STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 10/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT WINSTON SALEM	1900 W 1ST STREET WINSTON-SALEM, NC 27104

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F 000	INITIAL COMMENTS The survey team entered the facility on 10/6/22 to conduct a complaint investigation. The survey team was onsite 10/6/22 through 10/7/22. Further complaints were investigated onsite from 10/25/22-10/28/22 therefore the new exit date was 10/28/22. Event ID# EEI211. The following intakes were investigated NC 00192605, NC 00192363, NC00191522,NC00193553, NC00194100, NC0131344, NC 00192261, NC 00193571, NC 00193677 , NC 00192561 , NC 00193983, NC 00193786. 2 of the 39 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements.	F 607		11/15/22

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

Electronically Signed | 11/11/2022

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F 607	Continued From page 1 §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to report an allegation of abuse within the specified timeframe of 2 hours. The Administrator was made aware of the allegation on 10/05/22 and the initial report to the state was done on 10/6/22 for Resident #1. This was evident for 1 of 3 alleged abuse investigations reviewed. (Resident #1) Findings included: 1.The facility abuse policy "Allegation of Abuse, Neglect, and Exploitation" with the revision date of 11/01/2020 stated in part "Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) when specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury., or b. Not later 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury." An interview with the Administrator on 10/06/22 at 3:00 pm revealed she received a call from a provider that Resident #1 alleged that a staff member, Nursing Assistant (NA) #3, had pushed	F 607	F607 1. Resident #1 abuse allegation was reported on 10/6/2022. 2. On 11/11/2022 the Administrator audited reported allegations of abuse and/or neglect from the last 60 days to verify 24 hour and 5-day reports were completed and submitted timely as required by regulation and Elder Justice Act. 3. On 11/11/2022 the Regional Director of Clinical Services educated the Administrator on the abuse policy which states, “Reporting of all alleged violations to the Administrator, State Agency, Adult Protective Services and all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. immediately, but not later than 2 hours after the allegation is made if the event that cause the allegation involved abuse or result in serious bodily injury., or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury…”. 4. The Regional Director of Operations will monitor 24-hour and 5-day reports to ensure reports are sent in according to	

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F 607	Continued From page 2 her into the wall. The Administrator indicated she was informed of this alleged allegation of abuse on 10/05/22. The Administrator revealed the provider informed her that Resident #1 alleged a staff member had pushed her into the wall and the hospital reported Resident #1 had a fractured hip. Review of the initial allegation report of this allegation was submitted to the state on 10/06/202. During a second interview with the Administrator on 10/07/22 at 2:30 pm, she indicated it was her expectation to follow the abuse policies of the facility and the state regulation for reporting any allegation of abuse within the required timeframe of 2 hours.	F 607	the regulations weekly x 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance date 11/15/2022	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 610		11/29/22

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F 610	Continued From page 3 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to submit the 5-Working Day report to the State Survey Agency within the required timeframe for 1 of 4 residents (Resident #13) reviewed for abuse. Findings Included: Resident #13 ' s Minimum Data Set (MDS) dated 8/24/22 indicated Resident #13 had severe cognitive impairment and required supervision while ambulating and behaviors of wandering and resisting care. An interview was conducted on 10/26/22 at 8:10am with family member and she indicated that she had not received any follow up from the facility regarding a reportable event that was initiated on 8/23/22. She indicated that Resident #13 was sent to the hospital due to injuries of unknown origin. The injuries included bruising to the right cheek and right upper lip, right upper posterior back, and right 2nd knuckle. Resident #13 was sent to the hospital for evaluation and returned to the facility on the same day. Family member did not receive follow up from the facility regarding the results of the completed investigation. The facility ' s abuse investigations were reviewed, and the facility ' s former interim Director of Nursing completed, signed, and faxed in the 24- Hour initial report on 8/23/22 at 8:20am. She was not available for interview. the reported allegation was for an injury with unknown origin. The injuries included bruising to the right cheek	F 610	F610 1. Administrator submitted the 5 working day report to the State Survey 11/29/2022 for resident #13. 2. On 11/11/2022 the Administrator audited reported allegations of abuse and/or neglect from the last 60 days to verify 24 hour and 5-day reports were completed and submitted timely as required by regulation and Elder Justice Act. 3. On 11/11/2022 the Regional Director of Clinical Services educated the Administrator on the sending in the 5-day report to the State Survey Agency from the date the 24 hour was sent. 4. The Regional Director of Operations will monitor 24-hour and 5-day reports to ensure reports are sent in according to the regulations weekly x 4 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance date 11/29/2022	

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F 610	Continued From page 4 and right upper lip, right upper posterior back, and right 2nd knuckle. There was no record of a 5-Working Day report sent to the State Survey Agency. An interview was conducted on 10/27/22 at 1:24pm with the administrator. She indicated that she was made aware of the incident by the former interim Director of Nursing. The administrator was not able to provide documentation that the required 5-Working day report was completed and submitted to the State Survey Agency. An interview was conducted with the Regional Director of Clinical Services on 10/27/22 at 1:40 pm. She indicated that she was not able to locate a 5-Working day report and that it was her expectation for this to have been done to complete the investigation correctly.	F 610		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, hospital record review, Resident interview (Resident # 9), Medical Director interview, and staff interviews the facility failed to prevent a medication error for 1 of 1 Residents reviewed for free of medication errors (Resident # 9). Two antibiotic eye medications were not administered per orders for Resident # 9. The findings included:	F 760	F760 1. Resident #9 discharged on 11/8/2022. 2. On 11/11/2022 the Regional Director of Clinical Services reviewed current residents with antibiotic eye medications to ensure the medication was given as prescribed by the medical physician. Completed 11/11/2022. 3. On 11/11/2022 the Staff Development Coordinator educated current license	11/15/22

