STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted onsite on 01/12/21 and 01/14/21. Additonal information was obtained on 01/13/21 and 01/15/21 therefore the exit date was changed to 01/15/21. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID: 1QM911.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control and Complaint investigation was conducted onsite on 01/12/21 and 01/14/21. Additonal information was obtained on 01/13/21 and 01/15/21 therefore the exit date was changed to 01/15/21. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Center for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 8 allegations and all were unsubstantiated. Event ID# 1QM911. The facility contacted management on 02/10/21 and stated they had an action plan with auditing to support past noncompliance. This information was reviewed on 02/12/21, 02/15/21, and 02/16/21 and past noncompliance was validated on 02/16/21.	F 000		
F 600 SS=G	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	F 600		

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

Electronically Signed | 02/05/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 1 includes but is not limited to freedom from corporal punishment, involuntary seclusion and 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 observations, record review, resident and staff interview the facility failed to protect a resident's right to be free from physical abuse for 2 of 3 sampled residents reviewed for abuse (Residents #2 and #3). Resident #1 slapped Resident #2 on the left side of his face. Resident #1 also turned Resident #3 over backwards while she was seated in her wheelchair and placed a sock over her mouth and attempted to tie it around her head when she began to holler for help. This resulted in Resident #3 hitting her head on the floor and experiencing back and neck pain. Resident #3 also expressed being very uncomfortable that Resident #1 was in the facility. The findings included: Resident #1 was admitted to the facility on 08/28/18 with diagnoses that included: dementia, anxiety, major depressive disorder, history of traumatic brain injury and others. Review of the quarterly Minimum Data Set (MDS) dated 10/01/20 revealed that Resident #1 was cognitively impaired and had no behaviors during the assessment reference period. The MDS further indicated that Resident #1 was	F 600	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 2	F 600		

independent with walking in room and on the corridor. Resident #1 had no impairment to her bilateral upper and lower extremities and used walker for ambulation.

An observation of Resident #1 was made on 01/12/21 at 11:03 AM. Resident #1 was sitting next to her bed with a staff member sitting with her and they were observed to be coloring.

1 a. Resident #2 was readmitted to the facility on 07/30/19 with diagnoses that included dementia, depression, diabetes, and others.

Review of the quarterly MDS dated 10/01/20 revealed that Resident #2 was cognitively intact and required extensive assistance with toileting. The MDS further revealed that Resident #2 had no behaviors, rejection of care, wandering or delirium during the assessment reference period.

Review of a 24-hour initial allegation report dated 12/07/20 read in part, Resident #1 was reported to have entered Resident #2's bathroom in response to him hollering for assistance and slapped Resident #2 on the left side of the face. No injury was identified at the time. The report was completed by the Administrator.

Review of an Investigation report dated 12/14/20 read in part, on 12/07/20 Resident #1 was having a normal baseline day. She has a diagnosis of dementia without behaviors. Resident #2 was in the restroom and needed staff assistance, without turning on his call bell he began to yell for staff to come and assist him. Resident #1 entered Resident #2's bathroom in response to his yelling and open hand slapped Resident #2 on the left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 3	F 600		

side of his face. Staff overheard the altercation and immediately intervened. Resident #1 was escorted out of the room.
Resident #2 had a head to toe assessment completed and no injury, no redness, no bruising was noted. Emotional and psychosocial support was provided to both residents for the next 72 hours with no acute issues or needs identified.
Resident #1 was placed on 1:1 supervision immediately following the incident until the Nurse Practitioner (NP) evaluated her on 12/09/20 and agreed it was safe to stop the 1:1 supervision due to no further combative or aggressive behaviors and no wandering. The NP also reviewed Resident #1's medications and no changes were made. A urinalysis was ordered for Resident #1 which had no acute findings. During this process a referral was made to acute psychiatric unit. The summary was signed by the Director of Nursing (DON) and the Administrator.

Review of a nurses note, written by Nurse #3, dated 12/09/20 at 2:59 PM read, spoke with NP regarding reevaluating resident (Resident #1) due to 1:1 supervision due to aggression with another resident. She stated she had, resident does not recall the incident and no behaviors reported from staff since the 1:1 supervision so the 1:1 supervision may be stopped. Her medications were evaluated.

An observation was made of Resident #2 on 01/12/21 at 5:45 PM. Resident #2 was resting in bed and was covered with a blanket. There was no visible bruising or redness noted to Resident #2's face.

