	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G) DATE SURVEY COMPLETED C
		345283	B. WING			04/08/2025
NAME OF P	ROVIDER OR SUPPLIER		- I	STREET ADDRESS, CITY, STATE, ZIP COL)E	04/00/2020
	DEL MOORESVILLE			550 GLENWOOD DRIVE		
				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 00	00		
F 580 SS=J	04/02/25 through 04/0 onsite on 04/08/25 to allegations, therefore to 04/08/25. The follo investigated: NC0022 NC00226699, NC002 of 6 complaint allegat Immediate Jeopardy 9 CFR 483.10 at tag F5 of J. CFR 483.25 at tag F6 J. Tag F684 constitued 3 Immediate jeopardy b removed on 04/05/25 was completed. Notify of Changes (In CFR(s): 483.10(g)(14) S483.10(g)(14) Notified (i) A facility must imm consult with the reside consistent with his or representative(s) whe (A) An accident involv results in injury and h physician intervention (B) A significant chan mental, or psychosoc deterioration in health status in either life-thr clinical complications	, the exit date was changed wing intakes were 18886, NC00227180, 123333, and NC00222925. 1 ions resulted in deficiency. was identified at: 580 at a scope and severity 584 at scope and severity of Substandard Quality of care. began on 03/26/25 and was . A partial extended survey jury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring t; ge in the resident's physical, ial status (that is, a h, mental, or psychosocial reatening conditions or	F 58	80		4/30/25
		SUPPLIER REPRESENTATIVE'S SIGNATURE	 =	TITLE		(X6) DATE
	cally Signed	SUIT LIER REFRESENTATIVE S SIGNATURE	-	IIILE		04/30/2025

Electronically Signed

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

PRINTED: 05/20/2025

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/20/2025 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_	04/0) 08/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
				550 GLENWOOD DRIVE			
	DEL MOORESVILLE			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making notif (14)(i) of this section, all pertinent informatio is available and provid physician. (iii) The facility must a resident and the resid when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di- §483.5) must disclose its physical configurat locations that compris part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on record revi Physician Assistant (F interviews, the facility	an existing form of erse consequences, or to m of treatment); or sfer or discharge the ity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the lent representative, if any, or roommate assignment 0(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically nailing and email) and	F 58	The facility failed to Medical Provider v change in conditio	to immediately notify vhen Resident #1 ha n on 03/26/25 at 0 AM. Resident #1 ha	da	

Facility ID: 923353

If continuation sheet Page 2 of 41

		MEDICAID SERVICES			OMB NO. 09	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SUR COMPLETE	
	SUMEONOM	BENTI IOATION NOMBER.	A. BUILDING	3		0
			5.14/010		C	
		345283	B. WING	······	04/08/2	025
IAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	DEL MOORESVILLE			550 GLENWOOD DRIVE		
				MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE CO	(X5) MPLETIC DATE
F 580	Continued From page	e 2	F 58	30		
	• • • • • • • • • • • • • • • • • • •	On 03/25/25 between 2:00	1.00	a fall on 03/25/25 at approxima	tely 2.00	
		lent #1 had an unwitnessed		PM and was assessed by the r		
		was assessed to have no		to have no injuries and was tra	•	
		ansferred back to bed.		back to bed. On 03/26/25 at 8:3		
		scribed an anticoagulant		Resident #1 had a change in c		
		an 5 milligrams (mg) via		described by staff as having a		
		ce a day for atrial fibrillation.		level of consciousness, unable		
		were initiated. Resident #1		awakened, lethargic slow to res		
		he did not hit his head. On		much different than his baselin	-	
		ately 8:30 AM Resident #1		Medical Provider was not notifi		
	was noted by staff to	-		4:50 PM on 03/26/25 and gave		
		sive, and lethargic. The PA		blood work, urinalysis, and che		
		4:50 PM on 03/26/25 of the		On 03/27/25 Resident #1's fam	-	
	acute change in cond	lition. The PA ordered		visit and found him unresponsi		
	-	with culture and sensitivity,		called Emergency Medical Ser		
	and a chest x-ray for	reports of lethargy. On		(EMS). Resident #1 was transf	erred to the	
		Resident #1's family came to		Emergency Room and diagnos		
	the facility and found	him unresponsive and		large subdural hematoma with		
	called Emergency Me	edical Services (EMS) and		shift. Resident #1 was transfer	red to	
	Resident #1 was tran	sported to the Emergency		hospice and passed away on 0	3/31/25.	
	Department (ED) and	I diagnosed with a "huge left		On 4/3/25, the Director of Nurs	ing (DON)	
	subdural hematoma v	with a midline shift" (shifting		re-educated the nurse on the n	otification	
	of brain past its cente			policy and process to include ir		
		ce services and passed		notifying the Medical Provider	when a	
	away on 03/31/25. Th	nis affected 1 of 3 residents		resident has a change in condi		
	reviewed for notificati	on.		On 4/3/25, the DON and Nurse		
				Consultant completed an audit		
		began on 03/26/25 when the		residents on anticoagulant ther		
		not immediately notified		have experienced a fall within t		
		an acute significant change		hours to ensure timely notificat		
		te Jeopardy was removed		Medical Provider if a change in		
		e facility implemented an		condition occurs. Two residents		
		llegation of immediate		identified and no concerns ider		
		e facility will remain out of		On 4/4/2025, the facility review		
		r scope and severity D		residents with changes in cond		
		al harm with potential for		hours to ensure immediate not		
		arm that is not immediate		the Medical Provider occurred.		
		e education and ensure		residents were identified, and t	he Medical	
	monitoring systems p	out into place are effective.	1	Provider was notified.		

