STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/15/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 04/12/21 through 04/15/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness Event ID #8F5R11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint survey was conducted from 04/12/21 through 04/15/21. There were 26 allegations investigated and 8 allegations were substantiated. See Event ID #8F5R11.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		5/14/21

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

Electronically Signed | 05/09/2021

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F 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to promote a dignified dining experience by standing over 1 of 2 residents reviewed for dining (Resident #21). The finding included: Resident #21 was admitted to the facility on 09/09/20 with diagnoses that included Alzheimer's disease. The quarterly Minimum Data Set (MDS) assessment dated 01/18/21 indicated Resident #21's cognitive skills for daily decision making was severely impaired and required extensive assistance with eating. On 04/14/21 from 8:37 AM to 8:50 AM a continuous observation was made of Restorative Nurse Aide (RNA) #1 standing over Resident #21	F 550	All residents will be treated with dignity, respect and care in a manner and in an environment that promotes quality of life and recognizing individuality. 1. For Resident #21 a chair was placed in room for staff to provide care and assist while providing dignity, respect and provide eye to eye contact. 2. For all other residents having the potential to be affected the D.O.N. and/or Designee will assess all residents that require a chair for meal assistance. Chairs provided in chairs where assistance is needed. *In situations where a chair mat not be in a Resident's room, nursing staff educated to obtain a dining chair to accommodate the resident/staff eye to eye contact. 3. To ensure the deficient practice does not reoccur the D.O.N. and/or Designee	

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F 550	Continued From page 2 at the bedside while assisting the Resident with her breakfast. Observation of the Resident's room revealed there was no chair available for the RNA to sit and assist the Resident with her meal. An interview was conducted with RNA #1 on 04/14/21 at 9:05 AM. The RNA explained Resident #21 had always required assistance with eating but she (RNA) hardly ever sat down while she fed the residents. The RNA continued to explain that she understood it was important to promote dignity for Resident #21 while feeding her by sitting at her eye level and to not hurry her during the meal, but the RNA stated there was not a chair in Resident #21's room to sit on while she fed her. The RNA ended the interview with stating she could have gotten a chair from the dining room to use while she fed Resident #21 her breakfast. During an interview with the Assistant Director of Nursing (ADON) on 04/14/21 at 9:27 AM she explained that the staff was educated to sit at the residents' eye level to promote a pleasant dining experience. The ADON continued to explain that a chair could be left in Resident #21's room to be utilized while feeding the Resident. An interview was conducted with the Administrator on 04/14/21 at 1:58 PM. The Administrator explained the staff was educated to sit at eye level of the residents while they assisted them with their meals to promote a pleasant dining experience. The Administrator stated the RNA should have obtained a chair from the dining room before she fed Resident #21.	F 550	will provide education to all nursing staff on the policy/procedure and understanding of sitting, providing eye to eye contact with dignity and respect during meals. Nursing staff will be required to receive education prior to first scheduled work day. 4. D.O.N. and/or Designee will audit random meal services to ensure compliance 2 x week for 4 weeks, 1 x week for 4 weeks, 2 x month for 2 months, then monthly until compliance is achieved. Any negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance: 05-14-21	
F 558 SS=D	Reasonable Accommodations Needs/Preferences	F 558		5/14/21

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F 558	Continued From page 3 CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and Resident interviews the facility failed to place Resident #75's call light within reach to allow the Resident to request staff assistance when needed for 1 of 1 resident reviewed for accommodation of needs. The finding included: Resident #75 was admitted to the facility on 10/25/17 with diagnoses which included macular degeneration, blindness in one eye and low vision in the other. The quarterly Minimum Data Set (MDS) assessment dated 03/31/21 revealed, Resident #75 had clear speech and could make herself understood as well as could understand others. The MDS indicated the Resident's vision was severely impaired (no vision or see only light, colors or shapes; eyes do not appear to follow objects). Resident #75's cognition was moderately intact and required extensive assistance for bed mobility. Resident #75's updated care plan dated 08/27/20 revealed she was at risk for falls related to vision problems. The goal was for Resident #75 to not have any falls before the next review date by	F 558	Citadel Mooresville will provide reasonable accommodations to all resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. 1. For Resident #75 the call light was placed within reach and able to demonstrate use of call lights. 2. For Residents having the potential to be affected the D.O.N. and/or Designee assessed all Resident call lights to ensure call lights were within reach. 3. The SDC and/or Designee will provide 100% education to all staff on the importance of call lights being within reach by date of compliance. All staff will be required to complete education. New staff/Agency will be oriented to call light responsibilities during orientation. 4. The D.O.N. and/or Designee will audit and ensure call lights are within reach 2 x week x 4 weeks, 1 x week x 4 weeks, 2 x month x 2 months, then monthly until compliance achieved. Any negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance: 05-14-21.	

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F 558	Continued From page 4	F 558		

utilizing interventions that included: "Be sure the resident's call light is within reach and encourage her to use it for assistance as needed. The resident needs prompt response to all request for assistance."

On 04/15/21 at 8:49 AM an observation of Resident #75 was made of her lying on her back in her bed sleeping. Resident #75's call light was in the top drawer of a 3-tiered organizer which was positioned at the top of the right side of her bed against the wall. The Resident had the bed remote in her left hand.

On 04/15/21 at 9:50 AM an observation was made of Resident #75 sleeping and lying in the same position as described above.

On 04/15/21 at 10:18 AM an observation was made of Nurse Aide (NA) #3 leaving Resident #75's room. Resident #75 remained in the same position as described above and her call light remained in the top drawer of the organizer.

An interview was conducted with Nurse Aide #3 on 04/15/21 at 10:21 AM. The NA explained Resident #75 was alert and could voice her wants and needs. She continued to explain that the Resident could ring her call light if she needed assistance. During the interview with NA #3 an observation was made of Resident #75 lying in bed sleeping with the call light in the top drawer of the organizer. The NA stated she did not put the call light in the top drawer of the organizer and acknowledged the Resident could not reach the call light if she needed assistance. The NA explained she had been in the Resident's room a couple of times already that morning and should have made sure the call light was in her reach.

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F 558	Continued From page 5 The NA repositioned Resident #75 and put her call light in the Resident's right hand. An interview was conducted with Nurse #5 on 04/15/21 at 10:39 AM. The Nurse explained she had been in Resident #75's room twice that morning and did not notice that the Resident's call light was in the top drawer of the organizer and not in her reach. The Nurse explained that the last observation made by the staff when they leave any resident's room should be that the call light was in the resident's reach. During an interview with the Director of Nursing (DON) on 04/15/21 at 2:55 PM she stated she expected the staff to the resident's call light was in their reach before they left the resident's room. An interview was conducted with the Administrator on 04/15/21 at 4:18 PM. The Administrator explained the staff was educated to make sure the resident's call light was in their reach before they left the room. An interview and observation were made of Resident #75 on 04/15/21 at 5:26 PM who was sitting in her wheelchair beside her bed with her call light in her right hand. When asked if she could ring her call light the Resident stated she could if she needed to and demonstrated she could ring the call light.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		5/14/21

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F 578	Continued From page 6 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to maintain accurate advanced	F 578	Citadel Mooresville's Residents have the right to request, refuse, discontinue	