1 b. Resident #3 was admitted to the facility on 02/11/08 with diagnoses that included multiple

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 4	F 600		

sclerosis, Hodgkin's Lymphoma, and others.

Review of Resident #3's MDS dated 12/11/20 indicated Resident #3 was cognitively intact and required extensive assistance with activities of daily living. The MDS further indicated Resident #3 had an impairment to one upper extremity and impairment to bilateral lower extremities.

Review of an incident report for Resident #3, dated 12/10/20 at 8:15 PM read in part, heard Resident #3 yelling out found her in room in her wheelchair tipped over on the floor, Resident #3's lower body half in chair upper half on the floor. Resident #3 stated, "I did hit my head, but it does not hurt." No injury visible. Resident #3 also stated she was in her closet putting away clothes and Resident #1 wanted her to take her name off her clothes when she said no Resident #1 grabbed her wheelchair and tipped her over. The report was prepared by Nurse #1.

Review of a nurses note, written by the Supervisor (Nurse #2), dated 12/10/20 at 8:42 PM read, this nurse was summoned to Resident #3's room where she was observed tilted backward on the floor in her wheelchair. She was observed to have socks draped around her shoulders. Resident #3 stated that Resident #1 wrapped the socks around her neck and mouth as if to try and smother her. Staff assisted Resident #3 into an upright position, she had no physical complaint. DON aware of situation. Resident #1 was immediately placed on 1:1 supervision. The note was electronically signed by the Supervisor (Nurse #2).

Review of a care plan created 12/11/20 read in part, Resident #1 may be at risk of hitting the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 5	F 600		

other resident. The goal of the care plan read, Resident #1 will not hit or injury any other resident through the next re-evaluation date. The interventions included: 1:1 supervision, assist her in avoiding resident or situations that may incite outburst, coordinate care to help resident maintain control of her behavior, educate resident to alternative ways of dealing with anger, and intervene if she shows signs of hostility or anger.

An observation and interview were conducted with Resident #3 on 01/12/21 at 11:52 AM. Resident #3 stated that on 12/10/20 she was in her room with whom she shared with Resident #1. She was putting a big bag of stuff in her closet and was using her reacher and she dropped it. Resident #3 stated she grabbed her other reacher and opened her closet. Resident #1 grabbed her arm and took the reacher out of her hand and began pulling Resident #3 backward in her wheelchair towards her bed. Resident #3 stated she was attempting to roll forward but could not, so she asked Resident #1 if she had a hold of her wheelchair and Resident #1 stated no. Resident #3 explained that Nurse #1 came in to administer medications to Resident #1 and saw what was going on and instructed Resident #1 to let go of the wheelchair and she did. Resident #3 stated she then rolled forward towards her bed and Nurse #1 exited the room and shut the door. Resident #3 stated she began to lay her night clothes on the end of her bed that included her socks and Resident #1 got up and began tilting her wheelchair backwards by the handles. She instructed Resident #1 to quit because she was afraid, she was going to drop her on the floor. All the sudden Resident #1 tilted the wheelchair backwards and let go and the chair fell to the floor with the front wheels up in the air. Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 6	F 600		

stated she was hanging on as tightly as possible to the handles so she would not fall out of the chair. She explained that she hit her head on the floor, but her head did not hurt. She added that her back and neck were "killing her." Resident #3 stated that the clock on the wall directly in front of her read 8:30 PM and she knew that her Nurse Aide (NA) was in the shower room with another resident and was not due to return to the room until 9:30 PM so she hollered for help. Resident #3 stated that when she started to holler for help Resident #1 took the sock off the end of her bed and tried to tie it around her mouth and head. She stated she could feel Resident #1 trying to tie it at the back of her head but she kept telling Resident #1 to stop and as Resident #1 reached for the other sock she was able to yank the sock off of her mouth. Nurse #1 opened the room door and entered the room not long after she began yelling. Nurse #1 stated what are doing in the floor. Resident #3 stated that Nurse #1 the made sure she was ok and sat my wheelchair back upright. Resident #3 explained that the staff took her blood pressure which was "190 over something and my oxygen level was 100% so I was breathing fine." Resident #3 stated that they took her out in the hallway and again checked her out and I told them that she did not trust Resident #1 anymore and felt very uncomfortable with her being in the facility and actually did not go to bed that night. She added that they had someone sit with Resident #1 for the rest of the night and the next day they sent her to the hospital. Resident #3 stated that Resident #1 was back in the facility, but she had not had any contact with her since the incident on 12/10/20 but she still felt very "uncomfortable" with Resident #1 in the building and just did not trust Resident #1 anymore. She explained that she tolerated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 7	F 600		

