minimum Data Set (MDS) assessment dated 01/19/21 coded the resident as being cognitively intact. Section J-Health Conditions section J1300 was related to Current Tobacco Use and was marked as "No" on the MDS assessment.

The care plan for Resident #45 initiated on 03/18/20 and updated on 10/29/20 indicated his desire to smoke and that he had been assessed as an independent smoker.

A smoking assessment completed by the Social Worker on 1/27/21 indicated Resident #45 was a safe smoker.

During the survey, the facility provided a list of current residents that smoked, and Resident #45 was included on the list.

An observation of Resident #45 was conducted on 02/15/21 at 12:50 PM. He was observed smoking in the designated smoking area.

An interview was conducted with Resident #45 on 02/15/21 at 11:30 AM. He stated he was a smoker and he did not voice any desire to quit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 8	F 641		

The facility's MDS Nurse was interviewed via phone on 02/18/21 at 11:49 AM. She confirmed she had completed section J 1300 regarding Current Tobacco Use and stated she spoke with Resident #45 for the annual assessment dated 01/19/21 and he had told her he had stopped smoking prior to her assessment, but he had not. The MDS Nurse stated she should have put it down that he was a tobacco user and she had not spoken with staff to validate if he had quit.

NA #2 was interviewed on 02/17/21 at 2:50 PM. She stated that Resident #45 was a smoker and he went outside frequently to smoke.

An interview was conducted on 02/17/21 at 3:11 PM with NA #1 and it was stated Resident #45 was an independent smoker.

Nurse #1 was interviewed on 02/17/21 at 4:23 PM regarding Resident #45. The nurse stated he was an unsupervised smoker and smoked a couple times a shift.

A phone interview with NA #4 on 02/18/21 at 12:32 PM indicated that Resident #45 would smoke 5-6 times a shift and he was an independent smoker. She noted she had not heard him verbalize plans to quit smoking.

A phone interview was conducted with the Unit Manager on 02/18/21 at 12:05 PM. She said Resident #45 was a smoker and smoked 5-6 times a day and she was not aware of any time he had quit.

The Director of Nursing was interviewed via phone on 02/19/21 at 9:38 AM regarding the MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 9	F 641		

assessment for Resident #45. She indicated the MDS should code accurately.

The Administrator was interviewed by phone on 02/19/2021 at 8:29 AM. It was stated that the MDS Nurse should have followed up with Resident #45 when he stated he was not smoking. The Administrator noted the MDS Nurse could have informed him that he had been seen smoking and questioned him again as he was known to be forgetful.

3. Resident #10 was admitted to the facility 9/15/2017 with diagnoses to include hemiplegia, hypertension and peripheral vascular disease.

A smoking assessment dated 8/20/2020 assessed Resident #10 to be a safe smoker and he did not require smoking supervision.
The annual Minimum Data Set (MDS) dated 8/24/2020 indicated no tobacco products were used.

Resident #10 was observed 2/15/2021 at 10:00 AM in the smoking area of the facility smoking a cigarette.

An interview was conducted with the MDS nurse on 2/17/2021 at 4:00 PM. The MDS nurse reported the smoking information for Resident #10 was missed during the annual MDS completion.

The Administrator was interviewed on 2/18/2021 at 3:25 PM. The Administrator reported it was her expectation the MDS were completed accurately.

4. Resident #65 was readmitted to the facility on 10/12/2020 with diagnoses to include heart disease, diabetes and heart failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 10	F 641		

A physician order dated 12/9/2020 for Resident #65 to receive oxygen at 2 liters per minute by nasal cannula as needed for comfort.

Resident #65 was observed on 2/15/2021 at 9:20 AM. Resident #65 was receiving supplemental oxygen delivered at 2 liters per minute by nasal cannula.

The quarterly MDS dated 2/2/2021 indicated no oxygen therapy while Resident #65 was a resident.

An interview was conducted with the MDS nurse on 2/17/2021 at 4:00 PM. The MDS nurse reported the oxygen therapy information for Resident #65 was missed during the quarterly MDS completion.

The Administrator was interviewed on 2/18/2021 at 3:25 PM. The Administrator reported it was her expectation the MDS were completed accurately.