Facility ID: 923353

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING С 345283 B. WING 04/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE THE CITADEL MOORESVILLE MOORESVILLE, NC 28115 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 580 Continued From page 3 F 580 On 4/3/25, the Administrator, DON, Vice The findings included: President of Risk and Quality Assurance (VPRQA), Nurse Consultant, Physician Resident #1 was admitted to the facility on Assistant and Medical Director held an Ad 02/28/25 with diagnoses that included atrial Hoc QAPI meeting to discuss the incident fibrillation, history of pulmonary embolism, history to determine root cause analysis of the of cerebral infarction with hemiplegia and facility's failure to immediately notify the traumatic brain injury. Medical Provider when Resident #1 had a change in condition. Root cause analysis Review of a physician order dated 02/28/25 read; determined that the facility failed to have apixaban (anticoagulant) 5 milligrams (mg) via effective systems in place and monitoring gastrostomy tube two times a day for atrial measures to ensure that a licensed nurse fibrillation. understood the seriousness of their responsibility to notify the Medical A review of Resident #1's Medication Provider when a resident experiences a Administration Record (MAR) for 02/2025 and change in condition post-fall, especially 03/2025 indicated the Resident had received an those on anticoagulants. anticoagulant medication apixaban 5 mg via On 4/3/2025, the VPRQA, Nurse gastrostomy tube twice a day for atrial fibrillation. Consultant, DON, Administrator, and The MARs indicated Resident #1 received the Physician Assistant (PA) reviewed the anticoagulant as ordered since his admission notification and fall policy. No updates date of 02/28/25. were made. An incident report dated 03/25/25 at 2:00 PM and Effective 4/3/25, the DON, Nurse written by Nurse #1 revealed Resident #1 was in Consultant, and Nursing Administration bed after lunch when Nurse #1 was called to the initiated education with all facility and Resident's room and upon arrival Resident #1 contracted licensed nurses and Certified was lying on the floor next to his bed. Resident #1 Nursing Assistants on the facility stated he rolled over and he did not know what he Notification of Changes in Condition and Fall Prevention Policies. Education was trying to do. A head-to-toe assessment was done, and Resident #1 was moving all extremities includes the licensed nurse's without any problems. The Resident complained responsibility to immediately notify the of back pain which he does most of the time and Medical Provider of any resident's change was given some pain medication for pain. No in condition, especially post-fall, with a injuries were noted, and Resident #1 was history of stoke and pulmonary embolism assisted back to bed using the total lift. on an anticoagulant. Certified Nursing Neurologic checks were initiated, and all vital Assistants will immediately communicate signs were within the normal limits. Staff were to to the licensed nurses any change in do frequent rounding and ensure correct Residents condition. The DON will ensure

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 05/20/2025

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA		LE CONSTRUCTION		D. 0938-039 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
						С
		345283	B. WING		04	/08/2025
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
THE CITAI	DEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 580	Continued From page	e 4	F 58	0		
	positioning while in b			all newly hired facility ar licensed nurses and cer		
	During an interview w	vith Nurse #1 on 04/02/25 at		assistants will be educat		
	-	onfirmed that she worked the		orientation and/or prior t	•	
	7:00 AM shift on 03/2			assignment.		
		explained that when she 03/27/25 for the 7:00 AM		As of 4/5/25, the DON/U Manager/Nurse Supervi		
		ned her that Resident #1 was		using a Quality Assuran		
		not think to ask how long he		monitoring will ensure til		
	-	lurse #1 explained that she		the medical provider res		
		lent #1, and he was sleeping		change in condition posi		
		o wake him up, the Resident nd he was lethargic. She		anticoagulation therapy. monitoring will be condu		
		his progress notes which		week x 4 weeks, biweek		
		drawn and a urine sample		then weekly x 4 weeks.	-	
		s due to be done. Nurse #1		DON/Administrator will r	•	
		t Manager (UM) asked her		of the QA monitoring mo	-	
		s doing that day and Nurse he was lethargic, and the		Quality Assurance Proce (QAPI) committee for co		
		esident had labs drawn the		compliance and/or revis		
	day before. Nurse #1	reported that while she was				
		medications the radiology				
		obtain a chest x-ray. Shortly				
		'1's family came to visit and sident #1 was not acting like				
		re that he had a fall on				
	03/25/25 and stated t	that Resident #1 had a				
	-	leeds. The Nurse informed				
		that were ordered, and the				
	•	done but the family insisted ransferred to the hospital, so				
		PA and was given an order				
	to transfer Resident #	-				
		PM and 04/03/25 at 10:45				
		conducted with Nurse Aide				
	(NA) #1 who confirme to 3:00 PM on 03/26/	ed she worked from 7:00 AM 25 on a different				
	10 0.00 F W 01 00/20/		1			1