Resident #1 on a day to basis like when she would be sweet one minute and the next minute would curse at her or when she would stand in front of her door and not let me out. However Resident #1 had never physically harmed her before and she was certainly not expecting what occurred on 12/10/20 to occur. She stated Resident #1 did not know better and she was ok with that but after the incident on 12/10/20 she just could not trust her and was still uncomfortable knowing that she was in the facility

An interview was conducted with the NP on 01/12/21 at 3:35 PM The NP stated she was familiar with Resident #1 and #2 and #3. She indicated Resident #1 had a traumatic brain injury and all of a sudden had an anger or psychotic type break. She stated that on 12/07/20 she struck Resident #2 who was yelling and cursing. The NP stated she evaluated Resident #1 that day and believed she was a threat to others, so the facility placed Resident #1 on 1:1 supervision. The NP stated that on 12/09/20 she reevaluated Resident #1 and spoke to the staff that were providing 1:1 supervision and she had no behaviors of any type since the 12/07/20 incident. She added that prior to the 12/07/20 incident Resident #1 was "stubborn and head strong" but had never displayed those aggressive type of behaviors before and added that Resident #1 had enough of her left mentally to know what she wanted. The NP stated that at the time she believed she was no longer a threat to others and stopped her 1:1 supervision on 12/09/20. Following the incident on 12/07/20 and discontinuing the 1:1 supervision on 12/09/20 the NP stated she was off for a couple of weeks and when she returned was aware that an incident occurred but was not sure what the incident was.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 8	F 600		

At the time on 12/09/20 she did not believe that Resident #1 was appropriate or required a more control environment like a locked unit but after learning about what occurred between Resident #1 and #3 it would be a good recommendation to have Resident #1 in a more control environment for the safety of other residents. She added that Resident #1 always had a stubborn streak but was easily redirected and Resident #3 would always say things like "you don't know what it is like living with her" but never reported any aggressive behaviors and never any physical contact with Resident #1. Resident #1 would from time to time resist care but with some redirection would always do what was needed. The NP added that Resident #1 also suffered from Alzheimer's dementia and that coupled with a traumatic brain injury those residents don't always stabilize and would further decline with age and medical changes. She did add that there was nothing acute medically going on with Resident #1 to explain her sudden outburst of striking out at other residents but again reiterated that type of behavior was very uncharacteristic of Resident #1 and she certainly would not have predicted this type of aggressive behavior towards Resident #3 or any resident or she would have continued the 1:1 supervision.

An interview was conducted with Nurse #1 on 01/13/21 at 5:11 PM. Nurse #1 confirmed that she worked on 12/10/20 and was caring for Resident #1 and #3. She stated she was working on her evening medication pass and heard a commotion coming from their room. When Nurse #1 opened the door she observed Resident #1 had tipped Resident #3's wheelchair over and was holding onto the handles. Nurse #1 stated she instructed Resident #1 to let go of the handles and she got

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 9	F 600		

angry and called me a liar. Nurse #1 stated she had to show Resident #1 that she did indeed have a hold of Resident #3's wheelchair hands and she said "oh" and let go and she went and laid down on her bed. Nurse #1 stated she stepped out into the hallway and got on the loudspeaker and called for staff. Nurse #1 stated that when she stepped out of the room to get some help Resident #1 was lying on her bed and Resident #3 was tipped over in wheelchair and she knew she needed to get someone in the room to help. Nurse #1 could not recall who responded but she did recall the Supervisor (Nurse #2) coming to the room. She stated that the first thing they did was assess Resident #3 to makes sure she was not injured, and she was able to move all extremities. After determining Resident #3 had no injuries we set her back upright in her wheelchair and Resident #1 remained lying on her bed. She added that she immediately placed Resident #1 on 1:1 supervision after she returned to the room from calling for help and once Resident #3 was up, and the things had calmed down she did return to her medication pass but Resident #3 did not go to bed that night. Nurse #1 stated she did not know about the incident with the sock until 2 days later but Resident #1's behavior was very uncharacteristic for her and really surprised Nurse #1 nor did she know of the incident that Resident #3 spoke of when Resident #1 was holding onto her chair. She added she had never witnessed Resident #1 do anything like this before and was shocked. Normally Resident #1 was pleasantly confused and she generally was in their room at medication time and anytime that she was needed but generally the NAs would do the routine checks on both Resident #1 and #3 as they did with all the resident on the unit. Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 10	F 600		

