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 10/25/2023

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 000	INITIAL COMMENTS A complaint survey was conducted from 10/18/23 through 10/25/23. The following intakes were investigated NC00204661, NC00205655, NC00206046, NC00207364, NC00207854, and NC00208559. Intake NC00208559 resulted in immediate jeopardy. 5 of the 14 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J. The tags F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 08/28/23 and was removed on 10/22/23. An extended survey was conducted.	F 000		
F 689 SS=J	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 observations, record review, staff, and nurse practitioner interviews the facility failed to assess a resident's ability to safely operate the motorized wheelchair in the community, failed to educate the resident about safely operating the	F 689	On 10/17/2023, Resident #1 was sent to the hospital for medical treatment. All residents who leave the facility independently have the potential to be	10/26/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 11/13/2023

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 1

motorized wheelchair in the community, and failed to attempt safeguards for the resident with a diagnosis of dementia, traumatic brain injury and poor decision-making skills. On the morning of 10/17/23, Resident #1 left the facility in his motorized wheelchair and was struck by a garbage truck traveling 35 miles per hour (mph) when attempting to cross a four-lane highway with no marked crossing. Resident #1 was hospitalized with multiple bilateral fractures of the ribs both displaced and non-displaced, sternal fracture, multiple facial fractures, and spinal fractures, required intubation, and admitted into intensive care unit (ICU) where he remained hospitalized during the survey. In addtion, on 8/28/23 Resident #2 used an unlabeled bottle of a chemical solution he found in a common area to clean the seat of his wheelchair and accidentally sprayed his right pant leg. Resident #2 reported burning and pain of his right buttocks and the back his right leg at a level of 10 on a pain scale of 1 to 10 (10 being the worst pain) to the nurse and was sent to the hospital for evaluation and treatment. Resident #2 suffered partial thickness chemical burns to his right buttocks extending to the posterior surface of the mid-thigh which was assessed as approximately 7% to 8% body surface. The partial thickness chemical burn required heavy irrigation with normal saline, followed by scrub with warm soapy water. Resident #2 stated he could not tolerate the procedure and indicated his pain level was higher than 10. He was discharged back to the facility on 09/01/23. This was for 2 of 4 residents reviewed for provide supervision to prevent accidents (Resident #1 and Resident #2).

Immediate Jeopardy for Resident #2 began on 08/28/23 when he sprayed his wheelchair seat

F 689

affected by this alleged deficient practice.

On 10/17/23 the Administrator and the Interdisciplinary team (IDT) completed a review of all current residents who sign out and leave the facility independently. Four residents were identified as using motorized wheelchairs, three residents were identified as using a standard wheelchair, and six residents were identified that ambulated independently from the facility that could be at risk for injuries caused by accidents. The Nurse Managers, Assistant Director of Nursing, Director of Nursing, and the Therapy Manager reviewed the resident's Quarterly Functional Assessment to determine if there were any changes in the resident's assessment status. A review of the resident□s BIMS score and their latest Wander Risk Assessment was also used to determine if a resident could leave the facility independently.

On 10/17/2023, this assessment information was reviewed with the resident's medical provider and the IDT and none of the residents who leave independently were determined to be unsafe.

On 10/17/23 The Administrator and the IDT completed a review of the motorized wheelchair assessment completed by the therapy department for the four residents who use electric motorized vehicles. All four of these residents had rehab documentation of the motorized wheelchair assessments completed in the

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F 689 Continued From page 2

and right pant leg with a chemical solution in an unlabeled spray bottle. Immediate Jeopardy for Resident #1 began on 10/17/23 when he was struck by a garbage truck while in his motorized wheelchair and had not been assessed, educated, and had no safeguards in place. Immediate Jeopardy was removed on 10/22/23 when the facility provided an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

Findings included:

1. Resident #1 was admitted to the facility on 08/02/22 with diagnoses which included traumatic brain injury, anxiety, and depression.
Review of Resident #1's medical record revealed the Resident was his own responsible party (RP).

Review of progress note dated 03/23/23 Resident #1 got up at 5:20 AM and revealed he was going to a family member's house. Resident #1 refused to sign out, to tell nursing staff where he was going or how he was getting there and refused to wait until daylight.

Resident #1's care plan revised on 05/02/23 revealed the resident had a behavior problem due to refusing care at times, yelling and cursing staff, refusing to be changed and dressing inappropriately, refusing showers, refusing medications, attempting to leave the facility without signing out and leaving the facility without taking medication. Interventions included discuss

F 689

last six months and no status changes were identified by the IDT.

On 10/17/23 the Administrator and Social Services Director re-educated all current residents who use motorized vehicles, standard wheelchairs, and those that ambulated independently from the facility verbally and by printed materials:

1. Slow speeds only
2. The only person authorized to operate the Electric Motorized vehicle (EMV) on the premises is the owner/operator.
3. Approach intersections with caution and yield right of way to pedestrians.
4. EMV operators will use caution in order not to bump into people, walls, furniture, or other objects.
5. EMV operator will not use EMV to push open doors as it causes damage.
6. Residents who use EMV are solely responsible for all maintenance and repairs of EMV.
7. If the resident operates an EMV in an unsafe manner, causing injury to others or creating excessive damage to facility property, the facility may request that the resident use an alternative means of transportation in the facility.
8. Not to use the EMV in a threatening way to others or as a weapon.
9. No use of the EMV to tow other wheelchairs.
10. Do not use EMV to display verbal or physical aggression.
11. The resident is responsible for the maintenance and upkeep of the chair/scooter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 3

the Resident's behavior and explain/reinforce why behavior is inappropriate or unacceptable and educate the resident of the possible outcomes of not complying with treatment or care.

Resident #1's quarterly Minimum Data Set (MDS) dated 07/14/23 revealed Resident #1 was cognitively intact and required supervision with one staff assist with transfers. The MDS further revealed Resident #1 was coded for no upper and lower impairment and was also coded for no hearing or vision impairment.

Review of Resident #1's fall risk assessment dated 08/02/23 revealed Resident #1 was coded under Mental Status, "overestimates or forgets limits," and was marked high risk for falling.

Review of Resident #1's wandering assessment dated 08/08/23 revealed under Diagnosis Resident #1 was coded for "medical diagnosis of dementia/cognitive impairment; diagnosis impacting gait/mobility or strength."

Review of Resident #1's medical record revealed no safety assessment completed for Resident #1 to operate his motorized wheelchair out of the facility. The record review also revealed there was no documentation that Resident #1 had received any education on the risks of operating a motorized wheelchair in the community.

The facility sign out sheet revealed on 10/17/23 Resident #1 signed out to leave the facility. The sign out sheet further revealed no time was documented when the resident had signed out.

