AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WING		12	12/11/2020	
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITADEL AT MYERS PARK, LLC				00 PROVIDENCE ROAD HARLOTTE, NC 28207		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
E 000	Initial Comments		E 000			
F 000	Control Survey was c with exit from the faci interviews and record 12/11/2020. Therefor changed to 12/10/20. compliance with 42 C	The facility was found in FR §483.73 related to rt-B-Requirements for Long Event ID# C9YT11.	F 000			
F 000	Focused Infection Co on 12/10/2020 with ex 12/10/20. Additional were conducted on 12 exit date was change was not in compliance infection control regul implemented the CMS Control and Prevention practices to prepare for C9YT11.	interviews and record review 2/11/2020. Therefore, the d to 12/11/20. The facility e with 42 CFR §483.80 lations and has not S and Centers for Disease on (CDC) recommended for COVID-19. Event ID#				4/45/04
F 880 SS=D	§483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and tran diseases and infection §483.80(a) Infection p program.	(2)(4)(e)(f) ntrol blish and maintain an ind control program i safe, sanitary and ient and to help prevent the ismission of communicable	F 880			1/15/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERUS UPPLIER(LIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SUR COMPLETE NAME OF PROVIDER OR SUPPLIER 345008 B. WING 12/11/2 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 300 PROVIDENCE ROAD CHARLOTTE, NC 28207 12/11/2 Val ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) IP PROVIDENCE ROAD CHARLOTTE, ACTOR SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CO F 880 Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: F 880 F 880 F 880 Ş483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to \$483.70(e) and following accepted national standards; \$483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (1) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other IIII 12/11/2		RTMENT OF HEALTH AN ERS FOR MEDICARE &						FORM): 01/08/2021 APPROVED). 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE THE CITADEL AT MYERS PARK, LLC Image: transmission of the provide stress of the program, which must include, but are not limited to: Image: transmission of the provide stress of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, which must include, but are not limited to: Image: transmission of the program, the program	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA	R/CLIA (X2) MUL					(X3) DATE SURVEY COMPLETED	
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THE CITADEL AT MYERS PARK, LLC CHARLOTTE, NC 28207 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED To THE APPROPRIATE DEFICIENCY) 00 F 880 Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: F 880 Ş483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	NAME OF PR	F PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
CHARLOTTE, NC 23207 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTW ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 880 Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: F 880 F 880 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; S483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other I					3	800 PROVIDENCE ROAD				
PREFIX TAG (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO F 880 Continued From page 1 and control program (IPCP) that must include, at a minimum, the following elements: F 880 F 880 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: Image: Section of Sec		HADEL AT WITERS PARK, L	EC		c	CHARLOTTE, NC 2820	7			
and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	PREFIX	X (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880	and control program (a minimum, the follow §483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services un arrangement based u conducted according accepted national sta §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility (ii) When and to whor communicable diseas reported; (iii) Standard and trar to be followed to prev (iv)When and how isco resident; including bu (A) The type and dura depending upon the in involved, and (B) A requirement that least restrictive possil circumstances. (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the	(IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; estandards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other from possible incidents of se or infections should be asmission-based precautions ent spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the oble for the resident under the s under which the facility ees with a communicable kin lesions from direct o or their food, if direct the disease; and	F	880					

Facility ID: 953418

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OLIVIEN	S FOR MEDICARE &	MEDICAID SERVICES			OMB	NO. 0938-039		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345008		(X2) MULTIF A. BUILDING		(X3) DATE SURVEY COMPLETED				
		B. WING			12/11/2020			
NAME OF PROVIDER OR SUPPLIER			•	STREET ADDRESS, CITY, STATE, ZIP CO	DE			
THE CITADEL AT MYERS PARK, LLC				300 PROVIDENCE ROAD CHARLOTTE, NC 28207				
(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 TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 880	Continued From page	e 2	F 88	30				
	by staff involved in direct resident contact.							
	§483.80(a)(4) A syste identified under the fa corrective actions tak							
		lle, store, process, and s to prevent the spread of						
	IPCP and update the This REQUIREMENT	view. ιct an annual review of its ir program, as necessary. Γ is not met as evidenced						
		on, staff interviews and		Nurse #3 did not sanitize he				
	hygiene prior to donn	cility failed to perform hand ing of gloves to obtain a jar value from a resident who		to putting on gloves when ob blood glucose finger stick. N effects were incurred by resi	o adverse			
	required enhanced di	roplet precautions for 1 of 3 ho required finger stick blood		result of Nurse #3 s practic is a contracted nurse through	e. Nurse #3			
	sugar measurements occurred during the C	6 (Resident #2). This failure COVID 19 pandemic.		HealthCare Staffing. Nurse # serviced on hand sanitizing p	prior to			
	The findings included	ł:		donning gloves by the facility Nursing Services or designe start of her next assigned sh	e before the			
	protective equipment Centers for Disease	re for use of personal (PPE) provided by the Control and Prevention 020 directed performance of		service will also include Nurs explaining and demonstrating procedure back to the educa	se #3 g the			
	hand hygiene before			All residents have the potent affected by this deficient Pra				
	06/2018 directed was	eter process guideline dated shing of hands and donning aining a finger stick blood		To help ensure the deficient not reoccur, all current staff, and contract staff will be ree	practice does new hires ducated on			
	Resident #2 was read	dmitted to the facility on		sanitizing hands, hand wash hand sanitizer, when donning				

