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	345008	A. BUILDING _____ B. WING _____	C 12/18/2023

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

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F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted on 12/18/23. The following intakes were investigated NC00210256 and NC00211018. 3 of the 3 complaint allegations did not result in a deficiency.	F 000		
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 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.	F 867		12/29/23

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

Electronically Signed | 01/10/2024

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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F 867	Continued From page 1 §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 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	F 867		

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F 867	Continued From page 2	F 867		

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 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

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F 867	Continued From page 3 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 review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put in place following a complaint survey dated 12/11/20. The area of infection control and prevention was originally cited during an onsite complaint survey dated 12/11/20. The area was subsequently recited during the onsite complaint survey dated 12/18/23. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: The tag is cross referenced to: F880- Based on observations, record reviews and staff interviews, the facility failed to implement their hand hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene, prior to donning gloves to clean resident's (Resident #2) sacral wound with antiseptic cleanser and failed to doff gloves, sanitize hands and don clean gloves before applying treatment of betadine-soaked gauze, collagen, and covering with foam border gauze. The Treatment Nurse also failed to doff gloves and sanitize hands after cleaning resident's (Resident #3) left upper posterior thigh wound before applying treatment of border gauze to the wound. This occurred for 2 of 3 residents reviewed for wound care.	F 867	On 12/19/2023, the Director of Clinical Services educated the Administrator, the Director of Nursing, and the Assistant Director of Nursing on the appropriate function of the Quality Assurance Performance Improvement (QAPI) committee to include identifying issues and correction of repeat deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. On 12/20/2023, the Quality Assurance Committee held an Ad Hoc meeting to review the purpose and function of the QAPI committee as well as reviewed the ongoing compliance related issues regarding repeat F Tags from surveys. The Administrator educated the QAPI committee members consisting of the Medical Director, Administrator, Director of Nursing, Assisted Director of Nursing/Staff Development Coordinator, Unit Managers, Minimum Data Set Nurse, Dietary Manager, Activities Director, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on potential risk review and of the audit findings for compliance and/or revisions when necessary. The Director of Clinical Services will provide weekly oversight for 12 weeks and will validate the facility’s process,	

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F 867	Continued From page 4 During the recertification and complaint survey dated 12/11/20, the facility failed to perform hand hygiene prior to donning of gloves to obtain a finger stick blood sugar value from a resident who required enhanced droplet precautions for 1 of 3 sampled residents who required finger stick blood sugar measurements. An interview with the Director of Nursing (DON) and Administrator on 12/18/23 at 3:32 PM revealed monthly Quality Assurance (QA) meetings were held to review measures put in place and discussed with the Medical Director and other departments for their response and feedback to issues identified. When issues were identified a review and corrective action plan was implemented and if there was no improvement, the QA committee revisited it. The DON and Administrator felt interventions put into place were beginning to aid in preventing repeat deficiencies but need to be revisited by the QA committee to ensure ongoing compliance in all areas.	F 867	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. 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.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control	F 880		12/29/23

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program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct

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F 880	Continued From page 6 contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to implement their hand hygiene policy as part of their infection control policy when the Treatment Nurse did not perform hand hygiene, prior to donning gloves to clean resident's (Resident #2) sacral wound with antiseptic cleanser and failed to doff gloves, sanitize hands and don clean gloves before applying treatment of betadine-soaked gauze, collagen, and covering with foam border gauze. The Treatment Nurse also failed to doff gloves and sanitize hands after cleaning resident's (Resident #3) left upper posterior thigh wound before applying treatment of border gauze to the wound. This occurred for 2 of 3 residents reviewed for wound care. The findings included: The facility's policy entitled Hand Hygiene which is part of their Infection Control Policies and	F 880	For resident #2 and #3, the Director of Nursing (DON) assessed the resident, and no acute distress was noted. The treatment nurse was immediately educated on the Infection Control policy with a focus on hand hygiene during wound care by the Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC). All residents with wounds have the potential to be affected by this alleged deficient practice. 1) Competencies for nursing skills were audited for infection control/hand hygiene of current staff members that included agency staff. Any staff member without documentation had their competencies completed by the ADON/SDC by 12/26/2023.	