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F 578	Continued From page 7 directives throughout the medical record for 1 of 15 residents (Resident #14) reviewed for advanced directives. The finding included: Resident #14 was admitted to the facility on 07/03/20 with diagnoses which included paraplegia. A review of Resident #14's hard chart revealed a physician's telephone order dated 07/03/20 that indicated Resident #14 was a Full Code (cardiopulmonary resuscitation (CPR) to be initiated if his heart stopped beating). Further review of Resident #14's electronic health record (EHR) revealed there were no indications of an Advanced Directive on the Resident's profile page or in the physician orders. A review of the quarterly Minimum Data Set (MDS) assessment dated 01/12/21 revealed Resident #14 was cognitively intact. On 04/14/21 at 5:10 PM an interview was conducted with Social Worker (SW) #1. The SW reviewed and acknowledged that Resident #14's hard chart and EHR did not match and explained she had only been employed since February of this year and had identified that the Advanced Directive system was broken. The SW stated she had other stuff in the works and had not been able to give the system her full attention. On 04/15/21 at 9:15 AM an interview was conducted with the Assistant Director of Nursing (ADON). The ADON explained that every attempt should be made to obtain the Resident's desired	F 578	treatment and formulate Advanced Directives. 1. For Resident #14 immediate action took place by Social Services reviewing MOST with Resident and her wishes. The MOST, orders and care plan matched. 2. For Residents having the potential to be affected Social Services completed an Advanced Directive audit on all Residents. To ensured all MOST, orders and care plans matched. Although orders are in electronic record Social Services implemented a MOST binder at each nursing station with all Resident's MOST. This will provide easy access to staff in an emergency response. 3. Social Services and/or Designee will educate staff on the Advanced Directives policy/procedure for obtaining orders upon admission, implementation of MOST form, orders in electronic record,in care plan and process when Resident requests changes by date of compliance. All staff will be required to receive education prior to first scheduled work day. 4. Social Services to complete an Advanced Directive audit on all Residents to ensure all MOST forms, orders, and care plans match. Social Services will review orders, MOST forma, and care plans during 72 hour meeting & quarterly. Advanced Directives will be reviewed with Resident/Family to allow Resident/Family to express feelings, ask questions, and/or make changes. MOST forms will be reviewed and signed annually to ensure Resident's wishes are met. Advanced Directive audits will be on ongoing process to ensure compliance	

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F 578	Continued From page 8 Advance Directive on admission or as soon as possible afterwards. The ADON stated it was very important that both the hard chart and the electronic health record matched so that there was no confusion as to what the correct procedure should be if it became necessary to act on Resident #14's Advance Directive. During an interview with the Administrator on 04/15/21 at 4:23 PM she explained she was made aware of the situation of the Advanced Directives on 04/14/21. The Administrator indicated her expectation was for the residents' Advanced Directive be in place on or shortly after admission and that both the hard chart and the EHR match.	F 578	and a monthly audits for compliance. Any negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance: 05-14-21.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in	F 580		5/14/21

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F 580	Continued From page 9 §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to inform a cognitively intact resident of a new medication order added to her medication regimen for 1 of 1 resident sampled for notification of change (Resident #280). Findings included:	F 580	Citadel Mooresville will notify Resident/Family of any changes in condition, medications, new orders, injury, declines, room changes, etc. 1. Resident #280 known to be affected by not being informed of a new medication Lisinopril prescribed on 12-26-29 at 2:36 a.m. On 12-29-20 Lisinopril was discontinued by MD, per Resident refusal.	

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F 580	Continued From page 10 Resident #280 was admitted to the facility on 12/15/20 with diagnoses that included aftercare following a joint replacement surgery and did not include a diagnosis of hypertension. A Minimum Data Set (MDS) dated 12/22/20 revealed Resident #280 was cognitively intact. A physician's order dated 12/26/20 at 2: 36 AM written by the Nurse Practitioner revealed she was started on Lisinopril 20mg orally daily. The order was confirmed in the electronic medical record (EMR) on 12/26/20 and discontinued due to Resident #280's refusal on 12/29/20. An interview on 4/11/21 at 3:00 PM with Resident #280 revealed she had not felt well on the night of 12/28/20 which prompted Resident #280 to question Nurse #1 what medications she was being administered during the morning medication pass. Resident #280 stated Nurse #1 told her that she had been started on Lisinopril 20mg on 12/26/20 and had received the medication daily since then. Resident #280 indicated she immediately refused the Lisinopril, questioned why she was started on the medication, and why she had not been informed of the changes. Resident #280 explained Nurse #1 identified the Nurse Practitioner as ordering the medication for elevations in Resident #280's blood pressures. An interview on 4/15/21 at 11:00 AM with the Nurse Practitioner (NP) revealed she vaguely recalled prescribing Resident #280 Lisinopril after reviewing her chart late one night in December 2020, but she could not recall the exact date of the reviews. The NP stated she thought she remembered visiting with Resident #280 several	F 580	2. Resident/Family are to be informed with any changes in condition, treatment, new orders written by MD and/or NP, etc. For all Residents that may be affected by this deficient practice all new orders within the past 30 days will be audited to ensure Resident/Family have been notified of any new orders. 3. The D.O.N. and/or Designee will provide education to all nurses on the policy/procedure for Resident/Family notification of any changes in condition, medications, new orders, injury, declines, room changes, etc. This notification is to be documented in the electronic record. All nurses will be required to receive education prior to first scheduled work day. 4. The D.O.N. and/or Designee will audit 24 hour reports/orders 5 x week to ensure Resident/Family have been notified of changes. A negative trend will be reviewed in monthly QAPI meeting. 5. Date of compliance: 05-14-21.	

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F 580	Continued From page 11	F 580		

times the week preceding the new orders but did not recall discussing any elevations in her blood pressure. The NP stated she vaguely recalled seeing some elevations of blood pressure late on evening when reviewing Resident #280's electronic medical record, but was unsure why she had not documented a plan to initiate the new orders for Lisinopril or a new diagnosis of hypertension in the physician progress notes on that evening or any physician progress notes following that date before Resident #280 was discharged from the facility the following week. The NP acknowledged she had written the order in the electronic medical record independent of a facility nurse and had not notified the facility directly of the new diagnosis or the new orders for Lisinopril nor included them in her physician progress notes written following.

An interview on 4/15/21 at 2:51 PM with Nurse #1 recalled working with Resident #280 in December 2020. She did not recall being notified by the NP on the night the Lisinopril was ordered or that Resident #280 was being newly diagnosed with hypertension (elevated blood pressure) and therefore did not speak with Resident #280 on 12/26/20 regarding the changes to her medical regimen. Nurse #1 stated that when she "confirmed" the order early on the morning of 12/26/20 that was simply meant to authorize pharmacy to send the medications on the next delivery and since she was not notified by the NP of the medication being a new order she treated it the same as the medication being authorized as a refill. Nurse #1; however, did recall being the nurse on duty on the morning of 12/29/20 when Resident #280 complained of not feeling well and asked what medications she was being given. Nurse #1 stated when she told Resident #280

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F 580	Continued From page 12 one of the medications was Lisinopril, Resident #280 refused the medication. Nurse #1 explained Resident #280 told her that she had never had high blood pressure and wanted to know why she had not been notified by anyone before she was given the first pill An interview on 4/15/21 at 3:30 PM with the facility Administrator revealed she expected all nurses to notify residents of changes in their medical status when made aware by the NP; however, she had been made aware of the events related to Resident #280 not being made aware of a new diagnosis of hypertension and new orders for Lisinopril when Resident #280 refused her medications on 12/29/20 and questioned who had ordered the medications and why she was not notified. The Administrator indicated the NP was no longer employed with the facility.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.	F 584		5/14/21