The weather report dated 10/17/23 revealed at approximately 6:45 AM it was clear with the

F 689

12. Resident who requests to use an EMV must have a Rehab screen for functional abilities and safety awareness while using EMVs.
13. Rehab findings will be discussed with the resident, the nursing staff, and the attending physician.
14. If the resident does not pass the functional or safety part of the screen, the resident will be referred to therapy for skilled interventions.
15. Residents will need to sign out with the nursing staff.
16. The advantages of walking against traffic.
17. Using sidewalks when available
18. To look both ways before crossing the road.
19. To use crosswalks when available.
20. The procedure for notifying staff that they want to sign out and leave the facility.

New admissions who want to sign out and leave the facility using EMV, standard wheelchairs, or walking, will receive this education from the Social Services Director, a functional assessment by the nursing department and/or the therapy department and an assessment from their medical provider to confirm if they are safe to do so. A new assessment will be completed if the resident has a change in their baseline status. For residents who are determined not to be safe to leave independently, a referral to therapy will be made for skilled interventions and the physician will be notified for an assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689 Continued From page 4

beginning of sunrise. The report further revealed the temperature to be about 44 degrees Fahrenheit.

Law Enforcement report dated 10/17/23 at 7:05 AM revealed Resident #1 was in a motorized wheelchair and was struck by a driver. The report further revealed Resident #1 crossed at an area that was not marked as a cross walk and was dimly lit during the morning rush hour traffic. The report documented a witness observed a "shadow" roll into the street before Resident #1 was hit. The report revealed the driver had obeyed traffic laws. The report indicated Resident #1 was transported to the hospital with non-life-threatening injuries to his face and neck.

Review of the admission Emergency Room (ER) note revealed on 10/17/23 Resident #1 was admitted with large hematoma to right forehead, swelling to bilateral eyes with periorbital ecchymosis, multiple facial lacerations, swelling to the bridge of nose, laceration of the upper lip, facial instability, blood around bilateral nares and mouth clear fluid leaking around nares and eyes, soft tissue swelling to the neck, tenderness to bilateral chest wall, abrasions over right hand, and laceration to medial left foot and ankle.

A review of the hospital progress note dated 10/18/23 revealed Resident #1 arrived at the emergency room in stable condition but sustained multiple bilateral displaced and non-displaced rib fractures, sternal fracture, LeFort 2 fracture of the mid face, and LeFort 3 fractures of the nose, fracture bilateral C6 lamina of the spine, hyperextension injury to cervicothoracic spine, avulsion fracture ant inf endplate C7 of the spine, chalk stick fracture involving T5-T6, and fracture

F 689

Residents refusing to participate in this process, who fail the evaluation, re-evaluation, or who do not follow safety recommendations such as not using crosswalks to cross the road, must meet with the administrator, nursing, therapy, and physician. A course of action will then be decided, which may include re-education on safety when leaving the facility independently, therapy referrals for evaluation for appropriate modes of mobility, and reasonable accommodations for participation in our shopping and travel activities that occur with staff away from the facility.

On 10/21/2023, the maintenance director put reflective flags on the EMVs and standard wheelchairs of residents who leave the facility independently. Reflective safety vests were placed at each nursing station and at the exit doors. The nurse manager educated staff members who were present to have residents who ambulate wear these vests when they leave the facility. The Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff, contracted, and agency staff, without receiving this education. This education will be delivered verbally, in writing and may be delivered electronically by the Director of Nursing and nurse managers.

On 10/21/2023, the Director of Nursing made identification cards for all residents who leave the facility independently that included their name and contact

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689

Continued From page 5

right T12 to L4TP. Resident #1 was admitted into the intensive care unit in stable condition and remains to be treated.

Observation conducted on 10/19/23 at 11:30 AM of the incident site revealed Providence Road a major highway through Charlotte was a four-way highway that did not include a safe crossing for any individual to cross. The road included sidewalks on both sides of the highway that were observed to not have any accessible ways to get on the sidewalk. The highway was observed and did not include any caution signs of possible pedestrians or caution signs. The observation further revealed the speed limit to be 35 miles per hour (MPH) with lots of oncoming traffic. It was observed that the direction the garbage truck had come from the incident site was about 30 yards from a curb. The curb was observed to have overgrown bushes and trees which made it impossible to see upcoming traffic around the curb.

An interview conducted with the Nurse Practitioner (NP) on 10/18/23 at 10:35 AM revealed Resident #1 consistently left the facility without signing out and brushed it off when staff verbally educated him that the resident needed to sign out when leaving the facility. The NP further revealed Resident #1 was cognitively alert and felt like the resident was safe to leave the facility because he did daily. It was indicated the NP believed Resident #1 had poor decision-making skills because she had observed Resident #1 crossing in front of the facility where there is no crosswalk, traveling at a fast speed, and no caution or safety items on the resident ' s motorized wheelchair. The NP indicated she had reported to nurses on duty that Resident #1 had

F 689

information for the facility. Residents assessed after 10/21/2023 will also be given identification cards.

On 10/17/2023, the Administrator and Unit Managers educated all facility staff present regarding the requirement for residents to sign out prior to leaving the facility by a member of the nursing staff, wheelchair safety, safety recommendations for ambulatory residents, and adding vests and flags for resident safety. Included in this education was notification to the Administrator, Director of Nursing, and/or nurse managers any resident observed not following safety recommendations for leaving the facility independently. This education also includes that the safety vest can be located at each nurse's station and at the front receptionist desk. Nursing staff was also instructed on utilizing a list given to them of who can sign out and leave the facility independently. This list will be updated weekly for 12 weeks and as needed by the IDT. The licensed nurses were trained to utilize this list of residents to audit the presence of reflective devices and their identification cards prior to signing out of the facility. Staff will use the Maintenance Request Logs at each nursing station to alert when other wheelchairs require installation of a safety flag. During the evening hours, nights, and weekends, the first-floor nurse will be responsible for attaching and or reattaching flags as needed. Signage directing staff on the policy will be at each nursing station and

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 6	F 689		

unsafe behaviors in his motorized wheelchair. The NP indicated nursing staff were aware and had indicated they had consistently educated resident #1 to sign out when leaving and to not cross at unsafe areas in his motorized wheelchair.

An interview conducted with Nurse #2 on 10/18/23 at 3:40 PM revealed Resident #1 was alert and oriented and never seemed confused. Nurse #2 further revealed Resident #1 left the facility daily and had refused to sign out if staff were unable to get the sign out sheet immediately. Nurse #2 stated it had happened often. Nurse #2 indicated he had never observed Residents #1 outside of the facility but had been told by other nursing staff Resident #1 crossed the road unsafely and went into town to panhandle money at the bus stop. Nurse #2 revealed he had verbally educated Resident #1 often to sign out and to be safe when outside of the facility in his motorized wheelchair.

