STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING ______ B. WING ______	C 03/16/2023

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

(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 001 SS=L	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The	E 001		4/15/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/06/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 001	Continued From page 1 CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: E0001: Based on record review and staff interviews the facility failed to follow the Emergency Preparedness policy and provide education on the emergency preparedness plan for workplace violence to the facility staff. Staff failed to follow the emergency preparedness plan by not initiating the workplace violence procedures including calling the facility code to warn staff of a threatening situation (Code Silver) out loud and over the public address system, moving residents to a safe place, and initiating a lockdown of the building when an unknown male intruder entered the facility behind a severely cognitively impaired resident (Resident #88), rode an elevator to second floor, and vandalized the second-floor dayroom by destroying a television, knocking a hole in the wall, and breaking out two windows. This deficient practice had the potential to impact all residents in the facility because of the violent nature of the intruder and once the intruder was inside the facility, he had access to all resident areas of the facility. Immediate Jeopardy began on 02/02/23 when the second-floor staff failed to follow the emergency prepared plan by not calling facility code to warn staff of a situation involving violence (Code Silver), moving residents to a safe place, and initiating lockdown of the building when an unknown male intruder entered the building behind a severely cognitively impaired resident, rode the elevator to the second floor, and	E 001	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. This plan of correction is submitted as the facility's credible allegations of compliance. On 02/02/2023 there were no other residents in the hallway outside their rooms when the incident occurred. Once the stranger was removed from the facility the Administrative Nursing staff completed a round on all residents to ensure their safety during the first shift 02/03/2023. There have been no reported injuries associated with the remaining shards of glass and this was validated with weekly skin assessments completed by the charge nurse and reviewed by the wound nurse on 02/08/2023. All residents have the potential to be affected by this alleged deficient practice. By 03/08/2023 the Director of Nursing and Nurse Managers trained all facility staff including agency staff on the facility's	

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E 001

Continued From page 2

vandalized the second-floor dayroom which could have caused emotional harm to all residents on the floor. The immediate jeopardy was removed on 03/09/23 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "F" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective.

Findings included:

The facility was a three-story building located in a residential neighborhood on the outskirts of the city of Charlotte, surrounded by multiple businesses, and within one mile of two hospitals. Entrance to the building was covered and on the first floor located in the front of the building facing, open, and accessible from the main road. A second entrance was a side entrance or the "smoking porch" which faced the residential street, was covered, had steps in the front, a ramp to the side, was accessible from the parking lot, residential street, and main road. The first floor contained an elevator and stair entrance to all floors which was located next to the door leading to smoking porch, resident rooms, therapy room, and administrative offices. The second floor contained a dining room, resident rooms, nursing station, and dayroom. The third floor was the locked memory care unit for residents and contained resident rooms, dining room, and dayroom. All floors were accessible by the elevator or various stairwells.
Review of facility emergency preparedness plan

E 001

Emergency Preparedness Plan for Workplace Violence, the facility process for managing a Non-Medical Emergency and allowing entry into the facility from the smoking porch door. This education includes staff will immediately call 911, announce a code silver over the intercom, staff will assist residents into rooms, close doors, and monitor hallways as outlined in the Emergency Preparedness Plan. All staff will be trained to request information from visitors regarding whom they are visiting or the purpose of the visit prior to allowing entry into the facility through the smoke porch. The Director of Nursing will ensure that this education will be included in the orientation for newly hired staff and agency staff. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education. The Administrator and Director of Nursing will interview ten random staff members three times per week for 12 weeks to validate staff understand the process for calling a code silver, securing residents in their room, and locking down the facility as outlined in the Emergency plan, for any episode of workplace violence.

The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of completion: 03/10/2023

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E 001	Continued From page 3 last reviewed, signed by Administrator #2 and dated 11/01/20 revealed under workplace violence initial actions: dial 911 if there is any threat of workplace violence, announce the facility code to warn staff of situation (Code Silver), activate facility's Emergency Operations Procedure (EOP) and appoint facility incident commander if warranted, move residents to closest safe area: if dangerous or armed assailant is in the facility, flee the dangerous area if possible, assist residents and visitors to take cover behind doors, heavy furniture, or on floor, take refuge behind locked doors and if possible cover windows, maintain contact with 911 to provide and receive information, initiate lockdown procedures if it is appropriate to control facility access and contact Administrator. There was no documentation of prior in-service trainings on emergency preparedness plan to include workplace violence with staff. Per Administrator #1, she had begun to review the emergency preparedness plan and would begin in-service trainings of plan to include workplace violence procedures with all staff. Review of admission minimum data set (MDS) dated 12/23/22 revealed Resident #88 was severely cognitively impaired and was assessed as a current tobacco user. Resident #88 was also independent for transfers and locomotion and required only assistance of walker or wheelchair for mobility. A telephone interview was conducted with Nursing Assistant (NA) #7 on 03/07/23 at 7:04 PM revealed she worked on the second floor of the facility from 11 PM to 7 AM and was working the morning of 02/02/23 when the vandalism incident occurred. She stated residents on the	E 001		

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E 001	Continued From page 4 second floor wake up between 4 AM and 6 AM and come down to the dining room to have their morning coffee and then go outside to smoke unsupervised, including Resident #88. She revealed around 5:20 AM she was in the shower room, which was located next to the dining room, assisting another NA and resident when she could hear someone out in the hall. NA #7 stated she looked outside the shower room door to see who was in the hallway and saw an unknown male intruder wearing a jacket, scrubs, and what appeared to be men's briefs on his head like a mask heading towards the dining room. She revealed she had told the other NA to stay in the shower room with the resident while she investigated who the unknown male intruder was and checked on the residents in the dining room. She stated when she came out of the shower room the unknown male intruder was standing in the dining room looking around and had taken off his jacket and kicked it in the air. NA #7 revealed the unknown male intruder then began walking down the hall towards the second-floor dayroom and that is when she told the residents in the dining room to go back to their rooms or to go downstairs to the first floor away from the unknown male intruder. She stated she had asked the nurse on the floor to call 911 while she stood in the hallway and watched the unknown male intruder in dayroom. She revealed the unknown male intruder had sat down at the desk located in the dayroom and was mumbling to himself and then picked up a three-hole punch from the desk and threw it at the television on the wall shattering the screen. NA #7 stated the unknown male intruder picked up a chair from the dayroom and busted out two of the windows and threw television remote controls which caused a hole in the wall. She revealed the unknown male	E 001		

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E 001	Continued From page 5	E 001		

intruder turned around and started to charge back up the hall towards the dining room and that is when she went into nurse's station which was an office with windows that look out to the dining room and both hallways on the second floor and locked the door. She stated the unknown male intruder was in the dining room when the police arrived, and the police removed him from the unit with no issues. She stated she had worked at the facility for nine years and she was not aware of the emergency preparedness plan or workplace violence procedures and had not received any training to include calling Code Silver, securing residents, or initiating lockdown procedures for the facility.

A telephone interview was conducted with Nurse #5 on 03/07/23 at 5:52 PM revealed she had been working at the facility for over a year and was working 11 PM to 7 AM on 02/02/23 when the vandalism incident occurred. She stated Resident #88 was outside around 5:20 AM smoking unsupervised. She revealed an unknown male intruder entered the building and had ridden the elevator up to the second floor with Resident #88. Nurse #5 stated at first, she believed the unknown male intruder to be an agency staff due to him wearing scrubs but started noticing erratic behaviors such as standing in the dining room and taking off his jacket and kicking it in the air. She revealed Nursing Assistant #7 (NA) came out of the shower room and began watching the unknown male intruder while she went behind the nurse's station to call 911. She stated while NA #7 watched the unknown male intruder and told residents to go to their rooms, she went down to the first floor and was gone for maybe five minutes to escort officers up to second floor where they removed the unknown male intruder

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E 001	Continued From page 6 from the dining room. Nurse #5 revealed she later learned the unknown man had gone into the dayroom and broken out the windows, shattered the TV, and knocked a hole in the wall. She stated she had not received any training on workplace violence and had not been made aware of calling Code Silver, securing residents to a safe place, or performing lockdown procedures. An interview was conducted with Administrator #1, who was the Director of Nursing prior to 2/27/23, on 03/07/23 at 3:23 PM she was informed by the previous administrator of the incident with the unknown man intruder entering the building and vandalizing the second-floor dayroom. Administrator #1 revealed to her understanding, Resident #88 was outside on the smoking porch of the facility around 5:20 AM on 02/02/23 smoking unsupervised when an unknown male intruder followed Resident #88 back into the facility and rode the elevator with her to the second floor. She revealed Resident #88 nor staff knew who the unknown male intruder was so staff called 911 and before the police could arrive to remove the unknown male intruder from the facility, he vandalized the second-floor dayroom by shattering the television screen on the wall, knocked a hole in the wall, and had used a chair to break out two of the windows. The Administrator #1 stated she was told no residents had witnessed the incident but was not aware if the prior Administrator had spoken with any of the residents about the incident or had completed an investigation. She revealed she was not aware of any staff including herself being trained on the workplace violence or lockdown procedures as addressed in facility emergency preparedness plan. Administrator #1	E 001		

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E 001	Continued From page 7 stated staff should have been trained on workplace violence procedures such as calling Code Silver to inform of an intruder in the building, securing all residents to a safe place, and lockdown procedures of securing all exits. She revealed all facility staff including herself should have training on emergency preparedness plan to include workplace violence and lockdown procedures for the facility. An interview was conducted with Administrator #2 on 03/09/23 at 9:55 AM revealed he had been the facility Administrator when the vandalism incident occurred on 02/02/23. He stated he had received a text from staff about the vandalism incident and when he arrived around 6:30 AM at the facility the unknown male intruder had been removed from the facility and there were two officers there receiving statements from staff. He revealed his understanding of the vandalism incident was Resident #88 had gone outside earlier that morning to smoke unsupervised and she allowed an unknown male intruder to come back into the building with her and ride the elevator to the second floor with her. The Administrator #2 stated the unknown male intruder vandalized the second-floor dayroom by shattering the television, knocking a hole in the wall, and breaking out two of the widows with a chair. He revealed he only received verbal statements from staff, but no written statements and no investigation was completed. He stated he did not speak with any of the residents on the second floor about the vandalism incident and was not aware that any of the residents had been up that morning or had witnessed the vandalism incident. Administrator #2 revealed none of the staff at the facility had been trained on emergency preparedness plan to include workplace violence or on the procedures	E 001		

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E 001	Continued From page 8	E 001		

of calling Code Silver, securing all residents, and performing lockdown procedures for the facility. He revealed going forward all staff including himself should be trained on the emergency preparedness plan to include workplace violence and lockdown procedures.

The facility Administrator was notified of immediate jeopardy on 03/08/23 at 11:35 AM.

The facility provided the following plan for IJ removal.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to announce facility code to warn the staff of a situation (Code Silver) and move or assist residents to closest safe area, and initiate lockdown procedures. On 2/2/23 at approximately 5:20 am the door to the smoking porch was unlocked. A male stranger that had been discharged from the hospital, entered the facility through an unlocked door on the smoking porch with Resident #88 and rode the elevator with her to the 2nd floor, walked by the nurse's desk to the end of hall and busted the windows of the day room with a chair and the busted the TV glass with a chair. I don't like this verbiage as it is not clear to the reader that this was a stranger off the street and not one of the nursing home residents.
Staff went into the medication room, locked the door and called 911 leaving the residents unsupervised.

On 2/2/23 there were no other residents on the hallway outside their rooms when the event

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E 001	Continued From page 9	E 001		

occurred. Once the stranger was removed from the facility the Administrative Nursing staff completed a round on all residents to ensure their safety during 1st shift 02/03/23. There have been no reported injuries associated with the remaining shards of glass and this was validated with weekly skin assessments completed by the charge nurse and reviewed by the wound nurse on 2/8/23.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

By 3/8/23 The Regional Director of Operations educated the Administrator and the Director of Nursing on the facility's Emergency Preparedness Plan for managing Workplace Violence, the facilities process for managing a Non-Medical Emergency and Allowing entry into the facility from the smoke porch door. This education includes, in case of an emergency, staff will immediately call 911, announce a code silver over the intercom, assist residents into rooms, close doors, and monitor hallways as outlined in the Emergency Preparedness Plan. This education included a review and update of this Emergency Preparedness Plan quarterly and as needed.

By 3/8/23 the Director of Nursing and Nurse Managers trained all facility staff including agency staff on the facility's Emergency Preparedness Plan for Workplace Violence, the facility process for managing a Non-Medical Emergency and allowing entry into the facility from the smoking porch door. This education includes, staff will immediately call 911, announce a code silver over

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E 001	Continued From page 10	E 001		

the intercom, staff will assist residents into rooms, close doors, monitor hallways as outlined in the Emergency Preparedness Plan. All staff will be trained to request information from visitors regarding whom they are visiting or the purpose of the visit prior to allowing entry into the facility through the smoke porch.

By 3/8/23 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Maintenance Director regarding the monthly QAPI meeting and the addition of a quarterly review of the Emergency Preparedness Plan including the management of Workplace Violence.