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F 584	Continued From page 13 (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to clean sticky bedroom flooring in a residents' room for 1 of 19 rooms. The facility failed to repair walls with exposed metal dented L shaped corner brackets and chipped drywall for 3 of 19 rooms. The facility failed to repair peeling and cracked laminate on nightstands for 2 of 19 rooms. The facility failed to remove a broken toilet seat riser with visible sharp metal railing and 4 plastic pointed brackets that had been bolted to the commode seat for 1 of 19 rooms (Rooms 117, 118, 119, 307, 318). These observations occurred on 2 of 4 halls.	F 584	Citadel Mooresville will provide a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 1. For those Residents affected by deficient practice: *Room #117 was cleaned and disinfected to eliminate sticky floor issue. *Room #117 scuffs and damaged area to walls, including large dent and black streaks along walls cleaned and repaired. *Room #307 scuffed walls, dents and	

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F 584	Continued From page 14 Findings included: 1. An observation on 04/12/21 at 9:55 AM revealed the floor of an occupied room (Room #117) to be sticky causing the surveyors shoes to stick to the surface when the room was entered. The stickiness caused a creaking noise as the surveyor lifted her shoe to take the next step. An observation on 04/14/21 at 9:34 AM revealed the family visiting in Room #117. The floor in this room remained sticky when entered as observed on 04/12/21. 2. a. An observation on 04/12/21 at 10:44 AM revealed scuffs and damaged areas to the walls to include large dents and black streaking along the walls in Room #117. The room was occupied by a resident at the time of the observation. b. An observation on 04/12/21 at 4:38 PM revealed walls were scuffed and damaged areas to the walls to include large dents and black streaking along the walls in Room #307. The room was occupied by a resident at the time of the observation. c. An observation on 04/15/21 at 9:30 AM in room #118 revealed multiple color paints applied to large patches in the room and a large approximately 6 inch area of the wall with the dented L shaped metal brackets exposed beneath the drywall to the left side of the bed. The room was occupied by a new admission. 3. a. An observation on 04/14/21 at 1:55 PM in Room #119 revealed a night stand sitting to the door side of the bed with a large area of the top	F 584	black streaking along walls cleaned and repaired. *Room #118 with multiple color paints applied in large patches in room, dented L shaped metal bracket exposed beneath dry wall repaired. *Room #119 nightstand with peeled laminate, cracked & curled and drawer not closing replaced. *Room #118 with nightstand brown laminate peeling with green sticky raised pad replaced. *Room #318 with broken toilet seat riser with four metal post facing in an upward fashion with plastic pointed prongs on each side which had been bolted to the underside of the toilet seat - removed. 2. For all other Resident rooms that may be affected the Administrator, Maintenance Director and EVS Manager will check all Resident rooms for any repairs needed and any additional cleaning required. From this list of necessary repairs and/or cleaning, it will be prioritized based on safety & needs and completed by date of compliance. 3. Administrator will provide education to EVS staff and Maintenance staff on policy/procedure of ensuring a safe, clean, comfortable and homelike environment by date of compliance. EVS staff will report to EVS Manager as soon as areas that need repair are noted. EVS Manager to submit repair in TELS work order system. The Maintenance Director to review TELS daily for repairs. Based on priority and need TELS work order will be completed. 4. Administrator, Maintenance Director	

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F 584	Continued From page 15 drawer with laminate peeled, cracked, and curled up and the top drawer was not properly positioned on the drawer runner trough which prevented the drawer from shutting properly. b. An observation on 04/15/21 at 9:30 AM revealed a new admission had been placed in Room #118 and repairs had not been made to the nightstand prior to entry. The following was observed: a night stand sitting on the window side of the bed with approximately a 6 inch long x 1-2 inch wide area where the brown laminate was peeled off the middle drawer, the bottom drawer showed laminate peeled off on the right side and there was a green sticky raised pad type object which was partially attached and partially peeled off on the top drawer of the nightstand. 4. An observation on 04/14/21 at 9:40 AM of Room #318 revealed a broken toilet seat riser with four metal post facing in an upward fashion with plastic pointed prongs on each end which had been bolted to the underside of the toilet seat. An observation on 04/14/21 at 10:00 AM and 12:00 PM of Room #318 revealed the broken toilet seat riser remained attached during walking rounds with both the Maintenance Director and the Director of Nursing. An interview on 04/14/21 at 10:15 AM with Housekeeper #1 revealed he was a floor technician/housekeeper in the facility. Housekeeper #1 stated he had been assigned to clean the 100 hall New Admission Quarantine Unit due to a callouts on 04/14/21. Housekeeper #1 indicated he was required to clean all rooms and floors on the 100 hall and ensure all vacant	F 584	and EVS Manager will complete a weekly audit of Resident rooms to note any areas that need to be addressed. The Administrator will report negative trends in the monthly QAPI meeting. 5. Date of compliance 05-14-21.	

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rooms were cleaned and ready for a potential new admission. The room cleaning included sweeping, mopping, dusting, wiping overbed tables and nightstands, cleaning bathroom sinks and toilets daily. In vacant rooms, television and bedroom furniture were clean and dusted, and ensure bathrooms were cleaned and ready for a new admission to reside. He explained he was not sure why Room #117's floor would have been sticky on 4/12/21 and 4/13/21 but stated it should not be sticky after it has been mopped each day.

An interview on 04/14/21 at 11:04 AM with EVS Supervisor revealed she supervised housekeepers and floor technician staff in the facility. The EVS Supervisor indicated floor technicians were typically not scheduled to work as a housekeeper on a unit; however, Housekeeper #1 was assigned to clean the 100 hall Quarantine unit on 04/14/21. She explained all rooms were to be cleaned daily, high dusting should be completed on Monday, Wednesday, and Fridays, as well as spot checks in vacant rooms to ensure cleanliness was maintained in all resident rooms and ready for current and future residents. The EVS Supervisor acknowledged it everyone's responsibility to report maintenance concerns and housekeeping concerns to the appropriate department; however, she expected each unit housekeeper to observe for damaged walls, ceilings, bathroom fixtures, bedroom furniture and report any call lights malfunctions.

An interview on 4/15/21 at 9:16 PM with Housekeeper #2 revealed she was the routine housekeeper on the 100 hall. Housekeeper #1 indicated she had performed a terminal cleaning to all vacant rooms of the unit to ensure each were ready for a new admission. Housekeeper #2

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explained she noticed the peeling of the laminate from the bedroom furniture had not been reported to maintenance for repairs. Housekeeper #2 acknowledged it was the housekeeper's job duty to notify maintenance of all concerns found in resident rooms during routine and terminal room cleaning.

A walking interview on 04/15/21 at 10:00 AM with the Maintenance Director revealed he had a general idea of needed repairs, but he could not recall if any of the above needed repairs had been reported to him. The Maintenance Director indicated he did not have enough staff to properly make all needed repairs for the facility if they were to be performed correctly. The Maintenance Director stated he had made the facility administration aware of the need for nightstand replacement, but no approval had been given to purchase new bedroom equipment nor solutions to repair the laminate damage on the nightstands. The Maintenance Director stated his department had begun making some needed repairs primarily focused on the 100 hall which was designated as the new admission unit, but explained it was a very slow process. He also explained he had not been notified of the broken toilet seat riser in Room # 318. The Maintenance Director reported all staff could make repair request through the computer at the nurses' station at the time they were noticed to log and keep track of all needed and completed repairs.

A walking interview on 04/15/21 12:00 PM with the Director of Nursing (DON) revealed she expected staff should have made maintenance aware of the broken toilet seat riser in Room #318 and all other concern visualized.