An interview conducted with the facility Psychiatric Nurse Practitioner (NP) on 10/19/23 at 10:40 AM revealed Resident #1 was referred to psychotherapy due to history of depression and anxiety. The Psychiatric NP revealed she had never been notified of Resident #1's unsafe behaviors crossing the road, not signing out to leave the facility, and the incident that occurred on 10/17/23. It was indicated the last time Resident #1 was seen was July 2023 because Resident #1 had been out of the facility when the Psychiatric NP visited the facility. The NP revealed Resident #1 was alert and oriented and could make his own decisions, but she was notified of these concerns she would have been concerned about Resident #1's decision making

at the receptionist desk. The Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff, contracted, and agency staff, without receiving this education. This education will be delivered verbally, in writing and may be delivered electronically by the Director of Nursing and nurse managers. Those who receive the education electronically will send a statement via text or email that they have received and understand the education. Once the staff who confirm receipt of education electronically are in the building, the Director of Nursing, Assistant Director of Nursing, a Nurse Managers and Administrator will validate the information is understood. For weekends, the weekend manager and/or a designated nurse will complete staff validation. For nights, a nurse will be assigned by the Director of Nursing to complete validation of education. The Administrator will create a tracking tool to ensure all staff from 10/17/2023 and moving forward receive this education.

The Administrator or Designee will audit all current residents and new admits who leave the facility independently for 12 weeks for the completion of assessments related to their ability to leave the facility independently that includes the following information: Functional assessment for mobility capabilities, BIMs scores and Wander risk assessments. Included in the audits will be the availability of identification cards, presence of safety reflective devices, documentation of

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 10/25/2023

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 7

skills. The Psychiatric NP stated she should have been notified of Resident #1 ' s behaviors because they were unsafe, and she possibly could have assisted the facility with educating and making a plan for Resident #1 to keep the resident safe outside of the facility.

An interview conducted with Nurse Aide (NA) #1 on 10/19/23 at 8:45 AM revealed Resident #1 left the facility on 10/17/23 before breakfast and it was still dark outside. The NA further revealed Resident #1 was wearing dark clothing and had no safety precautions on his motorized wheelchair. NA #1 stated on multiple dates had refused to sign out and left the facility after being verbally educated by nursing staff to sign out. The NA further revealed she had observed Resident #1 riding down the middle of the four-lane road at times and traffic honking their horn and slamming on their brakes due to the resident not paying attention.

An interview conducted with the facility Social Worker (SW) on 10/19/23 at 2:55 PM revealed Resident #1 was alert and oriented and could make his own decisions. The SW indicated he observed Resident #1 refuse to sign out a few times and educated the resident verbally that the resident needed to sign out. The SW indicated nursing staff had made comments that Resident #1 needed to be more careful outside of the facility but did not recall any details.

An interview conducted with Nurse #1 on 10/19/23 at 9:40 AM revealed on 10/17/23 Resident #1 left the facility at an estimated time of 6:45 AM and signed out to leave the facility. Nurse #1 further revealed she was unable to see if it was still dark outside. Nurse #1 indicated

F 689

safety education, and any reported refusals to follow the safety guidelines. These audits will be used to update the list used by staff when residents sign out of the facility independently.

The results of these audits will be discussed in the weekly risk meeting for 12 weeks and monthly for three months during the QAPI committee meeting and the committee will make recommendations.

Date of completion: 10/26/2023

On 08/28/23, Resident #2 was sent to the hospital for medical treatment.

All residents have the potential to be affected by this alleged deficient practice.

On 8/29/23 the Administrator and the Housekeeping Supervisor completed an audit of all chemicals located in the facility and no similar substance was identified. The liquid was then discarded.
On 8/29/23 the Administrator and the Housekeeping Supervisor completed an audit of the entire facility to ensure all chemicals are secured safely.

On 8/30/23 the Administrator educated Resident #2 and all residents with BIMs scores 10 and above, regarding requirements to check in all items brought in from outside with the Nurse to ensure items are safe.

On 8/30/23 the Administrator educated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689

Continued From page 8

Resident #1 rarely left that early but had one a black hoodie that morning with no safety precautions observed on the resident's motorized wheelchair. Nurse #1 revealed she asked Resident #1 to sign out because in the past he had refused or left if nursing staff was busy and unable to retrieve the sign out sheet immediately. Nurse #1 indicated she had been educated to make sure residents had signed out when leaving and understood Resident #1 could leave whenever he wanted too if he signed out.

An interview conducted with the Director of Therapy on 10/19/23 at 3:320 PM revealed Resident #1 had an electric wheelchair when he was admitted into the facility which an assessment was not completed on the resident. The Director of Therapy further revealed an assessment completed in the facility would not cover safety outside of the facility because therapy would not know what kind of obstacles a resident might come across outside of the facility and therapy was not responsible for the motorized wheelchair if it was to malfunction. It was indicated therapy had made several attempts since admission to work with Resident #1, but the resident often refused and was rarely in the building to receive assistance.

An interview conducted with the Director of Nursing and the Administrator on 10/19/23 at 12:05 PM revealed Resident #1 was alert and oriented and was independent for transfers and using the bathroom. The Administrator stated on 10/17/23 Resident #1 left the facility at 6:48 AM and crossed in front of the facility on a four-lane highway where there was no cross walk and was hit by a garbage truck. The Administrator indicated Resident #1 sustained multiple fractures

F 689

the current staff regarding safe handling of chemicals, location and use of the Material Safety Data Sheets and ensuring chemicals are stored securely. For weekends and nights, the nurse manager and/or a nurse designated by the Director of Nursing, will complete staff education. Nurse Managers on all shifts will ensure no staff will be allowed to work, including any newly hired facility staff and agency staff, without receiving this education. Education will be completed verbally with handouts for reference. The Director of Nursing will be responsible for tracking staff to ensure all staff are educated before being allowed to work.

The education consists of:
1. All chemicals must the identified and labeled.
2. All chemicals must be secured appropriately.
3. Material Safety Data Sheets are required for chemicals in use and stored.
4. Any chemicals seen without labels must be removed immediately and given to the housekeeping supervisor, available manager, or Administrator to be appropriately discarded.
5. No sharp items are allowed. If staff identify sharp items they must be removed from the area and given to the housekeeping supervisor, available manager, or Administrator to be appropriately discarded.

On 8/30/23 the Housekeeping Supervisor re-educated the cleaning staff regarding the safe use, labeling, and storage of all

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 10/25/2023

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 9

and injuries. The Administrator indicated she observed facility video that observed Resident #1 did have a cell phone, was wearing dark clothing, and did not have safety precautions on the resident ' s motorized wheelchair. The DON and Administrator further revealed they had verbally educated Resident #1 multiple times regarding signing out but would often refuse. It was indicated to the Administrator and DON did not do any further education with Resident #1 because they had never observed resident #1 in the road and staff had not reported Resident #1's unsafe behaviors.

Administrator was notified of immediate jeopardy on 10/19/23 at 1:40 PM.

The facility provided the following immediate jeopardy removal plan.

The facility failed to complete a safety assessment for use of an electric wheelchair and leaving the facility for Resident #1 who has a history of a traumatic brain injury and known poor decision making. The facility was aware the resident crossed the four-lane highway without using the cross walk and signed out before daylight without interventions in place to warn drivers of the resident. There was no documentation of education to the residents about safety and risks. On 10/17/23 Resident #1 was struck by a garbage truck crossing the highway without using the crosswalk at an estimated time of 6:45 AM. Resident #1 remains hospitalized.

