PRINTED: 06/23/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			05/:	21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	<b>'</b>		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		EO	00			
F 000	was conducted on 4/2 The facility was found CFR §483.73 related	ents for Long Term Care GRF011.	FO	00			
	Control Survey and conducted on 4/25/20 Past-noncompliance	OVID-19 Focused Infection omplaint investigation were 020 through 5/21/2020. was identified at:					
F 552 SS=D	24 of the 30 complain substantiated resultin GRF011	orrected on 4/10/2020.  It allegations were g in deficiencies. Event ID:  Make Treatment Decisions	F 5	52			6/19/20
	The resident has the participate in, his or h  §483.10(c)(1) The rig language that he or s her total health status his or her medical cor  §483.10(c)(4) The rig advance, of the care in						
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE			(X6) DATE

Electronically Signed

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.

06/10/2020

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F 552	F 552 Continued From page 1		F 55	2	
	§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.  This REQUIREMENT is not met as evidenced by:  Based on record review, family interview, and staff interview, the facility failed to inform Resident #11 's Responsible Party of a change in the resident's planned admission placement to a private room with a 14-day quarantine to a semi-private room with a roommate and no quarantine. This occurred during the COVID-19 pandemic and was for 1 of 8 residents reviewed for the right to be fully informed.  The findings included:  Resident #11 was admitted to the facility on 3/31/20 with diagnoses that included Alzheimer 's Disease.			This plan of correction is submitted a required under Federal and State Regulation and statutes applicable to term care providers. This plan of correction does not constitute an agreement by the facility and such lia is hereby specifically denied. The submission of the plan does not cons an agreement by the facility that the surveyors' finding or conclusion are accurate, that the findings constitute deficiency, or that the scope and severegarding any of the deficiencies are correctly applied.	long bility titute
	Resident #11's Resident #11's Resident #11's Business of the former Admission following:  -At 8:40 AM Resident what the facility's presidents during the -At 8:59 AM the BOI admitting people, we private room for a fearen't exhibiting symmetric symmetric programmer.	ordence on 3/19/20 between sponsible Party (RP), the Office Manager (BOM), and ans Director (AD) revealed the office the sponsible Party (RP), the Office Manager (BOM), and ans Director (AD) revealed the office the sponsible party as a sponsible party and the sponsible		F-tag 552  1. Corrective action accomplished f those residents found to have been affected by the deficient practice. Resident #11 no longer resident in the facility  2. Identify other residents who have potential to be affected by the same deficient practice and the actions take New Admissions are at risk. Room placement for new admissions are to discussed at Morning Meeting by the Interdisciplinary Team prior to admissions There have been no new admissions	e the en. be

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				SALISBURY, NC 28147		
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F 552	Continued From page	÷ 2	F 5	52		
F 552	the private room). But allowing any visitors.  The facility 's census #11 was admitted on room with a roommat remained in this same roommate throughout.  The admission Minim assessment dated 4/2 had moderately impa supervision only for lowas independent for lutilized either a walker locomotion.  A phone interview war #11 's RP on 5/6/20 at that prior to his admission the BOM or AD that Fradmitted to a private days prior to being interpopulation. She state this was a precaution pandemic. She indicated admission (3/31/20) sacility with Resident restricted as a precaution she stated she was restricted as a stated she was resulted as a precaution she stated she was restricted as a precaution she stated she was resulted as a precaution she stated she was restricted as a precaution she stated she was resulted as a precaution she	record indicated Resident 3/31/20 to a semi-private e (Resident #26). He e room with the same this stay.  um Data Set (MDS) 7/20 indicated Resident #11 ired cognition and required ocomotion off the unit. He er or wheelchair for  s conducted with Resident at 8:15 AM. She reported esion she was informed by Resident #11 would be room and quarantined for 14 tegrated into the general ed that she was informed related to the COVID-19 atted that on the date of the was not able to enter the #11 as visitors were ution related to COVID-19. Not made aware on this date,	F 58	the facility since 4/7/20.  3. Measure/ systemic changelace to ensure the deficient not reoccur. The Interdisciplir including the Business Office Social Worker, Director of Nu Activity Director, and Director to be re-educated by the Nurs Administrator on the importar communicating room placement admissions with the Responsion and to notify of any changes placement on 6/5/20  4. Monitoring of the correct ensure the deficient practice reoccur. The Nursing Home Awill validate room placement admissions and perform an authat notification was given to and/or family member. This acompleted 5xper week for 4 volume 3xper week for 2 months. The Home Administrator will preserve the facility remains in compliant the facility remains in compliant.	practice does nary Team Manager, arsing, of Therapy sing Home noe of ent of new sible Party in room  ed action to will not Administrator of new udit to verify the resident audit will be weeks than e Nursing ent the ality rovement API s to ensure	
	semi-private room wit quarantined for any p reported that on 4/4/2 #11 at the facility, but restrictions she had to windows in the lobby Resident #11 had no	going to be admitted to a ch a roommate and not eriod of time. The RP co she went to visit Resident that due to visiting to visit him through the glass area. She reported that mask on during this visit, her as she thought he was				

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F 552	RP indicated that sh found out for certain a private room, but to communications with allowed her to see R which confirmed her The RP stated that it of the changes in play private room with quarom with no quarar reconsidered Reside facility.  A phone interview where Admissions Director She stated that she facility. She recalled shad no recollection of would be in a privated days. She indicated requirement for quard days when they were COVID-19.  A phone interview where Administrator on 5/6 asked if Resident #1 room and quarantine that he was. The central that he was the central that he was the communicated hereof with a roommat and that Resident #11 with a roommate on quarantined. The Administrator. The Administrator on that Resident #11 with a roommate on quarantined. The Administrator. The Administrator on the Administrator. The Administrator on the Administrator on the Administrator. The Administrator on the Administrator on the Administrator on the Administrator. The Administrator on the Admin	arrantine. Resident #11 's e was not sure when she that Resident #11 was not in hat she had multiple in the Medical Director who desident #11 via video call was not in a private room. If she had been fully informed anned placement from a arantine to a semi-private withine that she would have ent #11 's admission to the  as conducted with the former (AD) on 5/6/20 at 1:58 PM. In longer worked at the If speaking with Resident #11 's ident's admission, but she of telling them the resident arantining new residents for 14 containing new residents for 14	F 5	52		

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F 552	RP was not notified of that prior to admission communicating with a prior to admission communicating with a prior to admission of 5/6/20 at 4:21 PM Resident #11 's RP had no recollection of would be in a private days. The BOM indictifit was a requirement private room and quacturent residents at the admission (3/31/20), communicated with the correspondence and that information to see related to a private room of 5/6/20 at 4:56 PM of electronic correspondence and that information to see related to a private room 5/6/20 at 4:56 PM of electronic correspondence and that information to see related to a private room 5/6/20 at 4:56 PM of electronic correspondence and that information are correspondence and that information are correspondence and that information are supported by the second of the correspondence and that information are corres	as unable to explain why his of the change. She indicated on the RP would have been the former AD and BOM.  as conducted with the BOM is the recalled speaking with prior to admission, but she if telling them the resident room and quarantined for 14 cated that she could not recall into admit new residents to a carantine them from the he time of Resident #11's She stated that she nis RP via electronic she needed to read through the if anything was discussed	F 5			
	A phone interview wa Unit Manager (UM) # She confirmed that F a semi-private room She stated that upon	as conducted with former to 10:26 AM. Resident #11 was admitted to with a roommate on 3/31/20.  admission, Resident #11 eelchair throughout the				

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	A phone interview wa Assistant #12 on 5/12 stated that Resident # semi-private room wit quarantined on admis reported that at the tin able to self-propel his throughout the comm  In a follow up interviee the Administrator indic RP had a right be fully planned placement froquarantine to a semi-roommate and no quaexplain why this informatis RP.  Notify of Changes (In CFR(s): 483.10(g)(14) Notific (i) A facility must immon consult with the residuents of the consistent with his or representative(s) where (A) An accident involves (B) A significant chan mental, or psychosocideterioration in health status in either life-throlinical complications	e 5  s conducted with Nursing t/20 at 11:15 AM. She t/11 was admitted to a h a roommate and was not sion (3/31/20). She me of his admission he was wheelchair and did so on areas of the facility.  w on 5/21/20 at 11:20 AM cated that Resident #11 's y informed of the change in om a private room with private room with a arantine. She was unable to mation was not conveyed to fury/Decline/Room, etc.) )(i)-(iv)(15)  cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring t; ge in the resident's physical, ial status (that is, a h, mental, or psychosocial reatening conditions or	F	552		TE	6/19/20
	a need to discontinue	an existing form of erse consequences, or to					

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F 580	resident from the far §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatis available and prophysician. (iii) The facility must resident and the resident and	risfer or discharge the cility as specified in tification under paragraph (g) in, the facility must ensure that tion specified in §483.15(c)(2) yided upon request to the also promptly notify the ident representative, if any, in or roommate assignment .10(e)(6); or dent rights under Federal or ons as specified in paragraph in.  I record and periodically (mailing and email) and	F5	580		
	that is a composite §483.5) must disclo its physical configur locations that composite and must spector room changes betwounder §483.15(c)(9). This REQUIREMENT by: Based on record reparty, staff and physical failed to notify the rear resident's death (Formptly notify residuals) parties of COVID-18	posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to een its different locations.  IT is not met as evidenced views, resident, responsible sician interviews, the facility esident's responsible party of Resident #2) and failed to lents and/or their responsible test results (Residents #7, #20, #28 and #5). This was		1. Corrective action accomplishose residents found to have the affected by the deficient practice. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is completed by the physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is the first physician for #30 on 4/30/20, #17 in 5/6/20 of 4/22/20, and #24 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification is the first physician for #40 on 4/18/20. Responsible Party notification for #40 on 4/18/20.	peen re. nas been resident note, #7 on	

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F 580 Continued From page 7 for 9 of 9 residents reviewed for notification.  The findings included:  1) Resident #2 was initially admitted to the facility on 1/2/19 with multiple diagnoses that included Alzheimer's dementia. Her most recent readmission to the facility under Hospice care.  She returned to the facility under Hospice care.  The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party (RP).  The nursing progress notes dated 4/14/2020 at 1.16 PM, revealed Nurse #4 found Resident #2 without a heartbeat and respirations. The resident had expired. The progress note stated Hospice and the funeral home were notified and the funeral home were notified by the facility of the resident's death on 4/14/2020 but rather by the funeral home on 4/15/2020.  F 580  Continued From page 7 for 9 of 9 residents reviewed for notification.  #2 #5 #18 #20 #28 no longer reside in the facility 2. Identify other residents who have the potential to be affected by the same deficient practice and the actions taken.  All residents are at risk. A 100% audit was completed by the Director of Nursing for the past 30 days to ensure Responsible Party notification of Change in Condition.  This was completed on 6/8/20.  Responsible Party notification was completed appropriately for 100% resident Change in Condition  3. Measure/systemic changes put in place to engage propriately for 100% resident Coordinator beginning on 6/3/20 on the process of Responsible Party notification with a change in condition and/or refusal of physician recommendations. This education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor. New hire will receive					SALISBURY, NC 28147		
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The findings included:  1) Resident #2 was initially admitted to the facility on 1/2/19 with multiple diagnoses that included Alzheimer's dementia. Her most recent readmission to the facility was on 3/31/2020 after a hospitalization for gastrointestinal hemorrhage. She returned to the facility under Hospice care.  The resident's Clinical Resident Profile revealed a family member was listed as emergency contact #1 and responsible party (RP).  The nursing progress notes dated 4/14/2020 at 1:16 PM, revealed Nurse #4 found Resident #2 without a heartbeat and respirations. The resident had expired. The progress note stated Hospice and the funeral home were notified and the funeral home retrieved Resident #2 at 1:30 PM.  A phone interview was conducted with Resident #2's RP on 4/27/2020 at 2:00 PM. The RP revealed he was not notified by the facility of the resident's death on 4/14/2020 but rather by the funeral home on 4/15/2020.  I dentify other residents who have the potential to be affected by the same deficient practice and the actions taken.  All residents are at risk. A 100% audit was completed by the Director of Nursing for the past 30 days to ensure Responsible Party notification of Change in Condition.  This was completed on 6/8/20.  Responsible Party notification was completed appropriately for 100% resident Change in Condition  3. Measure/ systemic changes put in place to ensure the deficient practice does not recocur. The Licensed Nursing staff will be educated by the Staff Development Coordinator and or refusal of physician recommendations. This education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor. New hire will receive		for 9 of 9 residents re	viewed for notification.			reside in the	
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ducation will be provided by the Staff  A phone interview was conducted with Resident #2's RP on 4/27/2020 at 2:00 PM. The RP revealed he was not notified by the facility of the resident's death on 4/14/2020 but rather by the funeral home on 4/15/2020.  education will be provided by the Staff Development Coordinator and completed by 6/18/20 for Licensed staff including contract staff. Licensed staff not educated by 6/18/20 will receive education prior to working on the floor. New hire will receive		and the funeral home	were notified and the		with a change in condition ar	nd/ or refusal	
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resident's death on 4/14/2020 but rather by the funeral home on 4/15/2020. but rather by the working on the floor. New hire will receive		#2's RP on 4/27/2020	at 2:00 PM. The RP		by 6/18/20 for Licensed staff	including	
funeral home on 4/15/2020. working on the floor. New hire will receive							
						•	
		funeral home on 4/15	/2020.		_		
education upon hire through Orientation.							
A telephone interview occurred with Nurse #4 on  Physician orders will be reviewed during							
4/28/2020 at 11:35 AM. She was able to recall the morning clinical meeting 5 times per week						•	
resident and events that took place on 4/14/2020. to ensure compliance and to validate			•		•		
Nurse #4 explained around 12:00 PM on Responsible Party notification in the event						n in the event	
4/14/2020 she found Resident #2 without of resident refusal. respirations and a heartbeat. She retrieved the 4. Monitoring of the corrected action to						tod action to	
respirations and a heartbeat. She retrieved the acting Director of Nursing (DON- who was the ensure the deficient practice will not		•			_		
Assistant Director of Nursing at the time) for reoccur. The Director of Nursing will audit					- I		
verification and asked her how the facility handled all physician orders to verify that							
deaths. She went onto say the acting DON  deaths. She went onto say the acting DON  notification was given to the resident							
instructed her to call Hospice and Hospice would and/or family member. This audit will be							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 580	she called Hospice at the funeral home. So but she never called On 4/28/2020 at 11: interviewed via the transtructing Nurse #4 funeral home and the resident's RP.  A phone interview where sident of Complia 4/28/2020 at 1:50 Ple documentation for Resident for Reside	tifications. Nurse #4 stated and got the phone number for the phoned the funeral home, the resident's family.  46 AM, the acting DON was elephone and verified to call Hospice and the at Hospice would notify the as held with the Hospice Vice ance and Quality on M. She reviewed hospice desident #2 and stated by Nurse #4 on 4/14/2020 expired at 12:15 PM. She acility staff notified the garding a resident's death.  Trivas interviewed via the at 11:54 AM and confirmed at 11:54 AM and confirmed means the family to inquire about choice. The Medical Director are the family had not been and stated it would have an for the facility to notify the death as the nurse would be questions they might have  PM, a phone interview meral Home and stated when he called the e RP stated he was unaware	F 5	completed 5xper week for 4 3xper week for 2 months. TI Nursing will present the rest audit to the Quality Assuran Performance Improvement of monthly x3. The QAPI commake changes to ensure the remains in compliance.	he Director of ults of this ce committee nittee can	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			71. 501251	_			c
		345286	B. WING			05/	21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY		·	7	TREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	conducted with Hosp Nurse #4 called her of Resident #2 had expher twice. The first tirdeath for Resident #2 on to say she asked anything they could of was told "no". A few to back and asked it the record as the facility number was provided Nurse #1 added them that the family needed the facilities call the Finan interview with the facilities of the facility called confusion and breaked the families. The Admultimately the responsible packed the family with diagnos and hypertension.  The resident's Clinical family member was lift and responsible packed the family member was lift and resp	PM, a phone interview was sice Nurse #1. She verified on 4/14/2020 to report ired and had actually called me was to report the time of 2. Hospice Nurse #1 went Nurse #4 if there was do or calls to be made and minutes later Nurse #4 called ere was a funeral home on did not have one listed. The doto Nurse #4. The Hospice ere was no communication and to be called and normally RP's.  The Administrator on M, she indicated the facility end the RP when Resident #2 ent onto say that at times the dotall the families and other end and felt like caused down in communication with ministrator added it was sibility of the facility to notify to a resident's condition to admitted to the facility on es that included diabetes  al Resident Profile revealed a fisted as emergency contact party.	F	580			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3	COMPLETED		
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	I	05/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From pa #7 was cognitively	ŭ	F 5	80		
	Resident #7's response	note dated 4/7/2020 indicated onsible party (RP) was at the facility had tested 19.				
	was positive for CC	plan dated 4/8/2020 read she VID-19 with interventions that ne RP of any changes in ition.				
	4/10/2020 to 4/20/2 documented inform	ing progress notes dated 2020 did not include any ation that Resident #7's RP /ID-19 testing or positive 19.				
	occurred with Residual had been made aw	47 PM, a phone interview dent #7. She confirmed she are by the facility that she OVID-19 but was unable to tification.				
	#7's RP on 4/27/20 he had called the fa wellness check sind facility and was told Resident #7 had be 4/10/2020 and resu 4/13/2020, but was information to whet	vas conducted with Resident 20 at 2:17 PM. He explained acility on 4/15/2020 to do a ce he wasn't able to visit the by the answering nurse that een tested for COVID-19 on allts were received back on provided no further her she tested positive or s. The RP went on to say he				
	had not received an corporate level regaresults for COVID-1 COVID-19 pandem	ny calls from the facility or arding Resident #7's test I9 and that prior to the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION  NG	(X3)	COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	PROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	<b>I</b>	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	correspondence wiindicated Resident on 4/10/2020 with revealing she was padministrator further listed on the alert a which meant the recovide positive resident to inform the resident to inform the results. She verified notified that she test acknowledged the facknowledged the facknowledged the facknowledged the facknowledged the facknowledged that the regulations regarded resident and the Repositive COVID-19.  On 5/21/2020 at 11 was interviewed via presumed Resident talked frequently or Medical Director and have followed the renotification of both significant change of the facknowledged that the regulations of the significant change of the facknowledged the renotification of both significant change of the facknowledged that the facknowledged the facknowledged the facknowledged that the regulations regarded that the facknowledged the facknowledged that the facknowledged that the facknowledged the facknowledged that the facknowledged that the facknowledged the facknowledged the facknowledged that the facknowledged that t	ent #7.  :02 AM, via electronic th the Administrator, she #7 was tested for COVID-19 esults received on 4/13/2020 positive for the virus. The er stated Resident #7 was and oriented notification roster sident was notified of the ults.  the Administrator on AM, she stated for cognitively was the responsibility of the neir own RP's of the testing the Resident #7's RP was not sted positive for COVID-19 and facility should have followed arding notification of the P for the significant change of results.  :40 AM, the Medical Director of the telephone. He stated he to #7's RP knew since she in the phone with them. The knowledged the facility should egulations regarding the resident and the RP for the positive COVID-19 results.	F 5			
		as the resident's emergency				

STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION  G	(X:	(X3) DATE SURVEY COMPLETED		
		345286	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  DEL SALISBURY	1,000		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		05/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	Continued From pa contact #1 and resp	oonsible party.	F 5	80			
	#24 had moderately	1/17/2020 indicated Resident  impaired cognition.					
	AM, indicated Resid	note dated 3/13/2020 at 11:39 dent #24's responsible party visitors were not allowed due andemic.					
	was positive for CO	e plan dated 4/8/2020 read he VID-19 with interventions that ne RP of any changes in dition.					
	4/7/2020 to 4/20/20 documented inform	sing progress notes dated 20 did not include any ation that Resident #24's RP /ID-19 testing or positive 9.					
	#24's RP on 5/11/20 he was contacted b when visitors were never informed by t had been tested for	vas conducted with Resident 020 at 12:38 PM. He stated y the facility in March 2020, no longer allowed but was he facility that Resident #24 COVID-19 or that he had COVID-19 until the Nurse					
	Practitioner called how symptoms wou On 4/29/2020 at 10 correspondence wit indicated Resident; on 4/10/2020 with rerevealing he was po	nim on 4/15/2020 to discuss ald be handled as they arose. :02 AM, via electronic the the Administrator, she #24 was tested for COVID-19 esults received on 4/13/2020 ositive for the virus. The					
	listed on the alert a	er stated Resident #24 was and oriented notification roster sident was notified of the					

A. BUILDING	(X3) DATE SURVEY COMPLETED	
D WING	C /21/2020	
NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY  STREET ADDRESS, CITY, STATE, ZIP CODE  710 JULIAN ROAD  SALISBURY, NC 28147	21/2020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 580  CONID positive results.  In an electronic correspondence with the Administrator on 5/14/20 at 9:01 AM it read; resident RP's were notified by the corporate nurse if the resident was not capable of making their own decisions. This was done to assist the facility in contacting everyone as fast as possible.  The Nurse Practitioner was interviewed via the phone on 5/14/2020 at 10:27 AM and stated when she arrived at the facility on 4/14/2020 she was provided a list of residents who had tested positive for COVID-19. She asked the Administrator if she needed to make any calls and was told no because the corporate office would be notifying all RP's. She added it was her expectation, if the facility said corporate would be contacting RP's, then it should have been done when they were aware the resident had tested positive to COVID-19.  In an interview with the Administrator on 5/21/2020 at 11:15 AM, she stated for cognitively intact residents, it was the responsibility of the resident to inform their own RP's of the testing results. She verified Resident #24's RP was not notified he had tested positive for COVID-19 until the Nurse Practitioner called on 4/16/2020 during a routine call. She acknowledged the facility should have followed the regulations regarding notification of the resident and the RP for the significant change of positive COVID-19 results.  On 5/21/2020 at 11:40 AM, the Medical Director was interviewed via the telephone. He stated he presumed Resident #24's RP knew since he talked frequently on the phone with them. The		

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		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COI 710 JULIAN ROAD SALISBURY, NC 28147			
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F 580	notification of both to significant change of the significant when she RP on 4/15/2020 she had not notified him.  4. Resident #18 was diagnosis of Chroni Disease (COPD).  The resident's elect Resident #18 name Responsible Party.  Resident #18's annudated 3/26/20 indicated 3/26/	egulations regarding the resident and the RP for the of positive COVID-19 results.  80 PM, a phone interview urse Practitioner, who e contacted Resident #24's he was informed the facility of the COVID results.  8 admitted on 8/27/15 with a cobstructive Pulmonary  Tronic medical record indicated dota family member as his  10 all Minimum Data Set (MDS) atted he was cognitively intact.  11 and 4/7/20 at 6:04 PM read ponsible Party (RP) was dent at the facility had tested 19.  12 a plan dated 4/8/20 read he VID-19. Interventions included any changes in Resident #18's  13 are spondence with the 18/20 at 2:39 PM read Resident COVID-19 on 4/10/20 and	F 5	30		
		was notified of COVID-19				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _		,	C 05/21/2020
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F 580	3:56 PM.  A telephone intervie 1:18 PM with Reside was contacted on 4/ one resident had tes but that was all she was never notified the for COVID-19 or that COVID-19 until the 4/20/20. The RP sta discussed Resident decided that Reside measures only and  In an electronic corr Administrator on 5/1 resident RP's were nurse if the resident their own decisions. facility in contacting Management was le COVID-19 outbreak Resident Council Pr		F 5	· ·		
	The Medical Director and RP's as appropresults.  In another email cor Administrator on 5/1 Resident #18 was or and oriented and it was a second to the secon	ride care for the residents. It also spoke with residents riate regarding their test  respondence with the 4/20 at 4:46 PM read in the notification list as alert was an error. The RP was of positive COVID-19 results on 4/13/20.				

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F 580	Administrator stated residents, it was the residents, it was the residents, it was the residents, it was the residents own R She confirmed Residentified that he tested the Medical Director acknowledged the far regulations regarding and the RP for the sig COVID-19 results.  In a telephone intervithe Medical Director Resident #18's RP kr frequently on the phosignificant decline in he contacted Resident discuss comfort measucknowledged the far regulations regarding and the RP for the sig COVID-19 results.  5. Resident #17 was cumulative diagnoses retention. He was dia (COVID-19) on 4/13/2.  The resident's electron Resident #17 named Responsible Party.  Resident #17's quarte (MDS) dated 2/10/20 intact.	21/2020 at 11:20 AM, the for cognitively intact responsibility of the resident P's of the testing results. ent #18's RP was not d positive for COVID-19 until called her on 4/20/20. She cility should have followed in notification of the resident gnificant change of positive ew on 5/21/20 at 11:50 AM, stated he presumed new since they talked one up until he had a his condition. He confirmed int #18's RP on 4/20/20 to sures. The Medical Director cility should have followed in notification of the resident gnificant change of positive admitted 9/12/19 with sof Diabetes and urinary agnosed with Corona Virus 20.  Onic medical record indicated a family member as his	F 5	80			
	A nursing note dated	4/7/20 at 1:16 PM read a					

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F 580	Party (RP) regarding Resident #17's care in he was positive for Coincluded notifying the Resident #17's condition In an electronic correct Administrator on 5/8/2 #17 was tested for Copositive COVID-19 resident #17's as tested for Copositive COVID-19 resident #17 was as A nursing note dated Resident #17 was as A telephone interview 1:18 PM with Resident was contacted on 4/7 one resident had test but that was all she was never notified that for COVID-19 or that COVID-19.  In an electronic correct Administrator on 5/14 resident RP's were not nurse if the resident was letted to their own decisions. facility in contacting to Management was letted COVID-19 outbreak in Resident Council President Council President Council President Council President Council President Resident Residen	Resident #17's Responsible a facility update.  Colan revised on 4/13/20 read OVID-19. Interventions a RP of any changes in tion.  Spondence with the 20 at 2:39 PM read Resident OVID-19 on 4/10/20 and esults were received on a sults were received on 5/8/20 at 1:01 PM read a sults were received on 5/8/20 at 1:01 PM read a sults were received on 5/8/20 at 1:01 PM read a sults were received on 5/8/20 at 1:01 PM read a sults were received on a sul	F	580			

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F 580	The Medical Director and RP's as appropriaresults  In a telephone intervience Resident #17 stated It swab in his nose but him of the reason for informed that he tested. In an interview on 5/2 Administrator stated If intact and he was informed that he was informed that he seem of the facility should have regarding notification for the significant charesults.  In a telephone interviethe Medical Director's Resident #17's RP km frequently on the photable to tell the RP of the acknowledged the face regulations regarding and the RP for the significant #30 was 6. Resident #30 was	de care for the residents. also spoke with residents ate regarding their test  ew on 5/18/20 at 1:43 PM, he recalled staff putting a that the staff never informed the testing nor was he ad COVID-19 positive.  1/2020 at 11:20 AM, the Resident #17 was cognitively formed of the testing results of the resident and the RP had no 5/21/20 at 11:50 AM, stated he presumed the	F 58		
	that a family member Responsible Party (R	nic medical record indicated was Resident #30's			

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F 580	cognitive impairmer was coded indepen living.  Resident #30's nurs 11:42 AM read the him know that facilit the COVID 19 virus time.  Resident #30's nurs PM read the RP was Resident #30's revise read as suspected (COVID-19). An interest Resident #30's Resident #30's Resident #30's nurs Resident #30's nurs Resident #30's nurs Resident #30's nurs	sing note dated 3/13/20 at nurse spoke with RP letting by was taking precautions for and asked not to visit at this sing note dated 4/7/20 at 1:13 s given a facility update.	F	,		
	PM read Resident # and was asymptom  A Social Services P 1:23 PM read Resident # schedule another vi  A Physician Progres PM read Resident # about Resident # 30 specified the Physician	rogress note dated 4/29/20 at lent #30 was able to h his RP. Family was could contact the facility to				

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F 580	Continued From pa	ge 20	F 5	80		
	Administrator 5/8/20 #30 was not tested when attempted aga The Administrator s got confused and de tested positive for Confacility continued to signs and symptom roommate had tested In an electronic corn Administrator on 5/8 found no evidence of Resident #30's RP resident's refusal of  A telephone intervie at 1:38 PM with Res nobody from the fact him know Resident testing on 4/10/20. 4/30/20 when he ca inquire whether Res COVID-19 that he w #30 had refused pri was his expectation know that Resident April, so he could ha with Resident #30 to The RP stated the M Resident #30 was s COVID-19 on 4/30/20 A telephone intervie Worker (SW) #2 on	respondence with the D at 1:41 PM read Resident on 4/10/20. He refused and ain he continued to refuse. pecified the staff may have ocumented that Resident #30 COVID-19. She indicated the monitor Resident #30 for s of COVID-19 because his ed COVID-19 positive.  respondence with the B3/20 at 2:45 PM read she of anything documented that was made aware of the COVID-19 testing.  Rew was conducted on 5/11/20 sident #30's RP. He stated cility had contacted him letting #30 refused COVID-19  The RP stated it was not until alled the Medical Director to sident #30 was tested for was informed that Resident or testing. The RP stated it at that the facility would let him #30 refused testing earlier in ave called or video chatted to convince him to be tested. Medical Director told him that suspected as having 20 but was asymptomatic.				

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F 580	Continued From pa	ge 21	F 5	580		
	the RP that Resider testing or that he was positive.  In an interview on 5 Administrator stated have been notified COVID-19. She acknowled followed regular Resident #30's susting diagnosis prior to the RP on 4/30/20.  7. Resident #20 was 8/24/19 with multiplestage renal disease was diagnosed with quarterly Minimum dated 1/14/20 indice moderate cognitive of rejection of care	aring the call did she informed in #30 had refused COVID-19 as suspected COVID-19  6/21/2020 at 11:20 AM, the did Resident #30's RP should of his refusal to be tested for knowledged the facility should lations regarding notification of pected COVID-19 positive in Medical Director informing as admitted to the facility on the diagnoses including end at COVID 19 on 4/13/20. The Data Set (MDS) assessment lated that Resident #20 had impairment and had behavior that occurred 4-6 days.				
	PM revealed that R COVID 19 on 4/10/positive on 4/13/20 Administrator stated documentation that family was notified positive for COVID the regional office contifying the familie COVID 19 positive.  Interview with the re 5/13/20 at 12:04 PM	dministrator on 5/11/20 at 1:39 esident #20 was tested for 20 and the result came back. During the interview, the d that she didn 't have Resident #20 or the resident's that the resident tested 19. She further reported that consultant was responsible for s of residents who were egional office consultant on M revealed that she was o notify the family members of				

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F 580	for COVID 19. She in Practitioner (NP) and were responsible for oriented residents where resident was also members were not requested to notify high Resident #20 was also responsible party (Resident #20 was not notified.  A follow up interview conducted on 5/13/2 notification of reside when a resident was 19. She stated the father alert and orienter result but not the resident requested to Administrator was unthe person who notification of Resident #20 on 5/14/20 at 1: visited the resident was alert and the resident was alert and resident was alert and resident was alert and resident was alert and positive result. The positive result. He resident was already COVID positive result. The Physician states that the Corporate New York Physician States Physician States The	residents who tested positive indicated that the Nurse d/or the attending Physician is notifying the alert and ho tested positive for COVID. Consultant further stated that if irt and oriented, their family indiffed unless the resident iter/his family. She stated that ert and oriented and was the P) for herself so her family with the Administrator was a tested positive for COVID in actility is system was to notify different residents of the positive indent's family unless the point of the positive indent's family unless the positive the date or fied Resident #20 of the Administrator verified that the 20 was not notified since the	F 5	80		

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F 580	interviewed. The adfacility had received results back at the s expectation was for and/or the resident's results being receive other circumstances within 24 hours. The that there was a lack notification of reside members regarding COVID. The administ his notification be dimedical records.  8. Resident #28 was	AM, the Administrator was ministrator stated, that the over a hundred COVID test	F 5	80		
	Chronic Kidney Disease Pulmonary Disease Minimum Data Set (3/30/20 indicated that was intact.  A laboratory test coll reported on 4/13/20 tested positive for Colline Positive for Colline Positive on 4/10/2 positive on 4/14/20.  Interview with the re 5/13/20 at 12:04 PM helping the facility in	ase and Chronic Obstructive (COPD). The quarterly MDS) assessment dated at Resident #28's cognition ected on 4/10/20 and revealed that Resident #28				

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F 580	positive for COVID 19 Nurse Practitioner (N Physician were responsant oriented resident COVID. The regional that if the resident was family members were resident requested to stated that Resident and so his family was positive result.  An interview with the conducted on 5/13/20 that she visited Resided in think the COV Resident #28 was test 4/10/20 and the result 4/14/20. On 4/14/20, had a designated state alert and oriented resident #28 was alenot informed the resident was 19. She stated the fact the alert and oriented result, but not the resident requested to Administrator was unthe person who notifice COVID positive results.	D. She indicated that the P) and the attending insible for notifying the alert is that they were positive for a office person further stated is alert and oriented, their not notified unless the notify her/his family. She is at 2:20 PM. She stated ent #28 on 4/13/20 and she ID result was back yet. It is a came back positive on she was told that the facility if member who would notify idents. The NP verified that int and oriented and she had dent nor the family of the sult.  With the Administrator was at 2:20 PM regarding its and family members tested positive for COVID cility's system was to notify residents of the positive ident's family unless the notify them. The able to provide the date or ed Resident #28 of the in The Administrator verified ident #28 was not notified	F 5	580		

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F 580	interviewed. The additional facility had received results back at the sate expectation was for the and/or the resident's results being received other circumstances within 24 hours. The that there was a lack notification of resident members regarding COVID. The administration of the adm	AM, the Administrator was ministrator stated that the over a hundred COVID test	F	580		
	9/28/18 with diagnose Obstructive Pulmonal The Clinical Resident member was listed at Responsible Party (For The most recently conference (MDS) for Resident # assessment dated 1/2 assessed as cognitive Resident #5 's care had a suspected diaginterventions that incompassion Resident The nursing progress 4/20/20 did not includinformation that Resident Re	t Profile revealed a family s emergency contact #1 and RP).  Impleted Minimum Data Set #5 was a quarterly (3/20. Resident #5 was ely intact.  Impleted Minimum Data Set #5 was a quarterly (3/20 read she gnosis for COVID-19 with luded notifying the RP of any #5 's condition.				

