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	345008	A. BUILDING _____ B. WING _____	C 10/17/2024

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

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F 000	INITIAL COMMENTS An onsite complaint investigation survey was conducted during a revisit survey on 10/15/24 through 10/16/24 and offsite on 10/17/24. The following intakes were investigated NC00222552, NC00222832, NC00223068, NC00223122 and NC00223129. Five of five allegations did not result in a deficiency. Event ID:S3FH11.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing	F 607		10/18/24

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

Electronically Signed | 11/08/2024

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F 607	Continued From page 1 retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to identify, and immediately report to administration an injury of unknown origin and failed to notify Adult Protective Services (APS) when Resident #3 sustained discoloration underneath both eyes, bleeding from the nose, and left wrist swelling with bruising; injuries that were unwitnessed by staff. Resident #3 was evaluated in the emergency department and diagnosed with bilateral traumatic periorbital ecchymosis (black eyes) and a nasal fracture. This failure occurred for 1 of 4 sampled residents reviewed for abuse (Resident #3). The findings included: The facility policy, Abuse, Neglect and Exploitation, revised 10/22/20, recorded in part, that the facility would have and follow written procedures to assist staff in identifying the different types of abuse. Possible indicators of abuse include physical injury of a resident of an unknown source. The facility will have and follow written procedures that include reporting all alleged violations to the administrator, adult protective services and to all other required agencies within the specified time frames. Reporting would occur immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.	F 607	1. It is the intention of Myers Park Nursing Center to report immediately to administration an injury of unknown origin, allegations of abuse, neglect, or exploitation, and any resident to resident altercation. Resident 3 was assessed by the nurse with follow up assessment completed by FNP. FNP made recommendation to send resident to hospital for further evaluation. Administrator and DON began investigation following the findings of facial bruising and notification of injury. 2. This alleged deficient practice has the potential to affect residents who reside in the facility. 3. The facility Administrator and Director of Nursing were re-educated on the policy of Abuse and Neglect, including timely reporting of allegations on 10/15/2024. Allegations of abuse, neglect, and exploitation must be reported within 2 hours as per regulation. Allegations must be thoroughly investigated to include resident and staff interviews, witness statements, skin audits as indicated, environmental factors, psychosocial assessments and any other relevant information that would enhance the effectiveness of investigations. Findings must be reported to QAPI committee following investigation. Facility Administrator and Director of	

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F 607	Continued From page 2 Resident #3 re-admitted to the facility 7/24/23 with hospice care. Diagnoses included end stage Alzheimer's dementia, vascular dementia, cerebral atrophy, schizoaffective disorder, cognitive communication deficit, intermittent mood disorder, hard of hearing and macular degeneration. A July 2024 Wander Risk Assessment and Care Plan identified Resident #3 at risk for wandering. A 7/12/24 physician (MD) order recorded wander guard for wandering behavior to left ankle, check for functioning and placement every shift. A 9/29/24 10:38 PM Incident Report completed by Nurse #1 recorded Nurse Aide (NA) #1 brought Resident #3 to the nursing station after assisting him out of Resident #2's room. Nurse #1 noted a scant amount of bleeding coming from Resident #3's nose with both eyes purple in color. Resident #3 was unable to give a description of the incident which was unwitnessed by staff. The Report documented Resident #3 wandered into Resident #2's room, began touching the foot of her bed, the room was dark, and Resident #3 was kicked on the hand and in the face. The Report documented Resident #3 sustained ecchymosis (bleeding underneath the skin causing bruising) to his face, a nosebleed and soft tissue injury to the back of his left hand. The Report documented Resident #3's pain was 0, with no verbal/non-verbal signs of pain, alert, disoriented to place, time and situation. Predisposing factors were recorded as poor lighting, impaired memory, incontinent, impulsive behavior, impaired safety awareness, dementia, ambulating without assistance, and wandering.	F 607	Nursing re-educated facility staff on 10/15/2024, all staff including agency staff, are to report Abuse and Neglect immediately to the Administrator and or the Director of Nursing. Admin staff re-educated active staff regarding the importance of immediate reporting of Abuse or Neglect allegations to Administrator and or the Director of Nursing to ensure timely reporting of such. 4. Facility Administrator will perform audits on Abuse and Neglect reportables to ensure timely and thorough reporting weekly for four weeks, and once a month for 2 months. All findings must be reported to QAPI committee following investigation.	