On 10/17/23 the Administrator and the Interdisciplinary team (IDT) completed a review of all current residents who sign out and leave the

F 689

cleaning products. This will be added to the new hire orientation.
On 8/30/23 the Housekeeping Supervisor and Maintenance Director reviewed all chemicals and ensured all were properly labeled.

On 8/30/23 the Director of Nursing ensured Material Safety Data Sheets are available in the basement, in the laundry department, in the dietary department, and one at each of the three nurse□s stations for all chemicals used in the facility.

For 8 weeks, daily audits are performed by the housekeeping supervisor of the housekeeping carts to ensure that there are no unauthorized chemicals being used and that the chemicals that the facility uses are in correct bottles with appropriate labeling. This audit started on 08/31/2023.

For 8 weeks, weekly audits are performed by the Director of Nursing. Five random residents are checked to see if they have chemicals or sharps in their room, dining rooms, activity areas, shower rooms, nurse□s station, the exit lobby, smoking porch, and the front lobby. These audits started on 08/30/2023.
On 8/30/2023, the Administrator held an Ad Hoc QAPI meeting with the Interdisciplinary team to develop a plan to correct to prevent further incidents.

On 09/12/2023 and 10/10/23, the Administrator held the monthly QAPI

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 10/25/2023

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F 689	Continued From page 10 facility independently. Four residents were identified as using motorized wheelchairs, three residents were identified as using a standard wheelchair, and six residents were identified that ambulated independently from the facility that could be at risk for injuries caused by accidents. The Nurse Managers, Assistant Director of Nursing, Director of Nursing, and the Therapy Manager reviewed the resident's Quarterly Functional Assessment to determine if there were any changes in the resident's assessment status. The Functional Assessment identifies the resident performance in areas such as the ability to walk 10 feet up to 150 feet, the ability to wheel a standard or motorized wheelchair 50 feet to 150 feet and the ability to walk or wheel a standard or motorized wheelchair on uneven surfaces. A review of the resident's BIMS score and their latest Wander Risk Assessment was also used to determine if a resident could leave the facility independently. On 10/17/2023, this assessment information was reviewed with the resident's medical provider and the IDT and none of the residents who leave independently were determined to be unsafe. Eight of the residents who leave the facility independently have mobile phones. The remaining five residents have not expressed interest in a mobile device but do know the contact information for the facility. On 10/17/23 The Administrator and the IDT completed a review of the motorized wheelchair assessment completed by the therapy department for the four residents who use electric motorized vehicles. All four of these residents had rehab documentation of the motorized wheelchair assessments completed in the last six months	F 689	meeting with the Interdisciplinary team. The results for the audits were discussed and the audits will continue for compliance. No concerns were identified, and no revisions were made to the Corrective action plan. The next QAPI meeting will be held on 11/14/2023. Effective 8/30/23 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Date of completion: 09/21/2023	

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 10/25/2023

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F 689	Continued From page 11	F 689		

and no status changes were identified by the IDT. Resident #1 had no documentation of assessment due to repeated refusals as explained by therapy and nursing staff.

· 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 10/17/23 the Administrator and Social Services Director re-educated all current residents who use motorized vehicles, standard wheelchairs, and those that ambulated independently from the facility verbally and by printed materials:
1. Slow speeds only
2. The only person authorized to operate the Electric Motorized vehicle (EMV) on the premises is the owner/operator.
3. Approach intersections with caution and yield "right of way" to pedestrians.
4. EMV operators will use caution in order not to bump into people, walls, furniture, or other objects.
5. EMV operator will not use EMV to push open doors as it causes damage.
6. Residents who use EMV are solely responsible for all maintenance and repairs of EMV.
7. If the resident operates an EMV in an unsafe manner, causing injury to others or creating excessive damage to facility property, the facility may request that the resident use an alternative means of transportation in the facility.
8. Not to use the EMV in a threatening way to others or as a weapon.
9. No use of the EMV to tow other wheelchairs.
10. Do not use EMV to display verbal or physical aggression.

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 10/25/2023

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F 689		F 689		

Continued From page 12
11. The resident is responsible for the maintenance and upkeep of the chair/scooter.
12. A resident who requests to use an EMV must have a Rehab screen for functional abilities and safety awareness while using EMVs.
13. Rehab findings will be discussed with the resident, the nursing staff, and the attending physician.
14. If the resident does not pass the functional or safety part of the screen, the resident will be referred to therapy for skilled interventions.
15. Residents will need to sign out with the nursing staff.
16. The advantages of walking against traffic.
17. Using sidewalks when available
18. To look both ways before crossing the road.
19. To use cross walks when available.
20. The procedure for notifying staff that they want to sign out and leave the facility.

During the investigation and review of this incident, it was determined that new admissions who want to sign out and leave the facility using EMV, standard wheelchairs, or walking, will receive this education from the Social Services Director, a functional assessment by the nursing department and/or the therapy department and an assessment from their medical provider to confirm if they are safe to do so. A new assessment will be completed if the resident has a change in their baseline status. For residents who are determined not to be safe to leave independently, a referral to therapy will be made for skilled interventions and the physician will be notified for an assessment. The Social Services Director, the IDT was notified by the Administrator on 10/17/2023 of their responsibilities.

Residents refusing to participate in this process,

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 10/25/2023

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

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F 689	Continued From page 13 who fail the evaluation, re-evaluation, or who do not follow safety recommendations such as not using crosswalks to cross the road, must meet with the administrator, nursing, therapy, and physician. A course of action will then be decided, which may include re-education on safety when leaving the facility independently, therapy referrals for evaluation for appropriate modes of mobility, and reasonable accommodations for participation in our shopping and travel activities that occur with staff away from the facility. Current residents were made aware of expectations when they were educated on 10/17/2023. On 10/17/23, the Administrator and Unit Managers educated all facility staff present regarding the requirement for residents to sign out prior to leaving the facility, wheelchair safety, safety recommendations for ambulatory residents, and adding vests and flags for resident safety. This education includes that the safety vest can be located at each nurse ' s station, at the front receptionist desk, and at the side exit door with the door attendant. During the hours before 8am and after 8pm when the attendant is not available, vests will be available at each nurse ' s station. Staff will use the Maintenance Request Logs at each nursing station to alert when other wheelchairs require installation of a safety flag. During the evening hours, nights, and weekends, the first-floor nurse will be responsible for attaching and or reattaching flags as needed. Signage directing staff on the policy will be at each nursing station, the receptionist desk, and with the Door Attendant. The Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff, contracted, and agency staff, without receiving	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 689	Continued From page 14	F 689		

this education. This education will be delivered verbally, in writing and may be delivered electronically by the Director of Nursing and nurse managers. Those who receive the education electronically will send a statement via text or email that they have received and understand the education. Once the staff who confirm receipt of education electronically are in the building, the Director of Nursing, Assistant Director of Nursing, a Nurse Managers and Administrator will validate the information is understood. For weekends, the weekend manager and/or a designated nurse will complete staff validation. For nights, a nurse will be assigned by the Director of Nursing to complete validation of education. The Administrator will create a tracking tool to ensure all staff from 10/17/2023 and moving forward receive this education. The team was made aware of these requirements on 10/17/2023.