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F 580	Continued From pag	ge 26	F 5	580		
	occurred with Resid had been made awa tested positive to Co state the date of not A phone interview w #5 's RP on 4/28/20 reported that the factor any changes in c such as falls or infect 4/15/20 she was masources that the factor residents who tested stated that she was and was concerned information from the Resident #5 was test were. The RP report facility herself twice Resident #5 was test indicated that on the by an unknown staff would call her back reported that she was had not received a rephoned the facility a second phone call of Assistant Business of informed her that Recovided Resident #5 on 4/29/20 at 9:55 Accorrespondence with indicated Resident #5 on 4/10/20 with results.	as conducted with Resident at 4:30 PM. The RP illity normally contacted her condition with Resident #5 ctions. She indicated that on de aware by local media lity had a high number of a positive for COVID-19. She alarmed by this information as she had not received any facility on whether or not sted and if so what the results sted that she phoned the on 4/15/20 to find out if sted for COVID-19. She if first phone call she was told member that someone later with an update. The RP sited for several hours and eturn phone call, so she gain. She stated that on this n 4/15/20 she spoke with the Office Manager (ABOM) who esident #5 tested positive for				

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F 580	which meant the rest COVID-19 positive  A phone interview was 10:35 AM with the A 4/15/20 the facility such phone calls from far information on COV reported that due to the Administrator as the calls that came was given a list of their COVID-19 test asked her to inform they called in. The not initiated any phoreported that she has peaking to Reside regarding the COVI unsure what date so In an interview with at 11:15 AM, she st residents, it was the to inform their own acknowledged that reached out to the find would not have noticed to COVID-19 test result acknowledged the fithe regulations regardings.	ind oriented notification roster sident was notified of the results.  It was conducted on 4/29/20 at a about the abo	F5	580			
	interviewed via the presumed Resident	AM, the Medical Director was phone. He stated he #5 's RP knew she had COVID-19 as she was capable					

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		345286	B. WING _			05/	21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			7′	TREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	of talking to them by phone. The Medical Director acknowledged the facility should have followed the regulations regarding notification of both the resident and the RP for the significant change of positive COVID-19 results.			580			
F 656 SS=D	change of positive COVID-19 results.  Develop/Implement Comprehensive Care Plan		F	356			6/19/20

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUC	TION	(X3) DATE COMP	SURVEY LETED
		345286	B. WING _				21/2020
	ROVIDER OR SUPPLIER			STREET ADDR 710 JULIAN R SALISBURY		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 656	(B) The resident's prefuture discharge. Fac whether the resident' community was asselocal contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set fortisection.  This REQUIREMENT by:  Based on record revifacility failed to develous of smoking at the This was for 1 of 3 reaccidents.  The findings included Resident #22 was inion 10/18/18. Her dia Obstructive Pulmona heart failure.  The most recent Minicompleted for Resident assessment dated 1/ intact, and she require assistance with locon utilized a wheelchair received oxygen (O2)	eference and potential for illities must document a desire to return to the seed and any referrals to a sand/or other appropriate ose.  In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced iew and staff interview, the op a care plan related to the facility for Resident #22. sidents reviewed for  It is admitted to the facility gnoses included Chronic and Disease (COPD) and in the facility gnoses included Chronic and Disease (COPD) and in the facility gnoses included Chronic and Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses included Chronic and January Disease (COPD) and in the facility gnoses in the facili	F	1. Cor those re affected care pla reviewer screen c 2. Ider potentia deficient review h current I have be are in pl 6/5/20. All smok Social W appropri 3. Mea place to not reoc will be e	rrective action accomplished for sidents found to have been by the deficient practice. The n for resident #22has been d and updated and a new smootompleted by Social Worker. Intify other residents who have I to be affected by the same to practice and the actions taken has been completed on 8 of 8 like residents to ensure care plen updated and smoking screen ace by the Social Workers on 8 of 8 care plans were in placed and smoking screen were updated by Workers on 6/8/20 to validate liate care plans. In assure, systemic changes put in the ensure the deficient practice of cour. The Licensed Nursing standard and the process of	king the n. A ans ens e. loes ff	
	3/5/20 indicated O2 v (L) per minute (min) of A nursing note dated	for Resident #22 dated ria nasal cannula at 4 liters continuous.  3/17/20 completed by the rsing (DON) indicated		new adn change will also appropri	ing a Smoking Assessment on missions and as needed with of condition. The Licensed State be educated on completing ar iate care plan. This education ded by the Staff Development	ff 1	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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		345286	B. WING _		c	5/21/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				710 JULIAN ROAD		
THE CITAL	DEL SALISBURY			SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 656	Resident #22 was observed outside in the designated smoking area smoking a cigarette. Resident #22 had a portable O2 tank on the back of her wheelchair. The O2 tank provided continuous O2. The former DON wrote that the O2 was removed and taken inside the facility. The resident stated, "I just wanted to smoke" and when asked where she got her cigarette and how she lit it she responded, "I just got it". Resident #22 was educated that all residents who wished to smoke needed to be assessed for safe smoking and adhere to the facility 's smoking		F 6	Coordinator and completed b		
				Licensed staff not educated b will receive education prior to the floor	y 6/18/20 working on	
				4. Monitoring of the correcte ensure the deficient practice reoccur. The Director of Nurs all smoking assessments to e	will not ing will audit	
				appropriate care plan in place will be completed 5xper week than 3xper week for 2 months	e. This audit c for 4 weeks	
	use of O2 while smok	was informed that due to her king and without her being for smoking she would not		Director of Nursing will present of this audit to the Quality Ass Performance Improvement co	surance	
		e at this time at the facility. ted to nod her head and ing.		monthly x3. The QAPI commit make changes to ensure the remains in compliance.		
	former Unit Manager #22 was found smoki O2 tank attached to h running continuously	3/17/20 completed by (UM) #1 indicated Resident ng outside with a portable her wheelchair. The O2 was via nasal cannula. Resident				
	#22 was noted to refuse to extinguish her cigarette when staff approached her, so the portable O2 was removed from the wheelchair and taken inside. Following the incident, the resident refused to state where she obtained her cigarettes and lighter from.  Medical record review on 5/8/20 indicated no smoking assessment was completed for Resident #22 prior to or after the 3/17/20 incident of smoking while utilizing continuous O2.					
		for Resident #22 was nd revealed no care plan ss the risk of Resident #22				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	( (EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 656	smoking.  A phone interview wa #1 on 5/8/20 at 9:24 note that indicated R outside in the design enclosed courtyard) portable O2 tank in p continuous O2 via na stated that smoking a completed for resided the facility. She expl not expressed an interfacility prior to the incorprevious incidents of the 3/17/20 incident. Resident #22's care smoking at the facility the facility 's smoking she was not sure, but revised after the incidence of the stated that care be completed by any MDS Nurse #1 and M #1 stated that she not and that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she not and that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was una developed a care plasmoking incident for On 5/8/20 the following and received via election of the stated that she was unatable that she was unatable that the stated that she w	as conducted with former UM AM. She verified the 3/17/20 esident #22 was found ated smoking area (an with a lit cigarette and lace that was providing isal cannula. Former UM #1 assessments were only into who wished to smoke at ained that Resident #22 had erest in smoking at the cident, and she had no smoking at the facility before. Former UM #1 was asked if a plan incorporated the risk of and non-compliance with g policy and she stated that that it should have been dent to address this risk. plan revisions were able to staff member in addition to MDS Nurse #2. Former UM alonger worked at the facility able to recall if she had in to address the 3/17/20 Resident #22.	F6	956		
	there was no addition	Administrator indicated that nal information. She further no care plan in place to				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 656	address the incident A phone interview was 2:43 PM with Nursisstated that she beg April 2020 and she frequently. She revitated that this was because Resident which made smoking running while she was indicated that if she she would monitor an effort to prevent A phone interview was DON on 5/11/20 at to be reached.  A phone interview was Nurse #1 on 5/18/2 smoking while utilized Resident #22 was resident. MDS Nurse #1 on 5/18/2 smoking while utilized Resident #22 was resident. MDS Nurse #1 on 5/18/2 smoking while utilized mention of this incident. MDS nurse was resident was re	<u>~</u>	F 65	66		
	incident. MDS Nursplan and confirmed mention of this incidents smoking and non-a smoking policy. MI typically, incidents the morning meetin through Friday. She known about the indeveloped a care pexplained that Resi smoker, she had no she was utilizing Of	the care plan made no dent nor resident 's risk of dherence to the facility 's DS Nurse #1 stated that such as this were reviewed in gs that occurred Monday e revealed that if she had cident she would have lan for the resident. She				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATE S	_ETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	1 00/2	112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 656	the risk of smoking of providing them with order to prevent reo A phone interview where Walley on 5/18/20 smoking while utilizing Resident #22 was resident during a mount of the care-occurrence. Most explain why a care paddress Resident #20 smoking while utilizing Resident #20 smoking while utilizing Resident during a mount of the care-occurrence. Most explain why a care paddress Resident #20 smoking with the care paddress with the care paddress with the care paddress with the care paddress with the w	e plan informed the staff of for Resident #22 as well as interventions to implement in ccurrence.  Pas conducted with MDS  O at 12:32 PM. The 3/17/20 and continuous O2 incident for eviewed with MDS Nurse #2.  Precalled hearing about this prining meeting. She reported be of incident would be re plan due to the risk of S Nurse #2 was unable to plan was not developed to 22 's risk of smoking at the 'I cannot recall what may	F 69	56		
F 684 SS=D	5/21/20 at 11:20 AM a care plan to be de #22 's risk of smoki Administrator reveal multiple new staff, b without a care plan smoking, these staff with interventions to prevent further incid Quality of Care CFR(s): 483.25  § 483.25 Quality of Quality of care is a fapplies to all treatmer facility residents. Bat assessment of a residents.		F 68	34		6/19/20