#1 stated that when she entered the room when she heard Resident #3 yelling that was the first time, she had been in their room that day. Nurse #1 stated that maybe Resident #3 got her nights mixed up. Nurse #1 also stated she contacted the DON, the family, and the on-call provider to notify them of the incident as well.

An interview was conducted with NA #1 on 01/13/21 at 5:30 PM. NA #1 confirmed that she routinely cared for Resident #1 and was caring for Resident #1 and #3 on 12/10/20. She stated that normally Resident #1 was pleasantly confused and would wander from time to time on the unit. NA #1 had never witnessed any type of aggressive behavior from Resident #1 before and was shocked when she learned about the incident between Resident #1 and #3 on 12/10/20. She stated she was in the shower room when the incident occurred, but when she came out of the shower room, she was assigned the 1:1 supervision of Resident #1 for the remainder of her shift. NA #1 stated that she immediately took Resident #1 for a walk throughout the facility and we sat down in the dining room where she could see out of the glass windows. She stated that after about 10-15 minutes Resident #1 began getting agitated and stated people were trying to kill her. NA #1 stated she attempted to redirect the conversation and when that was not effective she took Resident #1 to view the Christmas trees that were in the facility and we sat around the tree which did not get her mind off people trying to kill her. She added I repeatedly told Resident #1 that no one was trying to kill her, NA #1 added she had never seen Resident #1 like this before. She continued the 1:1 supervision until the end of her shift and another staff member came to relieve her of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 11	F 600		

duty. NA #1 was not aware of any special interventions or observations that were in place prior to the incident on 12/10/20 because Resident #1 had never had those type of behaviors so day to day she would just routinely check on her and Resident #3 in their room because they did like to keep the door shut.

An interview was conducted with the Supervisor (Nurse #2) on 01/13/21 at 6:38 PM. The Supervisor reported that on 12/10/20 she responded to Resident #1 and #3's room because of an overhead page. She stated when entered the room she found Resident #3 backwards on the floor with her front wheelchair wheels up in the air. She stated when she walked into the room Resident #1 was lying on her bed and Resident #3 was near the bottom of her bed with her feet in the air on her back in her wheelchair. The Supervisor stated they assisted Resident #3 upright and began questioning her if she was hurt or not. Resident #3 denied any injuries and was able to move all extremities. As the Supervisor she stayed in the room to talk with Resident #3 and noticed that she had socks draped over her shoulders, she stated that Resident #3 reported that Resident #1 had placed them around her mouth but was not able to tighten them. She added that Resident #1 was placed on 1:1 supervision and remained that way through the end of her shift. The Supervisor stated she was not familiar with Resident #1 or her past; she had seen her around the facility but had never seen her act out aggressively towards any resident or staff before. She added that the on-call provider, the DON, and the family were all notified of the incident.

An observation and interview were conducted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 12	F 600		

with Resident #1 on 01/14/21 at 11:03 AM. Resident #1 was dressed and had a staff member sitting with her and they were listening to music. Resident #1 denied knowing Resident #2 or #3 and did not recall ever slapping anyone, tipping a wheelchair over or placing a sock around Resident #3's mouth and head. Resident #1 stated, "I have never seen anything like that here before." She could also not recall her recent hospitalization and stated, "did I go to the hospital?"

An interview was conducted with the DON on 01/15/20 at 2:16 PM The DON stated that on 12/07/20 Resident #1 slapped Resident #2 in response to him hollering and cursing. She stated following the incident Resident #1 was placed in 1:1 supervision after being evaluated by the NP. She stated that Resident #2 had no injury or redness from being slapped by Resident #1. The DON stated that following that incident they asked all resident if they felt safe in the facility including Resident #3 and they all reported they felt very safe in the facility. After 2 days of no further behaviors or aggressions the NP once again evaluated Resident #1 and reviewed her medication and believed she was no longer a threat to others or herself and the 1:1 supervision was stopped with no additional orders obtained. In addition to the 1:1 supervision Resident #1's medications were reviewed, and a urinalysis was done and nothing acute was going on. Then on 12/10/20 Nurse #1 called and reported that Resident #1 had tipped Resident #3's wheelchair over backwards. The DON stated she inquired about the resident and made sure they were both okay. Nurse #1 reported that she had already initiated 1:1 supervision with Resident #1 and once they assessed Resident #3 were able to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 13	F 600		