Effective 3/8/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 3/9/2023

On 03/16/23, the facility's credible allegation for immediate jeopardy removal effective 03/09/23 was validated by the following: Staff interviews revealed they had received training on workplace violence to include making sure to secure all residents, call code silver, call 911, and notify administration. Staff interviews also revealed they had received training on security of the facility and that doors are supposed to be locked at all times and staff making sure all doors are locked so all staff and visitors are using the smoking porch entrance so they could be seen on the camera and allowed entrance into the facility and on the smoking policy and that all residents are supervised smokers and there would be a

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E 001	Continued From page 11 smoking attendant during designated smoking times to ensure smoker safety and no residents allowed out to smoke except during smoking times. Observation of all entry doors being locked from outside and camera with two-way speaker working at smoking porch entrance and camera feed and speaker in working order at first shift nursing station. The Administrator had possession of all manually locked doors to ensure the doors stay locked and visitors are being allowed entrance into facility by staff. Audits were in process of being completed with all smoking residents about supervised smoking policy, smoking times, smoking attendant, and doors staying locked at all times and use of camera and two-way speaker.	E 001		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted onsite from 3/6/23 through 3/10/23. The team returned to the facility to validate the credible allegation of compliance on 3/16/23. Therefore the exit date of the survey was changed to 3/16/23. Event ID #EAD911. The following intakes were investigated NC00189794, NC00190650, NC00190806, NC00193503, NC00197553, NC00198397, NC00198775, NC00199246. Five of the 28 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.12 at tag F600 at a scope and severity (J) CFR 483.12 at tag F610 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity	F 000		

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F 000	Continued From page 12 (K) CFR 483.70 at tag F835 at a scope and severity (J) The tags F600, F610, and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 2/27/22 and removed on 3/11/23. An extended survey was conducted.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		4/15/23

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	345008	A. BUILDING ______ B. WING ______	C 03/16/2023

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F 550	Continued From page 13 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interview the facility failed to maintain a resident's dignity by not providing clean clothing for 1 of 2 residents (Resident #6) reviewed for resident rights. Resident #6 was not provided with clean clothing which resulted in the resident not wanting to get out of bed to participate in daily activities as he normally would and a reasonable person would expect to be dressed in their home when they wanted to be. Findings included: Resident #6 was admitted to the facility on 5/14/16. The annual Minimum Data Set (MDS) dated 12/23/22 revealed Resident #6 was severely cognitively impaired and required extensive assistance of one staff member for most activities of daily living (ADL). On 3/7/23 at 11:23 AM Resident #6 was observed	F 550	On 03/10/2023, the Nurse Manager ensured resident #6 was provided with clean clothes. Grooming and hygiene assistance was provided by the Certified Nursing Assistant and the resident was out of bed for activities and socialization. All residents have the potential to be affected by this alleged deficient practice. By 03/10/2023, the Nurse Managers completed an observation of all residents to identify other residents with dignity concerns related to not having clean clothes to get out of bed. Any opportunities identified were addressed immediately by the Director of Nursing and the Housekeeping Supervisor. On 03/10/2023, education by the Nurse Managers began and will be completed by 4/14/2023, for all facility staff, including agency staff on the facility policy for maintaining dignity for residents that	

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F 550	Continued From page 14 to be in the bed and wearing a hospital gown. An observation of Resident #6's closet revealed the resident had no clothing in his closet. A second observation was conducted at 2:00 PM of Resident #6 in the bed, wearing a hospital gown. On 3/7/23 at 2:35 PM an interview was conducted with NA #7. NA #7 stated Resident #6 was normally out of the bed every day at lunch time, but she didn't get him up because he had no clean clothes at the time, she was in the room getting him dressed for the day around 9:00 AM. She stated laundry services did not bring his clothes up until after lunch and by that time the resident did not want to get up. On 3/8/23 at 9:39 AM an interview was conducted with NA #8. NA #8 stated Resident #6 usually wanted to get out of the bed prior to lunch time. She stated on 3/7/23 she and NA #7 could not get the resident out of bed because he had no clean clothing in his closet. The interview revealed Resident #6 would not get up wearing just a hospital gown. She stated the laundry staff member was off over the weekend and the residents personal clothing piled up and nobody took them to the wash until Monday morning. On 3/8/23 at 9:17 AM an interview was conducted with Laundry Services Staff #1. She stated she worked in the building as the only staff member in laundry services Monday through Thursday with one day off. The interview revealed she rotated and worked every other weekend. She stated if she was off work over the weekend then no laundry in the facility was completed. The interview revealed the facility had ordered extra linens to ensure residents had enough towels, wash cloths and bedding but residents personal	F 550	includes, but not limited to providing clean clothing to ensure residents who desire to get out of bed have cleaned and appropriate clothing. The Director of Nursing will ensure that this education will be included in the orientation for newly hired staff and agency staff. The Nurse Managers and Director of Nursing will observe nine residents three times per week for 12 weeks for the availability of clean clothing to ensure the resident□s dignity is maintained. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of Completion: 04/14/2023	

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F 550	Continued From page 15	F 550		

clothing was not washed if she was not in the building. She stated she was off work last weekend and was still trying to catch up on personal clothing. The interview revealed she delivered two clean shirts and a pair of pants to Resident #6 on 3/7/23 around 11:00 AM and noticed the resident did not have any clean clothing in his closet. She stated she was struggling to keep up with laundry.

On 3/9/23 at 11:26 AM Resident #6 was observed to be in the bed and wearing a hospital gown.

On 3/9/23 at 1:41 PM a follow up interview was conducted with NA #7. She stated no personal clothing had been delivered to the unit for the day on 3/9/23 and she did not get Resident #6 out of the bed due to no clean clothing in his closet. She stated Resident #6 had the most personal clothes on the unit and there was no reason for him not to have clean clothing. The interview revealed Resident #6 did not want to be out of the bed in just a hospital gown. NA #7 stated the resident wanted to wear pants.

On 3/9/23 at 12:01 PM an interview was conducted with the Housekeeping Manager. He stated he had one staff member in laundry services that worked every day of the week but one day and rotated weekends. The interview revealed on the weekends she was off he would come in to ensure the facility had necessary linen but that his focus was not on personal clothing. He stated the goal turn around time for personal clothing would be 24 hours however the facility was not meeting that goal every day and they were trying to hire someone else for that role. The interview revealed he felt Laundry Staff Member #1 had a mindset to always complete linens first

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F 550	Continued From page 16 before personal clothing and that was creating an issue with residents not having clean clothing. On 3/9/23 at 5:25 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated Resident #6 liked to get out of bed to his wheelchair around lunch time. She stated the resident was normally out of bed for activities so being in the bed all day wasn't normally Resident #6's routine. The DON stated she knew laundry was an issue and the facility had been trying to hire someone to fill the role of assisting the one laundry staff member they currently have. The interview revealed the job had been posted on an online staffing site for 45 days with no interest. On 3/10/23 at 9:25 AM an interview was conducted with Resident #6's Responsible Party (RP). During the interview she stated Resident #6 was usually up for meals and in his wheelchair dressed. She stated she visited the facility daily and ensured he was dressed however due to an illness she had not been in the facility that week. The interview revealed Resident #6 would not have gotten out of the bed in just a gown and if the facility did not have clothing, they could have contacted her, and she would have brought in extra. She stated she felt like Resident #6 enjoyed being up for meals and in his wheelchair.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or	F 558		4/15/23

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F 558	Continued From page 17 other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with residents and staff, the facility failed to provide access to control the light behind the bed; and failed to place a call light within reach to allow the resident to request staff assistance if needed for 1 of 1 resident reviewed for accommodation of needs (Resident #39). The findings included: Resident #39 was admitted to the facility on 01/31/20. Review of the quarterly Minimum Data Set (MDS) dated 01/17/23 assessed Resident #39 with intact cognition and independent to walk inside the room. Review of Resident #39's medical records revealed he had moved to his current room on 03/03/23. During an observation conducted on 03/06/23 at 11:36 AM, the cord to control the switch of light behind Resident #39's bed was broken. It extended approximately 2.5 inches from the light fixture and was around 70 inches above the floor. Resident #39 was unable to reach the cord from the bed if needed. Observation of the cord for the call light revealed it had been rolled up, taped, and placed close to the power source by the wall. It extended about 12 inches from the wall and approximately 40 inches above the floor, making it inaccessible for Resident #39 to request staff assistance from the bed if needed. The call light functioning properly when it was tested.	F 558	On 03/09/2023, the Maintenance Director ensured that the access to control the light behind the bed was assessable to the resident and that the call light was within reach of the resident. All residents have the potential to be affected by this alleged deficient practice. By 03/09/2023, the Maintenance Director, Administrator, Director of Nursing, and Nurse Managers completed an observation of all residents to ensure that call lights were within reach and to ensure that all over the bed lights were accessible to the resident. On 03/09/2023 education began by the Nurse Managers and the Director of Nursing and will be completed by 04/14/2023, for all facility staff, including the agency staff to ensure all call lights are within reach of the resident and to ensure that the over bed light controls are accessible to the resident. This information will be added to the new hire orientation. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education.The Nurse Managers and Director of Nursing will observe ten residents three times per week for 12 weeks to ensure call lights are within reach of the resident. The Maintenance Director and the Assistant Maintenance Director will observe twenty over the bed lights per week for 12 weeks to ensure the	

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Continued From page 18

An interview was conducted with Resident #39 on 03/06/23 at 11:36 AM. He stated the switch cord for light had been broken and the electrical cord for the call light had been rolled up since the first day he moved into this room. He stated he had to get out from his bed each time to reach the switch cord to control the light or to trigger the call light as needed. He felt that it was very inconvenient to him, and he was frustrated why none of the staff would do something to fix the problems.

Subsequent observation conducted on 03/07/23 at 3:20 PM revealed the light cord and the call light were out of reach for Resident #39.

During a joint observation conducted with Nurse #3 on 03/08/23 at 11:50 AM, the light cord and the call light remained out of reach for Resident #39.

During an interview conducted on 03/08/23 at 11:54 AM, Nurse #3 stated he had provided care for Resident #39 daily, but he did not notice that the call light and the light cord were out of reach in the past few days. Otherwise, he would have notified the maintenance staff to fix it. He did not know who had rolled up the cord for the call light and acknowledged that it could make Resident #39 inaccessible to the call light from the bed. He added the string attached to the light behind the bed was too short and very inconvenient for Resident #39.

An interview conducted with Nurse Aide #4 on 03/08/23 at 12:43 PM revealed she had provided care for Resident #39 frequently in the past few months. She did not know who had rolled up and

F 558

light controls are accessible to the resident.

The Director of Nursing and the Maintenance Director will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of Completion: 04/14/2023

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F 558	Continued From page 19 taped the cord for Resident #39's call light. She acknowledged that the call light and the light cord were inaccessible for Resident #39. She explained it was her oversight to miss Resident #39's repair needs. During an interview conducted with the Maintenance Manager on 03/08/23 at 12:53 PM, he stated he walked through the facility at least 1-2 times weekly to identify repair needs. He also depended on staff to report repair needs through work order or verbal notification. He had been checking the work order boxes located at each nurse station and his office door at least once daily. He did not know that the cord for the light was in disrepair and the cord for the call light was inaccessible to Resident #39. An interview was conducted with the Director of Nursing (DON) on 03/08/23 at 4:12 PM. She expected all the facility staff to be more attentive to residents' living environment and reported all the repair needs in timely manner to accommodate residents' needs. During an interview conducted on 03/09/23 at 10:39 AM, the Administrator stated it was her expectation for the staff to notify the maintenance staff for all repair needs in timely manner to accommodate residents' needs.	F 558		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		4/15/23

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F 561	Continued From page 20 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to allow a resident who had been assessed as a safe independent smoker the choice to smoke unsupervised for 1 of 1 resident reviewed for choices (Resident #31). Findings included: Resident #31 was admitted to the facility on 02/13/17 with diagnoses including peripheral vascular disease, cognitive communication deficit, and other chronic pain.	F 561	On 3/10/2023, Resident #31 was assessed by the Administrator, per the Safe Smoking Screening, he is an unsupervised smoker. All residents that smoke have the potential to be affected by the alleged deficient practice. On 04/05/2023, the Director of Nursing and the Unit Managers conducted an audit of the Safe Smoking Screening assessment, current tobacco use, and the plan of care for all residents that smoke. A meeting was held on 04/06/2023 by the Unit Managers, the	

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F 561	Continued From page 21 Review of the revised smoking policy dated 02/01/20 revealed all residents were evaluated for smoking and smoking history, that evaluation would designate each resident as a non-smoker, safe-independent smoker, supervised smoker, or a dependent smoker. Safe smoking evaluation would be completed quarterly or as needed. Smoking times will be designated as per facility protocol, the exception is the independent smoker that does not require assistance of any kind and may smoke in the designated smoking area at will. The quarterly smoking assessment completed by Nurse #3 dated 11/03/21 revealed Resident #31 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #31 was assessed as able to smoke safely independently. Review of revised care plan dated 07/02/22 revealed Resident #31 was identified as a smoker with a goal of no accidents related to smoking through next review. Interventions include complete smoking safety assessment per facility policy and reviewing smoking policy with resident and or family. An interview conducted with Nurse #3 on 03/08/23 at 3:44 PM revealed he was familiar with Resident #31 and had assessed him as an independent safe smoker on the smoking assessment dated 11/03/21 due to him being cognitively intact, able to smoke and extinguish cigarette safely, and his ability to ambulate independently inside and outside of facility. He stated Resident #31 had always been assessed as an independent safe smoker and allowed to smoke unsupervised since his admission and he	F 561	Director of Nursing, the Social Services Director, and the Administrator, with residents who smoke for education of a new smoking policy which included but was not limited to the distinction between unsupervised versus supervised, location of the smoking area, and securing of smoking materials. By 04/14/2023, all staff, including agency staff will be educated on the new smoking policy by the Administrator, Social Services Director, Director of Nursing and Nurse managers. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education. This information will also be added to the new hire orientation. A smoking attendant will be available from the hours of 8am to 8pm to supervise those residents who are assessed as requiring supervision with smoking and to ensure residents that smoke secure their smoking materials in a secured designated area. The Director of Nursing or Designee will audit all residents who smoke weekly for 12 weeks to ensure all resident's are appropriately assessed as supervised or unsupervised smokers as indicated by the Safe Smoking Screening and if anyone has a change in status, a new assessment will be completed, and the resident's care plan will be updated. The Director of Nursing will report the results of the audits monthly for 3 months during the QAPI committee meeting and the committee will make	

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F 561	Continued From page 22 had no knowledge of any changes medically or behaviorally with Resident #31 and no changes with his ability to continue to smoke unsupervised. The annual Minimum Data Set (MDS) dated 02/23/23 revealed Resident #31 was cognitively intact and assessed as a current tobacco user. Review of the smoking assessment completed by the Unit Manager dated 03/06/23 revealed Resident #31 was able to hold the cigarette safely without a device, extinguish cigarette safely, and ambulate independently. Resident #31 was assessed as requiring supervision while smoking. An interview conducted with the Unit Manager on 03/09/23 at 11:12 AM revealed she was familiar with the facility safe smoking assessment and was informed by Director of Nursing (DON) on 03/06/23 that all smokers were to be reassessed as requiring supervision while smoking to include Resident #31. She stated Resident #31 had been assessed prior as an independent smoker requiring no supervision due to his ability to smoke safely, being able to move independently inside and outside of the facility and sign himself in and out of the facility at his leisure. The Unit Manager stated there were no changes to Resident #31's ability to smoke safely unsupervised other than her being told by the DON that all smokers were to be reassessed as requiring supervision while smoking. An observation conducted on 03/06/23 at 11:20 AM revealed Resident #31 sitting on the steps to the back side of facility building where the parking lot was located smoking unsupervised. Resident #31 was observed being able to hold cigarette to	F 561	recommendations. Date of completion: 04/14/2023	

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F 561	Continued From page 23	F 561		

smoke, ash the cigarette, and extinguish cigarette with no issues.