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		TE SURVEY MPLETED
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	5/2 1/2020
				710 JULIAN ROAD		
THE CITA	DEL SALISBURY			SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	684 Continued From page 34		F 68	34		
	practice, the compreh care plan, and the res	essional standards of nensive person-centered sidents' choices. is not met as evidenced				
	Based on record rev (NP), Physician and s failed to transcribe ve and to administer Numedications for 1 of 6 reviewed for provision professional standard choice (Resident #28 Findings included:  Resident #28 was ad 8/23/28 with multiple Obstructive Pulmona Chronic Kidney Disea Minimum Data Set (N	n of care according to ds, care plan and resident ' s		1. Corrective action accomplise those residents found to have be affected by the deficient practice. Resident #28 no longer resides facility  2. Identify other residents who potential to be affected by the state deficient practice and the action All residents have the potential affected. A review of physician call residents has been completed past 30 days to ensure all physical orders have been completed by Director of Nursing on 6/8/20 all were completed appropriately.  3. Measure/ systemic changes place to ensure the deficient practice to ensure the deficient practice.	een e. in the o have the ame is taken. It is to be orders for the ician or the it orders s put in actice does censed	
	by Nurse #5) reveale saturation was in the was started via nasal how many liters (L) o denied pain but was sounds, denied being up to his chest. His t degrees Fahrenheit (continue to monitor a A nurse's note dated by Nurse #5) reveale the resident's change	4/10/20 at 4:22 AM (written d Resident #28's oxygen 80's on room air. Oxygen cannula (the note didn't say f oxygen). The resident making a "whimpering" g cold but was holding covers emperature was 98.2 F). He denied cough. Will nd to report to doctor in AM.  4/10/20 at 7:56 AM (written d the NP was made aware of e in condition. New orders bunt (CBC), comprehensive		staff has been completed on the for following and transcribing ph orders and appropriate docume the Staff Development Coordinate beginning on 6/8/20. This educate be provided by the Staff Development Coordinator and completed by 6 Licensed staff including contract Licensed staff not educated by will receive education prior to withe floor  4. Monitoring of the corrected ensure the deficient practice will reoccur. The Director of Nursing speak with physician/ nurse prafor a list pf 5 random physician.	nysician Intation by Intation will Interpret by Interpret	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345286	B. WING _				21/2020
NAME OF PR	ROVIDER OR SUPPLIER		<del>-</del>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2020
				71	10 JULIAN ROAD		
THE CITAL	DEL SALISBURY				ALISBURY, NC 28147		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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F 684	Continued From page		F 6	84			
	metabolic panel (CMF				orders for completion weekly. This aud	it	
	sedimentation rate (E	SR), chest x-ray and to get			will be completed 5xper week for 4 week	eks	
	COVID 19 test done v	vhen available.			than 3xper week for 2 months. The		
					Director of Nursing will present the res	ults	
		10/20 revealed Nurse #5			of this audit to the Quality Assurance		
		ne NP was informed that			Performance Improvement committee		
	Resident #28 became	· ·			monthly x3. The QAPI committee can		
		and the resident was placed			make changes to ensure the facility		
		(L) per minute (min). The			remains in compliance.		
	oxygen saturation we						
	, 0	d to 4 L/min and the oxygen					
		o 91%. The note further					
		#5, the Nurse Aide (NA)					
		nt has "not been himself for					
		been staying in bed more,					
		d increased weakness. The e had mild body aches. The					
		acute respiratory failure					
		gen. Differential diagnoses					
		ımonia versus aspiration					
		OVID 19 (multiple positive					
		ers were given for chest					
	x-ray, complete blood	_					
	differential, comprehe	` ,					
		e sedimentation rate (ESR).					
		ated that after discussing					
	with the attending phy						
		piotic drug) 500 milligrams					
		for 5 days, albuterol inhaler					
		ent bronchospasm) and					
	Mucinex (a cold and o	cough medicine). The NP					
		with the resident's family					
	members regarding th	ne plan of care. The family					
		they were okay with the					
	conservative treatmer	nts but if the resident					
	-	they wanted to transition to					
	comfort measures onl	y.					
	The April 2020 Medica	ation Administration					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZI 710 JULIAN ROAD SALISBURY, NC 28147	P CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIA	
F 684	Azithromycin, Albute 4/10/20 were not trar Resident #20 since 4 The NP note dated 4 Resident #28 continu decline, very poor int generalized body ach He was seen sitting to keeping his eyes open He claimed that he was short of breath, lying beside him. He on oxygen at 4 L/min resident's condition, to transition to comforms was communicated was short of communicated was communicated was communicated was since the s	ealed the NP ordered rol inhaler and Mucinex on ascribed and administered to 1/10/20.  1/13/20 revealed that used to have overall functional ake, increased weakness, as but remained afebrile. Up in bed, with difficulty en during the examination. It was in pain and was examined that he but his oxygen cannula was a improved after placing him and the family stated they wanted out care. The plan of care with the family. Orders for analgesic) and Lorazepam	F	684		
	by Nurse # 4) revealed yelling for pain medical administered. He was and he was uncomfor 135/70 (blood pressurespiratory rate), 10 and 91% (oxygen sate of 19 on 4/10/20 and the on 4/14/20.  On 5/13/20 at 9:38 A She reported that Nurse and medical poin 4/10/20.	ministrator on 5/11/20 at 1:39  nt #28 was tested for COVID  e result came back positive  M, the NP was interviewed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP COD 710 JULIAN ROAD SALISBURY, NC 28147	E	00/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 684	his oxygen saturation and with increased worder to the Nurse for ESR. Then after tall physician, she gave Azithromycin, Albute NP indicated that shourse she had giver medications. The Naware that the medical value of the she had discussed to and it was frustrating been implemented, seen Resident #28 was no improvement made comfort care, she had written it or she had called the forto the nurse and the transcribed and carron on 5/13/20 at 3:31 for 4/9/20) was interested that she remembered and notified her of Formation. The NP of CMP, ESR and chereceiving orders for inhaler and Mucinex on 5/14/20 at 12:29 conducted with Nurseshe worked 3rd shift	quate supply of oxygen), and in was low, he was coughing weakness. She gave verbal or chest x-ray, CBC, CMP and king to the attending verbal order to start erol inhaler and Mucinex. The ne didn't know the name of the ne didn't ne ne didn't ne didn't ne didn't ne didn't ne didn't ne didn't ne ne ne didn't ne ne ne didn't ne ne ne ne didn't ne ne ne ne didn't ne	F	584		
	Albuterol inhaler and	orders for Azithromycin, d Mucinex. She added that called back after she left the				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345286	B. WING			C <b>21/2020</b>
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	21/2020
THE CITA	DEL SALISBURY			710 JULIAN ROAD SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	building and gave the Azithromycin, Albuter shift nurse who was a On 5/14/20 at 12:29 Finterviewed. She stat nurse and she remem Resident #28 on 4/10 didn't remember rece Azithromycin, Albuter the NP on 4/10/20 bu with Resident #28 that On 5/18/20 at 1:04 Pl Nursing (DON) was ir she asked Nurse #5 ir the medications from receiving medication of	verbal order for the ol and Mucinex to the 1st in agency nurse (Nurse # 4).  PM, Nurse #4 was sed that she was an agency abered being assigned to /20. She reported that she iving a verbal order for ol inhaler and Mucinex from the there was a lot going on the day.  M, the current Director of anterviewed. She stated that if she received the orders for the NP and she denied orders. The DON stated the had called the facility and	F	684		
F 698 SS=E	she expected the plan for the resident.  On 5/21/20 at 11:50 A Physician was conducted the facility to for the resident as recollar plants of the plants of the resident as recollar plants of the plants of the resident as recollar plants of the plants of	anducted. She stated that in of care to be implemented at M, interview with the cted. He stated that he implement the plan of care commended by the NP.	F	598		6/19/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING				24/2020	
NAME OF D	ROVIDER OR SUPPLIER	0.10200	1	ς.	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	21/2020	
NAME OF FI	NOVIDER OR SUFFLIER				10 JULIAN ROAD			
THE CITAL	DEL SALISBURY							
				5	ALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 698	Continued From pag	e 39	F 6	698				
	the residents' goals a	and preferences.						
	_	T is not met as evidenced						
	•	view, staff interviews, and			Corrective action accomplished for	r		
		ne facility failed to have a			those residents found to have been			
		esidents to receive dialysis			affected by the deficient practice.			
		monitor dialysis access sites			Resident #22 and #40 have had their			
		ne communication sheets to			dialysis orders reviewed and			
	exchange information				communication binders in place as of			
	•	with the dialysis center for 4			5/9/20 . Residents #20 and #25 no long	ger		
		its reviewed for dialysis			reside in the facility	<b>'</b>		
	(Residents # 20, #22	•			2. Identify other residents who have	:he		
	,	,			potential to be affected by the same			
	Findings included:				deficient practice and the actions taker	1.		
					All dialysis residents have the potential	to		
	1. Resident #20 was	admitted to the facility on			be affected. A review of physician orde	rs		
	8/24/19 with multiple	diagnoses including end			has been completed and a visual chec	ĸ		
	stage renal disease	(ESRD) and was on renal			on the communication binder have bee	n		
	dialysis. The quarter	ly Minimum Data Set (MDS)			completed by the Director of Nursing o	n		
	assessment dated 1/	114/20 indicated that			5/21/20 for 2 of 2 residents			
	Resident #20 had mo	oderate cognitive impairment			3. Measure/ systemic changes put in			
	and had behavior of				place to ensure the deficient practice d	oes		
	occurred 4-6 days. T	he assessment further			not reoccur. Education for all Licensed			
	indicated that the res	sident was receiving dialysis.			staff has been started on 6/8/20 by the			
					Staff Development Coordinator on the			
	•	sident #20 dated 1/14/20			process for ensuring the communication	n		
		was care planned for risk of			binder, orders, and appropriate			
		d to hemodialysis. The goal			documentation for dialysis residents. T	nis		
		) not to experience any			education will be provided by the Staff			
	complications related				Development Coordinator and complet	ed		
	_	ving hemodialysis through			by 6/18/20 for Licensed staff including			
		proaches included apply			contract staff. Licensed staff not educa			
		stula on dialysis days,			by 6/18/20 will receive education prior	Ю.		
		ess for bruit and thrill every			working on the floor			
	shift and as needed				4. Monitoring of the corrected action	to		
	signs/symptoms of fl	uid overload.			ensure the deficient practice will not			
					reoccur. The Director of Nursing will au			
		ruary 2020, March 2020,			dialysis residents for orders and binder			
	April 2020 and May 2	2020 Physician ' s orders			completion. This audit will be complete	d		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 710 JULIAN ROAD SALISBURY, NC 28147	CODE	03/21/2020
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 698	Continued From pag		F 6	98		
	Resident #20 had a 02/12/20, for Lidoca anesthetics) to be a	no physician 's orders for the ialysis treatments.  doctor 's order dated ine cream 2.5% (topical local oplied to dialysis access area days Monday, Wednesday		5xper week for 4 weeks the for 2 months. The Director present the results of this Quality Assurance Perform Improvement committee rough Capital Committee can make ensure the facility remains	r of Nursing will audit to the mance monthly x3. The e changes to	
	On 5/11/20 at 1:39 PM, the Administrator was interviewed. She reported that Resident #20 was tested for COVID 19 on 4/10/20 and the result came back positive on 4/13/20.					
	interviewed. She re #20 tested positive f received dialysis at a every Monday, Wed AM. After she was ther dialysis days we Thursday and Saturwould be performed Spencer, NC. When resident 's dialysis scommunicated to the	tion staff member was ported that before Resident or COVID 19 on 4/13/20 she a center in Salisbury, NC nesday and Friday at 6:00 ested positive for COVID 19, re changed to Tuesday, day at 1:00 PM and they at a dialysis center in asked how the change in the schedule and location were e staff, she responded that anges at the nurse 's station				
	with the Medical Rec member was conduct was informed by the in the dialysis sched 4/13/20. She indicat she had to personall dialysis change in so	AM, a follow up interview cords/Transportation staff cted. She reported that she dialysis nurse of the change ule for Resident #20 on ted that she didn't know that y inform the nurse of the chedule. She indicated that dent #20's dialysis days at				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	· ,	(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>5/21/2020</b>	
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP COL 710 JULIAN ROAD SALISBURY, NC 28147		5/21/2020	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 698	searched for the dialy from the thinned recoresident 's communions she indicated that the to fill out the communions revealed that staff did cream topically to the area on 4/21/20, 4/23, 4/30/20, when the diato Tuesday, Thursday On 5/12/20 at 9:35 A Nurse at the Kannap conducted. She state residents who were used to the topical to the state of the topical to the topical to the topical to the topical topical to the topical topi	and in the dialysis . She reported that she had ysis communication sheets ords and could not find the cation sheets after 4/8/20. e nurses might have missed nication sheet.  I 2020 and May 2020 MAR ation Records (MARs) d not apply the Lidocaine e resident 's dialysis access 8/20, 4/25/20, 4/28/20 and alysis schedule was changed by and Saturday.  M, interview with the dialysis olis, NC location was ed that their clinic was for under observation for COVID. that Resident #20 had 4/13/20 at their clinic. The ident #20 did not have a (with communication ing the treatment.  AM, Nurse # 1 was membered being assigned to	F 6				
	't know that her dialy Tuesday, Thursday a that based on the MA receive Lidocaine cre every Monday, Wedr added that she didn' did not have a doctor #1 stated she that sh	5/20 and stated that she didn visis days were changed to and Saturday. She indicated AR, Resident #20 was to earn topically on dialysis days nesday and Friday. Nurse #1 t know that Resident #20 ''s order for dialysis. Nurse e didn't know where the on book was kept for the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345286	B. WING		C 05/21/2020	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	1 33/11/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUNDER CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 698	interviewed. She won 4/13/20 and 4/22 she had sent Resid but she didn't remonstration she heard it from somet dialysis days were of Wednesday and Fri Saturday. Nurse #4 remember the exact told her about the cishe didn't know with the order for the Licothe resident's dialysis days were of that she didn't know have an order for dialysis days were of that she didn't know have an order for dialysis days were of that she didn't know have an order for dialysis days were of that she didn't know have an order for dialysis dialysis dialysis nurse reports.	D PM, Nurse #4 was ras assigned to Resident #20 1/20. The nurse revealed that ent #20 to dialysis on 4/21/20 ember filling out the dialysis et. She stated that she just body that Resident #20 's changed from Monday, iday to Tuesday, Thursday and reported that she didn 't tt date and the person who hange. She also stated that no was supposed to change locaine cream to be applied to lysis access area on Tuesdays, lurdays when the resident 's changed. She also reported what the resident did not lialysis.  AM, interview with the dialysis er, NC location was lurse revealed that Resident lialysis on 4/21/20, 4/23/20, d 4/30/20. She indicated that by the facility that Resident #20 s on 4/16/20 and 4/18/20. The lited that the facility did not liality is a side of the resident liality did not liality is a side of the resident liality did not liality is a side of the resident liality did not liality is a side of the resident	F 69	8		
	to Resident #20 on was assigned to the unsuccessful.  On 5/12/20 at 2:07	Nurse #2, who was assigned 4/25/20, and Nurse #3, who e resident on 4/23/20, were  PM, the current Director of interviewed. She stated that				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	' '	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		3/21/2020	
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		SHOULD BE	(X5) COMPLETION DATE			
F 698	to receive dialysis treinclude the number of week. She didn't red dropped off during the company and new corecords in February 2 was brought to her at the facility reinstated residents receiving dono 5/19/20 at 10:06 was conducted with that the dialysis clinic change in the dialysis Resident #20. They transportation person expected the transponurse of the change expected the nurse to application of the lide DON stated that she for the Lidocaine creations current DON stated to communication sheed dialysis clinic. The nuthe sheet in the dialy binder with the resident to dialys.  On 5/21/20 at 11:20 at Administrator was confacility's protocol was place. She reported for dialysis were drop changed ownership at	atment and the order should f dialysis treatments per alize that the orders had e transition to a new omputer system for electronic 2020. She added that after it tention during the survey, the order to all current fallysis.  AM, a follow up interview he current DON. She stated add not inform her of the schedule/location for might have informed the nof the change. She retation person to notify the nother dialysis schedule and to change the order for the change the order for the dialysis schedule. The her facility was using the to communicate with the larse was supposed to fill out sis binder and sent the eart during the dialysis not DON stated that she didness binder was not sent with	F6	98			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING _				21/ <b>2020</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, 710 JULIAN ROAD SALISBURY, NC		1 001	21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD E REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 698	had no record of ord place previously. She the facility to have a with the dialysis clin facility nurse to comsheet and the dialysis resident each time to the dialysis clinic would the binder was returned to send the binder was returned to the binder was returned	electronic records and she ders that may have been in the stated that she expected a consistent communication sic. The system was for the uplete the communication sis binder was sent with the they went to dialysis. Then build complete the form and med to the facility with the inistrator added that when d and dialysis schedule had were not used to prepping the stand education was not be binder with the resident. Ince the issue was brought to the survey, the staff had been	F	598				
	facility on 10/18/18 on 4/4/20. Her diag Renal Disease (ESF	s initially admitted to the and most recently readmitted moses included End Stage RD) and dialysis dependence.						
	completed for Resid	nimum Data Set (MDS) lent #22 was a quarterly I/30/20. Her cognition was on dialysis.						
	A Risk Meeting nurs	sing note dated 2/6/20						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	03/21/2020
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F 698	indicated Resident 4 times a week.  Resident #22's actifocus area of the riand complications interventions include resident to hemodia sending communic reviewing book upodialysis access site.  2a. The physician's through 5/7/20 reversident #22 to has staff to monitor her.  A phone interview was the facility's not physician's orders as physician's order sa physician's that included the dadialysis as well as oresident's access sorder summary from included no physici treatment and no oresident's access soon. She was unattention of the complex	er Unit Manager (UM) #1 #22 was continued on dialysis  ve care plan included the sk for impaired renal function related to hemodialysis. The led, in part, transferring alysis unit for treatments, ation book to dialysis and on return, and monitoring her every shift and as needed.  sorder summary from 3/1/20 ealed no physician's orders for ve dialysis treatment or for dialysis access site.  was conducted on 5/8/20 at er UM #1. She stated that it formal protocol to have for dialysis treatment as well ars to monitor and assess the ite at least once per shift.  with the Director of Nursing ted on 5/8/20 at 11:26 AM. facility's normal protocol was orders for dialysis treatment as to attend orders for assessing the ite. Resident #22's physician's m 3/1/20 through 5/7/20 that an's orders for dialysis rders for assessing the ite were reviewed with the able to explain why there were the story dialysis treatment or	F6	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING _				C <b>21/2020</b>
	ROVIDER OR SUPPLIER			71	TREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  ALISBURY, NC 28147	1 001	2172020
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 698	Continued From page assessing the access		F	698			
	On 5/8/20 physician's dialysis treatment and site were entered into record and were sign on 5/9/20.  A follow up interview DON by phone on 5/ revealed that after he 5/8/20 at 11:26 AM sign physician's orders for assessment of the accurrent dialysis reside #40) at the facility. Sign Medical Director that physician 's orders to	s orders for Resident #22's d assessing of her access of the electronic medical ed by the Medical Director  was conducted with the 18/20 at 1:46 PM. She or previous interview on the realized there were no or dialysis treatment or the ents (Residents #22 and the stated she spoke with the afternoon and received the data were entered into the					
	Medical Director on 5 DON explained that t ownership changed i believed that the dial	5/8/20 and signed by the 5/9/20 for Resident #22. The he facility 's corporate n February 2020 and she ysis orders were missed nedical records system was rent system.					
	5/21/20 at 11:20 AM interview and the DO facility's normal proto orders for dialysis tre days the resident wa orders for assessing She explained that the ownership changed i working at the facility there was also a chatime. She reported the solution of the protocol of t	col was to have physician's atment that included the s to attend dialysis as well as the resident's access site.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	<u> </u>	03/21/2020	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AIDEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 698	them.  A phone interview w Medical Director on stated that every fact had different protoco orders for dialysis tra access sites. He rep procedure was to for  2b. Resident #22 wa on 3/29/20 and was 4/4/20.  The dialysis commu Resident #22 from 4 no evidence of routin dialysis center.  On 5/8/20 at 8:09 Al correspondence the the facility's protocol with the dialysis cen binder. She wrote the their own binder whi	as they became aware of  as conducted with the 5/13/20 at 12:58 PM. He sility he provided services for ols related to physician's eatment and assessing of the ported that his normal llow the facility's protocol.  as discharged to the hospital readmitted to the facility on  nication documentation for 6/4/20 through 5/7/20 revealed ne communication with the	F6				
	9:24 AM with former stated that the facilit communication with binder to be sent ba to the dialysis cente that each resident a dialysis had their ow	as conducted on 5/8/20 at Unit Manager (UM) #1. She y's normal protocol for routine the dialysis center was for a ck and forth with the resident on each visit. She reported the facility who was on on binder. She explained that of at the nurse's station. She					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP C 710 JULIAN ROAD SALISBURY, NC 28147	ODE	33/2 // 2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 698	communication forms facility nurse prior to dialysis, a portion was center staff post-dialy final portion was comupon return to the face reported that the form information such as a resident's access site vital signs.  A phone interview wir (DON) was conducted the Admit of the verified the Admit of the verified the Admit of the resident to the dialysis of a binder to be the resident to the dialysis center from a communication of the treadmission on the tataff had not be communication binded dialysis center from a DON stated that there the facility as well as the times Resident # explained that due to staff were preparing transport and they we facility's protocol to communication to dialysis, resident for the dialysis, resident for the dialysis, and then to	this binder contained at the resident leaving for a completed by the dialysis are streatment, and then the upleted by the facility nurse contained pertinent an assessment of the are, the resident's weight, and the the Director of Nursing and on 5/8/20 at 11:26 AM. Inistrator and former UM facility's normal protocol for on with the dialysis center as sent back and forth with alysis center on each visit. 5/7/20 when evidence of on with the dialysis center wiew she realized there were arms for Resident #22 since and the since the sent back and forth with alysis center on each visit. 5/7/20 when evidence of the sent back and forth with alysis center on each visit. 5/7/20 when evidence of the sent shaded the sent and the since the sent sent sent in the since the sent sent sent sent sent sent sent sen	F	598		
		nd complete the remainder of sident returned from dialysis.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 698	Continued From pa	ge 49	F 6	98		
	5/21/20 at 11:20 AM all staff to follow the routine communical She reiterated the I had multiple new st not been educated maintaining routine dialysis center. The facility's corporate of February 2020, she in mid-February 2020 change in the DON reported that with the	with the Administrator on a she stated that she expected a facility's protocol for ongoing a sion with the dialysis center. DON's report that the facility aff at the facility and they had on the facility's protocol for communication with the Administrator added that the expensive changed in began working at the facility 20, and there was also a during this time. She he numerous changes she and are working on correcting time aware of them.				
	12/19/18 with diagn Renal Disease (ES) The quarterly Minimassessment dated 2 #40's cognition was dialysis. Resident #40's active focus area of the rishemodialysis 3 day included, in part, me	s admitted to the facility on oses that included End Stage RD) and dialysis dependence.  The Data Set (MDS)  2/18/20 indicated Resident intact, and he was on  The Care plan included the sk for complications related to sper week. The interventions position vital signs pre and post and monitor access site.				
	3a. The physician's	order summary from 3/1/20 aled no physician's orders for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTR			SURVEY
		345286	B. WING _			1	C <b>21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			710 JULIA	DDRESS, CITY, STATE, ZIP CODE N ROAD IRY, NC 28147	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 698	A phone interview wa 9:24 AM with former stated that it was the have physician's ordwell as physician's or the resident's access. A phone interview wi (DON) was conducted She stated that the fatto have physician's of that included the day dialysis as well as or resident's access site. On 5/8/20 physician's dialysis treatment an site were entered intercord and were sign on 5/9/20.  A follow up interview DON by phone on 5/10 revealed that after he 5/8/20 at 11:26 AM renormal protocol for presidents she realized sorders for dialysis to the access site for an residents (Residents She stated she spok that afternoon and rethat were entered into 5/8/20 and signed by 15/8/20 and si	e dialysis treatment or for alysis access site.  as conducted on 5/8/20 at Unit Manager (UM) #1. She facility's normal protocol to ers for dialysis treatment as rders to monitor and assess a site at least once per shift.  th the Director of Nursing ed on 5/8/20 at 11:26 AM. acility's normal protocol was orders for dialysis treatment as the resident was to attend ders for assessing the electronic medical and by the Medical Director  was conducted with the 18/20 at 1:46 PM. She er previous interview on elated to the facility 's hysician's orders for dialysis d there were no physician reatment or assessment of any of the current dialysis #40 and #22) at the facility. We with the Medical Director or the Medical Director	F	698			
	the access site for ar residents (Residents She stated she spok that afternoon and re that were entered int 5/8/20 and signed by 5/9/20 for Resident #	ny of the current dialysis #40 and #22) at the facility. e with the Medical Director eceived physician's orders to the electronic record on					