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F 584	Continued From page 18 An interview on 4/15/21 at 3:30 PM with the Administrator revealed she was aware the facility had some needed repairs; however, she was not aware of each of the needed repairs observed. The Administrator indicated she expects all staff to report any needed repairs observed to maintenance immediately and expects the maintenance department to complete repairs timely.	F 584		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		5/14/21

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F 657	Continued From page 19 assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, resident, and Psychiatric Nurse Practitioner (NP) interviews the facility failed to develop a person centered care plan which addressed the needs of a resident with dementia and how staff were to provide care and treatment also failed to revise a psychotropic care plan to reflect the addition of antipsychotic medication for 1 of 2 residents reviewed for dementia care (Resident #40) and failed to revise an advance directive care plan (Resident #38) for 1 of 3 resident reviewed for advance directives. The findings included: 1. Resident #40 was admitted to the facility on 10/16/20 with diagnoses that included: dementia, psychotic disorder with delusions, Alzheimer's Disease, major depressive disorder, anxiety, Parkinson's disease, and others. Review of a physician order dated 01/13/21 read; Seroquel 25 milligrams (mg) by mouth twice a day for dementia. Review of a Medical Director (MD) progress note dated 01/22/21 indicated that Resident #40 had a diagnosis of dementia without behavioral disturbances. The note read, appears agitated suspect underlying infection. Started on Seroquel (antipsychotic) today by psyche today. The note was electronically signed by the MD. Review of a Minimum Data Set (MDS) dated 02/13/21 revealed that Resident #40 was moderately cognitively impaired and required	F 657	Citadel Mooresville will complete care plans timely and revisions from new orders, change in condition, etc. will be completed timely. 1. For those Residents affected by the deficient practice: * The care plan for Resident #40 with multiple health issues including dementia and psychotic disorder with delusions was updated. The care plan was updated to address the needs for dementia resident and how staff to provide care for resident. In addition, a behavioral care plan with the use of antipsychotic medication was put in place. * The care plan for Resident #38 was updated to reflect MOST, orders for advanced directives and care plan matched. 2. For Residents having the potential to be affected all Residents with the diagnosis of dementia and/or Alzheimer's Disease will be audited by Care Plan Nurse and care plans updated by the date of compliance. 3. The D.O.N. and/or Designee will provide educations to interdisciplinary team on policy/procedure for reviewing 24 hours reports and orders to ensure care plans are updated timely. 4. The Interdisciplinary Team will audit 24 hour reports and orders, including MOST orders 5 x week to ensure care plans are updated timely. A negative trend will be reported by D.O.N./Care Plan Nurse to monthly QAPI meeting for review.	

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F 657	Continued From page 20 extensive assistance with activities of daily living. Review of a Psychiatry Progress Note dated 03/23/21 indicated that Resident #40 had a diagnosis of dementia appears to be Alzheimer's type and possibly Parkinson's Dementia. Review of Resident #40's care plans revealed there was no care plan developed to address her dementia diagnosis or the use Seroquel. An observation of Resident #40 was made on 04/13/21 at 4:02 PM. Resident #40 was resting in bed with her eyes open and was talking with a staff member. Once the staff member exited the room Resident #40 began to describe some issues she was having with her oxygen and stated she was waiting for "that man to return." Resident #40 was in no distress and denied any pain. Resident #40 would jump from one topic to the next with no reasoning of the conversation. An interview was conducted with Nurse Aide (NA) #6 on 04/13/21 at 4:03 PM. NA #6 confirmed that she was familiar with Resident #40 and routinely took care of her. NA #6 stated that Resident #40 routinely screamed out and frequently talked to herself. She stated that Resident #40 hallucinated and she would attempt to redirect her or to calm her down. NA #6 stated that a lot of nights Resident #40 would not sleep and would stay awake talking to and responding to herself and at times was disruptive to the other residents so they kept her door cracked so they could still keep an eye on her. An observation of Resident #40 was made on 04/14/21 at 1:21 PM. Resident #40 was sitting up in her bed and was eating her lunch alone in her	F 657	5. Date of compliance 05-14-21.	

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room. She was talking loudly to herself about non sequential things.

An interview was conducted with MDS Nurse #2 on 04/15/21 at 10:25 AM. MDS Nurse #2 stated that if a resident had a diagnosis of dementia and was on medication then it should be care planned. She explained either the facility's social worker or herself could initiate the care plan and after reviewing Resident #40's care plan stated, "she needs to have a dementia care plan in place that would include the Seroquel." MDS Nurse #2 further explained that Resident #40 was due for a quarterly care plan review in the next week and she would add a dementia care plan during that review.

An interview was conducted with Psychiatric Nurse Practitioner (NP) on 04/25/21 at 3:39 PM. The NP confirmed that Resident #40 was being treated for multiple mental health issues including dementia and psychotic disorder with delusions. She stated that Resident #40 was started on Seroquel about 6 weeks ago and last week she had to increase the dosage because she was very upset and delusional. The NP added that Resident #40 talked frequently to no one in room and often times verbalized auditory and visual hallucinations. The NP also added that she would eventually gradually reduce the Seroquel but at this time Resident #40 was not ready for that.

An interview was conducted with the Director of Nursing (DON) on 04/15/21 at 4:13 PM. The DON stated that the care plan process was an interdisciplinary team process driven by the MDS Nurses through the quarterly process. She stated that in addition to those quarterly updates each morning in clinical meeting they reviewed new

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orders including medications and updated care plans and stated that the when Seroquel was added for Resident #40 it should have been added to her care plan. The DON stated that she expected residents that had a diagnosis of dementia to have a care plan that had interventions in place to direct the care of those residents.

2. Resident #38 was admitted to the facility on 11/06/19 with diagnoses that included chronic pain, depression, insomnia, and others.

Review of a care plan created on 02/17/20 and revised on 02/19/20 read, Resident #38 has an established advance directive: DNR form completed on 11/08/19. The goal read; Resident #38 will have advance directives followed. The interventions included: activate residents advance directive as indicated, inform resident of any change in status, offer opportunity to complete advance directives, review contents and provide opportunity to update and /or make changes.

Review of a quarterly Minimum Data Set (MDS) dated 02/15/21 indicated that Resident #38 was cognitively intact and required set up assistance with activities of daily living.

Review of a physician order dated 03/30/21 read, Full Code.

An interview was conducted with Resident #38 on 04/12/21 at 2:42 PM. Resident #38 stated that when she first come to the facility she elected to be a DNR but she realized she had a lot to live for and changed her mind and wanted to be a full code. She stated she let the facility staff know and they made the change for her.

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F 657	Continued From page 23 An interview was conducted with Social Worker (SW) #1 on 04/14/21 at 1:04 PM. SW #1 stated that she recently started at the facility and prior to her coming the facility had not had a SW and she quickly learned that there was some broken processes in the facility. SW #1 stated she immediately began updating everyone's code status and getting the appropriate paperwork filled out. She stated that Resident #38's code status has not changed since she has been at the facility, but she had updated her paperwork and knew that she was a full code. SW #1 stated that she has not yet gotten to the care plan part of the process and that when Resident #38's code status changed her care plan should have been updated at that time. An interview was conducted with the Director of Nursing (DON) on 04/15/21 at 4:26 PM. The DON stated that the care plan process was an interdisciplinary team process driven by the MDS Nurses through the quarterly process. She stated that in addition to those quarterly updates each morning in clinical meeting they reviewed new orders and updated care plans at that time. She further explained SW #1 was new to the facility and was working on updating everyone's code status, but she would expect Resident #38's care plan to be revised and reflect the accurate code status.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		5/14/21