5. Resident #73 was readmitted to the facility 3/15/2018 with diagnoses to include dementia, peripheral vascular disease and hypertension.

The most recent annual MDS dated 2/5/2021 documented Resident #73 received anticoagulant medication 7 out of 7 days during the look-back period.

A review of physician orders for January and February 2021 revealed Resident #73 was not prescribed anticoagulant medications.
An interview was conducted with the MDS nurse on 2/17/2021 at 4:00 PM. MDS nurse reported the anticoagulant medication for Resident #73

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 11	F 641		

was incorrectly coded during the annual MDS completion.

The Administrator was interviewed on 2/18/2021 at 3:25 PM. The Administrator reported it was her expectation the MDS were completed accurately.

6. Resident #75 was admitted to the facility 3/20/2015 and discharged to another facility 11/24/2020. The most recent discharge MDS assessment dated 11/24/2020 documented Resident #75 had been discharged to an acute hospital.

A progress note dated 11/24/2020 documented Resident #75 was discharged to another skilled nursing facility per his family request.

An interview was conducted with the MDS nurse on 2/17/2021 at 4:00 PM. The MDS nurse reported the discharge disposition information for Resident #75 was miscoded for the discharge MDS assessment.

The Administrator was interviewed on 2/18/2021 at 3:25 PM. The Administrator reported it was her expectation the MDS were completed accurately.
7. Resident # 8 was admitted to the facility on 03/10/2020 with diagnoses that included non-Alzheimer's dementia.

A review of the medical record of Resident # 8 revealed a letter dated 01/30/2019 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 8 was determined to have a halted PASSR level II. Halted is defined as no need for future level I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 12	F 641		

screening unless a significant change occurs with resident mental status.

A review of a comprehensive admission Minimum Data Set (MDS) dated 03/17/2020 included that Resident # 8 had no cognitive impairment and section A 1500 was coded that Resident # 8 did not have a level II PASSR.

On 02/17/2021 at 11:57 AM an interview was conducted with social worker (SW) #1 and SW # 2. SW #1 revealed that the it was the responsibility for either the SW or the MDS nurse to complete section A 1500 on the comprehensive MDS and that SW # 1 had received PASSR level training in the past and believed that she was told that if a resident received a halted PASSR status that the resident should not be coded with a level II PASSR. SW #2 revealed that she had not been aware of not to code PASSR level II status at any time and that she coded all PASSR levels that were not determined to be a level I on the comprehensive MDS. SW #1 revealed that on review of the Resident Assessment Instrument (RAI) it did not specify not to code a halted level II PASSR.

An interview conducted with the MDS nurse on 02/17/2021 at 4:01 PM revealed that she had been employed for 2 months and that she was not aware of any concerns related to PASSR coding on the MDS and that the social workers completed that section of the MDS.

On 02/19/2021 a telephone interview was conducted with the facility administrator at 9AM. The administrator stated that it was her expectation that all residents with a level II PASSR be coded accurately on the MDS as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 13	F 641		

directed by the RAI.

8. Resident # 44 was admitted to the facility on 10/26/2012 with diagnoses that included Alzheimer's disease, mood disorder and insomnia.

A review of the medical record of Resident # 44 revealed a letter dated 12/29/2019 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 44 was determined to have a halted PASSR level II. Halted is defined as no need for future level I screening unless a significant change occurs with resident mental status.

A review of a comprehensive annual MDS dated 04/02/2020 included that Resident # 44 had no cognitive impairment and section A 1500 was coded that Resident # 44 did not have a level II PASSR.

On 02/17/2021 at 11:57 AM an interview was conducted with social worker (SW) #1 and SW # 2. SW #1 revealed that the it was the responsibility for either the SW or the MDS nurse to complete section A 1500 on the comprehensive MDS and that SW # 1 had received PASSR level training in the past and believed that she was told that if a resident received a halted PASSR status that the resident should not be coded with a level II PASSR. SW #2 revealed that she had not been aware of not to code PASSR level II status at any time and that she coded all PASSR levels that were not determined to be a level I on the comprehensive MDS. SW #1 revealed that on review of the RAI it did not specify not to code a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 14	F 641		

halted level II PASSR.