turn her wheelchair back upright. The DON stated after she got off the phone with Nurse #1, she called back to circle back through the events and make sure they had done everything that needed to be done. The DON stated that Resident #1's actions were definitely out of character and with her impulsivity and paranoia we again placed her in 1:1 supervision. She added "I think her actions definitely had the potential to be harmful" and we were very lucky that Resident #3 was not physically harmed. Both times the DON spoke to Nurse #1 via phone the sock incident never came up, the DON stated she learned about that the next day when she was reading the progress note and went to talk to the Supervisor (Nurse #2). The DON stated as reported by Resident #3 the sock incident would be a form of abuse. The staff were educated on a monthly basis about abuse and how to identify and handle potential occurrences of abuse and were once again reeducated after the incident on 12/07/21. The DON stated that the staff were trained to first protect the resident that was being abused and then report to the Nurse, Supervisor, Administrator, or herself. She again confirmed that initially she did not see the issue as abuse but after learning of the sock incident that would definitely be a form of abuse, she added that the following day after the incident they were able to get Resident #1 admitted to an acute care psychiatric unit for treatment. The DON stated since the event on 12/10/20 she frequently checked on Resident #3, offered her talk therapy and chaplain services and she declined both.

An interview was conducted with the Administrator on 01/15/21 at 4:54 PM. The Administrator stated that on 12/07/20 Resident #1 struck Resident #2 which was very out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 14	F 600		

character for her and the team was very taken back by her behavior, so they placed her on 1:1 supervision. A couple of days later the NP again revalued Resident #1 and with no further behaviors or aggressive indicators the decision was made to stop the 1:1 supervision. The NP also evaluated her medications, but no changes were made, and no further orders were obtained. The Administrator stated that they had already began the process of getting Resident #1 into an acute psychiatric unit, but a bed was not available at that time. Then on 12/10/20 she was called by the Supervisor and notified of the incident where Resident #1 turned over Resident #3's wheelchair with her still in the chair. Initially the Administrator stated she was not aware of the incident with the sock until the next day but when investigating she could not confirm or deny that the incident had occurred. The Administrator stated that she did not think in Resident #1's state of mind she was trying to be abusive, she believed it was all reactionary on Resident #1's part. The Administrator stated that she did go and speak to Resident #3 and she was more upset that Resident #1 was still in the facility which was a legitimate concern as it was a concern for her as well. She added that they were able to get Resident #1 into an acute psychiatric unit on 12/11/20. She added if Nurse #1 would have reported the sock issue it certainly would have led us down the abuse path, but we discussed as a team and with our corporate consultants to make sure we were doing what we needed to be doing. If Nurse #1 had noticed the socks draped around Resident #3 shoulders or had then been marks on Resident #3's face, then yes I would certainly say this was abuse. When Resident #1 returned from the hospitalization she remained on 1:1 supervision and Resident #3 had seen Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 15	F 600		

#1 was back in the facility and on the same unit she was very upset, so we had to make a room change for Resident #1. The Administrator specified that Resident #1 was generally docile but, "I don't trust her at this point." The Administrator stated that Resident #3 was still very concerned with Resident #1 being in the building and they were providing frequent reassurance to Resident #3 that a staff member was always with her and would be watching her to make sure nothing else occurred.

The facility provided a plan of correction with a correction date of 12/14/20. The plan of correction included:

Resident to Resident Altercation:
- On 12/07/20 Resident #1 went into Resident #2's bathroom. Resident #2 was yelling loudly instead of using call light. Resident #1 slapped Resident #2 on the side of the face. Nursing staff immediately escorted Resident #1 out the bathroom she was cooperative but confused.
-A nursing assessment was completed on Resident #2 to find no injury, no redness, or no bruising.
-Emotional and psychosocial support was provided to Resident #2 with no acute issues or needs identified.
-Resident #1 was placed on one on one observation until further notice.
-All interviewable residents were interviewed for safety. A skin check was completed on all non interviewable residents for any signs or symptoms of abuse.
-Nurse Educator immediately initiated training on abuse and management of difficult residents to all staff and agency staff on 12/08/20.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 16	F 600		

-On 12/09/20 The NP assessed Resident #1. The behavior of 12/07/20 was not usual behavior for this resident and she had never displayed aggression in the past. The NP deemed Resident #1 to be cleared from one on one observation.