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F 677	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to clean a dependent residents' fingernails (Resident # 47) and failed to trim a dependent residents' toenails (Resident #17). This affected 2 of 11 residents investigated for activities of daily living. The findings included: 1. Resident #47 was readmitted to the facility on 10/24/19 with diagnoses that included end stage renal disease, diabetes, major depressive disorder, and others. Review of a care plan created on 02/16/20 read in part, the resident has an activity of daily living self-care performance deficit related to generalized weakness and end stage renal disease. The goal read, the resident will maintain current level of functioning through the review date x 90 days. The interventions included: the resident requires extensive assistance by staff with personal hygiene and oral care. Review of the quarterly Minimum Data Set (MDS) dated 03/01/21 indicated that Resident #47 was moderately impaired for daily decision making and required extensive assistance with personal hygiene. The MDS further revealed no rejection of care was noted during the assessment reference period. An observation and interview were conducted with Resident #47 on 04/12/21 at 12:17 PM. Resident #47 was resting in bed with head of bed elevated. She was alert and verbal. Resident #47's fingernails were observed to be a half inch	F 677	Citadel Mooresville will provide necessary services to maintain good nutrition, grooming and personal/oral hygiene care to Residents who are unable to carry out activities of daily living. 1. For those Residents affected by deficient practice: * Resident #47's fingernails were cleaned and trimmed. * Resident #77's toenails were trimmed on 04-15-21. 2. Residents that have the potential to be affected: a 100% fingernail and toenail audit will be completed. Nail care will be provided by all Residents in need of fingernail and/or toenail care by date of compliance. 3. The D.O.N. or Designee will provide education to nurses and nursing assistants on the importance of nail care by date of compliance. All nurses and nursing assistants will be required to receive education prior to first scheduled work day. Orientation will be provided to all nursing staff including agency nursing staff. 4. The D.O.N. will implement a Shower Sheet to include fingernail and toenail care(Shower Sheets will be located at Nursing Station). The C.N.A.s will complete Shower Sheet on each shower given and submit to D.O.N. daily for review. The D.O.N. and/or Designee will Fingernail and toenail audit will be conducted 2 x week x 4 weeks, 1 x week x 4 weeks, 2 x month x 2	

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F 677	Continued From page 25 long on both hands and each nail was observed to have dried dark black substance under them. Resident #47 stated that she preferred to have long fingernails but stated they needed to be cleaned but could not recall if she had told anyone at the facility. Resident #47 was observed to be using her right hand to reach into her brief and scratch her peri area and then wipe her fingernails on her white t-shirt. The white t-shirt contained several places that contained a dark black substance. An observation was made on 04/12/21 at 12:40 PM. Resident #47's lunch tray was brought into her room and sat in front of her. Resident #47 picked up a French fry with her right hand and ate it and then began to pick up the other items on her tray and eat them. Resident #47's fingernails remained dirty with dark black substance under each nail on both hands. An observation of Resident #47 was made on 04/13/21 at 9:48 AM. Resident #48 was resting in bed with head of bed elevated. Her fingernails remained dirty with dark black substance under each nail. She was observed to pick up a carton of milk off her bedside table with her right hand and take a drink of it. An observation of Resident #47 was made on 04/14/21 at 11:27 AM. Resident #47 was observed to have just returned from an appointment and the staff were assisting her back to bed. Resident #47's fingernails were observed to be dirty with dark black substance under each nail. Once she had been transferred back to bed Resident #47 was observed to be picking the dark black substance from under her nails and wiping it on her shirt.	F 677	months, then monthly until compliance is achieved. Any negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance 05-14-21.	

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An observation of Resident #47 was made on 04/15/21 at 10:46 AM. Resident #47 was resting in bed with her eyes closed. Her fingernails were observed to be dirty and contained dark black substance under each of her nails.

An observation and interview were conducted on 04/15/21 at 11:46 AM. Restorative Aide (RA) #1 and Nurse Aide (NA) #5 were performing care to Resident #47. RA #1 and NA #5 were observed to wash, dry, and apply lotion to Resident #47's skin. Once she had been washed and dried, they placed a clean brief on Resident #47 and then dressed her for the day. Once the care had been completed RA #1 and NA #5 confirmed that they were finished and were just tidying up her room. NA #5 stated that she had given Resident #47 a shower on Tuesday 04/13/21 but had not cleaned her nails during that time. She stated she had washed her from head to toe but just overlooked nail care. NA #5 also stated that Resident #47 did like to keep her nails long because she liked to scratch herself from time to time. RA #1 confirmed that Resident #47's fingernails were dirty and needed to be cleaned and stated she would get an orange stick and take care of them.

An interview was conducted with the Director of Nursing (DON) on 04/15/21 at 4:06 PM. The DON stated that cleaning of nails was done routinely by the nursing staff, during bath/shower time or during care in the room. The DON stated that anytime the nursing staff saw that Resident #47's nails were dirty they should have cleaned them at that time.

2. Resident #77 was admitted to the facility on 10/22/18 with diagnoses that included muscle

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F 677	Continued From page 27	F 677		

weakness, difficulty walking, lack of coordination, feeding difficulties, and abnormal posture.

A review of Resident #77's most recent quarterly Minimum Data Set Assessment dated 01/15/21 revealed her to be cognitively intact for daily decision making. Resident #77 required limited assistance with bed mobility, dressing and personal hygiene. She was totally dependent on others for bathing. The assessment did not note any rejection of care during the assessment reference period.

An observation and interview were conducted with Resident #77 on 04/14/21 at 3:03 PM revealed she felt two of her toenails were too long. She reported she had received a shower earlier in the day but stated the staff member who provided her bath failed to check and trim her toenails. Resident #77 proceeded to show the toenails which she was complaining about and they were observed to be protruding out past the end of her toes and the nails were noted to be yellow and jagged.

An additional observation of Resident #77's toenails was completed on 04/15/21 at 9:09 AM. Her toenails continued to be long and jagged on her left foot Resident stated no staff members had come to trim her nails and she wished they would. Resident #77 also reported that facility staff had not trimmed her toenails "for a while".

During an interview with NA #3 who was assigned to Resident #77 on 04/15/21 at 9:29 AM, she reported that the facility's nurse aides were responsible for providing residents with showers. She stated when it came to nail care, it was her understanding that nails were trimmed and

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F 677	Continued From page 28 cleaned by the facility's beautician. She reported she does not provide nail care to residents when she provides showers. During an interview with Unit Manager #1 on 04/15/21 at 9:36 AM, she reported she was the staff member who provided Resident #77 with a shower on 04/14/21. She stated she did not notice any long toenails on Resident #77, nor did Resident #77 request any nail care at that time. She reported if Resident #77 had voiced a complaint, she would have trimmed her nails at the time she provided her with a shower. An interview with the Director of Nursing (DON) on 04/15/21 at 9:42 AM revealed the facility did have a beautician but stated she was not responsible for trimming resident nails. The DON reported nail care was the responsibility of hall nurse aides. She stated the only exception to that policy was if a resident was diabetic, then it would be a hall nurse that was responsible for trimming a resident's toenails. An observation of Resident #77 with the DON on 04/15/21 at 9:45 AM revealed she still had long and jagged toenails. The DON stated at this time that nail length should be to the individual resident's preference and if a resident wanted their toenails trimmed, then they should have been trimmed. The DON reported she would ensure that hall nurse aides were educated and stated she would trim Resident #77's toenails personally at that time.	F 677		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F 761		5/14/21