An observation was conducted of Resident #31 on 03/07/23 at 6:20 PM revealed him outside smoking unsupervised. Resident #31 was observed being able to hold his cigarette to smoke, ash his cigarette, and distinguish his cigarette with no issues.

An interview conducted with Nurse Aide (NA) #10 on 03/09/23 at 11:45 AM revealed he had been assigned as the staff smoking attendant to supervise smokers during scheduled smoking times and distribute their smoking materials. He stated he was informed this morning by the DON that all smokers were to be supervised during scheduled smoking times (8 AM, 11 AM, 1 PM, 4 PM, 6PM and 8 PM) and he was to distribute all smoking materials from the locked box. He revealed Resident #31 had previously been allowed to smoke unsupervised but this morning he had to inform him that he could only smoke during the scheduled smoking times, had to be supervised while smoking, and keeping his smoking materials in locked box so they could be distributed during scheduled smoking times.

An observation on 03/09/23 at 4:00 PM of Resident #31 revealed him being accompanied by staff out to the smoking porch during a designated smoking time, receiving smoking materials from staff, and being supervised while smoking with staff.

An interview conducted with Director of Nursing (DON) on 03/09/23 at 5:11 PM revealed an incident had occurred on 02/02/23 when an unknown male intruder entered the building

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THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 561	Continued From page 24	F 561		

during the early morning hours behind a resident who had been outside smoking unsupervised and rode the elevator to the second floor and vandalized the second-floor dayroom. The DON stated after that incident the facility administration discussed all smokers being assessed as requiring supervision and implementing staff supervised smoking times. She revealed the facility had a meeting with staff and some of the smokers to discuss these changes, but she was not aware if Resident #31 was in attendance for the meeting and to her knowledge there were no forms completed or signed with any resident stating they understood the smoking changes and all smokers being supervised. The DON stated Resident #31 had always been an independent smoker due to his ability to smoke safely and ambulate independently inside and outside of the facility. She revealed she was told by the Administrator that all smokers were to be assessed as requiring supervision while smoking including previous safe independent smokers, and that is why she informed the Unit Manager to complete the reassessment for Resident #31 to become a supervised smoker.

An interview conducted with the Administrator on 03/09/23 at 5:59 PM revealed she had started her position as facility Administrator on 02/27/23 and prior to that had been the DON for the facility. She stated the facility smoking policy had been in effect for several years and addressed both independent smokers who were able to smoke at will with no supervision and supervised smokers who required staff supervision during scheduled smoking times. The Administrator stated after the incident that occurred on 02/02/23 where an unknown male intruder entered the building behind a resident who was outside during the

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F 561	Continued From page 25 early morning hours smoking unsupervised, rode elevator to second floor and vandalized the second-floor dayroom, she and the previous Administrator began discussing supervised smoking for all residents, scheduled smoking times, and staff smoking attendant assigned to supervise. She revealed as part of the changes to smoking she had discussed with the DON to have all smoking residents reassessed as requiring supervision while smoking to include Resident #31 who prior to his current assessment date of 03/06/23 had been an independent safe smoker due to his ability to smoke safely, ambulate independently inside and outside of the facility, and sign himself in and out of facility at his leisure. She revealed the facility was currently working on revising the facility smoking policy and discussing with each resident who smokes the changes.	F 561		
F 584 SS=E	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	F 584		4/15/23

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F 584	Continued From page 26 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, 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 observations and staff interviews, the facility failed to maintain a homel like environment for 3 of 3 shower rooms not having warm running water and failed to maintain cleanliness. The findings included: 1. An observation conducted of the shower room on the 300 Hall on 03/06/23 at 12:20 PM revealed a strong odor of urine, the shower drain cover was missing, and the toilet in the shower room was covered in yellow dried stains and brownish substance resembling stool.	F 584	On 3/09/23 the Maintenance Director conducted water temperature audits on all three shower rooms to ensure the water maintained the temperature settings and covered the shower drain. The Housekeeping Supervisor and housekeeping staff cleaned all three shower rooms. All residents have the potential to be affected by this alleged deficient practice. By 3/10/23 the Maintenance Director collected water temperatures on all showers and sinks used by residents and	

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F 584	Continued From page 27 An interview and observation conducted with Nurse #7 on 03/06/23 at 4:00 PM revealed there had been a shortage of housekeeping staff, and nobody had cleaned the shower room in several days. Nurse #7 and asked to leave the shower room due to the strong urine odor. Nurse #7 indicated the shower room was dirty and needed to be cleaned. An observation was conducted on 03/07/23 on the 300 Hall at 9:15 AM revealed the shower room had a strong odor of urine, the shower drain cover was missing, and the toilet in the shower room was covered in yellow dried stains and brownish substance resembling stool. An interview conducted with Nurse Aide (NA) #11 on 03/09/23 at 1:45 PM revealed she had worked all three halls and there had been issues with housekeeping being short staffed. NA # 11 further revealed she had cleaned the shower rooms and residents' rooms due to being dirty and they had not been cleaned. 2. An observation conducted on the 200 Hall on 03/07/23 at 12:25 PM revealed the shower faucet ran for an estimated time of five minutes and the water temperature was barely warm. This was the only shower in this shower room. An observation conducted on the 100 Hall on 03/07/23 at 1:15 PM revealed the shower faucet ran for an estimated time of five minutes and the water temperature was barely warm. This was the only shower in this shower room. An interview conducted with NA #11 on 03/09/23 at 1:45 PM revealed there had been issues with the temperature of showers and multiple	F 584	staff. Any water temperatures out of range were immediately corrected by the Maintenance Director. On 03/09/2023 education was initiated by the Administrator and Director of Nursing and will be completed on 04/14/2023, to re-educate all staff, including agency staff on the facility process for notifying the Maintenance Director of needed repairs by making a notation in the Maintenance Log at each Nurses station. Beginning 03/10/2023 the Maintenance Director was educated by the Administrator on the responsibility of reviewing these repair requests daily and completing the repair or adding to the prioritized list. The Administrator will ensure this education will be included in orientation for newly hired staff and agency staff.The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education. The Maintenance Director and assistant maintenance staff will review nine resident rooms and all three shower rooms two times a week for 12 weeks to ensure appropriate water temperatures. The Administrator will review all maintenance requests from the maintenance request logs in the morning Stand Up meeting and will review any follow needed concerning the log in the afternoon Stand Down meeting. The Administrator will observe all three shower rooms three times a week for 12 weeks to ensure cleanliness. The Housekeeping Supervisor will ensure that a daily cleaning log is signed by the housekeeping staff daily to ensure	

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F 584	Continued From page 28 residents had complained daily. NA #11 stated she had reported the water temperatures to the Maintenance Director several times but was not aware if anybody had looked at the issue. An interview conducted with the Director of Housekeeping on 03/08/23 at 9:00 AM revealed the facility has had shortages with staff and housekeeping and residents' rooms and shower rooms had not be cleaned daily like he would like. The Director of Housekeeping further revealed he was aware of the shower water temperature being an issue and had reported this to the Maintenance Director multiple times. An interview and observation with the Maintenance Director and the Administrator #2 on 03/08/23 at 1:00 PM revealed the Maintenance Director was aware there had been issues with water temperature and had it looked at. The Maintenance Director was unable to locate any documentation that the water had been looked at by a professional. He indicated the water temperature was an ongoing issue, but did not have a plan for getting it fixed. Administrator #2 stated he was unaware of the water temperature issues but would expect for the residents to be able to have warm to hot showers.	F 584	cleanliness of the shower rooms. The Administrator will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of completion: 04/14/2023	
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and	F 600		4/15/23

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F 600	Continued From page 29 any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect a cognitively impaired resident from staff to resident physical abuse for 1 of 1 resident (Resident #396) reviewed for abuse. On 02/27/22 when nursing staff were serving breakfast, Resident #396 was standing next to the meal cart and reached for a carton of milk. Nurse Aide (NA) #9 told Resident #396 to stop twice in a "loud aggressive manner" and when the resident did not comply NA #9 pushed the resident on the left side of his torso above his hip onto the ground. Resident #396's cognitive impairment prevented him from expressing an adverse outcome. A reasonable person would have been traumatized by being physically abused by a caregiver in their home environment. Immediate Jeopardy began on 02/27/22 when Nurse Aide (NA) #9 pushed Resident #396 to the ground while the resident was reaching for an item from the meal cart on the memory care unit of the facility. The Immediate Jeopardy was removed on 03/11/23 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of a "D" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of	F 600	Resident #396 was discharged from the facility on 10/13/2022. Nurse Aide #9 was suspended by the Administrator from the facility on 02/27/2022. All residents have the potential to be affected by these deficient practices. On 3/10/2023 the Director of Nursing and Nurse Managers completed an interview with current facility staff and current residents with a BIMS of 10 or higher to identify any unreported observations or allegations of abuse and neglect. Nurse Managers completed skin assessments for residents unable to be interviewed to assess potential abuse. Any allegations identified because of this audit will be reported to the Administrator immediately, accused staff will be suspended pending investigation and a 24-hour report will be initiated with Adult Protective Services and Law enforcement notification. On 03/09/2023 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for Prevention of Abuse and Neglect including	

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education and monitoring systems put into place are effective.

The findings included:

Resident #396 was admitted to the facility on 10/22/21 with diagnoses which included dementia, Parkinson's disease, muscle weakness, and difficulty walking.

Resident #396's care plan with a revision date of 10/14/21 revealed the resident had impaired cognitive function and impaired thought processes and communication due to dementia. The care plan goals indicated Resident #396 would be able to communicate basic needs daily through the review date. Interventions included to use the resident preferred name, identify yourself at each interaction, face the resident when speaking and make eye contact, and reduce any distractions. Interventions also included the resident understands consistent, simple, directive sentences and provide the resident with necessary cues and return if the resident was agitated. The care plan for Resident #396 also revealed he had a behavior problem that included, in part, the following behaviors: refusing care, wandering, and sitting on the floor, and taking food from other residents.

Review of the quarterly Minimum Data Set (MDS) dated 01/28/2022 revealed Resident #396 was moderately cognitively impaired and required extensive assistance with ambulation and locomotion. majority of activities of daily living. The MDS further revealed Resident #396 was coded for no behaviors or rejection of care. Resident #396 was not steady but able to stabilize without staff assistance for walking.

F 600

and the Elder Justice Act as well as providing care for residents with Dementia and Impaired Cognition. This education includes a focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care. Staff were also taught to walk away if they are feeling frustrated with a resident and not to put their hands on them. Staff were provided with reassurance to express challenges and frustration with their job without retaliation. All staff were re-educated regarding requirements to report any observation or allegation to the Administrator or Director of Nursing. On 03/10/23 The staff were notified that the contact information for the Administrator and Director of Nursing was posted at each Nurses station for after hours and weekend reporting. It will be the responsibility of the Administrator and Director of nursing to maintain a tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any newly hired staff and agency staff receive this training during orientation.The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. The Administrator and

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F 600	Continued From page 31 Review of the facility initial allegation report completed by Administrator #2 dated 02/27/22 (a Sunday) revealed on 02/27/22 at 4:00 PM Administrator #2 was made aware of a staff to resident abuse allegation. Nurse #6 alleged NA #9 pushed Resident #396. The report further revealed Resident #396 sustained no injuries. An interview conducted with Nurse #6 on 03/09/23 at 8:15 AM revealed on 02/27/22 she was sitting at the nurses' desk charting while other staff were giving out breakfast trays. Nurse #6 further revealed she heard NA #9 tell Resident #396 in a loud manner to stop and she looked up to observe Resident #396 standing next to the meal cart reaching for an item on the meal cart. Nurse #6 stated NA #9 walked back to the cart towards the nurses' desk and told Resident #396 to stop again but said it in a louder and aggressive tone. Nurse #6 observed NA #9 push Resident #396 on his left side in the middle of his torso above his hip and the resident fell to the floor on his right side. Nurse #6 indicated she immediately went to Resident #396 who was observed to look startled and assisted the resident off the floor and assessed for injuries. Nurse #6 revealed Resident #396 sustained no injuries but was observed to be startled. An interview conducted with NA #8 on 03/09/23 at 9:40 AM revealed on 02/27/22 she was handing out breakfast trays and heard NA #9 state to Resident #396 twice to "stop it" in a loud aggressive manner. NA #8 further revealed she heard a loud thump and left a resident's room and observed Nurse #6 assisting Resident #396 off of the floor.	F 600	Director of Nursing will review concern logs weekly for 12 weeks and interview five random residents and five random staff weekly for 12 weeks, to ensure incidents of abuse are reported, staff involved are suspended and investigations are conducted. The Director of Nursing will report the results of the audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of completion: 04/14/2023	

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An interview conducted with NA #9 on 03/10/23 at 11:10 AM revealed on 02/27/22 she was handing out breakfast trays and Resident #396 kept trying to grab a milk carton off the meal cart. NA #9 further revealed she told Resident #396 to stop a couple times because he continued to grab for a milk carton. NA #9 indicated she never touched Resident #396 and the resident never went down to the floor.