An interview conducted with the MDS nurse on 02/17/2021 at 4:01 PM revealed that she had been employed for 2 months and that she was not aware of any concerns related to PASSR coding on the MDS and that the social workers completed that section of the MDS.

On 02/19/2021 a telephone interview was conducted with the facility administrator at 9:43 AM. The administrator stated that it was her expectation that all residents with a level II PASSR be coded accurately on the MDS as directed by the RAI.

9. Resident # 49 was admitted to the facility on 11/16/2017 with diagnoses that included non-Alzheimer's dementia, anxiety disorder, depression and a psychotic disorder.

A review of the medical record of Resident # 49 revealed a letter dated 11/13/2017 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 49 was determined to have a halted PASSR level II. Halted is defined as no need for future level I screening unless a significant change occurs with resident mental status.

A review of a comprehensive annual MDS dated 01/26/2021 included that Resident # 49 had no cognitive impairment and section A 1500 was coded that Resident # 49 did not have a level II PASSR.

On 02/17/2021 at 11:57 AM an interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 15	F 641		

conducted with social worker (SW) #1 and SW # 2. SW #1 revealed that the it was the responsibility for either the SW or the MDS nurse to complete section A 1500 on the comprehensive MDS and that SW # 1 had received PASSR level training in the past and believed that she was told that if a resident received a halted PASSR status that the resident should not be coded with a level II PASSR. SW #2 revealed that she had not been aware of not to code PASSR level II status at any time and that she coded all PASSR levels that were not determined to be a level I on the comprehensive MDS. SW #1 revealed that on review of the RAI. it did not specify not to code a lalted level II PASSR on the MDS.

An interview conducted with the MDS nurse on 02/17/2021 at 4:01 PM revealed that she had been employed for 2 months and that she was not aware of any concerns related to PASSR coding on the MDS and that the social workers completed that section of the MDS,

On 02/19/2021 a telephone interview was conducted with the facility administrator at 9:43 AM. The administrator stated that it was her expectation that all residents with a level II PASSR be coded accurately on the MDS as directed by the RAI.

10. Resident # 63 was admitted to the facility on 06/22/2012 with diagnoses that included non-traumatic brain dysfunction, depression, schizophrenia and affective mood disorder.

A review of the medical record of Resident # 63 revealed a letter dated 08/29/2012 from the North Carolina Department of Health and Human Services Division of Mental Health,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 16	F 641		

Developmental Disabilities and Substance Abuse Services revealed that Resident # 63 was determined to have a halted PASSR level II. Halted is defined as no need for future level I screening unless a significant change occurs with resident mental status.

A review of a comprehensive annual MDS dated 02/02/2021 included that Resident # 63 had no cognitive impairment and section A 1500 was coded that Resident # 63 did not have a level II PASSR.

On 02/17/2021 at 11:57 AM an interview was conducted with social worker (SW) #1 and SW # 2. SW #1 revealed that the it was the responsibility for either the SW or the MDS nurse to complete section A 1500 on the comprehensive MDS and that SW # 1 had received PASSR level training in the past and believed that she was told that if a resident received a halted PASSR status that the resident should not be coded with a level II PASSR. SW #2 revealed that she had not been aware of not to code PASSR level II status at any time and that she coded all PASSR levels that were not determined to be a level I on the comprehensive MDS. SW #1 revealed that on review of the Resident Assessment Instrument (RAI) it did not specify not to code a halted level II PASSR.

An interview conducted with the MDS nurse on 02/17/2021 at 4:01 PM revealed that she had been employed for 2 months and that she was not aware of any concerns related to PASSR coding on the MDS and that the social workers completed that section of the MDS.

On 02/19/2021 a telephone interview was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 17	F 641		

conducted with the facility administrator at 9:43 AM. The administrator stated that it was her expectation that all residents with a level II PASSR be coded accurately on the MDS as directed by the RAI (Resident Assessment Instrument).

11. Resident # 68 was admitted to the facility on 08/03/2007 with diagnoses that included non-traumatic brain dysfunction, schizophrenia, non-Alzheimer's dementia, anxiety disorder and bipolar disorder and paranoid personality disorder.