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A 9/29/24 10:57 PM nurse progress note written by Nurse #1 recorded NA #1 brought Resident #3 to the nursing station after finding him in Resident #2's room. Nurse #1 noted scant amount of bleeding from Resident #3's nose and discoloration to both eyes. Pressure was applied to bleeding with effective results. Resident #3 remained alert and responsive; neuro checks (a neurological exam of the nervous system) were within normal limits. Staff continued to monitor; but Resident #3 was non-compliant and continued to ambulate with staff assistance and redirection. The on-call provider was notified and gave orders to continue to monitor.

A 9/29/24 11:08 PM Change in Condition progress note written by Nurse #1 recorded Resident #3 was found by NA #1 in Resident #2's room with injuries to the face and nose. Resident #3 was not observed on the floor. No mental status changes were observed, bruising was noted to his face, a bloody nose was noted, no behavioral changes were observed, no respiratory changes were observed, skin assessment with discoloration was noted.

A 9/30/24 2:10 AM nurse progress note written by Nurse #2 recorded Resident #3 did not appear to be in any distress, continued wandering around dining area with staff close behind, bruises were noted to his face particularly around his eyes bilaterally.

A 9/30/24 facility Initial Allegation Report completed by the Director of Nursing (DON) was faxed to the State agency on 9/30/24 at 1:50 PM, per fax confirmation. The Report indicated an allegation of resident-to-resident abuse. A 9/29/24 written statement by NA #1 recorded that during

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rounds, NA #1 heard Resident #2 screaming, NA #1 found Resident #3 at the foot of Resident #2's bed and saw Resident #2's leg go back. NA #1 removed Resident #3 from the room, took him to his room to provide incontinence care and during the care NA #1 observed Resident #3 was bleeding from his nose. NA #1 immediately took Resident #3 to Nurse #1 to report the nosebleed. The facility documented the details that Resident #3 was struck in the face by Resident #2 on 9/29/24 which caused redness and bruising to his face and that the facility became aware on 9/30/24 at 11:00 AM. The Report documented that law enforcement was notified on 9/30/24 at 11:00 AM. Both Residents were assessed, separated and placed on every 15-minute checks.

A 10/1/24 9:36 AM nurse progress note written by Nurse #3 recorded Resident #3 denied pain or discomfort, was noted walking around the dining room, hospice nurse was notified of resident facial bruises, with a request for an order for an Xray. MD order was received from the Nurse Practitioner (NP) to get Xray.

A 10/2/24 progress note electronically signed at 8:27 PM by the NP recorded nursing reported Resident #3 was involved in an altercation with another resident. Nursing reported Resident #3 wandered in another Residents' room overnight, sat on the end of the bed and touched the Resident's foot causing the Resident to be startled. The Resident reactively kicked their foot inadvertently hitting Resident #3 in the face. Resident #3 was escorted from the room safely and no further interactions occurred amongst residents. Neuro-checks were initiated. X-ray was pending. Resident #3 had no loss of

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consciousness or change in visual status. Resident #3 remained ambulatory without difficulty, no conjunctival (swelling of blood vessels in the eye) injection, no visual deformities of facial trauma beyond bruising. Resident #3 was observed to eat/drink well. No recent falls, mood, or behavioral concerns. Bilateral periorbital (tissues around the eye) bruising noted and bluish discoloration of eye sockets and lower conjunctival sacs. Conjunctivae (a thin, protective, clear membrane that covers the inside of the eyelids) appear normal, pupils equal, round, and normally reactive to light. Bruising and swelling at nasal bridge. There was no epistaxis (nosebleed) or overt nasal deformity noted. The left wrist was noted with swelling and bruising. The NP recorded a diagnosis and assessment of a black eye of left side, a black eye of right side, swelling of the left wrist, traumatic periorbital ecchymosis (bleeding underneath the skin) of left eye, and traumatic periorbital ecchymosis of right eye. The NP wrote an order to transfer Resident #3 to emergency department for further evaluation and imaging to rule out a subdural hematoma and other sequelae (injury) from the altercation.

A 10/2/24 7:45 AM nurse progress note written by Nurse #4 recorded EMS (emergency medical services) arrived at 8:10 AM and took Resident #3 to the hospital, hospice nurse and family notified.