С		(X2) MULTIPLE CO	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	
05/24/2020		B. WING	345286		
05/21/2020	T ADDRESS, CITY, STATE, ZIP CODE  ULIAN ROAD  SBURY, NC 28147	STRI	0.0200	PROVIDER OR SUPPLIER	
(X5) COMPLETION DATE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ID PREFIX TAG	Y MUST BE PRECEDED BY FULL	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	
	DETICIENCY	F 698	the believed that the dialysis when the electronic medical ransferred to the current with the Administrator on the verified former UM #1's N's interview that the col was to have physician's extment that included the sto attend dialysis as well as the resident's access site. The facility's corporate in February 2020, she began in mid-February 2020, and the provided services for strength of the provided services for strength of the physician's extment and assessing of the provided that his normal ow the facility's protocol.  The believed that the dialysis as well as the resident's access site. The provided services for strength of the provided services for strength of the provided services for the provided services for strength of the provided that his normal ow the facility's protocol.  The believed that the dialysis are believed that his normal ow the facility's protocol.	February 2020 and shorders were missed were cords system was to system.  During an interview we 5/21/20 at 11:20 AM sinterview and the DOI facility's normal protocorders for dialysis treadays the resident was orders for assessing to She explained that the ownership changed in working at the facility there was also a chartime. She reported the changes she and the on correcting issues at them.  A phone interview was Medical Director on 5 stated that every facil had different protocol orders for dialysis treadaccess sites. He reported the corrections or the system of the s	F 698
			atment that included the set to attend dialysis as well as the resident's access site. The facility's corporate in February 2020, she began in mid-February 2020, and the facility's protocol.  The facility's corporate in February 2020, she began in mid-February 2020, and the facility's protocol in the DON during this that with the numerous current DON were working as they became aware of the facility in the provided services for its related to physician's atment and assessing of the facility in the facility's protocol.  The facility is protocol.	orders for dialysis treadays the resident was orders for assessing to the explained that the ownership changed in working at the facility there was also a chartime. She reported the changes she and the on correcting issues at them.  A phone interview was Medical Director on 5 stated that every facil had different protocolorders for dialysis treadecess sites. He reported was to follow the following the form the dialysis common for Resident #40 from revealed the last comby facility staff was decommunication forms.	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  3	1, ,	DATE SURVEY COMPLETED
		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY	1 0,020		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 698	with the dialysis cenbinder. She wrote the their own binder whi with the resident to twisit.  A phone interview with 9:24 AM with former stated that the facility communication with binder to be sent barto the dialysis center that each resident and dialysis had their owneach binder was kepfurther explained that communication form facility nurse prior to dialysis, a portion was center staff post-dial final portion was confupon return to the fareported that the forminformation such as resident's access sit vital signs.  A phone interview with (DON) was conducted the Admit of the reported that the forminformation such as reports that the fact routine communication was for a binder to be the resident to the displacement of the communication was requested for resident to the displacement.	for routine communication ter was maintained in a nat each dialysis resident had ch was sent back and forth he dialysis center on each  as conducted on 5/8/20 at  Unit Manager (UM) #1. She y's normal protocol for routine the dialysis center was for a ck and forth with the resident on each visit. She reported the facility who was on n binder. She explained that at the nurse's station. She at this binder contained is that were completed by a the resident leaving for as completed by the dialysis ysis treatment, and then the nepleted by the facility nurse cility. Former UM #1 in contained pertinent an assessment of the e, the resident's weight, and  with the Director of Nursing and on 5/8/20 at 11:26 AM. Ininistrator and former UM #1 is cility's normal protocol for on with the dialysis center on each visit. In 5/7/20 when evidence of on with the dialysis center wiew she realized there were unication forms for Resident	F 69	98		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345286	B. WING _	_		05/	21/2020	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITAL	DEL SALISBURY			7	10 JULIAN ROAD			
IIIL OIIA	DEL SALISDONI			5	SALISBURY, NC 28147			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 698	stated that there were facility as well as cha	ough present. The DON e multiple new staff at the nges that occurred with the	F	698				
	times Resident #40 a explained that due to staff were preparing I transport and they we facility's protocol to comprior to dialysis, resident for the dialysis dialysis, and then to the dialysis center and the form when the resulting an interview w 5/21/20 at 11:20 AM all staff to follow the froutine communication.	these changes, different Resident #40 for dialysis ere not familiar with the complete the communication send the binder with the sis staff to complete post review the information from ad complete the remainder of sident returned from dialysis.  With the Administrator on she stated that she expected facility's protocol for ongoing on with the dialysis center.  DN's report that the facility ff at the facility and they had in the facility's protocol for						
	maintaining routine of dialysis center. The facility's corporate ow February 2020, she to in mid-February 2020 change in the DON dreported that with the the current DON were issues as they becan 4. Resident #25 was 3/29/20 with diagnost Renal Disease (ESR).	ommunication with the Administrator added that the vinership changed in began working at the facility on, and there was also a uring this time. She anumerous changes she and the working on correcting the aware of them.  admitted to the facility on the est that included End Stage (D) and dialysis dependence.						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DATE COMP	LETED
		345286	B. WING		05/	21/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	1 03/	172020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 698	Continued From pa	ge 54	F 69	98		
	of the risk for comples hemodialysis initiate interventions included resident to go to solve on Monday, Wednes and change dressin document, and more Resident #25 expired 4a. The physician's through 4/12/20 reversident #25 to staff to monitor his control of the resident it was the have physician's or well as physician's or well as physician's or well as physician's or the resident's access the stated that the to have physician's that included the days and the resident's access that included the days of the resident's access that included the days of the resident's that included the days of the resident's that included the days of the resident's access that included the days of the resident included the d	ed on 4/8/20. The ed, in part, encourage neduled dialysis appointments sdays, and Fridays, check g daily at access site and nitor vital signs as indicated.  ed at the facility on 4/12/20.  order summary from 3/29/20 ealed no physician's orders have dialysis treatment or for dialysis access site.  vas conducted on 5/8/20 at r Unit Manager (UM) #1. She e facility's normal protocol to ders for dialysis treatment as orders to monitor and assess as site at least once per shift.  vith the Director of Nursing fied on 5/8/20 at 11:26 AM. facility's normal protocol was orders for dialysis treatment tys the resident was to attend orders for assessing the				
	DON by phone on 5 revealed that after h 5/8/20 at 11:26 AM	w was conducted with the 5/18/20 at 1:46 PM. She her previous interview on related to the facility's normal an's orders for dialysis				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED			
		345286	B. WING _			C <b>5/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 710 JULIAN ROAD SALISBURY, NC 28147	•	5/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 698	physician's orders for assessment of the aduring his stay at the 4/12/20) or for any or residents at the facili with the Medical Dirreceived physician's residents (Residents entered into the election signed by the Medical Resident #25. The facility's corporate of February 2020 and orders were missed records system was system.  During an interview 5/21/20 at 11:20 AM interview and the Dofacility's normal protorders for dialysis to days the resident was orders for assessing She explained that townership changed working at the facilit there was also a chattime. She reported changes she and the on correcting issues them.  A phone interview we Medical Director on stated that every fact had different protocol.	ge 55 ed there had been no or dialysis treatment or access site for Resident #25 e facility (3/29/20 through of the current dialysis ity. She stated she spoke ector that afternoon and a orders for the current dialysis is #22 and #40) that were ectronic record on 5/8/20 and hal Director on 5/9/20 for DON explained that the wnership changed in she believed that the dialysis when the electronic medical transferred to the current  with the Administrator on I she verified former UM #1's DN's interview that the ocol was to have physician's eatment that included the has to attend dialysis as well as the facility's corporate in February 2020, she began by in mid-February 2020, and hange in the DON during this that with the numerous the current DON were working has conducted with the bolisty he provided services for has conducted to physician's the eatment and assessing of the	F	698		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION  G	' '	DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	0.0200		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	I	05/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 698	procedure was to for 4b. The dialysis cor	eported that his normal billow the 's protocol.	F 69	98		
		om 3/29/20 through 4/12/20 nication form dated 4/1/20 for				
	Documentation from the dialysis center indicated Resident #25 attended dialysis on 3/30/20, 4/1/20, 4/3/20, 4/6/20, 4/8/20, and 4/10/20.					
	the facility's protoco with the dialysis cer binder. She wrote t their own binder wh	M via electronic Administrator indicated that of for routine communication nter was maintained in a that each dialysis resident had ich was sent back and forth the dialysis center on each				
	9:24 AM with forme stated that the facilit communication with binder to be sent bat to the dialysis center that each resident a dialysis had their over each binder was kerfurther explained the communication form facility nurse prior to dialysis, a portion we center staff post-dial final portion was co	vas conducted on 5/8/20 at r Unit Manager (UM) #1. She ty's normal protocol for routine in the dialysis center was for a ack and forth with the resident er on each visit. She reported at the facility who was on with binder. She explained that pt at the nurse's station. She at this binder contained in that were completed by a contained of the resident leaving for was completed by the dialysis alysis treatment, and then the impleted by the facility nurse acility. Former UM #1				

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	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CO 710 JULIAN ROAD SALISBURY, NC 28147	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 698	vital signs.  A phone interview wi (DON) was conducted She verified the Adm #1's reports that the routine communication was for a binder to be the resident to the discherevealed that on routine communication was requested for reconly one communication was requested the communication was requested the communication was requested to complete the remained of the resident returned from the province communication was recommunicated to the province communication was recommunicated to the province communication was recommunicated to the province of the province communication was recommunicated to the province communication was requested to the province communication	th the Director of Nursing of on 5/8/20 at 11:26 AM. inistrator and former UM facility 's normal protocol for on with the dialysis center e sent back and forth with alysis center on each visit. 5/7/20 when evidence of on with the dialysis center view she realized there was tion form completed for his stay at the facility 2/20). The DON stated that new staff at the facility and r with the facility 's protocol munication form prior to der with the resident for the lete post dialysis, and then tion from the dialysis center nainder of the form when the m dialysis.  With the Administrator on she stated that she expected facility's protocol for ongoing on with the dialysis center. ON 's report that the facility ff at the facility and they had in the facility's protocol for ommunication with the Administrator added that the	F	598		
		pegan working at the facility ), and there was also a luring this time. She				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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	ROVIDER OR SUPPLIER  DEL SALISBURY			7	TREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147	1 00/	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 698	•	numerous changes she and e working on correcting ne aware of them.		698 880			6/10/20
SS=L	CFR(s): 483.80(a)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)	ntrol blish and maintain an and control program a safe, sanitary and bent and to help prevent the asmission of communicable ans.  brevention and control blish an infection prevention (IPCP) that must include, at ving elements:  am for preventing, identifying, g, and controlling infections seases for all residents, bors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following and order, and order, and bogram, which must include, allance designed to identify ble diseases or a can spread to other					

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		345286	B. WING _			05/	21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			71	TREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	to be followed to prev (iv)When and how isc resident; including but (A) The type and dura depending upon the involved, and (B) A requirement that least restrictive possilic circumstances.  (v) The circumstances must prohibit employed disease or infected secontact with residents contact will transmit the (vi)The hand hygiene by staff involved in directive actions take §483.80(a)(4) A system identified under the factorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual revented facility will conduct IPCP and update their This REQUIREMENT by:  Based on record review "COVID-19 Policy/Plainterviews with resided Director, and Nurse Fto update, have and the interviews and	asmission-based precautions ent spread of infections; plation should be used for a trot limited to: ation of the isolation, infectious agent or organism at the isolation should be the pole for the resident under the solution of the isolation should be the pole for the resident under the solution of the isolation should be the pole for the resident under the solution of the isolation of the isol	F	380	Past noncompliance: no plan of correction required.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	, ,	OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER  DEL SALISBURY	1		STREET ADDRESS, CITY, STATE, ZIP COD 710 JULIAN ROAD SALISBURY, NC 28147	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 880	(Centers for Medical failing to have new a separated from curre residents (Residents #32, #33, #34, #35, admitted and/or read 3/11/20 through 4/4/ also failed to fully im guidance for the use residents until 5 day released (4/2/20). To during the COVID-1 likelihood of affecting them at an increased transmitting COVID-COVID-19 positive residents with the second completed which shoresidents were COVID-19 testing of covidents which shoresidents were covidents which shoresidents which shoresidents were covidents which shoresidents which shoresidents were covidents which shoresidents which	ge 60 and Prevention) and CMS re and Medicaid Services) by admissions and readmissions ent residents for 12 of 12 s #2, #11, #19, #22, #25, #27, #36, and #39) who were dmitted to the facility from 20. In addition, the facility plement CDC and CMS of facemasks for staff and s after the guidance was this system failure occurred p pandemic and had a high g all residents by placing d risk of developing and 19. The facility 's first esident was identified on p). On 4/10/20 mass facility residents was owed a total of 100 out of 124 ID-19 positive. As of 5/13/20 ints had tested positive for	F	880		
	Services) guidance of 3/9/20, in accordance of 1/9/20, in accordance of	edicare and Medicaid from "QSO-20-14-NH" dated e with CDC (Centers for I Prevention) guidance,				

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	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	I	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	serve as a step-dowr 14 days with no symp as usual on short-ten long-stay original roo 1. The following facil	n unit where they remain for otoms (instead of integrating m rehab floor or returning to	F 8	880		
	3/11/20, indicated the related to new admis "Each facility will atte admissions to a community waiting period of 5 da	e following information sions:				
	incorporate the CDC (effective 3/9/20) of p	-				
	3/11/20 through 3/18 (Residents #27, #32, and/or readmitted to	ssions/readmissions list from /20 revealed 3 residents and #33) were admitted the facility on general were not designated for				
	the hospital on 3/11/2 included Atrial Fibrilla Accident and Multiple the white blood cells marrow) in remission electronic medical readmitted to a semi-pu (Resident #37) within	s admitted to the facility from 20. Her admission diagnoses ation, Cerebral Vascular Myeloma (cancer formed in and accumulates in bone . Review of Resident #27 's cord indicated she was rivate room with a roommate in the general population on at Resident #27 was not				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CORRECTIVE ACTION DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	PM read Resident # to move into another requested would be management. Revie electronic medical r moved from the 300 another semi-privat (Resident #22) on 3 general population #27 was not quarar Resident #27 's ad (MDS) dated 3/18/2 intact.  Review of a nursing PM read Resident # was susceptible to in Resident #27 was a COVID-19 on 4/8/2 #27 's care and synguidance and the faincluded placing Resident Resident Resident #27 was a COVID-19 on 4/8/2 #27 's care and synguidance and the faincluded placing Resident Re	g note dated 3/14/20 at 7:10 #27 complained about wanting er room. The note read her e communicated to ew of Resident #27 's record indicated she was 0 hall to the 200 hall into e room with a roommate 8/16/20. The 200 hall was a hall indicating that Resident intined.  mission Minimum Data Set 0 indicated her cognition was g note dated 3/18/20 at 2:46 #27 was encouraged to wear a s out of her room since she	F8			
	were confirmed CO Resident #27 was s 4/10/20 and with po 4/13/20.  In a telephone inter former UM #1 confi admitted on 3/11/20 population with a ro	win separate wing/hall who VID-19 positive.  Swabbed for COVID-19 on sitive results received on view on 5/12/20 at 10:26 AM, rmed Resident #27 was 0 into room within the general commate (Resident #37). On 27 moved into a different				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		ATE SURVEY DMPLETED
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F 880	In a telephone interval Nursing Assistant (Narecalled Resident #2 quarantine after admot worn anything by Resident #27 while and 200 hall during her admission.  In a telephone interval on recollection of Reson admission but raisemi-private room was general population of stated it was her und Administrator and Daregarding placement readmissions.  In a video phone cal 5/12/20 at 3:32 PM, on any type of quaratime frame after her all in a telephone interval in a telephone interval in a quarantine purpoccurred.  During a phone interval in president #27 is emissioned in the p	rith a new roommate general population hall.  riew on 5/12/20 at 1:38 PM, IA) #3 stated she had not 27 being on any form of hission (3/11/20) and she had at gloves when caring for working with her on the 300 the 14-day timeframe after  riew on 5/12/20 at 2:16 PM, by (OT) stated that she had esident #27 being quarantined ther she was admitted into a rith a roommate within the of the facility on 3/11/20. She derstanding that the ON made decisions and  I with Resident #27 on she stated that she was not antine during the 14-day admission (3/11/20).  riew on 5/12/20 at 3:50 PM, bergency contact stated she resion that Resident #27 was a private room on admission coses, but that had not review with the Medical at 12:58 PM he reported that for Resident #27 to have	F8	880		