Administrator #2 was notified of immediate jeopardy on 3/9/23 at 4:20 PM.

The facility provided the following immediate jeopardy removal plan on 3/16/23.

On 3/10/23 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Nurse Managers on the facility policy for Prevention of Abuse and Neglect, the Elder Justice Act as well as providing care for residents with Dementia, Impaired Cognition.

This education includes the following:

· The definition of abuse as the willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental and emotional distress

· There will be a zero tolerance for resident abuse.

· A focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care.

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F 600	Continued From page 33 · The requirements to immediately intervene and provide safety for any resident in an abusive situation. · The expectation that the residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms. · The following signs and symptoms of abuse -Welts, bruises, abrasions or lacerations of unexplained origin, especially those that appear symmetrical -Broken bones, fractures, or dislocations (unknown cause/multiple) -Broken glasses or black eyes/dentures or broken teeth -Sexual exploitation/Rape -Excessive exposure to heat or cold -Visible signs of restraint, markings on wrist -Multiple burns or human bites -Fearful demeanor when specific care giver is around · On 3/9/23 the Administrator, Director of Nursing and Nurse Managers re-educated all	F 600		

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facility staff, including agency staff, on the facility policy for Prevention of Abuse and Neglect including and the Elder Justice Act as well as providing care for residents with Dementia and Impaired Cognition. This education includes a focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care.

· Staff were also educated to walk away if they are feeling frustrated with a resident and not to place your hands on them. Staff were provided with reassurance to express challenges and frustration with their job without retaliation.

This education includes the following:

· The definition of abuse as the willful infliction of injury, intimidation, or punishment resulting in physical harm, pain, or mental and emotional distress

· There will be a zero tolerance for resident abuse.

· A focus on a calm approach, allowing time for residents to complete tasks without rushing and explaining what to expect before beginning to provide care, as well as giving agitated residents a break before continuing care.

· The requirements to immediately intervene and provide safety for any resident in an abusive situation.

· The expectation that the residents have the right to be free from abuse, neglect, misappropriation

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of resident property and exploitation. This includes but is not limited to freedom from punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident ' s symptoms.

· The following signs and symptoms of abuse

-Welts, bruises, abrasions or lacerations of unexplained origin, especially those that appear symmetrical

-Broken bones, fractures, or dislocations (unknown cause/multiple)

-Broken glasses or black eyes/dentures or broken teeth

-Sexual exploitation/Rape

-Excessive exposure to heat or cold

-Visible signs of restraint, markings on wrist

-Multiple burns or human bites

-Fearful demeanor when specific care giver is around

All staff were re-educated regarding requirements to report any observation or allegation to the Administrator or Director of Nursing. On 3/10/23 The staff were notified that the contact information for the Administrator and Director of Nursing was posted at each Nurses station for after hours and weekend reporting. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect

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F 600	Continued From page 36 will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. The Director of Nursing will ensure any new hired staff and agency staff receive this training during orientation and their responsibility to maintain the tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any new hired staff and agency staff receive this training during orientation. Effective 3/10/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/11/2023 On 3/16/23, the facility credible allegation for immediate jeopardy removal of 3/11/23 was verified through onsite validation. Staff interviews revealed they had received education and training on resident abuse. This included information on the facility's policy for prevention of abuse and neglect, the Elder Justice Act, how to provide care for residents with dementia and impaired cognition, what resident abuse and neglect looks like, and the importance of reporting immediately. Interviews confirmed nursing staff was educated on how to how to walk away from a resident if the resident that is frustrated or agitated and how to	F 600		

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F 600	Continued From page 37 approach in a calm manner. The facility's immediate jeopardy removal plan was validated to be completed as of 3/11/23.	F 600		
F 610 SS=J	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to protect residents when Nurse Aide (NA) #9 was not removed from a resident care assignment after Nurse #6 witnessed NA #9 push Resident #396 on the left side of his torso above his hip onto the ground. The facility also failed to thoroughly investigate abuse and to notify Adult Protective Services and Law Enforcement of abuse for 1 of 1 resident reviewed for abuse (Resident #396).	F 610	Resident #396 was discharged from the facility on 10/13/2022. Nurse Aide #9 was suspended by the Administrator from the facility on 02/27/2022. The Administrator initiated a 24-hour report on 02/27/2022 and delivery was verified with the Health Care Personnel Registry on 03/10/2023. The Administrator notified Adult Protective Services and Law enforcement on 03/10/2023.	4/15/23

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Continued From page 38

Immediate Jeopardy began on 02/27/22 when the facility allowed NA #9 to continue working after she was observed by Nurse #6 to physically abuse Resident #396. The immediate jeopardy was removed on 3/11/23 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out of compliance at a lower scope and severity "D" (no actual harm with potential for harm) to ensure monitoring systems are put into place are effective.

The findings included:

A review of the facility policy and procedure titled" Abuse, Neglect, and Exploitation", with a revised date of 10/22/20, read in part "it is the policy of this facility to provide protections for the health, welfare, and rights of each residents by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property." The "Investigation of Alleged Abused, Neglect, and Exploitation: " Section specified in part: 6. Providing complete and thorough documentation of the investigation. The "Reporting/Response" section specifies in A1, "Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all required agencies (e.g. law enforcement when applicable) within specified time frames". The "Protection of Resident" section reads in part: "The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after an investigation".

Resident #396 was admitted to the facility on 10/22/21.

F 610

All residents have the potential to be affected by these deficient practices.

On 03/10/2023 the Administrator and Director of Nursing reviewed the grievance log for the last 30 days to ensure there were no unreported allegations of abuse or neglect. Any allegations identified because of this audit will be followed up, the accused staff will be suspended pending investigation, a 24-hour report will be initiated, Adult Protective Services and Law enforcement will be notified. On 03/10/2023 the Administrator and Director of Nursing reviewed previously reported allegations of abuse occurring during the last 90 days and validated the investigation was completed and residents were protected.

On 03/10/2023 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for preventing abuse and neglect, providing protection to residents and immediate reporting to the Administrator and Director of Nursing including location of contact information for after hours and weekend reporting. All staff were re-educated regarding the requirement to immediately provide safety for any resident in an abusive situation and then report any observation or allegation of abuse or neglect to the Administrator or Director of Nursing. On 03/10/2023 the staff were notified that the contact information for the Administrator and Director of Nursing is posted at each Nurses station for after

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Review of the facility initial allegation report completed by Administrator #2 dated 02/27/22 (a Sunday) revealed on 02/27/22 at 4:00 PM Administrator #2 was made aware of a staff to resident abuse allegation. Nurse #6 alleged NA #9 pushed Resident #396. The report further revealed Resident #396 sustained no injuries.

Review of the facility internal investigation completed on 02/27/22 by Administrator #2 related to the staff to resident physical abuse allegation involving NA #9 and Resident #396 revealed no documentation of statements from those involved, education provided to staff, or notification that law enforcement and adult protective services was completed.

An interview conducted with Nurse #6, an agency nurse, on 03/09/2023 at 8:15 AM revealed on 02/27/22 she was sitting at the nurses' desk charting while other staff were giving out breakfast trays. Nurse #6 further revealed she heard NA #9 tell Resident #396 in a loud manner to stop and she looked up to observe Resident #396 standing next to the meal cart reaching for an item on the meal cart. Nurse #6 stated NA #9 walked back to the cart towards the nurses' desk and told Resident #396 to stop again but said it in a louder and aggressive tone. Nurse #6 observed NA #9 push Resident #396 on his left side in the middle of his torso above his hip and the resident fell to the floor on his right side. Nurse #6 indicated she immediately went to Resident #396 who was observed to look startled, and she assisted the resident off the floor and assessed for injuries. Nurse #6 revealed Resident #396 sustained no injuries. Following the assessment of the resident she went to Administrator #2's office to report the incident, but Administrator #2

hours and weekend reporting. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation. On 03/10/2023 the Administrator notified the Director of Nursing and Assistant Director of Nursing of their responsibility to provide education and maintain a tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any newly hired staff and agency staff receive this training during orientation. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education.

The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of completion: 03/10/2023

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had people in his office and she was unable to report what was observed. Nurse #6 stated she went back to the memory care unit and contacted Unit Manager (UM) #1 who was on call and reported the incident she observed. Nurse #6 revealed she was told somebody from the facility would handle the situation and speak to NA #9. Nurse #6 indicated NA #9 continued to work the rest of the shift working with residents until 3:00 PM. Nurse #6 indicated she was hired through agency but was educated to report any kind of abuse immediately to an upper management staff. Nurse #6 stated she did not think it was appropriate for NA #9 to continue to work the rest of the shift but was told by UM #1 somebody for the facility would handle it. Nurse #6 indicated she did not work at the facility again after the incident date.

An interview conducted with NA #8 on 03/09/23 at 9:40 AM revealed on 02/27/22 she was handing out breakfast trays and heard NA #9 state to a Resident #396 twice to "stop it" in a loud aggressive manner. NA #8 further revealed she heard a loud thump and left a resident's room and observed Nurse #6 assisting Resident #396 off the floor. NA #8 stated she spoke to Administrator #2 at the end of shift and reported the same information but did not write a written statement. NA #8 indicated she believed NA #9 pushed Resident #396 down and could not understand why the NA was allowed to work the full shift. NA #8 revealed she recalled Nurse #6 had reported to staff over the phone.

An interview conducted with NA #9 on 03/10/23 at 11:10 AM revealed on 02/27/22 she was handing out breakfast trays and Resident #396 kept trying to grab a milk carton off the meal cart. NA #9

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F 610	Continued From page 41 further revealed she told Resident #396 to stop a couple times because he continued to grab for a milk carton. NA #9 indicated she never touched Resident #396 and the resident never went down to the floor. NA #9 revealed she had worked the full shift and spoke to Administrator #2 at the end of her shift. NA #9 stated she did not complete a written statement but was suspended for further investigation for a couple of days. NA #9 indicated she did not receive any abuse training after the incident had occurred. An interview conducted with the Unit Manager (UM) #1 on 03/09/23 at 11:12 AM revealed she was the on-call supervisor on 02/27/22 but was not involved with the incident that occurred with Resident #396. The UM #1 did not recall Nurse #6 reporting the incident to her. An interview conducted with the prior administrator, Administrator #2, on 03/09/23 at 9:50 AM revealed he was the abuse coordinator at the time of 2/27/22 incident involving the staff to resident physical abuse allegation for NA #9 and Resident #396. He revealed he could not locate any written documentation for the investigation completed on Resident #396 on 02/27/22. Administrator #2 further revealed he was not made aware of the incident until later in the day on 02/27/22 but could not recall who had reported it. Administrator #2 indicated he did not report the incident to law enforcement or adult protective services because he felt like it was not a crime. Administrator #2 could not recall Nurse #6 coming to him to report abuse and had not gathered written statements from nursing staff but had interviewed staff about the incident. Administrator #2 stated NA #9 had worked the full shift on 02/27/22 but was suspended for a few	F 610		

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F 610	Continued From page 42	F 610		

days after this date to complete an investigation. Administrator #2 revealed he had completed in-service with NA #9 and nursing staff he interviewed who worked the memory care unit during the incident on how to re-direct residents. Administrator #2 was unable to locate documentation of who he had in-serviced and what education was received. Administrator #2 could not recall if he had assessed residents who could have been affected. Administrator #2 further revealed he had suspended NA #9 during an investigation for a couple days, but NA #9 was allowed back to work because he felt like no crime was committed.

Administrator #1 was notified of immediate jeopardy on 3/9/23 at 4:20 PM.

The facility provided the following immediate jeopardy removal plan on 3/16/23.

· Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

The facility failed to protect Resident #396 and maintain the right to be free from physical abuse. Resident #396 has a diagnosis of dementia and lives in the memory care unit. Resident #396 was observed being pushed by staff and sustained a fall. Resident #396 was assessed by the charge nurse following the incident and no injuries were identified.
The facility failed to protect Resident #396 and other residents after physical abuse was observed at approximately 12:00 noon on 2/27/22. The accused Nurse Aide was allowed to continue to work with residents until 4:00pm on 2/27/22, when the allegation of abuse was

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reported to the Administrator.

The Administrator initiated a 24-hour report on 2/27/22 and delivery was verified with the Health Care Personnel Registry on 3/10/23. The Administrator notified Adult Protective Services and Law enforcement on 3/10/23. A five-day report was resubmitted on 3/10/23 with documentation of completed investigation.

On 3/10/23 the Administrator and Director of Nursing reviewed the grievance log for the last 30 days to ensure there were no unreported allegations of abuse or neglect. Any allegations identified as a result of this audit will be followed up, the accused staff will be suspended pending investigation, a 24-hour report will be initiated, Adult Protective Services and Law enforcement will be notified.

On 3/10/23 the Administrator and Director of Nursing reviewed previously reported allegations of abuse occurring during the last 90 days and validated the investigation was completed and residents were protected.

All residents have the potential to be affected by these deficient practices.

· Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

On 3/10/23 the Regional Director of Operations re-educated the Administrator and Director of Nursing on the facility policy for completing a 24 hour and 5-day report for abuse and neglect, reporting to the survey agency within 2 hours

F 610 Continued From page 44 F 610

when there is a suspicion of a crime, notification to law enforcement and notification of Adult Protective Services. This education included requirements for a complete investigation including resident and staff interviews, medical record review and incident re-enactment when appropriate.