Facility ID: 953418

If continuation sheet Page 3 of 5

	CENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345008		(X2) MULTIPI A. BUILDING	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
			B. WING	12/11/2020		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITADEL AT MYERS PARK, LLC				300 PROVIDENCE ROAD CHARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETI	
F 880	 11/28/2020 on enhan Admission orders incl finger stick blood sug and at bedtime. Observation at 11:25 an Enhanced Droplet Resident #2's closed enhanced droplet pre N95 mask or surgical perform hand hygiene gloves when entering Observation at 11:30 Nurse #3 entered doo electronic Medication top of the medication approximately 9 feet f #2's room. On top of bottle of hand sanitize mask and face shield disposable gown and did not sanitize her has gloves. Continued observatio entered the room and stick blood sample fro Nurse #3 removed ar gloves. Nurse #3 sar glove disposal. Interview with Nurse a 12/10/2020 revealed hand sanitizer before Nurse #3 reported sh 	ced droplet precautions. luded direction to obtain ar measurements at meals AM on 12/10/2020 revealed Precaution sign posted on room door. Steps for cautions included use of a mask, eye protection, e and wear gowns and the room. AM on 12/10/2020 revealed cumentation on the Administration Record on cart. Nurse #3 walked to the outside of Resident a 3-drawer chest was a er. Nurse #3 wore a N95 . Nurse #3 put on a donned gloves. Nurse #3 ands prior to putting on the In revealed Nurse #3 took Resident #2's finger om his right index finger. ad discarded the gown and hitized her hands after the #3 at 11:50 AM on she should have used the putting on the gloves. e usually sanitizes her on gloves and after taking	F 88	 gloves by the Director of Nursing S or designee by 01/15/2021. Compe will be determined by a return demonstration or staff being able to explain the procedure back to the I of Nursing Services or designee. S who are not present will be educate to the beginning of their next shift. Beginning on 01/15/2021, audits w conducted 3 times weekly for 4 we staff sanitizing hands, hand washir using hand sanitizer, when donning doffing gloves by the Director of Nu or designee. Thereafter, audits will conducted twice weekly for four we and then weekly for four weeks Results will be reviewed by the administrator weekly and shared w facility Quality Assurance Committee monthly. Date of Completion will be January 2021. 	etency Director Staff ed prior ill be eks on ng or g or ursing be eeks,	

If continuation sheet Page 4 of 5

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/08/2021 M APPROVED D. 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345008	B. WING			12	/11/2020		
NAME OF PROVIDER OR SUPPLIER			•		STREET ADDRESS, CITY, STATE, ZIP CODE				
THE CITADEL AT MYERS PARK, LLC			300 PROVIDENCE ROAD CHARLOTTE, NC 28207						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 880	12/10/2020 revealed hands or use hand sa gloves. Gloves were blood sugar testing an required enhanced dr An interview was con Nurse Consultant at 1 Regional Nurse Cons wash hands or use ha gloves. Telephone interview v (DON) at 11:04 AM of Resident #2 required precautions since he the hospital. As the fi Preventionist, the DO staff for correct hand	t Manager at 1:40 PM on staff should either wash initizer before donning required for performance of nd care of a resident who oplet precautions. ducted with the Regional 1:48 AM on 12/10/2020. The ultant reported staff should and sanitizer prior to donning with the Director of Nursing in 12/11/2020 revealed enhanced droplet was newly admitted from	F	880					

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