On 10/21/2023, the maintenance director put reflective flags on the EMVs and standard wheelchairs of residents who leave the facility independently. Reflective safety vests were placed at each nursing station and at the exit doors. The nurse manager educated staff members who were present to have residents who ambulate wear these vests when they leave the facility. The Director of Nursing and Nurse Managers will ensure no staff will be allowed to work, including any newly hired staff, contracted, and agency staff, without receiving this education. This education will be delivered verbally, in writing and may be delivered electronically by the Director of Nursing and nurse managers.

On 10/21/2023, the Director of Nursing made identification cards for all residents who leave the facility independently that included their name

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 10/25/2023

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F 689	Continued From page 15	F 689		

and contact information for the facility. Residents assessed after 10/21/2023 will also be given identification cards.
The nearest crosswalk to the facility is a quarter of a mile in each direction. On June 27, 2023, the Administrator began negotiating with the Contract Agent for the City of Charlote to install a Pedestrian Beacon on the property site of the facility. A Pedestrian beacon provides special types of traffic signal indications exclusively intended for controlling pedestrian traffic. This will include stop bars on Providence Road, in front of the facility, to show cars where to stop, and stop lights will be hanging from a mast arm above the street.

On 10/17/2023, the Administrator held an Ad Hoc QAPI meeting with the Interdisciplinary team to develop a plan to correct to prevent further incidents.

Effective 10/17/23 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

Alleged date of IJ removal: 10/22/23

On 10/25/23, the facility credible allegation for immediate jeopardy removal of 10/22/23 was verified through onsite validation. Staff interviews revealed they had received education and training on resident safety. This included information on reporting unsafe behaviors of wheelchair use, educating residents to sign in and out, reporting and notifying residents' changes in behaviors or health, and making sure residents have safety precautions on their wheelchairs when out of the facility and education to residents on the risks of

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 10/25/2023

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F 689	Continued From page 16	F 689		

unsafe behaviors. The Administrator, therapy, and facility Nurse Practitioner (NP) met and discussed residents who could leave the facility in a safe manner. Observations and interviews with residents in motorized wheelchairs were conducted to verify education had been provided and safety measures were in place.

The facility's immediate jeopardy removal plan was validated to be completed as of 10/22/23.

2. Resident #2 was admitted to the facility on 12/1/2022. His diagnoses included type 2 diabetes with peripheral angiopathy (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs) without gangrene and bilateral below the knee amputations. A review of his annual Minimum Data Set (MDS) dated 9/8/2023 revealed Resident #2 was cognitively intact and required supervision to limited assistance of one person for activities of daily living (ADL).

An interview was conducted with Resident #2 on 10/19/2023 at 9:10 AM: Resident #2 stated he had been outside on the smoking porch, by himself, at nighttime, he could not recall the date of the incident, when he decided his wheelchair needed to be cleaned. He found an unlabeled spray bottle of pink liquid, that he assumed was a cleaning product, which was sitting on the smoking porch. Resident #2 picked up the spray bottle and sprayed his wheelchair seat with the pink liquid, he accidentally sprayed his right pant leg with the solution. He sat back down on the wheelchair seat with the pink liquid on the seat. He reported that at first, he felt a warm sensation on his right buttock and right thigh, the warm sensation intensified to pain by the time he got

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 17	F 689		

from the downstairs smoking porch to his room on the 2nd floor. He removed his clothes and put himself to bed. He stated the pain was so intense that he called the nurse to come into his room. The nurse attempted to wash the chemical off his right buttock and right thigh, but it did not help. The nurse called 911. Resident #2 reported that when the emergency medical services (EMS) arrived, they gave him some pain medication. His pain was a 10/10 on the pain scale. He stated that while he was in the hospital, his pain level was 10/10. The nurses at the hospital attempted to scrub his right buttock and right thigh, but the pain was so intense, 10/10 on the pain scale, that he could not tolerate the procedure. He stated that his pain level would have been higher than 10/10 if there was a number higher. Resident #2 reported that while in the hospital he received pain medication and that he currently was not on any pain medication as his burn had healed. He rated his current pain as 3 or 4 out of 10 on the pain scale. Resident #2 stated he knew he should have asked for help to clean his wheelchair but did not and decided to clean the wheelchair himself.

Review of the Nursing note dated 8/28/2023 at 11:02 PM by Nurse #3 stated, "Resident with reaction to thigh, unknown what happened but skin darkened and abrasions appearing. DON (Director of Nursing) alerted. MD (Medical Doctor) to send resident to ER (Emergency Room). 911 activated to (name of hospital).

Nurse #3 was unavailable for interview. Review of the statement she provided to the facility revealed: On Monday, 8-28-2023, at approximately 10:45 PM, Resident #2 rang doorbell for entry from smoke porch. Nurse Aide

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 10/25/2023

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F 689	Continued From page 18 (NA) let resident in, when I then witnessed resident roll by desk independently with shirt unbuttoned wearing grey sweat shorts. Resident made no contact with nurse, complained of no pain or distress. Resident independently rolled self to his room and got in bed. Approximately 10 minutes later, Resident called out loudly for "NA". NA went to resident's room immediately and came back to this nurse to report that resident complained of pain to his leg and what she visualized as a "blackened" area to resident's leg. This nurse then went to Resident's room and noted resident laying naked, on right side in bed. Resident with cell phone in hand states, "my leg is burning; I want to go to the hospital." This nurse noted Resident's right back of thigh was dark, appeared to be burnt, and noted abrasions forming to skin. When this nurse asked resident what happened, resident states, "spilt cleaning stuff in wheelchair." This nurse immediately assessed surroundings, noted that grey sweat shorts were in wheelchair and the leg of the shorts were wet and smelled of chemical. Area immediately rinsed with normal saline flushes. Resident refused to go to shower room and kept repeating, "I want to go to hospital." Education on importance of rinsing affected area was unsuccessful. Area continuously rinsed while 911 was activated at approximately 11:00 PM. DON made aware. First responders were fire department, who investigated "cleaning stuff" resident reported to be on the porch that was in a spray bottle. MSDS (Material Safety Data Sheet) book obtained, and this nurse escorted Fire Chief to basement to attempt to locate pink solution. Fire Chief found what was thought to match spray bottle and contacted poison control per bottle instructions. This nurse left resident in care of first responders, reported off to oncoming nurse who	F 689		

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 10/25/2023

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

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F 689	Continued From page 19	F 689		

was made aware of situation and EMS (Emergency Medical Services) arrived at approximately 11:35 PM. Resident taken to hospital for further evaluation.