A review of the medical record of Resident # 68 revealed a letter dated 03/12/2016 from the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities and Substance Abuse Services revealed that Resident # 68 was determined to have a halted PASSR level II. Halted is defined as no need for future level I screening unless a significant change occurs with resident mental status.

A review of a comprehensive annual MDS dated 11/11/2020 included that Resident # 68 had mild cognitive impairment and section A 1500 was coded that Resident # 68 did not have a level II PASSR.

On 02/17/2021 at 11:57 AM an interview was conducted with social worker (SW) #1 and SW # 2. SW #1 revealed that the it was the responsibility for either the SW or the MDS nurse to complete section A 1500 on the comprehensive MDS and that SW # 1 had received PASSR level training in the past and believed that she was told that if a resident received a halted PASSR status

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 641	Continued From page 18 that the resident should not be coded with a level II PASSR. SW #2 revealed that she had not been aware of not to code PASSR level II status at any time and that she coded all PASSR levels that were not determined to be a level I on the comprehensive MDS. SW #1 revealed that on review of the Resident Assessment Instrument (RAI) it did not specify not to code a halted level II PASSR. An interview conducted with the MDS nurse on 02/17/2021 at 4:01 PM revealed that she had been employed for 2 months and that she was not aware of any concerns related to PASSR coding on the MDS and that the social workers completed that section of the MDS. On 02/19/2021 a telephone interview was conducted with the facility administrator at 9:43 AM. The administrator stated that it was her expectation that all residents with a level II PASSR be coded accurately on the MDS as directed by the RAI (Resident Assessment Instrument).	F 641		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		3/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 812	Continued From page 19 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff interviews and observations the facility failed to provide cleaning and painting in food preparation areas on 10 of 10 ceiling vents that were located between the 2 stoves and the steam tables. 10 of 10 vents in the kitchen had scattered reddish-brown areas and 3 of 10 had gray fuzzy matter protruding downward and between the grids on the vents in the ceiling. Findings included: A tour of the kitchen was conducted on 02/15/21 at 9:15 AM with the Dietary Manager. An observation was done of the ceiling vents. It was noted that 10 of 10 ceiling vents between the stoves and the steam tables had scattered reddish brown areas on the surface and 3 of 10 of these ceiling vents were noted to have gray fuzzy matter protruding downward and also between the grids on the vents. An interview with the Dietary Manager on 02/15/21 at 9:30 regarding the ceiling vents was done. The manager stated the vents were on a weekly sanitation inspection list and she had asked for the vents to be taken down, cleaned and painted a couple of months ago. The manager acknowledged the reddish-brown areas	F 812	1. The ceiling vent in the dietary department have been cleaned and painted by the Maintenance Department on 2/16/2021 2. The maintenance of the ceiling vents have been added to the monthly Preventative Maintenance schedule requiring a signature as of 2/19/2021 3. The Certified Dietary Manager has been educated on the use of the computer system for preventative maintenance on by the Administrator on 2/19/2021. Dietary Staff to be educated on work order process by the Certified Dietary Manager beginning on 3/4/21 and to be completed by 3/15/2021. 4. Environmental Rounds to be completed 5 times weekly by the Administrator/ designee for 12 weeks beginning on 3/16/2021. The results of these rounds will be shared with the Maintenance Director/ designee and The Certified Dietary Manager during the Morning Meeting process. A copy of any Dietary work orders will be provided to the Administrator/ designee during Morning Meeting, Monday through Friday beginning 3/16/2021. Data obtained during audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 812	Continued From page 20 on the 10 vents, and she stated she did not know what the gray fuzzy matter was protruding from the vents. An interview with Dietary Aide/Cook #1 was conducted on 2/15/21 at 10:08 AM. When questioned regarding the reddish-brown areas and the gray fuzzy matter on the ceiling vents she stated she had not noticed that, but if she had she would have let maintenance know and it was a fire hazard. A phone interview was done with Dietary Aide/Cook #2 on 02/18/21 at 11:23 AM. She said if the ceiling vents were dirty or rusty, it was a safety issue and maintenance should be notified. A review of an Extended Sanitation checklist dated 11/18/20 noted that the vents needed repainting due to rust. It was signed by the Dietary Manager, Regional Culinary Director, and the Administrator. The Weekly Sanitation Audit conducted on 11/20/20 and signed by the Dietary Manager, Regional Culinary Director and the Assistant Administrator indicated the vents in ceiling need to be cleaned or painted. The Weekly Sanitation Audit dated 11/27/20 and signed by the Administrator and the Regional Culinary Director noted the vents needed cleaned and painted. A review of the 12/04/20 Weekly Sanitation Audit documented "the vents in the ceiling tile grids needed cleaned and painted." It was signed by the Regional Culinary Manager. A copy of the Repair Requisition form was also included with	F 812	analyzed for patterns and trends by the Quality Assurance and Process Improvement (QAPI)committee. This information will be reported during the Quality Assurance and Process Improvement (QAPI) for 3 months. The committee will make recommendations or changes as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 812	Continued From page 21	F 812		