Facility ID: 923353

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C		
		345283	B. WING			_		08/2025	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
THE CITA	DEL MOORESVILLE				550 GLENWOOD DRIVE				
					MOORESVILLE, NC 28				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	Continued From page #1 because he had fa him to be lethargic an as his usual self. The NA #2 get Resident # around mid-morning a like a rag doll and leth change in the Reside #1 reported that she w Therapy Assistant (PT Resident was acting s and they both put Res An interview was com- on 04/03/25 at 10:15 worked from 7:00 AM The NA explained that Resident #1 one time was alert and convers daughter with her nar when she went in to co- morning (03/26/25) an immediately that he w their previous encoun- response was slower, with her like he norma explain that around 10 get Resident #1 out o went to inform therapy acting and therapy an back to bed. NA #2 re- notify Nurse #2 of Re- Nurse #2 went to his explained that Resider	e 5 Illen on 03/25/25 and found d basically not responding NA stated that she helped 1 out of the bed for therapy and the Resident was limp hargic and that was a nt since the day before. NA went and got the Physical TA) and reported how the since the fall on 03/25/25 sident #1 back in the bed. ducted with Nurse Aide #2 AM who confirmed she to 3:00 PM on 03/26/25. t she had only worked with before 03/26/25, and he sed with her about having a ne. NA #2 reported that care for Resident #1 on that round breakfast, she knew vas acting differently from ter because the Resident's and he was not conversing ally did. NA #2 continued to 0:00 AM NA #1 helped her f bed for therapy and NA #1 y of how Resident #1 was id NA #1 put the Resident eported that she went to sident #1's condition and room to assess him. NA #2		58(DEFICIENCY)			
	Assistant (PTA) on 04	ith the Physical Therapy 1/02/25 at 11:45 AM the PTA d worked with Resident #1							

Facility ID: 923353

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE COMP	SURVEY LETED
		345283	B. WING			_		C 08/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE			
				М	OORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	morning of 03/26/25 h go to Resident #1's ro had a fall out of bed th and they had gotten h session, but he was m behavior. The PTA sta #1's room and could s and not responding to she and NA #1 put the PTA explained that sh Nurse #2 and the Nur reported to her that R PTA continued to exp checked on Resident the shift and he barely PTA. She indicated th and moaning sounds' Interviews were cond 04/02/25 at 9:20 PM a Nurse confirmed that #1 on 03/25/25 throug to 7:00 AM shift and 7 03/26/25 through 03/2 that she received in th Resident #1 sustained neurologic checks we continued to explain t Nurse #2 on the morr informed the Nurse th and that his neurologi had been stable throu documented it on the #3 stated when she c 03/26/25 she checked that Resident #1 was	and he was able to She reported that on the NA #1 came and got her to oom because the Resident he day before (03/25/25) him out of bed for his therapy not behaving like his normal ated she went into Resident see that he was lethargic o her as he normally did, and e Resident back to bed. The he reported her concern to rese informed her that no one esident #1 had a fall. The lain that she periodically #1 throughout the rest of y made eye contact with the re Resident made "groaning y while he was sleeping. ucted with Nurse #3 on and 04/04/25 6:55 AM. The she worked with Resident gh 03/26/25 for the 7:00 PM 7:00 PM to 7:00 AM for 27/25. Nurse #3 explained he report on 03/25/25 that d a fall from the bed and the re on going. Nurse #3 hat she reported off to hing of 03/26/25 and hat Resident #1 had a fall ic checks were on going and ighout the night and she 24-hour report sheet. Nurse ame on duty at 7:00 PM on d on the residents and found lethargic. Nurse #3 was	F	580				
	#1 on 03/25/25 throug to 7:00 AM shift and 7 03/26/25 through 03/2 that she received in th Resident #1 sustained neurologic checks we continued to explain t Nurse #2 on the morr informed the Nurse th and that his neurologi had been stable throu documented it on the #3 stated when she c 03/26/25 she checked that Resident #1 was	gh 03/26/25 for the 7:00 PM 7:00 PM to 7:00 AM for 27/25. Nurse #3 explained the report on 03/25/25 that d a fall from the bed and the re on going. Nurse #3 hat she reported off to hing of 03/26/25 and hat Resident #1 had a fall ic checks were on going and ighout the night and she 24-hour report sheet. Nurse ame on duty at 7:00 PM on d on the residents and found						