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F 761	Continued From page 29 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove lose and unsecure pills/capsules, failed to remove debris of paper shavings and rubber bands, failed to remove 2 unopened insulin vials and failed to remove an opened and undated insulin pen (delivered 12/26/21) from 3 of 5 medication carts reviewed for medication storage. The findings included: 1. An observation of the 100 Hall medication cart was conducted on 04/15/21 at 10:53 AM with	F 761	Citadel Mooresville will adhere to labeling of drugs and Biologicals, as well as maintaining a clean, sanitary storage of medications in medication carts. 1. For medication carts noted (100 hall, 600 hall & 300 hall): all carts were cleaned of debris of paper shavings, rubber bands and unsecured pills/capsules. All bottles, insulin pens, etc. were discarded if necessary or dated and labeled. 2. For all other medication carts: they were cleaned of debris of paper shavings, rubber bands and unsecured	

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F 761	Continued From page 30 Nurse #2. Stored on the medication cart were 2 unopened vials of insulin which were delivered on 04/13/21. An interview was conducted with Nurse #2 at the time of the observation. The Nurse explained that the unopened insulin vials should have been refrigerated when they were delivered on 04/13/21 until they were ready for use. The Nurse stated that the third shift nurse was responsible to ensure the medication cart was clean and orderly which included making sure there was no unopened insulin stored on the medication cart. 2. An observation of the 600 Hall medication cart was conducted on 04/15/21 at 11:23 AM with Nurse #3. Stored on the medication cart was one opened and undated insulin pen with the delivery date of 12/26/20. The bottoms of the drawers of the medication cart contained debris such as paper shavings and multiple rubber bands as well as a total of 26 pills and capsules of various shapes, sizes and colors which were laying loose and unsecure on the bottoms of the medication cart drawers. An interview was conducted with Nurse #3 at the time of the observation. The Nurse explained that the insulin pen should have been dated at the time it was opened. The Nurse continued to explain that she felt the debris of the white paper shavings, rubber bands and the loose pills and capsules on the bottoms of the drawers were due to the nurse missing the cup when they popped the pills from the medication card and not retrieving the lost pill from the medication cart drawers. Nurse #3 stated it was every nurses' responsibility to keep the medication cart clean and orderly.	F 761	pills/capsules. All bottles, insulin pens, etc. were discarded if necessary or dated and labeled. 3. The D.O.N. and/or Designee will provide education to nurses on the policy/procedure of med cart management: labeling all bottles, insulin pens, etc.,cleaning their med cart at the end of their shift, ensuring debris of paper shavings, rubber bands and unsecured pills/capsules are removed. The on-coming Nurse will audit med cart before accepting the keys by the date of compliance. 4. The D.O.N. and/or Designee will audit medication carts randomly 2 x week x 4 weeks, 1 x week x 4 weeks, 2 x month x 2 months, then monthly until compliance is achieved. 5. Date of compliance 05-14-21.	

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F 761	Continued From page 31	F 761		

During an interview with the Unit Manager (UM) on 04/15/21 at 11:53 AM she explained that third shift was responsible for cleaning the medication carts but stated the process had fallen through the cracks. The UM observed and acknowledged the cup of 26 pills and capsules and stated she thought every shift should be responsible for cleaning and organizing the medication carts at the end of the shift.

3. An observation was made of the 300 Hall Proximal medication cart on 04/15/21 at 11:58 AM with Nurse #4. The bottoms of the drawers of the medication cart contained debris such as white paper shavings and multiple rubber bands as well as a total of 18 pills and capsules of various shapes, sizes and colors which were laying loose and unsecure on the bottoms of the drawers.

An interview was conducted with Nurse #4 at the time of the observation. The Nurse stated she felt that the reason for the disorderly medication cart was because the nurses did not pay attention to what they were doing when they popped the pills out of the medication cards. She also explained that she was an agency nurse and had only been at the facility for about 3 weeks, therefore, she did not know who was responsible for ensuring the medication carts were neat, clean and orderly.

During an interview with the Assistant Director of Nursing (ADON) on 04/15/21 at 2:20 PM she explained that the third shift nurses were responsible for maintaining the medication carts which included making sure they were clean, orderly and there were no undated or unopened insulins on the medication carts.

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F 761	Continued From page 32 An interview was conducted with the Director of Nurses (DON) on 04/15/21 at 4:01 PM. The DON stated the unopened insulin should have been refrigerated until it was ready for use. She also explained that she expected the nurses to clean up after themselves and to keep the medication carts clean and orderly. At 4:41 PM on 04/15/21 the Administrator explained the DON had the UMs audit the medication carts and her expectation was that the medication carts be kept clean and orderly.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the	F 812	Citadel Mooresville will maintain food	5/14/21

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F 812	Continued From page 33 facility failed to properly label open food items in 1 of 1 freezer, 1 of 1 refrigerator, and 1 of 2 nourishments rooms. The facility also failed to date, and discard expired thicken water from 1 of 1 reach in refrigerator. The findings included: a. An observation of the freezer was made on 04/12/21 at 10:23 AM with the DM. The observation revealed the following: - a box of frozen egg patties that were open and undated. No signs of freezer burn were noted. - a box of fish cod tails that was open and undated. No signs of freezer burn were noted. - a box of fish cod loin that was open and undated. No signs of freezer burn were noted. - a box of Alaskan cod nuggets that were open and undated. No signs of freezer burn were noted. b. An observation of the refrigerator was made on 04/12/21 at 10:32 AM with the DM. The observation revealed the following: - a carton of chicken base that was open and undated. c. An observation of Unit #1 nourishment room was conducted on 04/12/21 at 5:10 PM. The observation revealed the following: - box of pizza snacks in the freezer that was open and undated. - box of ice cream bars in the freezer that was open and undated. - 2 boxes of orange dream ice cream bars in the freezer that was open and undated. - a bottle of strawberry jam in the refrigerator that was open and undated. - a bottle of orange drink in the refrigerator that was open and undated.	F 812	safety requirements and store, prepare, distribute and serve food in accordance with professional standards for food safety. 1. For the areas of deficient practice: All open and not dated items were discarded. DM reordered supplies and products that were needed. 2. For areas that may have been affected by deficient practice: DM checked all refrigerators and freezers were checked to ensure no open or undated items were present. 3. The DM will provide education to dietary staff on policy/procedures for managing food items i.e., labeling, dating, discarding after 3 days and closing/securing boxes of food by date of compliance. 4. DM and/or Designee will audit nourishment room refrigerators/cabinets 2 x day to ensure food is labeled and dated. If opened or not labeled to be discarded. DM and/or Designee will audit Dietary department's freezer and refrigerators daily for compliance. Any negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance 05-14-21.	