the report and had been completed by the Dietary Manager. The Repair Requisition noted "vents are dusty and dirty and need to be cleaned or painted."

A review of the 12/07/20 Weekly Sanitation Audit indicated the vents in the ceiling tile grids needed cleaned or painted. It was signed by the Regional Culinary Manager.

A review of the maintenance work orders provided by administration from 12/01/20 to 12/31/20 did not include the 12/04/20 request.

An interview with the Dietary Manager was conducted on 02/17/21 at 10:59 AM regarding the 12/04/20 maintenance request. She stated the maintenance staff had told her on multiple occasions they would be coming to paint and it was a night job, and they would do the vents at that time. She said maintenance had told her a month ago that when the vents had rust on them, it attracted more dust.

The Assistant Administrator was interviewed via phone on 02/19/21 at 9:58 AM regarding the dietary sanitation checklist from 11/20/20. He shared that the dietary management team had brought this to his attention, and he had reviewed the audit. He stated he asked the environmental staff to clean the vents and had told maintenance about the concerns. He stated he had given the checklist to the Administrator to conduct the follow up.

An interview with the Maintenance Director was conducted on 02/17/21 at 3:18 PM about the kitchen ceiling vents. He stated the process for maintenance work requests was the Dietary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 812	Continued From page 22	F 812		

Manager would complete a work order and put it on the clipboard, but most of the time they just asked him and he did it. He stated he did not have a work order from 12/04/20, however he was going to paint the whole kitchen but he did not have a set date. He was asked about the ceiling vents and he said maintenance usually dusted the vents when they changed the filters every month to month and a half. When asked if he had seen it with the gray material coming out to the vents, he noted he had noted that, and grease made the vents tacky and attracted the lint. He stated the vents could be cleaned more often and it would not get that bad, and he was hoping to replace the vents with plastic vents and that he was putting the vents on a monthly cleaning schedule.

An interview with the Regional Nutrition Consultant (RNC) was conducted on 02/17/21 at 11:00 AM in relation to the ceiling vents. The RNC said maintenance had said they had cleaned the vents a month ago and the rust attracted more dust. She noted it was important with the dust that the food would always be covered under the vents and the food prep should be done somewhere else since the steam tables and ovens were directly under the vents.

A phone interview was conducted with the Dietary Manager on 2/18/21 at 11:13 AM. She stated she had not completed another work order after 12/04/20 as she had been told they were coming to paint the kitchen and she assumed they would clean and paint the vents at that time. She said Weekly Sanitation Audits were done and then reviewed with the Administrator by the Regional Culinary Director and signed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL SALISBURY	710 JULIAN ROAD SALISBURY, NC 28147

(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 812	Continued From page 23 A phone interview was completed with the Regional Culinary Director on 02/18/21 at 1:28 PM. She noted that Weekly Sanitation Audits were being done and they looked low and high for dust and areas that needed painting. She stated they had noted on several occasions the vents needed painting. She said she had noticed the dust on the vents and the light fixtures a month to a month and a half ago and she knew maintenance had cleaned the light fixtures that day. Their process was that would review the audits with the Administrator. She stated the Dietary Manager was responsible to do the work orders.	F 812		