A 10/2/24 Emergency Department (ED) Report documented Resident #3 presented for further evaluation after facial bruising from a fall at the facility continued to get worse. Resident #3 was diagnosed with a nondisplaced right nasal bone fracture and raccoon eyes, bilateral (black eyes).

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A 10/4/24 facility Investigation Report completed by the DON was faxed to the state agency on 10/4/24 at 2:02 PM, per fax confirmation. The Report indicated the allegation of resident-to-resident abuse resulted in physical injury due to bruising sustained by Resident #3 to both eyes. The Report documented that APS was not notified and that the facility's investigation did not substantiate the allegation of abuse because there was no witness to any physical contact.

Multiple attempts to interview NA #1 were unsuccessful.

A 10/16/24 12:25 PM phone interview with Nurse #1 revealed she was the 3 - 11 PM shift Agency Nurse on 9/29/24 for Resident #2 and Resident #3. Nurse #1 stated Resident #3 was wandering on the unit during the shift and required frequent redirection. Nurse #1 stated NA #1 placed Resident #3 to bed before change of shift, and Nurse #1 saw him in bed during rounds. Nurse #1 stated a short time later NA #1 brought Resident #3 to the nurse's station and Nurse #1 observed him with a scant amount of blood in his nose that was not running out and there was discoloration to both eyes. Nurse #1 asked NA #1 what happened, and NA #1 told Nurse #1 that she found Resident #3 in the room of Resident #2 and that NA #1 did not know what happened. Nurse #1 said his injuries looked like he fell, because he walked on the unit a lot, so she thought he fell and got himself up and that's how the injuries happened, but she did not know for sure because she did not know what happened. Nurse #1 said she did not consider that the incident was an injury from an unknown origin or may have resulted from abuse, so she wrote on the incident

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report that Resident #3 wandered into Resident #2's room and was observed at the foot of Resident #2's bed because that's where NA #1 found him. Nurse #1 said staff did not know, but thought Resident #2 may have kicked Resident #3 if he startled her. Nurse #1 stated that the Supervisor (Nurse #5) was also at the nurse's station when the NA #1 brought Resident #3, so Nurse #5 was made aware of the incident at the same time. Nurse #1 stated she completed a nurse progress note, an incident report, reported the incident in shift report to Nurse #3, and Nurse #5 took it from there. Nurse #1 said that was the last time she worked at the facility.

During a 10/16/24 10:23 AM phone interview, Nurse #5 reported she was the weekend supervisor, on Sunday 9/29/24 when close to the end of the shift, Nurse #1 called her to the unit and asked her to assess Resident #3 because he wandered into Resident #2's room. Nurse #5 said it was reported to her that Resident #3 was found in the room by NA #1 and when she brought him out of the room, he had discoloration, described by Nurse #5 as redness, underneath his eyes and his nose was bleeding slightly. Nurse #5 stated she assessed Resident #3 with slight discoloration to his eyes, no nosebleed, and no pain even when she touched his face. Nurse #5 stated Resident #3 could not report what happened. Nurse #5 stated she asked Resident #2 if she kicked or touched Resident #3 and Resident #2 said "No, I did not touch that man." Nurse #5 stated that was the logistics of what she knew, Nurse #1 completed the documentation of the incident and notified "everybody." Nurse #5 described Resident #2 as mildly confused at baseline and Resident #3 was confused at baseline but stated that neither Resident had a

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history of aggressive behavior. Nurse #5 stated she was not exactly sure, but she did not think Resident #2 had the ability to kick that high to strike Resident #3 in the face. Nurse #5 described Resident #3 was at risk for falls due to a history of falls, he was able to get in/out of bed independently and stated she thought it was possible that Resident #3 fell from bed and got himself off the floor. Nurse #5 stated that when she was informed of the incident, she interviewed NA #1 who reported that she did not see any interaction between the Residents but found Resident #3 in another Resident's room. Nurse #5 stated that when she was notified of the incident, most of the staff had already left shift at 11:00 PM, so she did not get to interview them. Nurse #5 stated she thought about the abuse protocol, but also wondered if Resident #3 could have fallen and hit the corner of the nightstand in his room. Nurse #5 stated she was not able to determine how the injuries occurred, but she did not consider the incident as an injury of unknown origin, but she did consider that the injuries could have resulted from abuse. Nurse #5 stated that she did not know what happened, but believed Resident #3 could get himself off the floor without staff assistance if he fell, so she was not sure what happened. Nurse said she notified the DON of the incident via email but that she did not investigate the incident as an injury of unknown origin or as abuse. Nurse #5 stated she should have reported this to Administration immediately for an abuse investigation.