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F 880	CDC and CMS guid	(3/11/20) in accordance with elines.	F 8	80		
	facility on 11/18/19. diabetes, atrial fibrill spreading bacterial surface). Review of medical record indic from 3/3/2020 through record also specified facility to his private general population in	as originally admitted to the His diagnoses included ation, and cellulitis (a infection underneath the skin Resident #32 's electronic ated he was hospitalized gh 3/12/2020. The resident 's d he was readmitted to the room on the 300 hall in the indicating Resident #32 was esident #32 expired in the				
	(MDS) assessment, Resident #32 was or total assistance with had 2 venous/arteria wounds and receive A phone interview w	e in Status Minimum Data Set dated 2/17/20, indicated ognitively intact and required mobility and transfers. He al ulcers as well as surgical d intravenous antibiotics.				
	#32 was readmitted the 300 hall in the g	Opm, who recalled Resident to the same private room on eneral population. She could al precautions taken by the his care.				
	Nurse Aide (NA) #1 with Resident #32 a readmitted from the returned to the same general population of recall any special pr	ne interview occurred with at 9:35am. She was familiar and stated when he was hospital (3/12/20), he exprivate room, within the of the facility. NA #1 could not ecautions taken when care. She added he was				

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			STREET ADDRESS, CITY, STATE, ZIP COL 710 JULIAN ROAD SALISBURY, NC 28147	DE	03/21/2020
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFI) TAG	( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
bedbound on readmin A phone interview was 5/13/2020 at 9:42am Resident #32. She confrom the hospital on room within the generand was bedbound. Precautions were taken 1c. Resident #33 was 3/18/20 with diagnost Vascular Accident (Continued and to a private population on the 50 not quarantined.  The admission Minimassessment dated 3/433 's cognition was independent with Active Resident #33 was can COVID-19 on 4/8/20 #33 's care and symmoud guidelines and facility included initiating drand to restrict reside possible.	as held with NA #2 on , who was familiar with onfirmed he was readmitted 3/12/20 to the same private eral population of the facility NA #2 added that no special en when providing his care.  s admitted to the facility on es that included Cerebral evA) with left sided The admission list for March dent #33 was admitted espital. Review of Resident dical record indicated he was room within the general 0 hall indicating that he was initiates of Daily Living (ADLs).  are planned for suspected are planned for suspected by protocol. Interventions explet and contact precautions and the Resident #33 had a	F&	380		
A phone interview wa	as conducted with Nurse #7				
	Continued From pag bedbound on readmin A phone interview was 5/13/2020 at 9:42am Resident #32. She continued from the hospital on a room within the general was bedbound. The precautions were taken and was bedbound. The precautions were taken at the first section of the properties o	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65 bedbound on readmission from the hospital.  A phone interview was held with NA #2 on 5/13/2020 at 9:42am, who was familiar with Resident #32. She confirmed he was readmitted from the hospital on 3/12/20 to the same private room within the general population of the facility and was bedbound. NA #2 added that no special precautions were taken when providing his care.  1c. Resident #33 was admitted to the facility on 3/18/20 with diagnoses that included Cerebral Vascular Accident (CVA) with left sided hemiplegia/paresis. The admission list for March 2020 indicated Resident #33 was admitted (3/18/20) from the hospital. Review of Resident #33 's electronic medical record indicated he was admitted to a private room within the general population on the 500 hall indicating that he was not quarantined.  The admission Minimum Data Set (MDS) assessment dated 3/25/20 indicated Resident #33 's cognition was intact, and he was independent with Activities of Daily Living (ADLs).  Resident #33 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #33 's care and symptoms be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions and to restrict resident to his room to the extent	A BUILDIN 345286  B. WING_  ROVIDER OR SUPPLIER  DEL SALISBURY  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65  bedbound on readmission from the hospital.  A phone interview was held with NA #2 on 5/13/2020 at 9:42am, who was familiar with Resident #32. She confirmed he was readmitted from the hospital on 3/12/20 to the same private room within the general population of the facility and was bedbound. NA #2 added that no special precautions were taken when providing his care.  1c. Resident #33 was admitted to the facility on 3/18/20 with diagnoses that included Cerebral Vascular Accident (CVA) with left sided hemiplegia/paresis. The admission list for March 2020 indicated Resident #33 was admitted (3/18/20) from the hospital. Review of Resident #33 's electronic medical record indicated he was admitted to a private room within the general population on the 500 hall indicating that he was not quarantined.  The admission Minimum Data Set (MDS) assessment dated 3/25/20 indicated Resident #33 's cognition was intact, and he was independent with Activities of Daily Living (ADLs).  Resident #33 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #33 's care and symptoms be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions and to restrict resident to his room to the extent possible.  Record review indicated Resident #33 had a planned discharge to the community on 4/10/20.	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65  bedbound on readmission from the hospital.  A phone interview was held with NA #2 on 5/13/2020 at 9:42am, who was familiar with Resident #33. She confirmed he was readmitted from the hospital on 3/12/20 to the same private room within the general populations were taken when providing his care.  1c. Resident #33 was admitted to the facility on 3/18/20 with diagnoses that included Cerebral Vascular Accident (CVA) with left sided hemiplegia/paresis. 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A BUILDING  345286  345286  345286  345286  345286  345286  345286  345286  345286  345286  345286  345286  345286  345286  35TREETADDRESS, CITY, STATE, 2IP CODE  710 JULIAN ROAD  SALISBURY, NC 28147  SUMMARY STATEMENT OF DEFICIENCES  RECAL PROFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 65  bedbound on readmission from the hospital.  A phone interview was held with NA #2 on 5/13/2020 at 9-42am, who was familiar with Resident #32. She confirmed he was readmitted from the hospital on 3/12/20 to the same private room within the general population of the facility and was bedbound. NA #2 added that no special precautions were taken when providing his care.  1c. Resident #33 was admitted to the facility or and subject of the same private room within the general population on the 500 hall indicated he was admitted to a private room within the general population on the 500 hall indicated he was admitted to a private room within the general population on the 500 hall indicated he was admitted to a private room within the general population on the 500 hall indicated Resident #33 's electronic medical record indicated he was admitted to a private room within the general population on the 500 hall indicating that he was not quarantified.  The admission Minimum Data Set (MDS) assessment dated 3/25/20 indicated Resident #33 's cognition was intact, and he was independent with Activities of Daily Living (ADLs).  Resident #33 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #33's care and symptoms be managed per CDC guidelines and facility protocol. Interventions included initiating droplet and contact precautions and to restrict resident to his room to the extent possible.  Record review indicated Resident #33 had a planned discharge to the community on 4/10/20.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	\ , ,	OMPLETED
		345286	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY	1		STREET ADDRESS, CITY, STATE, ZIP OF 710 JULIAN ROAD SALISBURY, NC 28147	•	33/2 1/2323
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO DEFICIENCED TO TO THE PROVIDER TO TH	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	familiar with Resider was admitted (3/18/2) the general population indicated that Resident admission. She left his room for rehawheelchair. Nurse #	M. She stated that she was nt #33 and recalled that he 20) to a private room within on of the facility. She ent #33 was not quarantined reported that Resident #33 abilitation via a self-propelled 47 was unable to explain why ot quarantined for 14 days	F	380		
	through 3/18/20 reve of 26 beds (12 doub single occupancy ro and available during Record review revea positive facility resid (Resident #19). On testing of facility residentially listing of residents as of 4/15/20 residents. This list residents. This list residents. This list reference COVID-19 postopped at 1:35 PM swas a closed hall prothe facility is plan with quarantine purposes.	aled the first COVID-19 ent was identified on 4/7/20 4/10/20 mass COVID-19 dents was completed with 4/13/20 and 4/14/20. A dents with COVID-19 test included a total of 124 evealed 100 of 124 residents itive.  with the Administrator on she stated that the 100-hall or to the pandemic and that as to utilize this hall for a related to COVID-19.				
	3:21 PM with the Ad	ministrator. She was asked ' 's corporate policy for				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		345286	B. WING				21/2020	
NAME OF PI	ROVIDER OR SUPPLIER		1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
THE OITA	DEL CALIODUDY			7	710 JULIAN ROAD			
THE CITA	DEL SALISBURY				SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 880	3/11/20 to 3/18/20 the was for new admission of the facility that was population for a waiting being placed in a roopopulation. She state timeframe, these resiprivate room with a propulation within the residents from new a residents from new a residents were cominincreased their possil virus (COVID-19). We policy applied to readmissions were to they were symptomal unable to explain why policy had not applied residents were also of that increased their propulation within the residents were symptomal unable to explain why policy had not applied residents were also of that increased their propulation to explain why corporate policy was than a 14-day quarar and CMS guidance diadditionally unable to which was empty, we placement of new addition for the waiting the side of the side	ions. She stated that from a facility 's corporate policy on to be placed in a section a separate from the general and period of 5 days prior to m within the general and that during this 5-day dents were to be placed in a rivate bathroom and foom. The Administrator apose of this 5-day artion from the general facility was to protect current dmissions as these and in from environments that a bility of being exposed to the and the facility 's corporate and to readmissions as these and to readmissions as the second to the solution. The Administrator was also as the second to the solution of the corporate and the corpo	F	880				
	the former DON and	M via electronic Administrator indicated that the former Unit Managers ble for room placement						

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  IG		DATE SURVEY COMPLETED
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	<u> </u>	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 880	2020. Phone interviews we Director of Nursing (and 5/11/20 at 3:27 reached.  A phone interview w #2 (primarily assigne on 5/11/20 at 4:30 P recommendations to Administrator for roc admissions/readmisthe beginning of Aprhad not heeded her She stated that she admissions/readmis quarantined to a priving general population. new admissions/reaf for coming into contawhile at the hospital  A phone interview w #1 (primarily assigne halls) on 5/12/20 at room placement dec COVID-19 pandemic and she had not agrexplained that she be and/or readmissions quarantine as they we into contact with the hospital and/or in the A phone interview w	ere attempted with the former DON) on 5/6/20 at 5:07 PM PM. She was unable to be as conducted with former UM ed to the 500 and 600 halls) M. She stated that she made of the former DON and emplacement of new sions in March 2020 through il 2020, but the management clinical recommendations. In the believed new sions should have been exate room away from the UM #2 explained that these dmissions were at high risk fact with the virus (COVID-19) and/or in the community.  It is conducted with former UM end to the 100, 200, and 300 and 10:26 AM. She stated that the end were made by management end were made by management end with their decisions. She elieved new admissions should have been placed in were at high risk for coming virus (COVID-19) while at the end community.	F 8	80		
	Coordinator (ICP/SE	eventionist/Staff Development DC) on 5/13/20 at 12:10 PM. arch 2020 the facility was not				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED		
		345286	B. WING			C <b>5/21/2020</b>
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	readmissions relate that she had no input decisions. She stat Medical Director, ar room placement derevealed that throughwas not following the and/or CMS.  A phone interview with Medical Director on stated that he was redecision-making regionew admissions and COVID-19 pandemit their own COVID-19 were following. The his expectation was and CMS guidance admissions and readers.	w admissions and/or d to COVID-19. She reported ut in room placement ed that the former DON, and Administrator were making cisions. The ICP/SDC ghout March 2020 the facility to guidance from the CDC was conducted with the 5/13/20 at 12:58 PM. He not involved in any garding room placement of d/or readmissions during the to. He reported the facility had to corporate plan that they be Medical Director indicated of for the facility to follow CDC regarding placement of new dmissions.	F 88			
	was aware the facilic CMS guidance that indicated that if posted dedicate a unit/wing coming or returning were to remain for a prior to being integropopulation.  - At 3:27 PM the Ad believe that was a requirement on 3/9"	ministrator was asked if she ty was not following CDC and was effective on 3/9/20 which sible, the facility was to g exclusively for any residents from the hospital where they l4 days with no symptoms ated into the general ministrator responded, "I do ecommendation and not a '. She revealed that she was y was not in compliance with CDC and CMS				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	, , ,	(X3) DATE SURVEY COMPLETED	
		345286	B. WING _		0	C <b>5/21/2020</b>	
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From page On 5/14/20 at 10:48 a correspondence the a as of 5/13/20 a total o tested positive for CO of 127.  In a follow up intervie the Administrator con through 3/18/20 the f COVID-19 related to readmissions was no CDC and CMS guide confirmed that the CI admissions/readmiss 3/11/20 through 3/18, indicated that new ac should have been pla of the facility and qua confirmed the 100-ha a quarantine section through 3/18/20.  2. The facility corpora Policy/Plan for Facilit The section of the po admissions that state to locate new admiss	AM via electronic Administrator revealed that of 105 facility residents had DVID-19 out of a census high ow on 5/21/20 at 11:20 AM, firmed that from 3/11/20 acility 's corporate policy for admissions and t in accordance with the lines. She additionally DC and CMS guidelines for ions were not followed from 1/20. The Administrator Imissions/readmissions aced in a designated section trantined for 14 days. She all was open and available as of the facility from 3/11/20 at policy titled, "COVID-19 ies" was revised on 3/18/20.	F 8	DEFICIENCY			
	community" was struwas no longer part of There was no mentio (dated 3/18/20) of the admissions/readmiss population for quarar	ions from the general itine purposes. This revised by included the addition of					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCT	ION	(X3) DATE COMP	SURVEY PLETED
		345286	B. WING _			1	C <b>21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRE		1 00/	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	Nursing will assist in resident in a location considers the reason associated risks for ithe new resident as staff."  This 3/18/20 facility (incorporate the CDC (effective 3/9/20) of pentered the facility in The facility corporate Policy/Plan for Facili 3/28/20 with the add to referrals for admis "As of 3/28, the facili with known positive tested by the hospita and have a negative who are sent to the esymptoms of COVID shortness of breath. complete a careful a causes of symptoms unnecessary emerged While we are focuse overwhelming the hocommitted to keeping infection."  This 3/28/20 facility on tincorporate the C (effective 3/9/20) of pentered the facility in th	ntionist and/or the Director of placing the newly admitted within the facility that as for admission, any infection and the protection of well as other residents and corporate policy did not and CMS guidance placing residents who quarantine for 14 days.  The policy titled, "COVID-19 ties" was revised again on a stion of the following related sions:  This includes residents entered the state of the protection of the seed of the protection of	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	00/21/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	CMS and CDC recoto keep patients and actions included, in "Long-term care factor are using appropriate Equipment (PPE)] where the care of any resident available and per Coof PPE.  For the duration of the State, all long-term wear a facemask where the care of any residence COVID-19 per CDC PPE.  If COVID-19 transmine healthcare personned are of all residents diagnosis or symptom Patients and resident the facility for care (should wear facemar rooms."	cility Guidance" indicated ommended immediate actions of residents safe. These part, the following:  cilities should ensure all staff te [Personal Protective when they are interacting with ints, to the extent PPE is DC guidance on conservation  the state of emergency in their care facility personnel should hile they are in the facility.  worn per CDC guidelines for dent with known or suspected a guidance on conservation of the sission occurs in the facility, el should wear full PPE for the irrespective of COVID-19	F8	380		
	determining the con	rentionist] will assist in rect use of PPE by staff, for and the type of isolation				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	\ , ,	(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>5/21/2020</b>	
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP COI 710 JULIAN ROAD SALISBURY, NC 28147		5/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	any resident who has others. The [Infection and monitor any isolation to serve as it isolation to serve admit facility were placed of that were not designated.  2a. Resident #35 was 3/19/20 with diagnost disease, hypertension disease stage 3. The 2020 indicated Reside (3/19/20) from home, electronic medical readmitted to a private population on the 600 not quarantined.  Nursing notes dated indicated Resident #3 area of the 600 hall.  The admission Minimassessment dated 3/ was moderately imparts.	staff has received and guidance in caring for a the potential to infect a Preventionist] will establish ation required including aired posting of the type of notice to others."  ssions/readmissions list from 20 revealed 8 of 8 residents 419, #25, #34, #35, #36, and ted and/or readmitted to the magneral population halls ated for quarantine purposes.  s admitted to the facility on est hat included Alzheimer 's in (HTN), and chronic kidney endinssion list for March lent #35 was admitted. Review of Resident #35 's cord indicated she was room within the general D hall indicating that he was  3/20/20, 3/21/20 and 3/22/20 and 3/20/20, 3/21/20 and 3/22/20 and she was ivities of Daily Living (ADLs). Deech Therapy (ST),	F8				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C 5/24/2020	
	ROVIDER OR SUPPLIER  DEL SALISBURY	1 0.0200		STREET ADDRESS, CITY, STATE, ZIP CO 710 JULIAN ROAD SALISBURY, NC 28147		5/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Nurse #2 indicated R with rolling walker and Resident #35 was care COVID-19 on 4/8/20 #35 's care and sym guidance and the faci included initiating droprecautions, supply rencourage resident to room, and to restrict extent possible. The sinitiated on 4/8/20.  A phone interview wire conducted on 5/13/20 she was familiar with that she was admitted general population have rehabilitation. She significantly and significant was 5/13/20 at 12:20 PM. Resident #35 and standard and standard and semi-privation within the general diagnoses included to Diabetes and a history.	3/26/20 completed by MDS Resident #35 was ambulatory and was out of her room daily.  The goal was for Resident ptoms be managed per CDC cility protocol. Interventions uplet and contact resident with face mask and so wear if she must leave the resident to her room to the se interventions were  The MDS Nurse #2 was at 12:10 PM. She stated Resident #35 and stated d to a private room on a call (600 hall) for tated there was no or the resident at the time of as conducted with OT on as She recalled working with ated that she was not	F 8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		345286	B. WING				21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY		-	s 7	STREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  SALISBURY, NC 28147	<u>  05//</u>	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	with transfer, ambulat off the unit.  Review of a nursing r AM read, Resident #7 of breath, a dry cough The Physician was not the hospital for an evidence of a nursing r PM read Resident #1 emergency room on A Review of the emerged dated 4/6/20 indicated shortness of breath, a sputum. She was negothest tightness. Resident #19 was livit quarantine. There was this time.  Review of the electron Resident #19 was read the hospital notified and Resident #19 had tested positive emergency room on A recommendation. Resident #19 had tested positive emergency room on A notified and Resident precautions. Resident hospital at 8:45 PM. To	indicated she was a required limited assistance tion and locomotion on and note dated 4/6/20 at 10:12 lg complained of shortness in and generalized weakness. Otified, and she was sent to aduation.  Indee dated 4/6/20 at 11:30 lg returned from the 4/6/20 at 6:15 PM. Hency room discharge note dated the first was seen for cough and minimal yellow grative for a fever, chills of dent #19 exhibited no rey distress, but she was the note continued ing in a facility that could is no need for admission at the first medical record revealed admitted from the 4/6/20 into the same shout a roommate into the	F	880			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	In a telephone intervithe former Unit Man #19 tested positive fremergency room on facility the same day.  An interview occurre 5/21/2020 at 11:15 / emergency room vistested for COVID-19 with symptoms presunable to explain where the corporate policy related indicated residents to due to symptoms of readmitted until they a negative test result.	riew on 5/11/2020 at 4:30 PM, ager (UM) #2 stated Resident or COVID-19 at the 4/6/20 and returned to the back into the same room.  Add with the Administrator on AM regarding Resident #19 's sit on 4/6/2020 where she was and returned to the facility ent. The Administrator was by the 3/28/2020 facility sted to COVID-19 that ested in the emergency room COVID-19 would not be are symptom free and have t.	F 88	30		
	on 3/25/20. Review record indicated he semi-private room whall in the general private diagnoses included history of a pulmonate resident #34 's addited 4/1/20 indicated was coded as reassistance with his anon-ambulatory.  Resident #34 was code covid-19 on 4/8/20 #34 's care and syn	oith Resident #16 on the 300 opulation. Resident #34 ' s Dementia, Depression and a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP COD 710 JULIAN ROAD SALISBURY, NC 28147	E	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	with a dedicated ba with other residents were confirmed CO.  In a telephone interformer Unit Manage #34 was admitted or general population with #16).  In a telephone intersocial Worker (SW) admitted from the hissemi-private room wistated at one point, admissions into privimoving them into set this practice stopper recall why or exactly stated she thought admission, she was open up but the oth going home.  In another telephone.  In another telephone.  In another telephone with admitted, there were semi-private rooms 100-hall. She stated quarantine purpose room with a roommit unable to explain with a room within the geon the designated of the confirmation.	sident #34 in a private room throom as available or cohort in separate wing/hall who VID-19 positive.  view on 5/12/20 at 10:26 AM, er (UM) #1 confirmed Resident in 3/25/20 into room within the with a roommate (Resident with a roommate (Resident #34 was ospital on 3/25/20 into a with Resident #16. SW #1 the facility was placing new rate rooms for 3 days then emi-private rooms. She stated d and she was unable to y when it stopped. SW #1 at the time of Resident #34 's waiting on a private room to er resident did not end up  e interview on 5/13/20 at 1:56 and when Resident #34 was en o open private rooms or other than the rooms on the factor of the second in the late (Resident #34 was placed in the late (Res	F8	380		
		ector he reported that his Resident #34 to have been				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C 05/21/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 710 JULIAN ROAD SALISBURY, NC 28147	E	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 880		ge 78 quarantine on admission to accordance with CDC and	F 8	80		
	3/29/20 with diagnorenal disease and dependent from the admission list of Resident #25 was a hospital. Review of medical record indicated record indicated record indicated from the same that Resident #29/20, he moved from on the 500 hat (Resident #21).	as admitted to the facility on ses that included end stage dependence on renal dialysis. For March 2020 indicated admitted (3/29/20) from the resident #25 's electronic cated he was admitted to a with a roommate (Resident dent #25 was not quarantined. For each of the record indicated that on service Resident #25 's admission do to a different semi-private ll with a new roommate.				
	hall to the 600 hall i was a general popu utilized for quarantii The admission Mini assessment dated 4	mum Data Set (MDS) 1/3/20 indicated Resident #25				
	for Activities of Daily Resident #25 was of COVID-19 on 4/8/20	act, and he was independent y Living (ADLs).  Fare planned for suspected O. The goal was for Resident mptoms be managed per CDC				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP COI 710 JULIAN ROAD SALISBURY, NC 28147	DE	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA	DATE
F 880	included initiating droprecautions, supply encourage resident to room or be transport restrict resident to hi possible. These interview indicates the facility on 4/12/20.  A phone interview was Assistant (NA) #10 of stated that upon adm #25 self-propelled hi facility, was not on quality, was not on quality, was not on quality wore no mask was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard was unable to recall wearing masks at the sometime after the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though placement for Reside from the hospital and quarantined for a period of the standard that she though the standard that she though the standard that she though the standard that she she that she she that she though the standard that she she that she though the standard that she she she that she	cility protocol. Interventions oplet and contact resident with face mask and o wear if she must leave the ed from the facility, and to so room to the extent eventions were initiated on ated Resident #25 expired at 0.  as conducted with Nursing on 5/12/20 at 9:40 AM. She hission (3/29/20) Resident so wheelchair throughout the uarantine, attended dialysis and the resident wore no of his room. She stated she when providing care to the sion through 4/4/20. She the date that residents began the facility, but she knew it was taff began wearing masks on the seconducted with former than 10 to 11/2/20 at 10:26 AM. Resident #25 was admitted to with a roommate. She got this was an inappropriate each #25 as he was coming	F	380		
	outside of the facility UM #2 recalled Resi facility with no mask	y and attended dialysis three times a week. Former dent #25 moving about the on. She was unable to recall ts began wearing masks, but				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345286	B. WING			1	C / <b>21/2020</b>
	ROVIDER OR SUPPLIER	0.0230		710 J	ET ADDRESS, CITY, STATE, ZIP CODE  ULIAN ROAD  SBURY, NC 28147	<u> 1 05</u> .	21/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	A phone interview wi was conducted on 5/ asked to explain Res assignments. She stroommate difference admission (3/29/20) another semi-private hall) on the same dareported that on 4/1/2 open private room or #25 was moved to that there were multi 100-hall at the time of admission. She was Resident #25 was pla on the 500 hall and 1	that it was sometime after gan wearing masks.  th Social Worker (SW) #1 13/20 at 2:00 PM. She was ident #25 's room ated that there were swith his first placement on so his room was moved to room on the same hall (500 y as admission. She 20 she realized there was an a the 600 hall so Resident at room. SW #1 revealed ble open rooms on the f Resident #25 's unable to explain why aced in 3 different rooms (2 on the 600 hall) within the atther than on the designated	F8	380			
	3/31/20 with diagnos disease. The admiss indicated Resident # from home. Review medical record indicasemi-private room wi #26) within the general indicating that Reside The admission Minimassessment dated 4/had moderately impasupervision only for I	7/20 indicated Resident #11 ired cognition and required ocomotion on the unit and locomotion off the unit. He					