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F 880	Continued From page 7 Procedures last revised on 11/01/20 under "Policy Explanation and Compliance Guidance" read in part: 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. Hand Hygiene Table: Either soap and water or alcohol-based hand rub (ABHR is preferred) " After handling contaminated objects " Before applying and after removing personal protective equipment (PPE), including gloves " Before and after handling clean or soiled dressings, linens, etc. " After handling items potentially contaminated with blood, body fluids, secretions, or excretions. 1. a. A wound observation was made on 12/18/23 at 10:23 AM on Resident #2 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse sanitized her hands and donned gloves to remove the resident's drainage-soaked dressing from the sacral wound. She doffed her gloves after removing the dressing and without sanitizing her hands donned a clean pair of gloves and applied the betadine-soaked gauze with collagen to the wound and covered it with a foam border gauze. She proceeded to doff her gloves, washed her hands and gathered her supplies and left the room. b. A wound observation was made on 12/18/23 at 10:48 AM on Resident #3 with the Treatment Nurse. The Treatment Nurse gathered her supplies and placed them on a clean surface on the overbed table. The Treatment Nurse sanitized her hands and donned a clean pair of	F 880	2) A random audit of staff who were present on 12/19/2023 was by the ADON/SDC to validate hand hygiene competency. 3) By 12/21/2023, all residents with wounds were assessed by the nursing staff to determine if any showed adverse signs/symptoms because of the infection control policy not being followed. 4) New signage for hand hygiene was placed throughout the facility that gave direction on hand hygiene to include how to wash hands, how long to wash hands, and the purpose of washing hands. 5) On 12/19/2023, wound Care education with a focus on infection control through hand hygiene was started by the RN, ADON/SDC. The ADON/SDC will audit wound care provided by the nursing staff for compliance with the infection control policy three times a week, weekly for four weeks, twice a week weekly for four weeks, and weekly for four weeks. The ADON/SDC will audit hand hygiene for all other staff members compliance with the infection control policy three times a week, weekly for four weeks, twice a week weekly for four weeks, and weekly for four weeks. The results of these audits will be discussed weekly in a risk meeting for 12	

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gloves and removed the resident's drainage-soaked dressing from her left upper posterior thigh. She doffed her gloves after removing the dressing and without sanitizing her hands donned a clean pair of gloves and cleansed the wound with antiseptic cleanser. The Treatment Nurse then proceeded without doffing her gloves or sanitizing her hands and applying a clean pair of gloves and applied a new dressing on the wound. She proceeded to doff her gloves, washed her hands, and gathered her supplies and left the room.

An interview on 12/18/23 at 2:13 PM with the Treatment Nurse revealed she was not aware she didn't sanitize her hands after doffing her gloves and donning new gloves to begin treatment on Resident #2. She also stated she was not aware she had not sanitized her hands after removing the drainage-soaked-dressing and before donning new gloves to clean the wound for Resident #2. The Treatment Nurse further stated she was not aware she had not doffed her gloves after cleansing the wound, sanitized her hands, and donned new gloves before applying the new border gauze dressing to Resident #3's left upper posterior thigh wound. The Treatment Nurse stated she knew she was supposed to sanitize her hands each time she took off her gloves and said she must have been nervous and just forgot to follow the proper procedure for hand hygiene.

An interview on 12/18/23 at 3:23 PM with the Director of Nursing (DON) and Administrator revealed the Treatment Nurse had shared with them her errors during treatments for Resident #2 and Resident #3. The DON stated she thought she was nervous having someone watching her and she and the Infection Preventionist would

weeks and monthly in QAPI for 3 months. Recommendations based on the audit results will be made during the risk meeting and QAPI meetings.

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F 880	Continued From page 9 re-educate her on proper hand hygiene procedures and would be monitoring her during some of her treatments.	F 880		