On 3/10/23 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for preventing abuse and neglect, providing protection to residents and immediate reporting to the Administrator and Director of Nursing including location of contact information for after hours and weekend reporting. All staff were re-educated regarding the requirement to immediately provide safety for any resident in an abusive situation and then report any observation or allegation of abuse or neglect to the Administrator or Director of Nursing. On 3/10/23 the staff were notified that the contact information for the Administrator and Director of Nursing is posted at each Nurses station for after hours and weekend reporting. The Administrator or Director of Nursing will ensure any staff member accused of abuse or neglect will immediately be removed from the resident care area and supervised until exiting the facility pending an investigation.
On 3/10/23 the Administrator notified the Director of Nursing and Assistant Director of Nursing of their responsibility to provide the education and maintain the tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any newly hired staff and agency staff receive this training during orientation.

On 3/10/23 the Administrator began reviewing all

F 610 Continued From page 45 F 610

allegations of abuse or neglect with the Interdisciplinary team during the Morning Meeting. On 3/10/23 the Regional Director of Operations will begin a weekly review of all 24-hour reports to ensure staff are suspended, thorough investigations are completed with 5- day report submitted and documentation to reflect timely submissions.

Effective 3/10/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged Date of IJ Removal: 3/11/2023

On 3/16/23, the facility's credible allegation for immediate jeopardy removal effective 3/11/23 was validated by the following: Administrator #1 and Director of Nursing (DON) interview revealed they were re-educated on the facility for completing a 24 hour and 5-day report for abuse and neglect, reporting to survey agency within two hours when there is a possible crime, and notification to adult protective services (APS) and law enforcement. Education included when completing a thorough investigation to conduct staff interview, medical record review, and incident re-enactment when appropriate. Through interviews with nursing staff they verified education was provided for preventing abuse and neglect, provide protection to residents, and reporting possible neglect or abuse to the Administrator or DON immediately. Staff also revealed they were notified that the contact numbers for the DON and Administrator were posted at the nurses ' desks in case of possible abuse or neglect to report if they were not in the building. Administrator #1 further reveled she had

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F 610	Continued From page 46 started a new investigation on the incident and had suspended NA #9 pending the investigation. The Administrator indicated reports had been re-submitted. The facility's immediate jeopardy removal plan was validated to be completed as of 3/11/23.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		4/15/23

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(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-
(iii) Be culturally-competent and trauma-informed.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and observations the facility failed to implement a care plan intervention for 1 of 4 residents (Resident #21) reviewed for accidents.

Resident #21 was admitted to the facility on 07/16/22 with diagnoses which included vascular dementia and hypertension.

Review of Resident #21's nursing note dated 07/22/22 revealed Resident #21 was observed eating hair care products located at bedside and was also chewing a piece of plastic. The note further revealed Resident #21 was instructed to spit out the plastic and after two attempts she followed instructions and personal hair care items and hygiene items were placed at the nurse's station.

Review of Resident #21's care plan revised on 08/05/22 revealed Resident #21 had a behavior

On 03/08/2023, the Director of Nursing placed all resident #21 personal hygiene products in the designated cabinet at the nurse□s station.

All residents with impaired cognition have the potential to be affected by this alleged deficient practice. By 03/13/2023 the Nurse Managers and MDS Nurse had conducted an audit of all resident□s Kardex to ensure interventions are visible for the direct care staff.

On 03/10/2023 education began by the Nurse Managers and the Director of Nursing and will be completed by 04/14/2023, for all direct care staff of the facility and direct care agency staff to ensure staff understand how to view and follow the resident's Kardex to ensure interventions from the care plan are

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F 656	Continued From page 48 problem of eating hair products. The goal was for Resident #21 to have fewer episodes of behaviors by review date. Interventions included if reasonable to discuss the resident's behavior and explain why behavior is inappropriate and/or unacceptable to the resident. Interventions also included to keep hair care products at the nurse's station. Review of Resident #21's quarterly Minimum Data Set (MDS) dated 02/03/23 revealed the resident was severely cognitively impaired. An observation conducted on 03/06/23 at 12:15 PM revealed lotion, hand sanitizer, antifungal powder spray, blue nursing medical exam gloves, baby powder, after shower lotion, and baby oil on Resident #21's bedside table. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. An observation conducted on 03/06/23 at 3:22 PM revealed lotion, hand sanitizer, antifungal powder spray, blue medical exam gloves, baby powder, after shower lotion, and baby oil on Resident #21's bedside table. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. An interview conducted with the Resident #21's Resident Representative (RR) on 03/06/23 at 3:25 PM revealed nursing staff had continued to leave items beside Resident #21's bedside table. The RR further revealed Resident #21 had a habit of putting items in her mouth and the RR had put up a note in the resident's room and continued to educate staff. An interview and observation conducted with	F 656	followed. This information will be made available during the new hire orientation. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education. The Director of Nursing and Nurse Managers will observe five direct care staff members three times per week for 12 weeks to ensure the Kardex for the residents are followed. The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations Date of completion: 04/14/2023	

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(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 656	Continued From page 49 Nurse #7 on 03/06/23 at 4:00 PM revealed Resident #21's bedside table had lotion, hand sanitizer, antifungal powder spray, blue medical exam gloves, baby powder, after shower lotion, and baby oil placed on it. Observation included a large note written on Resident #21's closet door to keep items at the nurse's station. Nurse #7 indicated Resident #21 consistently put items in her mouth and those items should have not been left out. Nurse #7 picked up the items and placed them back at the nurse's desk. An observation conducted on 03/07/23 at 1:45 PM revealed two boxes of blue medical exam gloves and hand sanitizer on the bedside table. An interview and observation conducted with the Director of Nursing (DON) on 03/08/23 at 9:30 AM revealed two boxes of blue medical exam gloves and hand sanitizer. The DON revealed Resident #21 had a tendency of putting items in her mouth and the items observed should not have been left out.	F 656		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director	F 689	On 7/30/22 at or around 10:30 pm-10:45 pm, Resident #68 exited the memory care	4/15/23

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	345008	A. BUILDING ____ B. WING ____	C 03/16/2023

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F 689	Continued From page 50 interview the facility failed to prevent severely cognitively impaired residents from exiting the facility through unlocked doors without supervision for 2 of 2 residents reviewed for supervision to prevent accidents (Resident #88 and #68). Resident #88 who was severely cognitively impaired, exited the building through an unlocked door on the first floor to smoke without supervision. An unidentified male intruder entered facility behind Resident #88 through the unlocked door of facility and vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two windows. The facility failed to repair broken windows only covering windows with cardboard and wooden board that was easily removable leaving broken windows and shards of broken glass accessible to residents and failed to complete a facility investigation. Resident #68 was severely cognitively impaired and exited the memory care unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide (NA) when he went to his car, the resident was laying in the backseat of the NA's car asleep. The NA left Resident #68 in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help. Immediate Jeopardy began on 7/30/22 for Resident # 68 and 2/2/23 for Resident # 88 when the facility failed to provide supervision to cognitively impaired residents and failed to correct environmental hazards which put residents at a high likelihood for serious harm and injury. The immediate jeopardy was removed on 08/02/22 for Resident # 68 when the facility implemented an acceptable credible	F 689	unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide when he went to his car, the resident was laying in the backseat of the Nurse Aide□s car asleep. The Nurse Aide left the resident in the backseat asleep while he went back inside the building to get help. The Nurse Aide did not lock the vehicle when he left the resident. The windows were up on the vehicle and at the time of the incident on 7/30/22 it was 74 degrees. On 7/30/22 the Nurse aide immediately entered the facility, reported the incident to the nurse on the floor and obtained assistance from another Nurse aide, returned to the car, and assisted the resident back into the building. Resident #68 was assessed by the Charge Nurse, with no injuries noted. The facility initiated an investigation into the elopement and identified the door to the stair well on the 3rd floor had a broken lock. On 7/30/22 the Director of Nursing and Nurse Managers completed an elopement drill and visually accounted for all residents currently admitted to the facility. The Administrator and the Maintenance Director immediately repaired the lock on 7/30/22. A Nurse Aide was posted at the door until repairs were completed to ensure no other residents were able to exit. All other doors in the facility were evaluated for functioning locks, no other broken locks were identified.	

F 689 Continued From page 51

allegation for Immediate Jeopardy removal. The immediate jeopardy was removed on 03/11/23 for Resident # 88 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective.

Findings included:

1. Facility smoking policy dated 02/01/20 revealed smoking by residents who have been identified and assessed as unable to safely smoke independently may smoke only at the designated times and smoking will be supervised by a staff member. All smoking and fire igniting materials for residents who have been identified and assessed as unable to safely smoke independently shall be maintained by the facility and will be provided to residents by facility staff during designated smoking times.

Resident #88 was a female admitted to the facility on 12/16/22 with diagnoses to include impaired cognitive function, impaired thought processes related to memory and major depressive disorder. Resident #88 was petite in stature, suffered from unavoidable weight loss and was being treated under Hospice care due to diagnosis of cirrhosis of liver.

Review of admission smoking assessment dated 12/16/22 revealed Resident #88 was assessed to require supervision while smoking due to her inability to verbalize or demonstrate her

F 689

On 7/30/22 the Director of Nursing and Nurse Managers completed a review of current residents assessed at risk for elopement to ensure the wandering assessments, care plans were complete and current photos posted in the electronic record. All residents with wanderguards were assessed for placement, checked for functioning and Treatment Administration Records were reviewed to ensure daily monitoring was complete.

On 7/30/22 the Director of Nursing verified the Elopement and Leave of Absence Binders were in place at each Nurses station and the reception desk. These binders contain a list of residents with wanderguards, the resident□s photo, current wandering assessment, wandering care plan, and are updated weekly and as needed by the Director of Nursing and Nurse Managers.

On 8/1/22 the Director of Nursing and Nurse Managers completed education for all staff, including agency staff, on the facility policy for Elopement to include not leaving a resident who has exited the facility unattended until the resident can be assisted to return to the facility. After 8/1/22, the Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff and agency staff, without receiving this education. No staff was allowed to work without receiving this education.

Effective 7/30/22 the Administrator will be

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F 689	Continued From page 52 understanding of the facility time and place to smoke listed under section B for cognition. Review of admission minimum data set (MDS) dated 12/23/22 revealed Resident #88 was severely cognitively impaired, required use of walker and occasional use of wheelchair for mobility, and was assessed as a current tobacco user. Review of admission care plan dated 12/26/22 revealed Resident #88 was identified as a smoker with a goal of not smoking without supervision through next review. Interventions included instruct Resident #88 of the facility policy on smoking: locations, times, safety concerns and Resident #88 requires supervision while smoking. Review of Police Department Incident Report dated 02/02/23 revealed vandalism incident at facility occurred between 5:20 AM and 5:41 AM and included damages to windows, television, and interior wall located on second floor. The incident report stated, "On 02/02/23 at approximately 5:34 AM, officers were dispatched to facility in reference to a report of commercial breaking or entering call for service. When officers arrived on the scene, the listed suspect was on scene damaging the facility's property on the second floor. The suspect was detained by officers and transported to nearby medical facility. Warrants were issued for the listed suspect". A telephone interview was conducted with Nursing Assistant #7 (NA) on 03/07/23 at 7:04 PM revealed she worked on the second floor of the facility from 11 PM to 7 AM and was working the morning of 02/02/23 when the incident occurred. She stated residents on the second	F 689	responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Date of completion: 08/02/2022	

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F 689	Continued From page 53 floor wake up between 4 AM and 6 AM and come down to the dining room to have their morning coffee and then would go outside to smoke unsupervised including Resident #88. She revealed at 5:20 AM she was in the shower room, which was located next to the dining room, assisting another NA and resident when she heard someone walking down the hall. NA #7 stated she looked outside the shower room door and saw an unknown male intruder wearing a jacket, scrubs and what appeared to be men's briefs on his head like a mask heading towards the dining room. She revealed she had told the other NA to stay in the shower room with the resident while she investigated who the unknown male intruder was and checked on the residents in the dining room. She stated when she came out of the shower room the unknown male intruder was standing in the dining room looking around and had taken off his jacket and kicked it in the air. NA #7 revealed the unknown male intruder then began walking down the hall towards the second-floor dayroom and that is when she told the residents in the dining room to go back to their rooms or to go downstairs to the first floor. She stated she had asked Nurse #5 who was on the floor to call 911 while she stood in the hallway and watched the unknown male intruder in the dayroom. She revealed the unknown male intruder had sat down at the desk located in the dayroom and was mumbling to himself and then picked up a three-hole punch from the desk and threw it at the TV on the wall shattering the screen. NA #7 stated the unknown male intruder picked up a chair from the dayroom and busted out two of the windows and then threw TV remotes which caused a hole in the wall. She revealed the unknown male intruder turned around and started to charge back up the	F 689		

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F 689	Continued From page 54 hall and that is when she went into nurse's station and locked the door. She stated the unknown male intruder had gone back into the dining room when the police arrived and removed him from the floor. She also stated she provided her statement to the police but was never asked to give a verbal or written statement to the facility. NA #7 revealed she was later informed the unknown male intruder had entered the building and rode the elevator to the second floor with Resident #88 who had been outside smoking unsupervised. She stated she was not aware of Resident #88 being a supervised smoker and requiring supervision, but she and other residents would go outside during all hours of night and early mornings to smoke unsupervised. She revealed the door leading out to the smoking porch had been left unlocked after-hours to accommodate residents and staff with coming in and out of the building. NA #7 stated the facility had placed a camera and two-way speaker outside of the door but was not aware of who supposed to be monitoring the camera and the door continued to require a manual lock and wasn't aware of who's responsibility it was to manually lock door. She revealed she had worked from 11 PM- 7AM last night and door was unlocked all through the night and residents were continuing to go outside and smoke unsupervised. NA #7 stated the broken windows and glass had been there since incident happened and maintenance had placed a piece of cardboard and wood over the broken windows that were able to be removed by one hand. She revealed in her opinion this could have been dangerous to residents on the second-floor due residents being ambulatory or able to reach from wheelchair, easy removal of coverings placed on windows, and cognitive issues of residents	F 689		

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F 689	Continued From page 55 causing them to hurt themselves or others. A telephone interview was conducted with Nurse #5 on 03/07/23 at 5:52 PM revealed she was working 11 PM to 7 AM on 02/02/23 when incident occurred. She stated apparently Resident #88 had gone outside that morning to smoke unsupervised and around 5:20 AM when entering back into the building, an unknown male intruder entered the building behind her and rode the elevator up to the second floor. Nurse #5 stated at first, she believed the unknown male intruder to be an agency staff due to him wearing scrubs but started noticing erratic behaviors such as standing in the dining room and taking off his jacket and kicking it in the air. She revealed Nursing Assistant #7 (NA) came out of the shower room and began watching the unknown male intruder while she went behind the nurse's station to call 911. She stated while NA #7 watched the unknown male intruder and told residents to go to their rooms, she went down to the first floor to escort officers up to second floor where they removed the unknown man from the dining room. Nurse #5 revealed she later learned the unknown male intruder had gone into the dayroom and broken out the windows, shattered the TV and knocked a hole in the wall. She stated the door leading to the smoking porch has always been kept unlocked at night for staff and residents to be able to go outside and smoke. She revealed a camera and two-way speaker had now been placed outside the door, but the door still had to be manually locked and to her knowledge continued to stay unlocked. Nurse #5 stated maintenance came up after incident and covered windows with just a board and cardboard which in her opinion was dangerous because the second-floor residents could easily remove	F 689		

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F 689	Continued From page 56	F 689		

coverings and hurt themselves or others.