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F 760	Continued From page 5 Resident # 9 was admitted to the facility on 09/20/22. Her relevant diagnoses included severe corneal ulcer of left eye secondary to Staphylococcus aureus infection (type of bacteria). The most recent Minimum Data Set (MDS) coded as an admission assessment on 09/23/22 revealed Resident # 9 was cognitively intact. Resident # 9 was coded for impaired vision with corrective lenses used. No behaviors coded and no rejection of care were coded. Review of discharge summary from hospital dated 09/20/22 revealed Resident # 9 was originally admitted to the hospital on 08/28/22 due to severe corneal ulcer of left eye due to staph aureus. During hospitalization, Resident # 9's eye symptoms improved after several eye medications. Medications continued at discharge included Moxifloxacin HCl twice a day and erythromycin ointment twice a day for 14 days. Resident # 9 was discharged to the facility with strict return precautions to the emergency room if symptoms worsened or if persistence of current symptoms and/or new concerning symptoms occurred. Record review of admission orders dated 09/20/22 revealed two antibiotic eye medications were to be given due to a severe corneal ulcer of left eye secondary to Staphylococcus aureus. The medications included Erythromycin Ointment 5 MG/GM Instill 1 application in left eye two times a day for infection for 14 Days and Moxifloxacin HCl Solution 0.5 % Instill 1 drop in left eye two times a day for infection for 14 Days.	F 760	nurses and medication aids on ensure medications are given as prescribed by the medical physician and charted in the residents' medical record. Completed on 11/15/2022. New licensed nurses and medication aides will receive this education in orientation. 4. Director of Nursing and/or designee will review residents on antibiotic eye drops to ensure given as medical physician ordered and recorded in the residents' medical record weekly x 4 weeks. Results of these audits will be reviewed at Monthly Quality Assurance Meeting X 2 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected. Compliance Date: 11/15/2022	

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F 760	Continued From page 6	F 760		

Per the Medication Administration Record (MAR) for 09/22/22 through 09/30/22 the Erythromycin eye Ointment was documented as given per orders.

Record review of Nurse Practitioner note dated 09/28/22 revealed Resident # 9 reported persistent left eye limited vision. Mild conjunctival redness and cloudy pupil, no drainage, and no periorbital redness or swelling noted.

Per the Medication Administration Record (MAR) the Erythromycin eye Ointment was not documented as given on 10/01/22 at 9:00 AM or at 5:00 PM. Also, per the MAR the Moxifloxacin HCl Solution eye drops were not documented as given on 10/01/22 at 8:00 PM.

Interview with Resident # 9 was conducted on 10-26-22 at 9:50 AM. She stated she had not received all doses of the two antibiotic eye medications that were scheduled for the infection in her left eye because the nurses did not administer them when giving medications. She also stated that when she asked one of the nurses where her eye medications were the nurse stated that she could not locate them on the medication cart. Another time the nurse told Resident # 9 that she would administer the eye drops and ointment after Resident # 9 got out of bed, but the nurse did not come back with the medications. She did not know the nurse's names or what dates these incidents occurred but stated it was during the first 2 weeks at the facility. She did not report that she had not received the eye medications until 10/24/22. Observation of left eye on 10/25/22 at 1:15 PM, 10/26/22 at 9:50 AM, and 10/27/22 at 3:38 PM revealed her left eye to be red, slightly swollen, and she had difficulty

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F 760	Continued From page 7	F 760		

opening the eye (photosensitive).

The nurse assigned to resident # 9 on 10/01/22 and 10/02/22 was unable to be interviewed. Attempted to call Nurse # 7, on 10/26/22 at 1:10pm and 10/27/22 at 4:21PM. Left message twice to return call, no return call received. Nurse # 7 worked on 10/01/22 and 10/02/22. Both doses of the Erythromycin Eye Ointment were not documented as given on 10/01/22 and the Moxifloxacin HCl Solution eye drops were not documented as given on 10/01/22 at 8:00 PM.

Interview with Unit Supervisor # 1 was conducted on 10/26/22 at 1:50 PM. She stated that Resident # 9 did not report the eye drops had not been received until 10/24/22.

Interview with Medical Director was conducted on 10/26/22 at 3:17 PM. He stated the eye drops for Resident # 9 should have been administered per orders. He also stated he could not say her eye would have gotten worse if the prescribed eye medications were not given per orders. A follow-up phone interview with Medical Director was conducted on 10/27/22 at 10:10 AM. Per the discharge summary dated 09/20/22, the infection to the left eye was improving when Resident # 9 was discharged to the facility but the prognosis on her vision was what was unclear. He stated that the eye infection for Resident # 9 was different than the loss of vision.

Interview with the Director of Nursing was conducted on 10/26/22 at 12:00 PM. She stated that the Nurses should sign the medication administration record when they administer the medications, and the medications should be given per orders.

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F 760	Continued From page 8 Interview with Administrator was conducted on 10/26/22 at 1:55 PM. She stated that the medications should be given per orders.	F 760		