-On 12/10/20 Resident #1 was in an altercation with Resident #3 who was her roommate. This altercation resulted in Resident #1 turning Resident #3 backward in her wheelchair. This was a continuation of Resident #1's new behaviors.
-Following the incident Resident #1 was again placed on one on one observation until discharged to a psychiatric hospital for evaluation and treatment.

-On 12/11/20 in morning meeting the 24 hour clinical report was reviewed and discovered a nurses note written by the Supervisor and additional details of socks wrapped around Resident #3's neck were discovered.
-The Supervisor was called and brought into the facility for further investigation. Her statement was obtained and counseling provided.
- Nurse #1 was re-interviewed and continued to deny seeing the stocking. The DON interviewed Resident #3 and emotional support provided.
- The Nurse Educator completed training on abuse and management of difficult residents to all staff and agency staff on 12/14/20.

Residents Interviewed that may have been affected:
-On 12/08/20 the Social Worker interviewed interviewable residents. The residents verbalized that they felt safe and reported no issues with other residents.
-Skin Checks were completed on all non

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 17	F 600		

interviewable residents for signs of abuse on 12/09/20.
-New Admission interviews continue on all new admissions and will continue to ensure their comfort and satisfaction.

Implementation of changes to prevent resident to resident reoccurrence:
-Nurse Educator or designee will ensure all new hires or new agency staff are trained on abuse policy and management of difficult residents.
-The Social Worker or designee will meet with random interviewable residents monthly and report findings to QAPI. QAPI will evaluate the need for frequency.
-Upon Resident #1's readmission from the psychiatric hospital she remains on one on one observation.
-The DON will audit the 24 hour report daily Monday through Friday and review for residents exhibiting any type of aggressive behavior to identify early reporting and interventions.

Monitoring through QAPI to ensure performance and corrective actions sustained:
-Nurse Educator or designee will ensure all new hires or new agency staff are trained on abuse policy and management of difficult residents.
-The Social Worker or designee will meet with random interviewable residents monthly and report findings to QAPI. QAPI will evaluate need for frequency.
-New Admission interviews will continue on all new admissions to ensure their comfort and satisfaction.