Review of the hospital discharge summary dated 8/29/2023 revealed:
A 52-year-old male with a complicated past medical history significant for HTN (hypertension), DM2 (type 2 diabetes) on insulin, PVD (peripheral vascular disease) and bilateral BKA (below the knee amputation both legs) who presents to the emergency department for evaluation of burn. Physical exam revealed partial thickness burn extending from buttocks to mid-thigh on posterior surface and superficial burn on left posterior thigh. Burn does not appear to have any peritoneal (tissue that covers most of the organs in your abdomen) involvement. Partial thickness burn is approximately 7 to 8% body surface area by patient's hand as measurement. Sensation intact over entire burn area. EMS and fire department were called to scene and patient was reported to be cleaning his wheelchair with chemical solution and somehow had accidental chemical spill onto wheelchair for which he sat on and felt pain with burning. The spray bottle with chemical solution had an unknown label so fire got facility to open storage and found an industrial chemical with similar color and consistency labeled as Clean Slate Knoxville (disinfectant, sanitizer and virucide kills SARS-C0V-2, which causes Covid-19 on hard porous surfaces and kills 99.9% of bacteria and viruses on hard, non-porous surfaces). The poison center was consulted and informed of possible chemical burn and the name of possible chemical solution. They recommended reported chemical is detergent and recommended heavy irrigation and wound

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F 689	Continued From page 20 care. Trauma was consulted and saw patient at bedside. They recommended consulting the Burn Center for recommendations. Burn Center consulted due to burn extending over major joint and possible chemical burn. They recommended heavy irrigation, followed by scrub with warm soapy water, and applying Silvadene to areas where skin was removed and lotion to burn area. Nursing staff heavily irrigated patient's burn with 3 liters of normal saline over 20 minutes and attempted to scrub with warm soapy water, but patient could not tolerate pain even after pain medication. Trauma was informed of poison control and burn center recommendations as well as nursing staff attempt to scrub with warm soapy water but unsuccessful due to patient not being able to tolerate procedure due to pain. Trauma said they will admit patient for wound debridement and care with possible OR (operating room) usage if pain control not able to be achieved at bedside. Patient was admitted to trauma service. Resident #2 hospitalized from 8/29/2023 through 9/1/2023. Review of the label for the concentrated Clean Slate Knoxville reads: Disinfectant+Sanitizer+Virucide: Kills SARS-CoV2, which causes Covid-19 on hard non-porous surfaces in just 30 seconds! Kills 99.9% of bacteria and viruses on hard, non-porous surfaces. If product gets on skin: take off contaminated clothing. Rinse skin immediately with plenty of water for 15-20 minutes. Call poison control center or doctor for treatment advice. HAZARDS TO HUMANS AND DOMESTIC ANIMALS. DANGER: KEEP OUT OF REACH OF CHILDREN, CORROSIVE. Causes irreversible eye damage and skin burns. Do not get in eyes, on skin, or on clothing. Wear goggles	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 21 or face shield, rubber gloves, and protective clothing. Harmful if swallowed. Remove contaminated clothing and wash before reuse. Wash thoroughly with soap and water after handling. An interview was conducted with Nurse Aide (NA) #2 on 10/18/2023 at 3:29 PM: NA #1 stated he was familiar with Resident #2 and that he was cognitively intact. He reported he had not witnessed any housekeeping supplies left out. He stated if he saw any housekeeping supplies left out, he would pick them up and return them to the Director of Nursing (DON). He revealed he had received training after the incident on making sure all housekeeping supplies are put up after use. He reported he had not seen any cleaning products in Resident #2's room. NA #1 was interviewed on 10/19/2023 at 8:46 AM: NA #1 stated she was familiar with Resident #2. She reported that he was cognitively intact. NA #1 reported she had seen 2 housekeeping bottles of cleaner left out in a resident's room, and she picked up the 2 bottles and returned them to the housekeeper, this happened last week. NA #1 reported that the cleaning bottles were not in Resident #2's room. She stated she had never found the housekeeping closet left unlocked. NA #1 stated that Resident #2 told her that he had picked up a bottle of housekeeping cleaner outside on the smoking porch. Resident #2 reported to her that his wheelchair was dirty, and he had decided to clean it himself by spraying the liquid on the seat of his wheelchair and then sat in the fluid, causing a burn. She reported she had never seen a cleaning bottle without a label. NA #1 stated she had received training after the incident on making sure cleaning	F 689		

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 10/25/2023

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 22	F 689		

supplies are put up in a locked cabinet.

An interview was conducted with Nurse #2 on 10/18/2023 at 3:42 PM: Nurse #2 stated he was familiar with Resident #2, and he was cognitively intact. He stated he did work on the day the chemical burn happened, but he worked 1st shift and the incident happened on the 2nd shift. Nurse #2 stated he had not seen any housekeeping cleaning supplies left out on the unit and if he did, he would pick them up and report to the DON's office. He also clarified that he had not seen any cleaning supplies in Resident #2's room. He reported he had received training after the incident on not leaving cleaning supplies out but to make sure they are put up in a locked cabinet.

An interview was conducted with Nurse #3 on 10/19/2023 at 9:32 AM: Nurse #3 stated she was familiar with Resident #2, and he was normally on her assignment when she worked. She reported that Resident #2 was cognitively intact. Nurse #3 reported she had never found any cleaning supplies in his room or any left out in the building or on the smoking porch. Nurse #3 stated Resident #2 was no longer receiving treatments to the chemical burn on his right buttock and right thigh because it had healed and was just a large scar now. She reported he had been on pain medication, oxycodone, when he had the chemical burn and now that it had healed, he only received Tylenol. Nurse #3 stated she had received training after the incident on making sure that all cleaning supplies are put up in a locked cabinet.

Nurse #1 was interviewed by telephone on 10/19/2023 at 9:39 AM: Nurse #1 stated she was

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689	Continued From page 23 familiar with Resident #2 and that he was cognitively intact. She reported she had never seen housekeeping liquids left out in the facility or on the outside smoking porch. Nurse #1 stated she had not found the housekeeping closet unlocked, "the only people that have the code is the housekeepers and maintenance." She reported that the cabinets in the shower room also have a combination lock on them and they are high up on the wall so that residents cannot reach them. Nurse #1 reported that Resident #2 had told her that he had gotten the housecleaning cleaner outside on the smoking porch. She stated she had not seen any cleaning supplies in Resident #2's room. She stated she had received training after the incident on making sure no housekeeping cleaners were not left out and were to be locked up. The Wound Nurse was interviewed on 10/19/2023 at 10:44 PM: The Wound Nurse stated she was familiar with Resident #2. She stated he was cognitively intact. The Wound Nurse stated she was no longer treating the chemical burn on Resident #2, that it had healed and was only a pink-white scar now. He had no drainage or treatments to the wound at the present time. She stated that Resident #2 had received pain medication (oxycodone) prior to his burn treatments. The Wound Nurse reported that Resident #2 had told her that he had gotten the bottle of chemical cleaner outside on the smoking porch. She reported that supervised smoking occurred daily from 8:00 AM- 8:00 PM and residents that are not assessed to be supervised go outside on the smoking porch and smoke at all hours. She stated she had received training after the incident to make sure all cleaning supplies are put up and locked up after use. She reported	F 689		