A 10/15/24 1:18 PM interview with Nurse #3 (Unit Manager) revealed she was the charge nurse on the 7AM to 3PM shift on 9/30/24 for Resident #2 and Resident #3. Nurse #3 said she received a shift report from Nurse#1 on 9/30/24 and was

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notified of the incident for Resident #3. Nurse #3 said she saw bruises under the eyes of Resident #3 and his nose was red/black, but she was not notified, nor did she observe swelling/bruises to his left wrist. Nurse #3 stated Resident #3 did not verbalize or show signs/symptoms of pain even when she touched his face. Nurse #3 stated staff reported that Resident #3 wandered into Resident #2's room and that Resident #2 kicked him. Nurse #3 said she monitored Resident #3 and his vital signs during the shift on 9/30/24 and reported that he remained at baseline throughout the shift with no acute changes or distress noted. Nurse #3 stated when she returned to work on 10/1/24, she processed the MD orders to obtain X rays for Resident #3 and when the NP rounded early the morning of 10/2/24, the X Ray order had not been completed yet, so the NP wrote an order to transfer Resident #3 to the ED for further evaluation. Nurse #3 said Resident #3 was transferred out.

A 10/15/24 1:47 PM interview with Nurse #6 revealed she was the Unit Manager on Monday 9/30/24 from 8:00 AM until 4:30 PM or 5:00 PM. Nurse #6 stated that during the morning clinical meeting on 9/30/24 she read the incident report completed by Nurse #1 and that was how she found out about the incident. Nurse #6 stated when the incident was discussed during the clinical meeting, the team determined that since the incident was not witnessed, it should have been reported to Administration immediately and investigated as abuse. Nurse #6 stated she interviewed staff on Monday, 9/30/24 after the clinical meeting and staff reported to her that no one saw it occur. Nurse #6 state when she spoke to NA #1, she said she heard Resident #2 screaming "get out of here get out of my room" so

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she went to the room and said she saw Resident #3 standing and touching the bottom of Resident #2's bed so we thought Resident #3 may have startled her and she kicked him in the face. Nurse #6 said she also spoke to Resident #2 who reported that "a man came in my room, and I had to get him out of here", but that Resident #2 denied having any physical contact with Resident #3. Nurse #6 stated she notified the NP on Monday, 9/30/24.

A 10/15/24 2:40 PM phone interview with the NP revealed the incident with Resident #3 was reported to on call on 9/29/24 and that she was notified on Monday, 9/30/24 by Nurse #6. The NP stated that Nurse #6 reported Resident #3 sustained bruising around his eyes from an incident and the NP advised to continue to monitor him. The NP stated that the next day, 10/1/24 she received a call from Nurse #3 stating the bruising had gotten worse and requested an order for X Rays, so she provided the order. The NP stated she arrived early on Wednesday morning, 10/2/24, to round, and Resident #3 was in bed lying on his left side and left arm. The NP stated she awakened Resident #3 and described that his cognitive status did not allow staff to know what was going on with him from his perspective. The NP stated that when she assessed him, she noted bruising/swelling to his left wrist, his eyes were black and puffy and there was a little bruising to his nose. The NP stated Resident #3 did not grimace or verbalize any pain, even when she touched his face. The NP stated there were no signs or symptoms of a nasal fracture, but his nose and face was bruised, and the X Ray was pending, so she wrote an order to send him out for further evaluation since staff reported the bruising became more

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F 607	Continued From page 11 pronounced. The Administrator and DON were both interviewed on 10/15/24 at 2:36 PM. During the interview, the DON stated she received an email regarding the incident that occurred for Resident #3 during the 3PM to 11PM shift on 9/29/24 which was reviewed along with the incident report and nurse progress note on 9/30/24 during the morning clinical meeting. The DON stated that based on review of the incident report, email and progress note, the clinical team recognized this incident should have been investigated as abuse, but did not consider the incident an injury of unknown origin. The DON stated staff should have reported this to Administration immediately. The DON stated it was not reported to APS because the investigation for abuse was not substantiated. The Administrator stated that initially, staff did not think the incident was abuse and did not notify Administration immediately. The Administrator stated that she expected staff to notify Administration immediately for determination of abuse, and an email did not meet the criteria for immediate notification.	F 607		