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		345286	B. WING			C 05/21/2020	
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP COL 710 JULIAN ROAD SALISBURY, NC 28147		3/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	COVID-19 on 4/8/20 #11 's care and sym guidance and the faci included initiating droprecautions, supply rencourage resident to room or be transport restrict resident to his possible. These inter 4/8/20.  Record review indicate the facility on 4/21/20.  A phone interview war #11 's Responsible I AM. She reported the was informed Reside a private room and query to being integrated in The RP reported that Resident #11 at the frestrictions she had the windows in the lobby Resident #11 was now visit on 4/4/20.  A phone interview war Unit Manager (UM) # She confirmed that Fa semi-private room stated that she though placement for Reside from the community quarantined for a period of the semi-private room stated for a period of the community quarantined for a period of the community	re planned for suspected  The goal was for Resident ptoms be managed per CDC cility protocol. Interventions uplet and contact resident with face mask and o wear if she must leave the room to the extent ventions were initiated on ted Resident #11 expired at	F 88	30			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		DATE SURVEY COMPLETED
		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY	1 3,020		STREET ADDRESS, CITY, STATE, ZIP C 710 JULIAN ROAD SALISBURY, NC 28147	CODE	05/21/2020
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF  (EACH CORRECTIVE ACT  CROSS-REFERENCED TO T  DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 880	his wheelchair throughask. She was una residents began were able to state that it with when staff began were A phone interview was and that he was not (3/31/20).  A phone interview was and that he was not (3/31/20).  A phone interview was 5/12/20 at 11:15 AM #11 was not quarant additionally stated the (3/31/20) he was able wheelchair and did significant record indicated and readmitted to the diagnoses that include gastrointestinal hemorecord also specified original semi-private (Resident #1) within 600-hall, indicating Figurarantined.  The annual Minimum assessment dated 1/42 had moderately in dependent on staff for care.	ghout the facility and wore no ble to recall the date that aring masks, but she was as sometime after 4/4/20 paring masks.  as conducted with Nursing an 5/12/20 at 10:47 AM. She familiar with Resident #11 quarantined on admission  as conducted with NA #12 on the stated that Resident ined on admission. She at at the time of admission to e to self-propel his to without a mask in place and areas of the facility.  Toriginally admitted to the eview of the electronic ated she was hospitalized to facility on 3/31/2020 with ded dementia and torrhage. Resident #2 's a she was readmitted to her room with a roommate the general population on the desident #2 was not  The Data Set (MDS) (6/2020 indicated Resident may and all personal corrected that and all personal corrected that and sorrected the parine cognition and was per mobility and all personal	F	380		
	Resident #2 was car	e planned for suspected				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	00.2 2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	Resident #2 's care managed per CDC g protocol. Interventic and contact precauti The electronic medic #2 expired at the fact Review of Resident 4/20/2020 indicated death was dementia On 5/8/2020 at 3:38 correspondence with indicated Resident # readmitted to the fact Administrator went or returned with hospic diagnoses of Alzheir depression it was dewas most comfortab roommate. The Administrator went to the hospital not have any respirar A phone interview or #4, on 5/12/2020 at recall that Resident for original room with a from the hospital. Shot quarantined upo and there were no swhen providing care On 5/12/2020 at 5:10 occurred with Nurse Resident #2. She with the original room	220. The goal was for and symptoms to be guidelines and facility ons included initiating droplet ions.  221 records revealed Resident cility on 4/14/2020.  #2's death certificate dated her immediate cause of .  PM, via electronic on the Administrator, she face was not quarantined when cility on 3/31/2020. The conto explain Resident #2 are care and due to her mer's Disease, anxiety and exided to place her where she le, her same room with ministrator added Resident #2 due to rectal bleed and didutory symptoms.  Courred with Nurse Aide (NA) 12:47 PM. She was able to #2 was placed back in her roommate on readmission he added Resident #2 was in readmission to the facility pecial precautions in place	F8			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		345286	B. WING			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880		age 84 e #5 added there were no s present when providing care	F 8	30		
	the hospital on 4/1. included muscle w swallowing) and la the electronic med admitted to a semi (Resident #37) witl	vas admitted to the facility from /2020 with diagnoses that eakness, dysphagia (difficulty ck of coordination. Review of cal record indicated she was private room with a roommate hin the general population on ting Resident #36 was not				
	assessment dated #36 to be cognitive	imum Data Set (MDS) 4/8/2020 revealed Resident ly intact and received ssistance with mobility and all				
	4/8/2020. The goal and symptoms to be guidelines and facilincluded initiating of precautions.  A phone interview 5/13/2020 at 9:35 Are Resident #36 and a semi-private roor general population	care planned for COVID-19 on all was for Resident #36 's care be managed per CDC lity protocol. Interventions droplet and contact coccurred with Nurse Aide #1 on AM. She was familiar with recalled her being admitted to m with a roommate within the NA #1 could not recall any is taken when rendering				
	4/3/20 with diagnor	vas admitted to the facility on ses that included heart failure. for April 2020 indicated				

NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY   STREET ADDRESS, CITY, STATE, ZIP CODE  710 JULIAN ROAD  SALISBURY, NC 28147   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION			TE SURVEY MPLETED				
NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY   STREET ADDRESS, CITY, STATE, ZIP CODE  710 JULIAN ROAD  SALISBURY, NC 28147   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  710 JULIAN ROAD  SALISBURY, NC 28147  D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			345286	B. WING _			C <b>05/21/2020</b>
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	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
Resident #39 was admitted (4/3/20) from the hospital. Review of Resident #39 "s electronic medical record indicated he was admitted to a private room within the general population on the 600 hall indicated providing the private room within the general population on the 600 hall indicated providing the providing that Resident #39 was not quarantined.  An admission note completed by Nurse #6 dated 4/3/20 indicated Resident #39 was admitted post hospitalization for flu and staff were utilizing masks as a precaution.  The 4/10/20 admission Minimum Data Set (MDS) assessment indicated Resident #39 "s cognition was intact, and she was independent for locomotion on and off the unit.  Resident #39 was care planned for suspected COVID-19 on 4/8/20. The goal was for Resident #39 "s care and symptoms be managed per CDC guidance and the facility protocol. Interventions included initiating droplet and contact precautions, supply resident with face mask and encourage resident to wear if she must leave the room or be transported from the facility, and to restrict resident to his room to the extent possible. These interventions were initiated on 4/8/20. Record review indicated Resident #39 was discharged from the facility and admitted to the hospital on 4/19/20.  A phone interview was conducted on 5/13/20 at 10:59 AM with Nurse #6. Nurse #6 stated that she thought Resident #39 was admitted following hospitalization for the flu and that staff wore masks when providing care. She confirmed that when the resident was admitted, she was placed	F 880	Resident #39 was an hospital. Review of medical record indicaprivate room within the 600 hall indicating the quarantined.  An admission note of 4/3/20 indicated Reshospitalization for flumasks as a precaution.  The 4/10/20 admissi assessment indicate was intact, and she was intact, and	dmitted (4/3/20) from the Resident #39 's electronic ated he was admitted to a he general population on the lat Resident #39 was not completed by Nurse #6 dated sident #39 was admitted post and staff were utilizing on.  On Minimum Data Set (MDS) and Resident #39 's cognition was independent for ff the unit.  Are planned for suspected of the unit.  Are planned for suspected of the unit in the process operation was independent for suspected of the unit in the process operation was independent for suspected of the unit in the process operation was independent for suspected of the unit in the process operation was for Resident in the process operation with face mask and to wear if she must leave the steed from the facility, and to so room to the extent reventions were initiated on ated Resident #39 was facility and admitted to the as conducted on 5/13/20 at the #6. Nurse #6 stated that the #39 was admitted following the flu and that staff woreing care. She confirmed that	F8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 710 JULIAN ROAD SALISBURY, NC 28147	I	03/21/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE
F 880	the facility. She add hall was not designal Nurse #6 was unable #39 was not admitted designated for quara Review of the facility through 3/28/20 indiction of 26 beds (12 doubsingle occupancy roand available during the first resident (Re 100-hall due to respicontinued to be oper 3/29/20 through 4/3/ Record review revea positive facility resident #19). On testing of facility resident #19 on testing of facility residents as of 4/15/20 residents. This list recovidents. This list recovidents. This list recovidents. This list recovidents are considered and interview with the facility is plan with a considered with the facility is plan with the facility is plan with the Admits and the side with the side with the Admits and the side with the side	itionally confirmed that this ted for quarantine purposes. The to explain why Resident do to the section of the facility intine purposes.  The section of the facility intine purposes.	F8	380		
	3/19/20 to 4/3/20 the	sions. She stated that from				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345286	B. WING			05/	21/2020
	ROVIDER OR SUPPLIER  DEL SALISBURY			7	TREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	admitted residents in that considered the reassociated risks for in the new resident as we staff. The Administra was responsible for the room placement. She important to separate general population with current residents from residents were comin increased their possil virus (COVID-19). The explain why the fact no mention of the separate difference in the comment of the separate difference in the COVID-19) also unable to explain policy, revised on 3/1 accordance with 14-ce the in the CDC and comment of the separate difference in the CDC and comment of the separate these reside population of the facility of the separate these resides population of the facility of the separate difference corresponding the separate difference in the corresponding that masks of 4/4/20. She wrote start wearing masks of the separate difference in the	assist in placing newly a location within the facility easons for admission, any infection and the protection of well as other residents and tor reported the former DON mese clinical decisions for the indicated that it was a new admissions from the eithin the facility to protect in new admissions as these ag in from environments that boility of being exposed to the me Administrator was unable contained an environments ossibility corporate policy made contained from environments and the facility corporate sossibility of being exposed to an why the facility corporate 8/20 and 3/28/20, was not in lay quarantine included in the second of the	F	880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345286	B. WING				21/ <b>2020</b>
	ROVIDER OR SUPPLIER			7	TREET ADDRESS, CITY, STATE, ZIP CODE  10 JULIAN ROAD  SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	resident coughing the wear a mask during of 4/7/20, the facility recresident who tested put that was when masks residents and were residents and were residents were out the residents were out Phone interviews were DON 5/6/20 at 5:07 FPM. She was unable On 5/11/20 at 3:57 PI correspondence the Athe former Unit Mana former DON with room admissions/readmiss through 4/3/20.  A phone interview wa #2 (primarily assigned on 5/11/20 at 4:30 PM recommendations to Administrator for room admissions/readmiss the beginning of April had not heeded her of She stated that she be admissions/readmiss quarantined to a privageneral population. Unew admissions/readfor coming into contain while at the hospital at A phone interview war #1 (primarily assigned)	astructed that if they had a bey could ask the resident to care. She stated that on serived notification of the first positive for COVID-19 and a were provided to all equired to be in place when at of their rooms.  The attempted with the former PM and on 5/11/20 at 3:27 at to be reached.  Movia electronic Administrator indicated that agers (UMs) assisted the magnetic placement decisions for ions from March 2020  The sconducted with former UM and to the 500 and 600 halls)  Movia electronic PM and the former DON and the former DON and the placement of new ions in March 2020 through 2020, but the management elinical recommendations.	F	880			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 710 JULIAN ROAD SALISBURY, NC 28147	DE	33/21/2020
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BI HE APPROPRIA	
F 880	COVID-19 pandemic and she had not agreexplained that she be and/or readmissions quarantine as they winto contact with the hospital and/or in the A phone interview winfection Control Precoordinator (ICP/SD She stated that in Meginning of April 20 quarantining any new readmissions related that she had no inpudecisions. She stated Medical Director, and room placement decrevealed that throug April 2020 the facility guidance from the Coplacement of admissions stated that she was adate that PPE begar residents related to the Aphone interview winded Medical Director on stated that he was not decision-making regulation and COVID-19 pandemic their own COVID-19 were following. The his expectation was and CMS guidance in the control of the covidence of th	isions throughout the awere made by management beed with their decisions. She elieved new admissions should have been placed in were at high risk for coming virus (COVID-19) while at the ecommunity.  The seconducted with the eventionist/Staff Development of the facility was not aw admissions and/or and to COVID-19. She reported to the facility was not administrator were making isions. The ICP/SDC thout March 2020 and early awas not following the DC and/or CMS related to sions/readmissions. She unable to recall the exact a to be worn by staff and/or COVID-19.  The seconducted with the seconducted with the solutions and staff and/or COVID-19.  The seconducted with the seconducted with the solutions at 12:58 PM. He	F			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345286	B. WING		C 05/21/2020
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	03/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 880	and CMS guidance On 5/13/20 the follor provided and receive correspondence with - At 2:20 PM the Adi was aware the facilit CMS guidance that indicated that if poss dedicate a unit/wing coming or returning were to remain for 1 prior to being integra population At 3:27 PM the Adi believe that was a re requirement on 3/9"	wing information was ed via electronic in the Administrator: ministrator was asked if she ty was not following CDC and was effective on 3/9/20 which sible, the facility was to exclusively for any residents from the hospital where they 4 days with no symptoms ated into the general ministrator responded, "I do ecommendation and not a . She revealed that she was y was not in compliance with	F 880		
	105 facility residents COVID-19 out of a co 5/13/20.  In a follow up intervithe Administrator co through 4/3/20 the fa COVID-19 related to readmissions was n CDC and CMS guid confirmed that the Co admissions/readmis 3/19/20 through 4/3/ indicated that new a	Administrator revealed that shad tested positive for sensus high of 127 as of sew on 5/21/20 at 11:20 AM, on firmed that from 3/19/20 acility 's corporate policy for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C <b>05/21/2020</b>
	ROVIDER OR SUPPLIER  DEL SALISBURY	ı		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	00/21/2020
(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 COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	of the facility and que confirmed the 100-havailable as a quara from 3/19/20 through additionally confirmed following the CDC at on 4/2/20, for staff to facility and residents their rooms. She we required to wear man were not required to their rooms until 4/7 explain why this CD 4/2/20 related to PP implemented until 4/3. CMS guidance, do Long-Term Care Factors and CDC records to keep patients and actions included, in "Long-term care factors included, in "Long-term care factors and resident available and per Clof PPE.  For the duration of the State, all long-term of wear a facemask where the care of any resident and resident and resident available and per Clof PPE.	arantined for 14 days. She all had open beds and was intine section of the facility h 4/3/20. The Administrator ed that the facility was not and CMS guidance, effective of wear masks while in the set to wear masks when out of wrified that staff were not sks until 4/4/20 and residents wear masks when out of 20. She was unable to C and CMS guidance dated E use was not fully 27/20.  Tated 4/2/20, titled "COVID-19 cility Guidance" indicated mmended immediate actions I residents safe. These	F8	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————			(X3) DATE SURVEY COMPLETED				
		345286	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	healthcare personn care of all residents diagnosis or symptor Patients and reside the facility for care (should wear facema rooms."  The facility corporate Policy/Plan for Facility end for Faci	ission occurs in the facility, el should wear full PPE for the irrespective of COVID-19 oms.  Ints who must regularly leave (e.g., hemodialysis patients) asks when outside of their leave (e.g., hemodialysis patients) asks when outside of their leave (e.g., hemodialysis patients) asks when outside of their leave (e.g., hemodialysis patients) asks when outside of their leave policy titled, "COVID-19 lities", that was in place at the leave (e.g.) CMS guidance related to rentionist] will assist in rect use of PPE by staff, for and the type of isolation estaff has received and guidance in caring for as the potential to infect on Preventionist] will establish llation required including quired posting of the type of	F8	80			
	This 4/4/20 revised COVID-19 also incl	facility corporate policy for uded the addition of the n under the heading, "Use of					

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		345286	B. WING _			C <b>05/21/2020</b>	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	I	03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 880	"All Staff will be requsurgical/isolation mafacility Any resider COVID 19 for a posi Person Under Invest Enhanced Droplet Is Airborne Isolation with Airborne precautions until such time as the isolation is no longer isolation utilizes privapproved roommate or N95 if available, eat all times when in the This 4/4/20 facility conducted the CDC 4/2/20) for all resided diagnosis and/or syrout of their rooms.  A review of the admit 4/4/20 indicated 1 rereadmitted to the fact population hall that we quarantine purposes.  Resident #22 was made admit fact of the admits of th	Equipment and Isolation  lired to wear a sk at all times while in the at placed in isolation for tive COVID result or as a tigation will be kept in colation (also referred to as thout the use of AIIR) or a modified for available PPE exphysician determines such a clinically appropriate This atter oom or cohort with situation with Surgical Mask eye protection, gloves, gown the presence of the resident."  Torporate policy had not and CMS guidance (effective ents, regardless of COVID-19 enptoms, to wear masks when sident, Resident #22, was stillity and placed on general was not designated for	F8	80			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 880	the 200 hall indicating quarantined.  The most recent Miniassessment for Residuated 1/30/20. This was intact and she reassistance with locor was on dialysis.  Dialysis documentatinattended her dialysis  Record review revea positive facility reside (Resident #19). On a testing of facility reside (Resident #19). On a testing of facility reside results returning on a facility listing of residents. This list recovidents. This list recovidents. This list recovidents. This list recovidents. A phone interview was 3:21 PM with the Adrito confirm the facility COVID-19 related to admissions/readmiss of the building that was at risk. She stated the 100-hall. She exito separate these new population within the residents as the new	in) with a roommate of the general population on general population of the general pop	F 88	30			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		COMPLETED	
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	ROVIDER OR SUPPLIER  DEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	I	05/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	readmission of Residesemi-private room we population hall (200 Administrator. She is available rooms on this resident was reasonable to explain policy was not follow placed within the generather than on the de (100 hall) when she stay on 4/4/20.  A phone interview we 9:24 AM with former (primarily assigned thalls). She was astreturned to her previand within the gener (200 hall) after her half 4/4/20 hospital) and Former UM #1 state She indicated that sledecision, but managopinion. She stated dialysis resident and wheelchair throughous that Resident #22 hareadmission (4/4/20) room until after all rewear masks (4/7/20). Per electronic correse Administrator on 5/1 indicated that masks of 4/4/20. She wrote	the virus (COVID-19). The dent #22 on 4/4/20 to a ith a roommate on a general hall) was reviewed with the revealed that there were he 100-hall on 4/4/20 when admitted. The Administrator in why the facility corporate red when Resident #22 was heral population (200 hall) esignated quarantine hall returned from her hospital as conducted on 5/8/20 at Unit Manager (UM) #1 to the 100, 200, and 300 and why Resident #22 to us room with a roommate all population of the facility ospitalization (3/29/20 to was not quarantined. If that she "had no idea why", the had not agreed with this ement had not heeded her all that Resident #22 was a she self-propelled her ut the facility before and after on. She stated she recalled and not worn a mask after her of when she was out of her esidents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the state of the residents were required to the state of the stat	F 88	30			

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		345286	B. WING _			C <b>05/21/2020</b>	
NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147			03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN ( X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIA	DATE	
F 880	4/7/20, the facility red resident who tested p that was when masks residents and were residents and were residents and were residents were outleast the residents were outleast to be reached.  A phone interview was 2 (primarily assigne on 5/11/20 at 4:30 Ph placement decisions pandemic were made had not agreed with that she believed new should have been quaway from the general explained that these admissions/readmissions/readmissions/readmissicoming into contact while at the hospital at 4 phone interview with 412 on 5/13/20 at 12 422 was admitted to (200 hall) with a roon quarantined when show that a mask when she was her 4/4/20 readmission masks for all resident Resident #22 was about the resident #22 was about th	time. She stated that on beived notification of the first positive for COVID-19 and is were provided to all equired to be in place when but of their rooms.  The attempted with the former DON) on 5/6/20 at 5:07 PM in the former DON. She was unable to the sound of th	F	380			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY			STREET ADDRESS, CITY, STATE, ZIP OF THE STATE, Z		9.22020		
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F 880	Infection Control Precoordinator (ICP/SD) She reported that she placement decisions stated that the forme Administrator were madecisions. The ICP/Sunable to recall the eother PPE began to be residents related to Constated that he was not decision-making reganew admissions and COVID-19 pandemic their own COVID-19 were following. The his expectation was fand CMS guidance readmissions and read indicated he expected and CMS guidance residents.	as conducted with the ventionist/Staff Development C) on 5/13/20 at 12:10 PM. The had no input in room during the pandemic. She of DON, Medical Director, and haking room placement CDC stated that she was exact date that masks and the worn by staff and/or COVID-19.  The seconducted with the continuous for readmissions during the continuous for readmissions during the corporate plan that they medical Director indicated for the facility to follow CDC degarding placement of new missions. He additionally do the facility to follow CDC delated to the use of PPE.	F 8	380			
	explain why the facili 4/4/20 related to CO\ "isolation" rather than - At 4:04 PM the Adm language used in the	ty ' s corporate policy dated VID-19 used the term n "quarantine". ninistrator responded, "The					

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	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE	1 03/	21/2020
THE CITADEL SALISBURY				SALISB	URY, NC 28147		
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F 880	Continued From page	e 98	F 8	80			
	105 facility residents COVID-19 out of a ce 5/13/20.	Administrator revealed that had tested positive for ensus high of 127 as of					
	the Administrator verifacility corporate policifor new admissions/rea designated section quarantined for 14 da 4/4/20 facility corpora when Resident #22 w	w on 5/21/20 at 11:20 AM, fied that as of 4/4/20 the cy related to COVID-19 was eadmissions to be placed in of the facility and cys. She confirmed that this te policy was not followed was readmitted to the facility on hall (200 hall) rather than					
	on the designated quiconfirmed the 100-ha of Resident #22 's re was unable to explair policy was not followed additionally confirmed following the CDC and confirmed the confirmed following the CDC and confirmed the confirmed following the confirmed the confirmed following the confirmed the confi	arantine hall (100 hall). She Il had open beds at the time admission on 4/4/20. She why this facility corporate ed. The Administrator If that the facility was not d CMS guidance, effective					
	facility and residents their rooms. She veri required to wear mas were not required to witheir rooms until 4/7/2 explain why this CDC	wear masks while in the to wear masks when out of ified that staff were not ks until 4/4/20 and residents wear masks when out of 20. She was unable to and CMS guidance dated ks/PPE use was not fully 1/20.					
		n-compliance:  nts who have suffered, or serious adverse outcome as					

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NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY		STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		05/21/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	adhere with correct a control processes as Disease Control (CD and Medicaid (CMS) "QSO-20-14-NH indidedicate a unit/wing coming or returning deficient practice ocadmitted or readmitted and/or not quarantin required to stay in a residents in the facilia admitted and readmited and readmited and required to mask if a their room from 3/11 CDC guidance and for the same deficient poor to defic	risk from the failure to and adequate infection a guided by the Centers for C) and Centers for Medicare. CMS guidance from the cated that "if possible, exclusively for any residents from the hospital". The curred when residents were ed and were not separated ed to a specific unit and/or private room from other ty for 14 days in addition the tted residents were not addition the tted residents were out of 1/2020 to 4/4/2020 per the acility protocol.  Ility will identify other potential to be affected by ractice:  Ity received information that sted positive for COVID-19 in arse reported being contacted and advised she had tested unit was established on ine of residents who were admitted or readmitted and that was admitted prior to noved out of their room on so by the physician. In the collisty wide testing, room redinated in collaboration with or of Clinical Services and cure roommates who are ear and roommates which are	F 8	80		

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F 880	Continued From pag	ge 100	F8	80		
	systemic changes medicient practice will as on 4/7/2020 each would be placed in the quarantine of 14 days a "hot bed" meaning COVID-19. At that the made to either return facility, back to their the designated hall. consultation with the Disease physician and Department.  On 4/7/2020 the fact Clinical Consultant and Nursing re-educated consisted of clinical activities, social word dietary, therapy, department and the providers were to we will be something the system.	n admission or readmission the appropriate location for ys unless the facility becomes into area is free from time a decision would be to the resident, if they left the room or quarantine them on This decision would be in the Medical Director, Infectious to the hospital and the Health  Ility Administrator, Regional and the Assistant Director of to current employees that staff, housekeeping, the business office staff, to cartment managers and to entered into the facility the sto the corporate COVID-19 to luded: all healthcare the ear masks while in the facility, the wearing a mask when out				
	quarantine/isolate and admissions/readmis As of 4/7/2020 all not limited the factorial and limit	ny new				
		ole positives in the facility, the hysicians, Emergency				

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NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY				STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	ı	05/21/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	facility Administrator would continue to te nearly daily to determine the seed on all availabe this group, a facility in in "mitigation" phased in cases of full considered exposed investigation. In that be permitted to return former roommates with the above described on the seed of	partment, Medical Director, and Director of Nursing le-conference each day or mine the best course of action le information. According to that has many positive cases ase, rather than "containment" outbreak, all residents may be or to be persons under t event, readmissions would in to their own rooms with who had been fully exposed. The made by the Administrator stration in collaboration with a group of consultants.  Forence call was held with the Health and progressed to a cous Disease physicians, the cotor, Administrator and hat were scheduled for anys and Fridays which are  made to manage the level of the season of the se	F8	80		

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NAME OF PROVIDER OR SUPPLIER  THE CITADEL SALISBURY				STREET ADDRESS, CITY, STATE, ZIP COL 710 JULIAN ROAD SALISBURY, NC 28147	DE	03/21/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	or days since respir These criteria would an individual reside decisions when the recovered to begin a Beginning 4/7/2020 update, review and with Quality Assural (QAPI) committee in Nursing and Administrator and/o continue to maintain symptom log and upindicated, which be staff would continue signs of respiratory monitoring tempera. The facility alleged of correction effective As part of the on-sit 5/21/2020, the plan which included date in-services that wer resident log of symptoms of the continued of the cont	r days without fever and hours atory symptoms had resolved. If the used to determine when the was recovered and inform facility would be fully considering new admissions.  If the facility will continue to revise processes minimally not and Process Improvement monthly. The Director of strator would monitor sure appropriate room I starting on 4/7/20. The reprocess Director of Nursing would an and review the resident odate as symptoms were gan on 3/29/2020. Nursing to monitor residents daily for symptoms, to include ture for elevation.	F	380			
	Project, titled "COV date of 4/7/2020 du residents in the hos COVID 19. The foll	d a Performance Improvement ID 19 Outbreak" with initiation e to 1 agency nurse and 2 pital testing positive for owing were implemented tive COVID 19 test results:					

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F 880	completed on 4/10/2 2) Notify the Departr completed on 4/7/20 3) Obtain hospital re there. This was con 4/10/2020. 4) Open 100 hall, what 4/8/2020.  Multiple staff were in had received educate the importance of quantities of the importance of quantities when on the observations reveal PPE and residents when out of their roce.	or COVID-19. This was 2020 ment of Health. This was 2020. Sults on residents currently apleted on 4/7/20 thru which was completed on 4/7/20 thru which was c	F	380		