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F 812	Continued From page 34 - a box of fudge cakes in the pantry drawer that was open and undated. d. An observation of the reach in refrigerator in the kitchen was made on 04/12/21 at 10:19 AM with the DM. The observation revealed the following: - a container of lemon flavored thicken water that was undated and contained an expiration date of 03/30/21. An interview was conducted with the DM on 04/15/21 at 2:42 PM. The DM stated that all opened food items should be dated. Everyone was responsible for dating what they opened and for checking and make sure that it was properly dated before using an open food item. The DM stated he "was slipping and not checking like I should." He explained he audited the pantries on a daily basis and stated, "we may have missed some days." The DM again confirmed that all open food items in the kitchen and nourishment rooms should be dated once they were opened. The DM also stated all the food items that were open and undated had been discarded and reordered. An interview was conducted with the Administrator on 04/15/21 at 4:59 PM the Administrator stated the all open food items should be dated. She added that the DM was still fairly new and would fix these issues.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		5/21/21

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention 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 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

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F 880	Continued From page 36 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 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, facility infection control documents, resident, family, and staff interviews, the facility failed develop and implement a policy to follow guidelines established by the Center for Disease Control and Prevention (CDC) dated 11/20/20 which indicated personal protective equipment (PPE) to include a gown, gloves, face mask, and eyewear were to be worn when in resident care areas for new admission who under quarantine resident with an unknown COVID-19 status reside for 3 of 3 staff observed on the new admission quarantine unit (NA #1, Phlebotomist, and COTA #1) and prevent a contracted phlebotomist from wearing gloves in the hallway when she was observed at	F 880	Citadel Mooresville has an established infection prevention control program and will maintain infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. 1. 1A. For Resident #281 affected by the break in infection control prevention by C.N.A. re-educated on isolation, PPE application and handwashing. 1B. For Resident #281 affected by the break in infection control prevention by COTA re-educated on isolation, PPE	

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F 880	Continued From page 37 the central nurses station for 1 of 1 contracted staff (Phlebotomist) observed in a common area who were observed for infection control practices. These breeches in infection control practices occurred during a global pandemic. Findings included: A facility document titled, "Infection Control Guidelines for All Nursing Procedures" revised August 2012 indicated in part: prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on general infection control and exposure issues, including: facility protocols for isolation, location of all personal protective gear, location or medical waste disposal containers, facility exposure control plan, and facility protocol for occupational exposure to bloodborne pathogens. The document further indicated prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on managing infections in residents, including: types of healthcare-associated infections, methods of preventing their spread, how to recognize and report signs and symptoms of infection, and prevention of the transmission of multi-drug resistant organisms. The document revealed Standard Precautions will be used in the care of all residents in all situations regardless of suspected or confirmed infectious disease. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether they contain visible blood, non-intact skin, and/or mucous membranes. Transmission-based precautions will be used whenever measures more stringent than standard precautions are needed to prevent the spread of infections. Employees must wash their hands for 10 to 15	F 880	application and handwashing. 2A. For Resident #291 affected by the break in infection control prevention by Phlebotomist re-educated on isolation, PPE application and handwashing. 2B. For the break in infection control prevention by Phlebotomist re-educated on cross-contamination (lab tray/papers), gloves in hallways, isolation, PPE application and handwashing was completed. 2. Secondary to the break in infection control prevention, a root cause analysis will be conducted by Administrator, Nurse Practitioner, D.O.N., along with Attestation, timeline of education and assistance from QAPI Committee. 3. The Administrator will conduct a 100% education on Infection Prevention and Control to all employees, agency and contract staff by date of compliance. All employees, agency and contract staff will be required to receive education prior to first scheduled work day. 4. The D.O.N. and/or Designee will audit for infection control prevention, control and compliance 2 x week x 4 weeks, 1 x week x 4 weeks, 2 x month x 2 months, then monthly until compliance is achieved. All negative trends will be reviewed in monthly QAPI meeting. 5. Date of compliance 05-21-21.	

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seconds using soap and water or use alcohol-based hand rubs under the following conditions: before and after direct contact with residents, after removing gloves, and after contact with objects (e.g. medical equipment) in the immediate vicinity of the resident.

A facility document titled, "Isolation- Categories of Transmission-Based Precautions" revised 3/01/2020 indicated in accordance with CDC guidelines, a face mask, gown, and eye protection have been implemented and the Enhanced Droplet Isolation signage will be posted for COVID-19 confirmed or persons under investigation. The policy does not include residents who are new admission and under a 14-day quarantine period which includes posted signage of Enhanced Droplet Contact Precautions in the facility.

A review of a document updated 11/20/20 and published by the CDC titled Preparing for COVID-19 in the Nursing Home indicated in part under section headed Evaluate and Manage Residents with symptoms of COVID-19, residents known or suspected of COVID-19 should be cared for by HCP's using all recommended PPE which includes use of a N-95 or higher level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covered the front and sides of the face) gloves and a gown. The document defines HCP to include but not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapist, phlebotomist, pharmacist, students and trainees, contractual staff not employed by the facility, and person not directly involved in patient care, but who could be exposed to infectious agents that

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can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering, and facilities management, administrative, billing, and volunteer personnel.

1 a. Resident #281 was admitted to the facility on 04/7/21.

An observation on 4/12/21 at 9:55 AM of Resident #281's door included signage that indicated Enhanced Droplet Contact Precautions which illustrated the need for PPE to include a gown, gloves, face mask, and eyewear and to perform hand hygiene before and after care.

An observation on 04/12/21 at 9:57 AM revealed Nurse Aide #1 (NA #1) sitting in a chair directly in front of Resident #281. NA #1 was wearing a face mask and eyewear but was not observed to have donned a gown or gloves when interacting with Resident #281. NA #1 was observed to touch Resident #281's hand and chest to encourage him to stay seated and guide him safely back into his wheelchair. NA #1 revealed she was providing 1:1 care to Resident #281 to prevent him from getting up unassisted and prevent him from having a fall. NA #1 was not observed to wash her hands before exiting the room to obtain and apply PPE to include a gown and gloves which were in a plastic three drawer cart in the hallway outside Resident #281's room.

An interview on 4/12/21 at 9:57 AM with NA #1 revealed she was new to the facility. NA #1 verified she touched Resident #281 to direct him back into his wheelchair when he attempted to get up without assistance. NA #1 acknowledged she was not wearing a gown or gloves during this interaction. She explained she was aware

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Resident #281 was a new admission to the facility and under transmission based precautions (TBP) of Enhanced Droplet Contact Precautions which required the use of full PPE to include a gown, gloves, face mask, and eye wear and to perform hand hygiene before and after care. NA #1 stated she was not sure why she did not don a gown or gloves before entering the room of Resident #281.

1. b. An observation on 4/12/21 at 9:55 AM of Resident #281's door included signage that indicated Enhanced Droplet Contact Precautions that included the need for PPE which included a gown, gloves, face mask, and eyewear and to perform hand hygiene before and after care.

An observation on 4/14/21 at 9:34 AM revealed Certified Occupational Therapy Assistant (COTA #1) was sitting in a chair directly in front of Resident #281 during a therapy treatment session. Resident #281 and COTA #1 were both observed to be holding one end of a green and white rope type structure. Each were pulling at their end when COTA #1 touched Resident #281 to encourage him to sit up straight as he had leaned forward when COTA #1 had pulled her end of the rope. COTA #1 was observed to have worn a gown, face mask, and eye wear during the observation; however, she was not observed to have worn gloves when she was in Resident #281's room performing therapy exercises or perform hand hygiene before exiting the room.

An interview on 4/14/21 at 9:37 AM with Resident #281's family members who were in the room during the therapy session with COTA #1 revealed they each were wearing full PPE to include a gown, gloves, face mask, and a face

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shield. The female family member stated she was a healthcare worker and had noticed staff were not always following the TBP when entering the room of Resident #281. The family member elaborated staff always had on their face mask and eyewear but questioned why the staff rarely were observed to apply a gown or gloves unless they were performing incontinence care for Resident #281. The family members both acknowledged they had been informed by the front desk staff when being allowed to visit for compassionate care visits that a gown, gloves, face mask, and eyewear were to be worn at all times in Resident #281's room and hand hygiene was vitally important to decrease the potential spread of infection.

An interview on 4/14/21 at 10:10 AM with COTA #1 revealed she had completed the occupational therapy treatment for Resident #281 and acknowledged he was on TBP of Enhanced Droplet Contact Precautions. COTA #1 stated she had donned a performed hand hygiene and donned a gown prior to entering Resident #281's room but did not apply gloves during the therapy treatment using the rope. COTA #1 explained she had received training in infection control to include TBP and hand hygiene and was not sure why she was observed to not have on gloves when in a resident room labeled Enhanced Droplet Contact Precautions which indicated the required PPE to include a gown, gloves, face mask, and eyewear or to perform hand hygiene before she exited Resident #281's room.