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689	Continued From page 24 she had not seen any housekeeping supplies left unattended and had not seen any cleaning supplies in Resident #2's room. Observation of the right buttock and right posterior thigh was conducted on 10/19/2023 at 9:20 AM: Area noted to be from right buttock to right posterior thigh, past the knee to the area below the knee, approximately 3 inches. The area was pinkish-white, leathery appearance, no open areas or drainage noted. The area was approximately 4-6 inches wide. An interview was conducted with Housekeeper #1 on 10/19/2023 at 9:25 AM: Housekeeper #1 stated she normally worked on 200 hall; this is the hall that Resident #2 resided on. She reported she was not working when the incident happened with Resident #2. She stated she had not left any housekeeping chemicals out and she locked cleaning supplies in her housekeeping cart when she was finished with them. She reported that only housekeeping staff had the code to enter the housekeeping closets. Her cart was audited every morning by the housekeeping supervisor to make sure the cart was locked, and the cleaning supplies were secured. She stated if she found any housekeeping supplies left out, she would pick them up and take the cleaning supplies to her supervisor. She reported she had not seen any cleaning chemicals in Resident #2's room. Housekeeper #1 stated she had received training on making sure all housekeeping supplies are put up when not in use and locked up. The Housekeeping Supervisor was interviewed on 10/19/2023 at 3:00 PM: She reported that housekeeping staff are expected to lock up any chemicals after use. If another staff member	F 689		

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 10/25/2023

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 25 asked them for cleaning supplies, the housekeeper was to obtain the supplies asked for, go with the employee while they used the cleaning supplies, and then the housekeeper was responsible for locking up the chemical when finished. The Housekeeping Supervisor reported that the facility was unable to determine what chemical cleaner with which he was burned. She stated that to her knowledge, no housekeeping supplies had been left out in the facility unattended or in any resident room, except for one time when she found a bottle of Clorox left out, approximately 1-2 months ago, she picked up the bottle of Clorox and locked it back up. The Housekeeping Supervisor stated she had not seen any housekeeping chemicals in Resident #2's room. She stated she had searched the facility with the fire department, looking for a pink liquid in a bottle. She stated that the only pink solution found was pink fabric softener and red concentrated, commercial cleaner, called Clean Slate Knoxville, this commercial cleaner had to be diluted with water for use, and when diluted would lighten up the red color to pink. This information was reported to the hospital. She reported she made a round before the beginning of the shift and checked the housekeeping carts to make sure they were locked and what chemicals were stored on the cart. When the employee was ready to start the shift, she would check the cart again with the employee present and then the employee would sign that the cart had been checked. She stated that after the incident, staff were reeducated on making sure cleaning supplies were not left out after use and locked up either on the housekeeper's cart, in the housekeeping closet or in the locked cabinet in the shower rooms. She stated that the bottle with pink liquid was discarded in the trash.	F 689		

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689		F 689		

Continued From page 26

The Medical Doctor (MD) from Poison Control was interviewed by telephone on 10/20/2023 at 11:30 AM and a second telephone interview was conducted on 10/20/2023 at 2:07 PM: The MD stated that poison control was notified on 8/29/2023 at approximately 12:00 AM, by the hospital, that a 52-year-old male had been cleaning his wheelchair with a commercial cleaner and sat down on the cleaner and suffered partial thickness burns to his right buttock and right posterior thigh. The facility provided information to the hospital and poison control regarding the substance that they felt had caused the chemical burn. It was a product called Clean Slate. This is a commercial detergent. He stated that in his opinion, that the burns that Resident #2 had sustained was in-line with the chemical Clean Slate and not a fabric softener. The MD stated that fabric softener was not mentioned to poison control or the hospital. He stated that poison control did not go to the hospital that they consulted with the Emergency Room Doctors by telephone. He reported that Clean Slate left on the skin was not good and the compound would cause an injury to the person. He stated that he had contacted several of his colleagues and no one had heard of anyone sustaining a burn like this from fabric softener and that literature did not support a burn like this coming from fabric softener.

The Director of Nursing (DON) was interviewed on 10/19/2023 at 3:58 PM: The DON stated she was familiar with Resident #2, and he was cognitively intact. She was not present when Resident #2 received his chemical burn, the incident happened late on 2nd shift. The DON reported she did an investigation after the

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 10/25/2023

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		F 689		

Continued From page 27
incident and was not able to determine what chemical he was burned with and corporate came into the facility and tried to figure it out but were not able to determine what the chemical was. She stated she did find a can of Lysol in his room on 8/29/2023 and removed the can from the room. No other chemicals were found. The DON reported that Resident #2 did report generalized pain after the incident, no specific area about which he was complaining. Staff were educated after the incident to make sure that all chemicals are secured after use and to report to the Administrator herself, or the Housekeeping Supervisor if any chemicals were left unattended.

An interview was conducted with the Administrator on 10/19/2023 at 4:23 PM: The Administrator stated she was familiar with Resident #2 and that he was cognitively intact. She reported that an investigation was conducted after the incident, and they were not able to determine where he obtained the chemical or what the chemical was. His room was checked after the incident and a can of aerosol air freshener, and a bottle with clear liquid in it, the bottle was thrown out. The Administrator stated that audits were being conducted by housekeeping weekly to make sure housekeeping carts are locked and to make sure that no chemicals are left out unattended. She stated that no bottle of pink cleaning fluid was found in Resident #2's room. Staff were educated on making sure that all cleaning supplies are secured behind a locked cabinet, locked housekeeping closet or a locked housekeeping cart.

Administrator was notified of immediate jeopardy on 10/19/23 at 1:40 PM.

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 10/25/2023

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 28	F 689		

The facility provided the following corrective action plan.

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

The facility failed to properly store a bottle of cleaning fluid on 8/28/2023 at approximately 10:45 PM, which resulted in Resident #2 sustaining a chemical burn on 7% of his body surface. On 8/28/23 during the second shift Resident #2 reported having pain to his sacral area while seated in his wheelchair. The resident was assessed, and Resident #2 was transported to the Emergency Dept for treatment.

The event was immediately reported to the Director of Nursing on 8/28/2023 and based on the Charge Nurses investigation a strong chemical smell was identified on the wet wheelchair cushion observed in the wheelchair used by Resident #2. On 8/29/23 the Administrator and Director of Nursing initiated an investigation into the event. The Administrator identified an unlabeled spray bottle with a pink substance and when Resident #2 was interviewed by the Administrator he explained that he had obtained the cleaner from a visitor at his request. He did not report this to the nurse for review.

All residents are at risk because of this deficient practice.

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

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 10/25/2023

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 29	F 689		

On 8/29/23 the Administrator and the Housekeeping Supervisor completed an audit of all chemicals located in the facility and no similar substance was identified. The liquid was then discarded.

On 8/29/23 the Administrator and the Housekeeping Supervisor completed an audit of the entire facility to ensure all chemicals are secured safely.

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 8/30/23 the Administrator educated Resident #2 and all residents with BIMs scores 10 and above, regarding requirements to check in all items brought in from outside with the Nurse to ensure items are safe.