The corrective action plan was reviewed in addition to documents and audits which confirmed that inservice education had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 600	Continued From page 18 completed by 12/04/20, 24-hour reports had been reviewed for resident behaviors and the Social Worker or designee had completed interviews with interviewable residents. The full body skin assessments completed on 12/09/20 for the five residents that were not interviewable and resided on Resident #1's were reviewed. Resident #1 was observed with a staff member one on one on 01/12/21 and 01/14/21. During the onsite investigation conducted on 01/12/21 and 01/14/21 staff were able to verbalize recent abuse training and education. The action plan was validated on 02/16/21.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all	F 609		1/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 609	Continued From page 19 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 observation, record review, resident and staff interview the facility failed to implement their abuse policy in the area of reporting for an allegation of resident to resident abuse for 1 of 3 allegations of abuse reviewed. The findings included: Review of incident report dated 12/10/20 at 8:15 PM read in part, heard yelling coming from Resident #1's room and found Resident #1 bent over holding onto Resident #3's wheelchair and standing over Resident #3. Resident #1 was asked to let go of the wheelchair and she stated, don't have it. Redirection given and she did let go of wheelchair. Resident #1 denied tipping over the wheelchair. 1:1 supervision was initiated for Resident #1 and the Supervisor and Director of Nursing (DON) were notified. The report was prepared by Nurse #1. Review of a nurses note, written by the Supervisor (Nurse #2) dated 12/10/20 at 8:42 PM read, this nurse was summoned to Resident #3's room where she was observed tilted backward on the floor in her wheelchair. She was observed to have socks draped around her shoulders. Resident #3 stated that Resident #1 wrapped the socks around her neck and mouth as if to try and smother her. Staff assisted Resident #3 into an upright position, she had no physical complaint.	F 609	F609 Reporting of Alleged Violations Corrective actions taken the resident found to have been affected by the deficient practice: 1. The Director of Nursing and Administrator completed education and counseling with Supervisor for failure to report incident regarding socks draped over her shoulders and Resident #3□s report of socks. Education completed on abuse policy and reporting immediately. Completion date 12-11-20. 2. The Nurse Educator conducted an in-service for all staff and agency staff on abuse policy and importance of immediately reporting to Director of Nursing and Administrator from 12-11-20 through 12-14-20. Completion date 12-14-20. 3. The Director of Nursing or designee will audit the 24-hour clinical reports daily Monday through Friday. This review will be for residents exhibiting any incident or accident daily for signs and early detection of aggressive outbursts to ensure early interventions put in place for the safety and welfare of all residents. Completion date 12-14-20.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 609	Continued From page 20 DON aware of situation. Resident #1 was immediately placed on 1:1 supervision. The note was electronically signed by the Supervisor (Nurse #2). An observation and interview were conducted with Resident #3 on 01/12/21 at 11:52 AM. Resident #3 stated that on 12/10/20 she was in her room with whom she shared with Resident #1. Resident #3 stated she began to lay her night clothes on the end of her bed that included her socks and Resident #1 got up and began tilting her wheelchair backwards by the handles. She instructed Resident #1 to quit because she was afraid, she was going to drop her on the floor. All the sudden Resident #1 tilted the wheelchair backwards and let go and the chair fell to the floor with the front wheels up in the air. Resident #3 stated she was hanging on as tightly as possible to the handles so she would not fall out of the chair. She explained that she hit her head on the floor, but her head did not hurt. She added that her back and neck were "killing her." Resident #3 stated that when she started to holler for help Resident #1 took the sock off the end of her bed and tried to tie it around her mouth and head. She stated she could feel Resident #1 trying to tie it at the back of her head but she kept telling Resident #1 to stop and as Resident #1 reached for the other sock she was able to yank the sock off of her mouth. Nurse #1 opened the room door and entered the room not long after she began yelling. Resident #3 stated that Nurse #1 the made sure she was ok and sat my wheelchair back upright. An interview was conducted with Nurse #1 on 01/13/21 at 5:11 PM. Nurse #1 confirmed that she worked on 12/10/20 and was caring for Resident #1 and #3. She stated she was working on her	F 609	Corrective actions for those residents having the potential to be affected the same deficient practice: 1. The Nurse Educator conducted an in-service for all staff and agency staff on abuse policy and importance of immediately reporting to Director of Nursing and Administrator from 12-11-20 through 12-14-20. Completion date 12-14-20. 2. The Nurse Educator or designee will ensure all new hires or new agency staff are trained during orientation on abuse policy and importance of immediately reporting to Director of Nursing and Administrator. 3. Social Service Director or designee interviewed all interview able residents for the potential to be affected. Residents verbalized they felt safe and reported no issues with other residents. Completion date 12-08-20. 4. The Director of Nursing or designee completed a skin check on all non-interview able residents for any signs or symptoms of abuse on 12-09-20. 