Observation of second-floor dayroom on 03/07/23 at 3:00 PM revealed two broken windows that had not been repaired. Both windows measured waist high while standing and chest high while sitting and would have been accessible to all ambulatory residents and residents who required wheelchairs and rollators. One window had been broken through first pane and had sharp edges still intact on window and broken glass inside window and on windowsill and was only covered with cardboard. The second window had been broken through both panes only leaving the window screen intact with broken glass inside window and on windowsill and was only covered by a wooden board. Both window coverings were easily removable by hand and accessible to all residents. The second-floor dayroom was still accessible to all residents but there were no residents located in dayroom during observation.

An interview was conducted with Administrator #1 on 03/07/23 at 3:23 PM revealed she had started as the current Administrator of the facility on 02/27/23 and prior to that had been the Director of Nursing. She stated she was informed by Administrator #2 of the incident with the unknown male intruder entering the building and vandalizing the second-floor dayroom. Administrator #1 revealed to her understanding, Resident #88 was outside on the smoking porch of the facility during the early morning hours of 02/02/23 smoking unsupervised. She stated an unknown male intruder followed Resident #88 back into the facility and rode the elevator with her to the second floor. She revealed Resident #88 nor staff knew who the unknown male intruder was so staff called 911 and before the

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F 689	Continued From page 57 police could arrive to remove him from the facility, he vandalized the second-floor dayroom by shattering the television on the wall, knocked a hole in the wall, and had used a chair to break out two of the windows. Administrator #1 stated she was told no residents had witnessed the incident but was not aware if Administrator #2 had spoken with any of the residents about the incident or had completed an investigation. She revealed that she and Administrator #2 had discussed having a camera with a two-way speaker installed at the door leading to the smoking porch, but the door would still require to be locked manually. She stated the nursing staff on the first floor would be responsible for making sure door was locked afterhours. Administrator #1 revealed maintenance had placed a wooden board and a piece of cardboard to cover the broken windows until a contractor could come and repair the broken windows and to her knowledge the contractor had been contacted but no date scheduled for the repair. She stated the facility had scheduled smoking times for supervised smokers and Resident #88 had been assessed as requiring supervision while smoking and should not have been allowed outside to smoke unsupervised. An interview was conducted with Administrator #2 on 03/09/23 at 9:55 AM revealed he had been the facility Administrator from 2017 until 02/27/23 and was the acting Administrator when the incident occurred on 02/02/23. He stated he had received a text from staff about the incident and when he arrived at the facility the unknown male intruder had been removed from the facility and there were two officers there receiving statements from staff. He revealed that his understanding of the incident was that Resident #88 had gone outside	F 689		

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F 689	Continued From page 58 earlier that morning to spoke unsupervised and she allowed an unknown male intruder to come back into the building with her and ride the elevator to the second floor with her. The Administrator #2 stated the unknown male intruder vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two of the widows with a chair. He revealed he only received verbal statements from staff, but no written statements and no investigation was completed. He stated he did not speak with any of the residents on the second floor about the incident and was not aware that any of the residents had been up that morning or had witnessed the incident. The Administrator #2 revealed he did not have a formal meeting with staff about the incident, he and the Director of Nursing spoke and decided to implement the camera and two-way speaker to the outside of door leading to smoking porch. He stated the door would still have to be manually locked and first floor nursing was responsible for making sure the door was locked after-hours. The Administrator #2 revealed although the facility had implemented smoking times for supervised smokers, he knew there had still been issues with residents going out to smoke unsupervised all hours of day and night and issues with the doors staying unlocked, but they were working with residents and staff on these issues. He stated that Resident #88 was a supervised smoker and should not have been outside smoking unsupervised. He revealed he was responsible for having maintenance board up windows and was not aware that broken glass had been left in the window that was accessible to residents and that maintenance should have cleaned out windows and done a better job with boarding up the windows. The Administrator #2 stated that he	F 689		

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F 689	Continued From page 59 had contacted a contractor about the windows, and they had come out and measured for the replacements but did not have scheduled date to come out and replace them. Observation of door leading to smoking porch on 03/07/23 at 6:20 PM being unlocked and Resident #88 sitting in wheelchair smoking unsupervised. An interview was conducted with Maintenance Director on 03/08/23 at 12:15 PM revealed on 02/02/23 he arrived at work around 7 AM and was informed by Administrator #2 of the vandalism that had occurred in the second-floor dayroom. He stated he accompanied Administrator #2 to the second-floor dayroom and observed the television on wall with shattered screen, a hole in the wall, and two broken windows. The Maintenance Director revealed he was asked by Administrator #2 to remove television from wall and to cover broken windows until a contractor could be notified to repair broken windows. He stated he removed television from wall and covered both broken windows with materials he had available at the facility. The Maintenance Director revealed one window was covered with cardboard and the other window had been covered by a piece of wood and both had been secured in place by three nails placed at the bottom of the window into the windowsill but were easily removable to give access to contractor when he came to measure for replacement windows. He stated he did not think to remove the broken glass out of the windows or from the windowsills before applying the coverings to windows or the broken glass being accessible to residents. He revealed Administrator #2 was responsible for contacting contractor for	F 689		

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F 689	Continued From page 60 replacement windows and to his knowledge a contractor had been out to the facility to measure for the replacement windows, but no date had been scheduled for the repair. The Administrator was notified of immediate jeopardy on 03/07/23 at 5:50 PM. The facility provided the following plan for IJ removal. o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance Resident #88 with a brief interview for mental status (BIMS) of 6 and assessed as a supervised smoker was outside on the smoking porch on 2/2/23 at approximately 5:20 AM smoking unsupervised. The door to the smoking porch was unlocked. An unknown individual who did not reside in the facility, was on the smoking porch with Resident #88 and came into the facility with her when she finished smoking, rode the elevator with her to the 2nd floor, walked by the nurse's desk to the end of hall and busted the windows of the day room with a chair and then busted the TV glass with a chair. Staff went into the medication room, locked the door and called 911 leaving the residents unsupervised. On 2/2/23 the Administrator came to the facility immediately following notification from the facility regarding the event at 5:20am. The Maintenance Director assisted the Administrator to cover the broken windows prior to residents getting	F 689		

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F 689	Continued From page 61	F 689		

up for the day. On 3/7/23 the windows in the dayroom on
the 2nd floor revealed shards of glass exposed, one window covered with cardboard, and a second
window covered with wood. The glass repair vendor visited the facility on the afternoon of 2/2/23 to
obtain measurements for replacement and did not resecure the window covering. A quote was accepted
for required repairs on 2/8/23 and the work is scheduled for completion.

On 2/2/23 there were no other residents in the hallway outside their rooms when the event occurred.
Once the stranger was removed from the facility the 3rd shift Nursing staff immediately completed a
round on all residents on the 2nd floor to ensure their safety. There have been no reported injuries
associated with the remaining shards of glass and this was validated with weekly skin assessments
completed by the charge nurse and reviewed by the wound nurse on 2/8/23.

An interview was completed with current smokers by the Director of Nursing, Assistant Director of Nursing and Nurse Managers on 3/8/23 to identify any attempts by unknown individuals to enter the facility through the smoking porch door. No new incidents were identified.
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o Specify the action the entity will take to alter the process or system failure to prevent a serious

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	345008	A. BUILDING ______ B. WING ______	C 03/16/2023

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

(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 689	Continued From page 62 adverse outcome from occurring or recurring, and when the action will be complete On 2/7/23 the Administrator secured an outside vendor who installed a doorbell and a camera at the smoking porch door that is monitored at the Nurses station. Beginning 2/7/23 the smoking porch door always remains locked. The key to this door is secured with the Administrator. Facility staff are able to open the door from the inside without the key to allow entry. When the doorbell rings, the nursing staff view the visitor on the camera prior to unlocking the door for entry. By 3/8/23 the Director of Nursing and Nurse Managers trained all facility staff including agency staff on this process. On 3/8/23 the Administrator secured an outside vendor to repair the identified broken windows. Work is scheduled to be completed by 3/15/23. On 3/7/23 the Maintenance Director securely covered the identified windows with plywood. By 3/8/23 the Director of Nursing and Nurse Managers trained all facility staff including agency staff on the facility policy for Workplace Safety, the process for managing a Non-Medical Emergency and allowing entry into the smoking porch door. This education includes, staff will immediately call 911, announce a code silver over the intercom, staff will assist residents into rooms, close doors, monitor hallways. All staff will be trained to request information from visitors entering through the smoke porch door regarding whom they are visiting or the purpose of the visit prior to allowing entry into the facility. This training will be completed by 3/8/23 by the Director of Nursing and Nurse Managers.	F 689		

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On 3/8/23 a smoking attendant will be assigned daily by the Director of Nursing to monitor the smoking porch from 8am-8pm . All staff assigned to cover as a smoking attendant were educated by the Director of Nursing on 3/8/23 on the facility policy for smoking, managing Workplace Violence as outlined in the Emergency Preparedness Plan including the requirement to call 911 immediately in the event an unknown individual attempts to enter the facility through the smoking porch door. No one will be assigned this responsibility without receiving training. All current smokers have been educated regarding the facility smoking policy including a review of the smoking schedule for supervised smokers. All smokers have been educated to ring the doorbell and notify staff if a visitor or unknown individual approaches the smoking area. This education will be completed by 3/8/23 by the Director of Nursing and Nurse Managers.

By 3/8/23 all staff will be trained by the Director of Nursing and Nurse Managers on notifying the Administrator and Director of Nursing of any building repairs that represent a safety concern for residents.

After 3/8/23, the Assistant Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any new hired staff and agency staff, without receiving this education.

Effective 3/8/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance.

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F 689	Continued From page 64 Alleged Date of IJ Removal: 3/11/2023 On 03/16/23, the facility's credible allegation for immediate jeopardy removal effective 03/11/23 was validated by the following: Staff interviews revealed they had received training on workplace violence to include making sure to secure all residents, call code silver, call 911, and notify administration. Staff interviews also revealed they had received training on security of the facility and that doors are supposed to be locked at all times and staff making sure all doors are locked so all staff and visitors are using the smoking porch entrance so they could be seen on the camera and allowed entrance into the facility and on the smoking policy and that all residents are supervised smokers and there would be a smoking attendant during designated smoking times to ensure smoker safety and no residents allowed out to smoke except during smoking times. Observed broken windows on second floor dayroom to have been repaired and receipt showing they had been repaired on Friday 03/10/22. Observation of all entry doors being locked from outside and camera with two-way speaker working at smoking porch entrance and camera feed and speaker in working order at first shift nursing station. The Administrator had possession of all manually locked doors to ensure the doors stay locked and visitors are being allowed entrance into facility by staff. Audits were in process of being completed with all smoking residents about supervised smoking policy, smoking times, smoking attendant, and doors staying locked at all times and use of camera and two-way speaker. 2. Resident #68 was admitted to the facility on	F 689		

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F 689	Continued From page 65 06/13/21 with diagnosis that included: schizophrenia and Alzheimer's disease. A wandering assessment was completed on 07/31/22 and indicated that Resident #68 was at high risk for wandering. An annual Minimum Data Set (MDS) dated 06/13/22 indicated that Resident #68 was severely cognitively impaired and required limited assistance with mobility on the unit. The MDS indicated that Resident #68 had shown no wandering behaviors during the assessment reference period. A care plan initiated on 06/30/21 and updated on 1/19/23 revealed a focus area related to Resident #68 being an elopement risk/wanderer. The goal was for the resident's safety will be maintained through the review date. Interventions included address wandering behavior by walking with resident; redirect residents from inappropriate areas; Administer and monitor for the effectiveness and side effects of medications. A wanderguard was applied to Resident #68's left ankle. A nursing behavior note dated 6/27/22 at 10:33 PM revealed Resident #68 was up on the unit with increased wandering into other residents' rooms. Redirection was attempted and the residents Responsible Party (RP) was notified. A nursing progress note dated 7/30/22 at 11:08 PM written by Nurse #4 revealed at 10:57 PM Resident #68 was found inside an employee's vehicle, asleep in the backseat. Resident #68 was last seen by staff at 10:00 PM and provided incontinence care. Resident #68 was last seen by	F 689		

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Nurse #4 at 9:30 PM when administered his medication. The note revealed Resident #68 had a wanderguard on his left lower extremity that did not sound when he exited the floor. Resident #68 exited using the back stairs, no alarm was sounded. The resident was assisted back to the unit by a Nurse Aide (NA) #5. No bruising or injuries were noted. Resident #68 was in no pain or discomfort. He was placed back in the bed and put on every 15-minute monitoring. Nurse #4 documented she had notified the Director of Nursing (DON).