An interview with Nurse #6 on 4/14/21 at 2:20 PM revealed she was the Infection Control/Staff Development Coordinator and had provided all facility staff and contracted agency staff a 4-hour

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training prior to them being allowed to take an assignment within the facility. This training included hand hygiene, TBP, and proper use of PPE. Nurse #6 explained the expectation was for all staff to wear full PPE to include a gown, gloves, face mask, and eye wear when in a resident care are labeled Enhanced Droplet Contact Precautions and to perform hand hygiene before and after care with residents or environmental surfaces in these areas.

An interview on 4/15/21 at 12:00 PM with the Director of Nursing (DON) revealed she was aware Resident #281 was a new admission residing on the New Admission Quarantine Unit and was under TBP requiring a gown, gloves, face mask, and eye wear. The DON stated all staff including agency staff were provided a four hour course to include infection control, transmission based precaution, and hand hygiene upon hire to the facility and ongoing trainings were being provided as it related to changes in guidelines per the CDC for COVID-19. The DON explained she expected all staff entering rooms labeled with TBP signs to perform hand hygiene and don PPE according to each sign posted on the outside of the resident's door before entering the room to interact with the resident. The DON acknowledged the breech in infection control practice could result in cross-contamination and lead to the spread of infection.

2. a. Resident #291 was admitted to the facility on 04/08/21.

An observation on 4/12/21 at 10:20 AM of Resident #291's door included signage that indicated Enhanced Droplet Contact Precautions that included the need for PPE which included a

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gown, gloves, face mask, and eyewear and to perform hand hygiene before and after care.

An observation on 04/12/21 at 10:20 AM revealed a Phlebotomist was standing at the right side of Resident #291 bed facing towards the window while attempting to palpate for a venipuncture. As the surveyor donned PPE to enter the room the Phlebotomist was observed to walk around to the left side of Resident #291's bed, apply a tourniquet to Resident #291's left arm and begin to perform a blood draw for labs ordered. The Phlebotomist was not observed to be wearing an isolation gown or gloves as the surveyor approached Resident #291's bedside to question the Phlebotomist who had obtained the tube of blood by this time. The Phlebotomist assembled the blood in her lab draw tray, picked the tray and paperwork up off Resident #291's bed and started to exit the room when she was stopped by the surveyor about the observation. During the venipuncture, Resident #291's door was open, and the privacy curtain had not been drawn making the procedure visible at all times from the hallway.

An interview on 4/12/21 at 10:25 AM with the Phlebotomist revealed she was an employee of an outside laboratory company and had been assigned to draw the labs for all residents in the facility on 4/12/21. The Phlebotomist verbalized she had attempted to obtain blood from Resident #291's right arm with a failed attempt so she walked around to the left side before making a successful attempt to obtain the blood for the labs requested. The Phlebotomist acknowledged she was aware of the signage posted on the outside of Resident #291's room which indicated she was on TBP of Enhanced Droplet Contact

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Precautions. When the surveyor pointed to the sign and asked the Phlebotomist about the proper PPE required in Resident #291's room, the Phlebotomist stated she thought she had on the required PPE as she pointed to her face mask and eyewear, but simply frowned and shook her head when she confirmed she did not have on gloves or a gown during the venipuncture. The Phlebotomist confirmed she had received trainings about infection control, TBP, and hand hygiene prior to entering the facility on 4/12/21. The Phlebotomist was observed to exit the room without performing hand hygiene carrying her lab draw tray in one hand and her paperwork in the other.

2. b. An observation on 4/12/21 at 12:25 PM revealed the Phlebotomist in example #2.a. above walking down the 300-hall carrying a lab collection tray in one hand and several pieces of paperwork in her other. The Phlebotomist was observed to be wearing gloves on both hands as she approached and entered a locked lab room at the end of the 300 hall. She entered the door and placed an unidentified item inside the room and quickly closed the door as she exited the room and proceeded to the nurses' station still wearing gloves on both hands. As the surveyor approached the Phlebotomist, she had reached the central nurses' station and had stopped to hand the Unit Secretary some papers using her gloved hands. The Unit Secretary immediately spoke to the Phlebotomist telling her that gloves could not be worn in the hallway.

An interview on 4/12/21 at 12:27 PM with the Phlebotomist revealed she had completed the lab draws throughout the facility that morning and acknowledged she had been wearing gloves to

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both of her hands when she walked down the hallway of the 300-hall and entered the lab room by opening the door with her gloved hand to sit down an item and proceed to the nurses station without removing her gloves or performing hand hygiene. The Phlebotomist stated she did not recall being told not to wear gloves in the hallway, but had received training in infection control through her company and acknowledged it could be considered to be a potential for cross-contamination when touching multiple surfaces throughout the facility while wearing gloves and not performing hand hygiene.

An interview on 4/12/21 at 12:30 PM with the facility Administrator who had walked up as the Unit Secretary informed the Phlebotomist, revealed she was not to wear gloves in the hallway. The Administrator verified the Phlebotomist was from a local contracted agency and the Phlebotomist had been assigned to obtain blood from residents throughout the entire facility on 4/12/21. The Administrator stated she expected all staff and contracted workers to follow infection control practices to include removal of gloves when in the hallway and to perform hand hygiene after the removal of the gloves before potentially cross-contaminating additional surfaces throughout the nursing facility.

An interview on 4/14/21 at 10:57 AM with the Unit Secretary revealed she had been at the central nurses station on 4/12/21 when the Phlebotomist approached her wearing gloves on both hands and handed her some papers to include information on the resident labs she had drawn for that day. The Unit Secretary stated she had already noticed the Phlebotomist wearing gloves in the hallway earlier in the morning of 4/12/21

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and had told her she could not wear gloves in the hallway prior to the occasion. The Unit Secretary explained when the Phlebotomist approached her with gloves to turn in the paperwork she again attempted to educate the Phlebotomist she could not wear gloves in the hallway for any reason and that everyone should know it was a concern with cross-contamination when she touched multiple surfaces in the facility with her gloved hands. The Unit Secretary recalled the Phlebotomist had begun arguing over the gloves prior to removing them.

An interview on 4/14/21 at 2:20 PM with Nurse #6 revealed she was the Infection Control/Staff Development Coordinator and had provided all staff and contracted agency staff a 4-hour training prior to them being allowed to take an assignment within the facility. Nurse #6 acknowledged she had not however provided any training to the Phlebotomist as that contract worker was not their routine phlebotomist from the contracted company and was filling in that day but would expect that the Phlebotomist had received training in infection control to include hand hygiene, PPE, and TBP.

An interview on 4/15/21 at 12:00 PM with the Director of Nursing (DON) revealed she was aware Resident #291
was a new admission residing on the New Admission Quarantine Unit and was under TBP requiring a gown, gloves, face mask, and eye wear. The DON stated all staff including agency staff were provided a four hour course to include infection control, transmission based precaution, and hand hygiene upon hire to the facility and ongoing trainings were being provided as it related to changes in guidelines per the CDC for

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F 880	Continued From page 47 COVID-19. The DON explained she expected all staff entering rooms labeled with TBP signs to perform hand hygiene and don PPE according to each sign posted on the outside of the resident's door before entering the room to interact with the resident. The DON acknowledged the breeches in infection control practice could result in cross-contamination and lead to the spread of infection.	F 880		