5. The Director of Nursing or designee will audit the 24-hour clinical reports daily Monday through Friday. This review will be for residents exhibiting any incident or accident daily for signs and early detection of aggressive outbursts to ensure early interventions put in place for the safety and welfare of all residents effective 12-16-20. Measures implemented for systemic changes to ensure that the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 609	Continued From page 21 evening medication pass and heard a commotion coming from their room. When Nurse #1 opened the door she observed Resident #1 had tipped Resident #3's wheelchair over and was holding onto the handles. Nurse #1 stated she instructed Resident #1 to let go of the handles and she got angry and called me a liar. Nurse #1 stated she had to show Resident #1 that she did indeed have a hold of Resident #3's wheelchair hands and she said "oh" and let go and she went and laid down on her bed. Nurse #1 stated she stepped out into the hallway and got on the loudspeaker and called for staff. Nurse #1 could not recall who responded but she did recall the Supervisor (Nurse #2) coming to the room. She stated that the first thing they did was assess Resident #3 to makes sure she was not injured, and she was able to move all extremities. After determining Resident #3 had no injuries we set her back upright in her wheelchair and Resident #1 remained lying on her bed. She added that she immediately placed Resident #1 on 1:1 supervision after she returned to the room from calling for help. Nurse #1 stated she did not know about the incident with the sock until 2 days later but Resident #1's behavior was very uncharacteristic for her. An interview was conducted with the Supervisor (Nurse #2) on 01/13/21 at 6:38 PM. The Supervisor reported that on 12/10/20 she responded to Resident #1 and #3's room because of an overhead page. She stated when entered the room she found Resident #3 backwards on the floor with her front wheelchair wheels up in the air. She stated when she walked into the room Resident #1 was lying on her bed and Resident #3 was near the bottom of her bed with her feet in the air on her back in her	F 609	practice will not occur: 1. The Nurse Educator or designee will ensure all new hires or new agency staff are trained during orientation on abuse policy and importance of immediately reporting to Director of Nursing and Administrator. 2. The Director of Nursing or designee will audit the 24-hour clinical reports daily Monday through Friday. This review will be for residents exhibiting any incident or accident daily for signs and early detection of aggressive outbursts to ensure early interventions put in place for the safety and welfare of all residents. 3. Social Service Director or designee will interview random interview able residents monthly and report findings to QAPI. QAPI will evaluate the need for frequency change. Monitoring through QAPI to ensure performance, evaluate effectiveness and that corrective actions are sustained. 1. The Nurse Educator or designee will ensure all new hires or new agency staff are trained during orientation on abuse policy and importance of immediately reporting to Director of Nursing and Administrator. 2. The Director of Nursing or designee will audit the 24-hour clinical reports daily Monday through Friday. This review will be for residents exhibiting any incident or accident daily for signs and early detection of aggressive outbursts to ensure early interventions put in place for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 609	Continued From page 22 wheelchair. The Supervisor stated they assisted Resident #3 upright and began questioning her if she was hurt or not. Resident #3 denied any injuries and was able to move all extremities. As the Supervisor she stayed in the room to talk with Resident #3 and noticed that she had socks draped over her shoulders, she stated that Resident #3 reported that Resident #1 had placed them around her mouth but was not able to tighten them. She added that Resident #1 was placed on 1:1 supervision and remained that way through the end of her shift. Review of the facility's 24-hour reports and 5 day investigation reports on 01/14/21 revealed no initial 24 hour report or 5 day investigation report was filed regarding the incident with Resident #1 and Resident #3 on 12/10/21. An interview was conducted with the DON on 01/15/21 at 2:16 PM The DON stated that on 12/10/20 Nurse #1 called and reported that Resident #1 had tipped Resident #3's wheelchair over backwards. The DON stated she inquired about the resident and made sure they were both okay. Nurse #1 reported that she had already initiated 1:1 supervision with Resident #1 and once they assessed Resident #3 were able to turn her wheelchair back upright. The DON stated after she got off the phone with Nurse #1, she called back to circle back through the events and make sure they had done everything that needed to be done. Both times the DON spoke to Nurse #1 via phone the sock incident never came up, the DON stated she learned about that it the next day when she was reading the progress note and went to talk to the Supervisor. The DON stated as reported by Resident #3 the sock incident would be a form of abuse. She again confirmed that	F 609	the safety and welfare of all residents. Findings will be reported to QAPI for evaluation and action plans taken. 3. Social Service Director or designee will interview random interview able residents monthly and report findings to QAPI. QAPI will evaluate the need for frequency change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	550 GLENWOOD DRIVE MOORESVILLE, NC 28115

(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 609	Continued From page 23	F 609		

initially she did not see the issue as abuse but after learning of the sock incident that would definitely be a form of abuse and should have been reported as such. She stated that they discussed the incident with the Administrator with input from Corporate Consultants but ultimately the decision of what to report would come from the Administrator as she was the abuse coordinator.

An interview was conducted with the Administrator on 01/15/21 at 4:54 PM. The Administrator stated that she was called by the Supervisor on 12/10/20 and notified of the incident where Resident #1 turned over Resident #3's wheelchair with her still in the chair. Initially the Administrator stated she was not aware of the incident with the sock until the next day but when investigating she could not confirm or deny that the incident had occurred. The Administrator stated that she did not think in Resident #1's state of mind she was trying to be abusive, she believed it was all reactionary on Resident #1's part. She added if Nurse #1 would have reported the sock issue it certainly would have led us down the abuse path, but we discussed as a team and with our corporate consultants to make sure we were doing what we needed to be doing. If Nurse #1 had noticed the socks draped around Resident #1 shoulders or had then been marks on Resident #3's face, then yes I would certainly say this was abuse and would have reported it as such.