A Medication Administration Record (MAR) note dated 7/30/22 at 11:04 PM written by Nurse #4 revealed under the order to check wander guard placement for functioning every shift that Resident #68 needed a new wander guard because the current one in place did not sound.

A wandering assessment was completed on 07/31/22 and indicated that Resident #68 was at high risk for wandering.

On 3/8/23 at 1:47 PM an interview was conducted with Resident #68's Responsible Party (RP). During the interview she stated the facility contacted her on 7/31/22 to explain that Resident #68 was found in a Nurse Aide's car around 11:00 PM the night before. The interview revealed Resident #68 had not exited the building prior to that incident nor had he exited after the incident. She stated he wandered constantly in the facility and that is why he was admitted onto the locked unit.

On 3/8/23 at 3:09 PM an interview was conducted with the Administrator. She stated at the time of

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F 689	Continued From page 67 the incident she was the Director of Nursing (DON) and was notified by Nurse #4 that Resident #68 had gotten out of the building via text message. She stated she did not see the message on her phone until the following morning. The interview revealed it was reported to her when staff were doing their rounding on the unit they did not see Resident #68. The Administrator stated Nurse #4 had last seen the resident at 9:30 PM when she was administering bedtime medication and Resident #68 was wandering on the unit. She stated NA #6 assisted him with incontinence care and helped him get into bed around 10:00 PM. It was reported at 10:30 PM Resident #68 had gotten back out of bed and was wandering the halls when Nurse #4 assisted him back to bed for the second time. The Administrator stated at 10:45 PM NA #5 had gone to his car when he saw Resident #68 laying in the backseat. She stated it was reported to her he then called into the building to get a staff member to assist the resident back into the building. The interview revealed Nurse #4 completed a head-to-toe assessment, initiated every 15-minute monitoring, and notified her. On 3/8/23 at 3:40 PM an interview was conducted with Nurse Aide (NA) #1. NA #5 stated he was about to end his shift at 10:45 PM. He stated when he got into his car parked outside of the facility in the parking lot, he sat down in the driver's seat when he started to feel like someone was behind him. He stated he looked behind him and saw Resident #68 laying down in the backseat of his car. The interview revealed he immediately jumped out of the car without locking the doors and ran into the building to the third floor to get Resident #68's Nurse Aide (NA). He stated NA #6 was responsible for Resident #68	F 689		

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F 689	Continued From page 68 and did not know he was missing when he saw her on the third floor. The two NAs went back down to NA #5's car and assisted Resident #68 get his shoes on and ambulate back inside of the building. He stated the staff from the third floor were all in shock because they had not noticed he was missing from his room. NA #5 stated Resident #68 was hot and sweating from being in the backseat of the car. He stated Resident #68 was startled and did not say much when they were assisting him inside. NA #5 stated he did not know the door was unlocked because he did not work on the memory care unit. On 3/8/23 at 4:01 PM an interview was conducted with Nurse #4. She stated she worked as agency staffing in the building since June 2022 and was responsible for Resident #68 on the night of 7/30/22. Nurse #4 stated she believed a man that was working the 3:00 PM to 11:00 PM shift went to his car and noticed the resident in his backseat asleep. She stated she did not know the resident was missing from the third floor until NA #5 came and said he had found the resident. Nurse #4 stated she had been charting in the dining room so she could see the door to the stairway because the lock had been broken for several weeks and she knew residents could get out. The interview revealed she was providing care to other residents and did not see the resident leave the unit. Nurse #4 stated she had not specifically told anyone the door was unlocked on the third floor because she felt like everyone knew the lock was broken to the door going to the stairway. The interview revealed the door had always been open since she had orientation in the building in June and staff did not have to put in a key code to get through the door. She stated the NAs on the floor were completing	F 689		

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their last rounds on the 3:00PM to 11:00 PM shift when she saw Resident #68 out of bed wandering on the unit. She stated she assisted him back to his bed at approximately 10:30 PM. When the NA's brought Resident #68 back to the unit she assessed him for any injuries and saw no bruising. Nurse #4 stated Resident #68 was sweaty but did not seem in distress. She stated she assisted the resident back to bed and initiated every 15-minute monitoring. Nurse #4 notified the Director of Nursing (DON) via text message and gave report to the oncoming shift.

On 3/8/23 at 4:24 PM an interview was conducted with NA#2. She stated she had been working on the third floor and was Resident #68's NA on 7/30/22. The interview revealed she had gotten Resident #68 situated in bed around 10:00 PM and went onto complete other resident's care. She stated the next thing she remembered was NA #5 came running onto the unit saying Resident #68 was laying in the backseat of his car asleep. NA #6 stated she was shocked along with everyone that had been working on the third floor to learn the resident was outside of the building. She stated when she got to the car, she saw Resident #68 laying in the backseat asleep with his hat off and shoes off in the floorboard. She stated Resident #68 was sound asleep. NA #6 stated Resident #68 was sweaty because the windows to the car were up and it was hot outside. Resident #68 did not say much to her but just seem addled like he just woke up since they woke him up. She stated they assisted him upstairs and got him situated in the bed with Nurse #4. She stated she left the facility shortly after because it was after 11:00 PM in which her shift ended. The interview revealed the lock on the door going to the stairway on the third floor

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hadn't worked for a month. NA #6 stated everyone in the facility knew the door didn't lock. NA #6 stated Resident #68 had gotten out of the unlocked door on the third floor and went down three flights of stairs exiting the building through a side door on the first floor. The interview revealed staff had heard no alarms from the residents wander guard when he left the unit.

Review of an invoice from the Door System repair company dated 7/31/22 read in part;" mag lock was in bypass and one wander guard is bad; disconnect white wire to door with bad wander guard. Have pictures of customer equipment sending to sales".

On 3/9/23 at 10:10 AM an interview was conducted with a representative from the Door System repair company. During the interview he stated when the service member went to the facility, the door to the memory care unit was in bypass mode. He explained that meant the door was unlocked and did not require a key code to exit through. The interview revealed there was also a bad transmitter on the door so the wander guard alarm would not sound if a resident went out of the door. He stated the service member had obtained new parts and repaired the door to the third floor on 7/31/22.

On 3/9/23 at 10:20 AM a follow up interview was conducted with the Administrator. She stated once she arrived to the facility on 7/31/22 she initiated one on one supervision for Resident #68 and began an investigation into what had happened. She stated all doors in the facility were checked and properly functioning and alarming, including wander guard system. All residents had updated wandering risk assessments completed

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and the facility elopement binders were updated. Education was provided to all staff on wandering/ elopement policy and response in the event of a missing resident. Reeducation was provided to Nurse #4 on calling not just texting in the case of a missing resident incident.

On 3/16/23 at 9:25 AM an interview was conducted with the Medical Director (MD). During the interview he stated he evaluated Resident #68 on 8/02/22 following the incident on 7/30/22 when the resident was found outside of the building. The MD stated when he assessed the resident, he had no signs of injuries nor was in any distress. He stated the resident was stable and on one-to-one supervision with a staff member. The interview revealed he was concerned that Resident #68 had gotten off the secure unit with no difficulty. He stated the resident was on the unit because he wandered and should not have been able to exit the building.

On 3/16/23 at 10:00 AM an interview was conducted with the Maintenance Director. He stated the previous maintenance director was working at the time of the incident. The interview revealed the facility had no issues with the door lock system to the memory care unit since he had been employed.

On 3/16/23 at 11:05 AM a voicemail was left for the previous Maintenance Director of the facility. No return phone call was received.

The Administrator was notified of the Immediate Jeopardy on 03/09/23 at 11:15 AM.

The facility provided the following the following

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corrective action plan with completion date of 08/02/22:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

On 7/30/22 at or around 10:30 pm-10:45 pm, Resident #68 exited the memory care unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide when he went to his car, the resident was laying in the backseat of the Nurse Aide's car asleep. The Nurse Aide left the resident in the backseat asleep while he went back inside the building to get help. The Nurse Aide did not lock the vehicle when he left the resident. The windows were up on the vehicle and at the time of the incident on 7/30/22 it was 74 degrees.

On 7/30/22 the Nurse aide immediately entered the facility, reported the incident to the nurse on the floor and obtained assistance from another Nurse aide, returned to the car, and assisted the resident back into the building. Resident #68 was assessed by the Charge Nurse, with no injuries noted. The facility initiated an investigation into the elopement and identified the door to the stair well on the 3rd floor had a broken lock.

On 7/30/22 the Director of Nursing and Nurse Managers completed an elopement drill and visually accounted for all residents currently admitted to the facility.

o Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete The Administrator and the Maintenance Director immediately repaired the lock on 7/30/22. A Nurse Aide was posted at the door until repairs were completed to ensure no other residents were able to exit. All other doors in the facility were evaluated for functioning locks, no other broken locks were identified.

On 7/30/22 the Director of Nursing and Nurse Managers completed a review of current residents assessed at risk for elopement to ensure the wandering assessments, care plans were complete and current photos posted in the electronic record. All residents with wander guards were assessed for placement, checked for functioning and Treatment Administration Records were reviewed to ensure daily monitoring was complete.

On 7/30/22 the Director of Nursing verified the Elopement and Leave of Absence Binders were in place at each Nurses station and the reception desk. These binders contain a list of residents with wander guards, the resident's photo, current wandering assessment, wandering care plan, and are updated weekly and as needed by the Director of Nursing and Nurse Managers.

On 8/1/22 the Director of Nursing and Nurse Managers completed education for all staff, including agency staff, on the facility policy for Elopement to include not leaving a resident who has exited the facility unattended until the resident can be assisted to return to the facility. After 8/1/22, the Director of Nursing and Nurse Managers will ensure no staff will be allowed to

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F 689	Continued From page 74 work, including any new hired staff and agency staff, without receiving this education. Effective 7/30/22 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. On 3/16/23, the facility's corrective action plan for immediate jeopardy removal effective 8/2/22 was validated by the following: Staff interviews revealed they had received education on the elopement policy, including to not leave a resident who has exited the building unattended. All staff were educated on notifying Administration immediately by a phone call if they have a resident who is missing from the facility. Treatment Administration Records were reviewed to ensure daily monitoring was complete. Elopement and Leave of Absence Binders were in place at each Nurses station and the reception desk. On 3/16/23 all doors were checked and in functioning order. The facility's action plan was validated to be completed as of 8/2/22.	F 689		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		4/15/23

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(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 761	Continued From page 75 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to remove expired medication in accordance with manufacturer's expiration date and failed to store unopened medications in the temperatures specified by manufacturer's guidelines for 2 or 5 medications carts observed during medication storage checks (Third-floor long hall and Third-floor short hall). The findings included: 1. An observation was conducted on 03/08/23 at 10:22 AM for the third-floor long hall medication cart in the presence of Nurse #1. The observation revealed one bottle of opened liquid iron supplement (Ferrous Sulfate) with concentration of 220 milligram (mg) per 5 milliliter (ml) containing approximately 450 ml in the medication cart. It was expired on 01/31/23 and available for administration. On the bottle, a	F 761	On 03/08/2023, the nurse for the first-floor long hall cart destroyed the expired medication and the nurse for the third-floor short hall destroyed the unopen eye drops that were on the cart stored at room temperature. All residents have the potential to be affected by this alleged deficient practice. On 3/08/2023, the Nurse Managers and the Medical Records/Supply Clerk checked all medication storage areas and medication carts for expired medications and products. None were found. On 03/08/2023, education began by the Director of Nursing and Nurse Managers and will be completed on 04/14/2023, for all current Licensed nurse, registered nurses, medication aides, and the supply clerk on removing expired medication	

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Continued From page 76

marker stated it was opened on 03/07/23.

An interview was conducted with Nurse #1 on 03/08/23 at 10:26 AM. She stated she was the nurse who had dated the liquid Ferrous Sulfate after pulling it from the medication storage room on 03/07/23. She explained she did check the expiration date that indicated it expired in 2023 it . However, she had missed noting that it was expired in January 2023.

2. An observation was conducted on 03/08/23 at 10:32 AM for the third-floor short hall medication cart in the presence of Nurse #2. The observation revealed one unopened bottle of Latanoprost eye drop wrapped in the plastic seal for Resident #79. It was stored in the medication cart under room temperature and available to be used. The bag containing this eye drop had a sticker stated, "After opening, may store at room temperature. Throw away any drug left after 6 weeks."

Review of manufacturer's package insert for Latanoprost eye drops reveled unopened bottle should be stored under refrigeration between 36° to 46° Fahrenheit (F) and protected from light. Once opened, Latanoprost may be stored at room temperature up to 77° F for up to six weeks.

Review of physician's orders and medication administration records revealed Resident #79 had a current order to receive one drop of Latanoprost solution in left eye once daily in the evening started 06/18/22.

During an interview conducted on 03/08/23 at 10:36 AM, Nurse #2 stated she started to work for the facility about 10 days ago. Typically, she would check the medication cart during her shift

F 761

from the medication carts and medication storage. These items are to be placed in the medication room for destruction and/or to be returned to pharmacy as appropriate. This education also included checking for the expiration date prior to opening and use as well as dating medications when opened. The Director of Nursing and Nurse Managers will ensure all licensed nurses, registered nurses, and medication aides including agency staff will receive this education prior to working. The Director of Nursing will ensure this education will be included in orientation for newly hired staff and agency staff. The Director of Nursing and Nurse Managers will conduct weekly audits of the medication cart and medication storage areas weekly for 12 weeks. The Pharmacy consultant will conduct monthly audits of the medication carts and medication rooms for expired medications.