On 8/30/23 the Administrator educated the current staff regarding safe handling of chemicals, location and use of the Material Safety Data Sheets and ensuring chemicals are stored securely. For weekends and nights, the nurse manager and/or a nurse designated by the Director of Nursing, will complete staff education. Nurse Managers on all shifts will ensure no staff will be allowed to work, including any newly hired facility staff and agency staff, without receiving this education. Education will be completed verbally with handouts for reference. The Director of Nursing will be responsible for tracking staff to ensure all staff are educated before being allowed to work. Staff were made aware of this task on 08/30/23.

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 10/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 689	Continued From page 30	F 689		

The education consists of:
1. All chemicals must the identified and labeled.
2. All chemicals must be secured appropriately.
3. Material Safety Data Sheets are required for chemicals in use and stored.
4. Any chemicals seen without labels must be removed immediately and given to the housekeeping supervisor, available manager, or Administrator to be appropriately discarded.
5. No sharp items are allowed. If staff identify sharp items they must be removed from the area and given to the housekeeping supervisor, available manager, or Administrator to be appropriately discarded.

On 8/30/23 the Housekeeping Supervisor re-educated the cleaning staff regarding the safe use, labeling, and storage of all cleaning products. This will be added to the new hire orientation.

On 8/30/23 the Housekeeping Supervisor and Maintenance Director reviewed all chemicals and ensured all were properly labeled.

On 8/30/23 the Director of Nursing ensured Material Safety Data Sheets are available in the basement, in the laundry department, in the dietary department, and one at each of the three nurse's stations for all chemicals used in the facility.

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed.

For 8 weeks, daily audits are performed by the housekeeping supervisor of the housekeeping

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 10/25/2023

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 31	F 689		

carts to ensure that there are no unauthorized chemicals being used and that the chemicals that the facility uses are in correct bottles with appropriate labeling. This audit started on 08/31/2023.
For 8 weeks, weekly audits are performed by the Director of Nursing. Five random residents are checked to see if they have chemicals or sharps in their room, dining rooms, activity areas, shower rooms, nurse's station, the exit lobby, smoking porch, and the front lobby. These audits started on 08/30/2023.
On 8/30/2023, the Administrator held an Ad Hoc QAPI meeting with the Interdisciplinary team to develop a plan to correct to prevent further incidents.

On 09/12/2023 and 10/10/23, the Administrator held the monthly QAPI meeting with the Interdisciplinary team. The results for the audits were discussed and the audits will continue for compliance. No concerns were identified, and no revisions were made to the Corrective action plan. The next QAPI meeting will be held on 11/14/2023.

Effective 8/30/23 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance.

On 10/25/23, the facility's corrective action plan with a completion date of 09/01/23 was verified through onsite validation. Staff interviews revealed they had received education on safe handling of chemicals, location and use of the Material Safety Data Sheets and ensuring chemicals are stored securely. Audits were completed that cleaning supplies were not left

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 10/25/2023

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 32 unsupervised, and residents did not have chemicals in reach. Observations revealed no chemical was left out in reach of residents. The facility's corrective action plan for this example could not be validated as past noncompliance due to example #1.	F 689		
F 867 SS=G	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	F 867		10/26/23

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 10/25/2023

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 33	F 867		

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 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

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 10/25/2023

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 34	F 867		

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 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

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 10/25/2023

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 35 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 staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee previously put in place following the recertification and complaint investigation survey of 03/16/23. The repeated deficiency was in the area of free of accident hazards and supervision to prevent accidents. The facility's continued failure during two Federal surveys showed a pattern of the facility's inability to sustain an effective QAA program. The findings included: F 689: Based on observations, record review, staff, and nurse practitioner interviews the facility failed to assess a resident's ability to safely operate the motorized wheelchair in the community, failed to educate the resident about safely operating the motorized wheelchair in the community, and failed to attempt safeguards for the resident with a diagnosis of dementia, traumatic brain injury and poor decision-making skills. On the morning of 10/17/23, Resident #1 left the facility in his motorized wheelchair and was struck by a garbage truck traveling 35 miles per hour (mph) when attempting to cross a four-lane highway with no marked crossing. Resident #1 was hospitalized with multiple bilateral fractures of the ribs both displaced and non-displaced, sternal fracture, multiple facial fractures, and spinal fractures, required intubation, and admitted into intensive care unit	F 867	On 10/25/2023, the Quality Assurance Committee held an Ad Hoc meeting to review the purpose and function of the Quality Assurance Performance Improvement (QAPI) Committee as well as reviewed the ongoing compliance related issues regarding the F689 Tag received during the October 18, 2023, complaint survey. By 10/25/2023, the Director of Clinical Services educated the Administrator, the Director of Nursing and the Assistant Director of Nursing on the appropriate functioning on the QAPI Committee and the purpose of the Committee to include identifying issues and correction of repeat deficiencies, use of rounding tools, daily review of documentation, and observations during leadership rounds. By 10/25/2023, the 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. By 10/25/2023, the Administrator educated the QAPI committee members consisting of Medical Director,	

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F 867

Continued From page 36

(ICU) where he remained hospitalized during the survey. In addtion, on 8/28/23 Resident #2 used an unlabeled bottle of a chemical solution he found in a common area to clean the seat of his wheelchair and accidentally sprayed his right pant leg. Resident #2 reported burning and pain of his right buttocks and the back his right leg at a level of 10 on a pain scale of 1 to 10 (10 being the worst pain) to the nurse and was sent to the hospital for evaluation and treatment. Resident #2 suffered partial thickness chemical burns to his right buttocks extending to the posterior surface of the mid-thigh which was assessed as approximately 7% to 8% body surface. The partial thickness chemical burn required heavy irrigation with normal saline, followed by scrub with warm soapy water. Resident #2 stated he could not tolerate the procedure and indicated his pain level was higher than 10. He was discharged back to the facility on 09/01/23. This was for 2 of 4 residents reviewed for provide supervision to prevent accidents (Resident #1 and Resident #2).

F 689: During the recertification and complaint investigation survey of 03/16/23 the facility was cited for failure 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. A resident 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 the resident 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

F 867

Administrator, Director of Nursing, Assisted Director of Nursing/Staff Development Coordinator, Unit Managers, Minimum Data Set Nurse, Wound Nurse, Activities Director, Dietary Manager, Environmental Services Manager, Director of Social Services, and the Director of Rehabilitation, on weekly risk review of the audit findings for compliance and/or revision when necessary.

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.

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F 867	Continued From page 37	F 867		

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. A resident that 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. The resident 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 the resident in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help. The resident 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. The resident 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 in the unlocked car with the windows up, unattended in 74-degree weather while he went back inside for help.

An interview conducted on 10/19/23 at 12:05 PM with the Administrator who also headed the QAA committee explained the facility had discussed possible accident concerns daily in meetings. The Administrator stated she had younger residents that were more alert and oriented and had trouble getting these residents to follow facility rules.