The Director of Nursing will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations.

Date of completion: 04/14/2023

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F 761	Continued From page 77 for expired medication and improper storage. She did not know who had pulled the Latanoprost eye drop and stored it in the medication cart prior to her shift. She explained she was so busy in the morning that she had missed the unopened Latanoprost eye drop when she did the medication cart check. An interview was conducted with the Director of Nursing (DON) on 03/08/23 at 4:12 PM. She expected nursing staff to check the expiration date when pulling medication from the medication storage room to ensure each medication cart was free of expired medication, and to follow the manufacturer's recommendations for storage of medications in proper temperature. Interview with the Administrator on 03/09/23 at 10:39 AM revealed she expected nurses to check the expiration date of the medication when they pulled it from the medication storage room, or before administering the medication to the residents. It was her expectation for the staff to store all medications according to manufacturer's recommendation and free of expired medications.	F 761		
F 812 SS=E	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	F 812		4/15/23

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F 812	Continued From page 78 facilities from using produce grown in facility 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 observations and staff interviews, the facility failed to maintain a clean and damage free kitchen for food production. These practices had the potential to affect food production and food served to residents. Findings included: An observation of the kitchen on 03/06/23 at 10:20 AM revealed a large air vent covered in dust, dirt, and lint. Clean dishes were noted to be stored underneath the dirty vent. Observations of the kitchen's ceiling revealed paint peeling and paint flakes were observed on the floor. The paint peelings were observed on the floor around the food production area. A floor drain had a missing cover, and several floor tiles were missing near the washing station. Observations also included an estimated of 2 by 4-foot area was cut out of the ceiling. The area was uncovered and located above the dishwasher and cleaning area. An interview conducted with Dietary Aide #1 on 03/06/23 at 10:30 AM revealed he had been working in the facility for about a year and the broken floor tiles, missing drain cover, and peeling paint on the ceiling had been there since	F 812	On 03/08/2023, the Maintenance Director cleaned the large air vent and replaced the floor drain. On 03/10/2023, the peeling area of the ceiling was repaired by the Maintenance Director. A contractor was obtained to repair the tile on the kitchen floor and the hole in the ceiling. All residents have the potential to be affected by the alleged deficient practice. The Maintenance Director and Administrator conducted an audit on 03/10/2023 of the kitchen area and made a list of required repairs including but not limited to the hole in the ceiling and missing tiles. On 03/10/2023, education began by the Administrator, Dietary Manager and Director of Nursing, and will be completed on 04/14/2023, for all facility staff and agency staff on how to alert the facility of needed repairs by usimg the Maintenance logs at each nursing station. The Director of Nursing and the Administrator will ensure that no staff will be allowed to work without receiving this education.The Administrator will observe the kitchen	

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F 812	Continued From page 79 he had started working in the facility. The Dietary Aide further revealed the hole in the ceiling had been there for over three months. The Dietary Aide indicated the Maintenance Director was responsible for changing and cleaning air vents and was unsure why it had not been clean. The Dietary Aide indicated he had tripped over the drain without a cover and missing floor tiles before and Administrator #2 had been made aware. An interview conducted with the Dietary Manager (DM) on 03/06/23 at 10:45 AM revealed she had been working in the facility for almost two months as the DM and was aware that the air vent was dirty that was over the cleaning station, paint peeling from the ceiling, missing drain cover, large hole in the ceiling above the dishwasher, and broken floor tiles. The DM further revealed she had disclosed these issues multiple times to the maintenance director, but they had not been fixed yet. An interview and observation conducted with the Maintenance Director and Administrator #2 on 03/08/23 at 1:00 PM revealed the air vent over the cleaning station was dirty, paint peeling from the ceiling, missing drain cover, large hole above the dishwasher, and broken floor. The Maintenance Director further revealed he had changed the air filter but was not aware he was supposed to clean the air vent. The Maintenance Director indicated the hole in the ceiling was due to water damage and he had contacted professionals to make repairs but was unable to provide documentation that any issues were expected to be fixed. Administrator #2 further revealed he was not aware of all the issues and the condition of the kitchen was not acceptable	F 812	area and the maintenance request logs weekly for 12 weeks to determine if tasks listed on the log are repaired and if any follow is required. The Administrator will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of completion: 04/14/2023	

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F 812	Continued From page 80 and fixes needed to be made.	F 812		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility Administration failed to provide leadership and oversight to facility staff to ensure effective systems were in place to supervise smokers assessed as unsafe when they went out to smoke through an unlocked door, keep residents safe from outside intruders by not ensuring the building was locked and secured, they failed to have the door to the third-floor locked memory care unit repaired ensure the door locked to prevent wandering residents from exiting the facility. Administration also failed to ensure broken windows with exposed shards of glass in a room accessible to residents were repaired. Immediate Jeopardy began on 07/30/22 for Resident #68 when the facility failed to have systems in place to prevent cognitively impaired residents from exiting the facility. The immediate jeopardy was removed on 08/02/22 for Resident # 68 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. Immediate Jeopardy began for Resident #88 on 2/2/23 when the resident was outside	F 835	By 03/08/2023 The Regional Director of Operations educated the Administrator and the Director of Nursing on the facility policy for Workplace Violence, the process for managing a Non-Medical Emergency and allowing entry into the facility from the smoke porch. This education includes, in case of an emergency, staff will immediately call 911, announce a code silver over the intercom, assist residents into rooms, close doors, and monitor hallways. All residents have the potential to be affected by the alleged deficient practice. On 03/09/2023 The Regional Director of Operations educated the Administrator on the requirements of F835. This education included the expectations of oversight and completion of building repairs, as well as providing a safe environment for residents until repairs are completed. This education also includes the Administrator's responsibility to maintain a safe smoking program based on the	4/15/23

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F 835	Continued From page 81 smoking unsupervised and an outside intruder entered the building with her when she came in from smoking. The immediate jeopardy was removed on 03/11/23 for Resident # 88 when the facility provided and implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "F" (No actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and monitoring systems put into place are effective. Findings included: This tag is cross referred to F689 and E0001. F689: Based on observation, record review, staff, resident, Nurse Practitioner and Medical Director interview the facility failed to prevent severely cognitively impaired residents from exiting the facility through unlocked doors without supervision for 2 of 2 residents reviewed for supervision to prevent accidents (Resident #88 and #68). Resident #88 who was severely cognitively impaired, exited the building through an unlocked door on the first floor to smoke without supervision. An unidentified male intruder entered facility behind Resident #88 through the unlocked door of facility and vandalized the second-floor dayroom by shattering the TV, knocking a hole in the wall, and breaking out two windows. The facility failed to repair broken windows only covering windows with cardboard and wooden board that was easily removable leaving broken windows and shards of broken glass accessible to residents and failed to complete a facility investigation. Resident #68 was severely cognitively impaired and exited the	F 835	facility's smoking policy and daily monitoring to ensure adherence to required supervision. By 03/09/2023 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Maintenance Director regarding the Daily Morning Meeting including the discussion of facility repair needs with weekly monitoring of all doors to ensure alarms and locks are functioning properly, adherence to the smoking policy with staffing of the smoking attendant, and monitoring of the elopement management plan by scheduling elopement drills and reviewing these results with the Interdisciplinary Team which includes the Director of Nursing, Social Service Director, Maintenance Director and Dietary Manager. The Administrator will report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee will make recommendations. Date of Completion: March 10, 2023	

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memory care unit through an unlocked door to the staircase. The resident went down three flights of stairs and exited the facility through a side door. Resident #68 was found by a Nurse Aide (NA) when he went to his car, the resident was laying in the backseat of the NA's car asleep. The NA left Resident #68 in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help.

E0001: Based on record review and staff interviews the facility failed to follow the Emergency Preparedness policy and provide education on the emergency preparedness plan for workplace violence to the facility staff. Staff failed to follow the emergency preparedness plan by not initiating the workplace violence procedures including calling the facility code to warn staff of a threatening situation (Code Silver) out loud and over the public address system, moving residents to a safe place, and initiating a lockdown of the building when an unknown male intruder entered the facility behind a severely cognitively impaired resident (Resident #88), rode an elevator to second floor, and vandalized the second-floor dayroom by destroying a television, knocking a hole in the wall, and breaking out two windows. This deficient practice had the potential to impact all residents in the facility because of the violent nature of the intruder and once the intruder was inside the facility, he had access to all resident areas of the facility.
On 03/10/23 at 6:45 PM an interview was conducted with the Regional Vice President of Operations. She stated after reviewing the identified concerns, additional one on one training needed to be completed with Administrator #1 and #2 to avoid additional incidents from occurring. She also stated they would be

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assisting Administrator #1 with reviewing and updating all current facility policies in an effort to prevent reoccurrence of the identified concerns.

Facility administration was notified of immediate jeopardy for Resident #68 on 03/08/23 at 11:35 AM.

The facility provided the following the following corrective action plan with completion date of 08/02/22:

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance

Administration failed to provide effective leadership and oversight to ensure effective systems were in place to keep residents safe from outside dangers, to ensure residents assessed as unsafe smokers were supervised and to keep residents safe from harm by not ensuring the building was secure, specifically the third-floor locked memory care unit and to prevent wandering residents from exiting the facility.The Administrator failed to ensure repair of broken windows leaving shards of glass exposed that were in a room accessible to residents and failed to ensure the door to the stairwell on the third floor was locking properly.All residents have the potential to be affected by these deficient practices.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

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By 3/8/23 The Regional Director of Operations educated the Administrator and the Director of Nursing on the facility policy for Workplace Violence, the process for managing a Non-Medical Emergency and allowing entry into the facility from the smoke porch. This education includes, in case of an emergency, staff will immediately call 911, announce a code silver over the intercom, assist residents into rooms, close doors, and monitor hallways.

On 8/1/22 the Regional Director of Operations educated the Administrator and the Director of Nursing on the facility policy for elopement, this included a focus on securing all doors in the facility with a focus on locking the doors on the 3rd floor memory care unit to ensure wandering residents are unable to exit the facility without supervision.

On 3/9/23 The Regional Director of Operations educated the Administrator on the requirements of F835. This education included the expectations of oversight and completion of building repairs, as well as providing a safe environment for residents until repairs are completed. This education also includes the Administrator's responsibility to maintain a safe smoking program based on the facility's smoking policy and daily monitoring to ensure adherence to required supervision.

By 3/9/23 the Regional Director of Operations re-educated the Administrator, Director of Nursing and Maintenance Director regarding the Daily Morning Meeting including the discussion of facility repair needs with weekly monitoring of all doors to ensure alarms and locks are functioning

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F 835	Continued From page 85 properly, adherence to the smoking policy with staffing of the smoking attendant, and monitoring of the elopement management plan by scheduling elopement drills and reviewing these results with the Interdisciplinary Team which includes the Director of Nursing, Social Service Director, Maintenance Director and Dietary Manager. Effective 3/8/23 the Administrator will be responsible to ensure implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 3/10/2023 On 3/16/23, the facility's corrective action plan for immediate jeopardy removal effective 8/2/22 was validated by the following: Administrative staff interviews revealed they had received education on the facility Emergency Preparedness plan and workplace violence and to provide training for staff on the plan, the process for managing a Non- Medical Emergency and allowing entry into the facility from the smoking area. The Director of Nursing and Administrator voiced they had received education on the elopement policy and the focus on securing all doors in the facility. The facility's action plan was validated to be completed as of 3/11/22.	F 835		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including	F 867		4/15/23

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adverse event monitoring. The policies and procedures must include, at a minimum, the following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after

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implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING ______ B. WING ______	C 03/16/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 88 conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and resident and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions previously put in place following the recertification survey of 03/06/21. The repeated deficiency was in the area of kitchen sanitation and food procurement, storage, preparation, and service. The facility's continued failure during the recertification survey showed a pattern of the facility's inability to sustain an	F 867	By 03/30/2023, the Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the on-going compliance issues regarding the F Tags received in this survey: E001, F550, F558, F561, F584, F600, F610, F656, F689, F761, F812, F835, and F867. By 03/23/2023 the Director of Operations	

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F 867

Continued From page 89

effective QAA program.

The findings included:

This tag was cross referenced to:
F-812: Based on observations and staff interviews, the facility failed to maintain a clean and damage free kitchen for food production. These practices had the potential to affect food production and food served to residents.

During the recertification survey of 03/06/21 the facility failed to the facility failed to follow USDA guidelines to refreeze a potentially hazardous food, follow USDA guidelines to store hot foods to prevent the growth of bacteria, discard expired produce with signs of spoilage, and date opened food. A pork roast that thawed under cold running water was refrozen, tomatoes were stored for use discolored and with signs of spoilage, and one half bag of sausage patties were undated. This occurred for 1 of 1 walk-in refrigerators and 1 of 1 walk-in freezers.

An interview was conducted on 03/10/22 at 9:30 AM with Administrator #1 who also headed the QAA committee. The Administrator stated the facility had discussed frequently at quarterly QAA meetings the kitchen issues. The Administrator further revealed she could did not know why the kitchen had been an ongoing issue.

F 867

and Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies. Education included identifying other areas of concern the Quality Improvement (QI) review process, for example: review of rounding tools, daily review of Point Click Care documentation, and observation during leadership rounds.

By 03/23/2023, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Unit Managers, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Dietary Manager, Director of Rehabilitation, Social Worker, and Pharmacy consultant at (minimum quarterly), on a weekly risk review of audit findings for compliance and/or revision needed. In addition to weekly risk review meetings for 12 weeks, the QAPI committee will continue to meet monthly. By 03/23/23 the Director of Operations or Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility's progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions.

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F 867	Continued From page 90	F 867	The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. Date of completion: 03/10/2023	