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			_		C 08/2025
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
				5	550 GLENWOOD DRIVE			
	DEL MOORESVILLE			N	MOORESVILLE, NC 287	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFEREI	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	she had to collect the the lab to pick up. The the urine, and the lab around 4:00 AM in the Resident's labs so tha which she reported to her report that mornin explain that Resident was able to perform th the grips because he indicated the Resident Nurse #3 reported if it she would have called the provider had alrea Resident #1's condition pending. Interviews were cond 04/02/25 at 11:30 AM Nurse #2 confirmed th Resident #1 on 03/26 PM and it was the first the Resident. Nurse # and 8:30 AM a therap informed her that Ress previous day (03/25/2 himself and she went stated Resident #1 we she called his name, I her. The Nurse indica Resident's vital signs limits and completed a assessment and report to the UM after the UI was around 10:30 AM Nurse #2 that she wo explained that they re	ed for Resident #1 and that urine and have it ready for e Nurse stated she obtained phlebotomist came in e morning to obtain the at just left the chest x-ray Nurse #1 when she gave ig. Nurse #3 continued to #1 slept all night, and she he neurologic checks except was sleeping. The Nurse it's vital signs were stable. thad been during the day d the provider, but she knew ady been informed of on and his lab work was ucted with Nurse #2 on and 04/03/25 at 11:35 AM. hat she worked with /25 from 7:00 AM to 3:00 t time she had worked with t2 stated between 8:00 AM by staff (PTA) member sident #1 had a fall the t5) and was not acting like to assess him. Nurse #2 puld open his eyes when but he would not respond to ted that she obtained the which were within normal	F	580				

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	-					FORM	: 05/20/2025 APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION		(X3) DATE COMP	LETED
		345283	B. WING		_	04/	C 08/2025
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
THE CITA	DEL MOORESVILLE			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	the Nurse indicated the Resident and wanted condition to her Unit M A review of a Change completed by Nurse # revealed Resident #1 very less responsive. Pulse 64, Respiration via forehead and rece Decreased level of co- lethargic). The assess the responsible party A review of Resident # 03/26/25 written around for a Complete Blood (CBC/Diff) in AM, Urinand Sensitivity (UA/C X-Ray (CXR) for courd orders were written by Interviews were cond on 04/02/25 at 5:00 P AM. The UM explaine Resident #1's fall by M after the fall happener Resident did not susta The UM continued to 03/26/25 at approxim- out of the Risk Manage informed her that Resident document a change in responsible party. The stepped into Resident	e did not call the PA herself hat she was not familiar with to report the Resident's Manager. in Condition Assessment 2 on 03/26/25 at 2:35 PM was drowsy, lethargic and Blood Pressure 115/62, s 18 and Temperature 97.7 ent oxygenation 95%. onsciousness (sleepy, sment indicated the PA, and were notified. #1's physician orders on nd 5:40 PM indicated orders Count with Differential he for Urinalysis and Culture &S) if indicated and a Chest gh were obtained. The y the Unit Manager. Mand 04/03/25 at 10:45 ed that she was notified of Nurse #1 on 03/25/25 shortly d and was told that the ain any injuries from the fall. explain that the next day on ately 4:30 PM after she got gement meeting, Nurse #2 sident #1 had a change in hargic and she was going to n condition and call the	F 580				

Facility ID: 923353

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			NO. 0938-0391
A. BUILD	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
B. WING		_ 0	C 4/08/2025
•	STREET ADDRESS, CITY, S		
	550 GLENWOOD DRIVE		
	MOORESVILLE, NC 28	115	
	IX (EACH CORRE ; CROSS-REFERE	CTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE	(X5) COMPLETION DATE
the the had UM for n t ey e, on cility out d, vith d, vith d, vith cair. ted ED red c. , 40 ent ury) the holly			
	B. WING L PREF N) TAG	A BUILDING	A BOILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE SS0 GLENWOOD DRIVE MOORESVILLE, NC 28115 L PREFIX N) PREFIX TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 580 I the the had UM for n t t ey s, on on cility out d, r, ted ED red f, 40 nt ury) the holly r) rad L L L L L L L L L L L L L L L L L L

Facility ID: 923353

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	MENT OF HEALTH AN S FOR MEDICARE & I						FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			_		C 08/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	This results in severe hemisphere with 1.5 of developing right side of fluid deep within the of report indicated the R consulted on his cond condition the family of measures only and to Interviews were condu Assistant on 04/02/25 12:45 PM. The PA exp facility on 03/25/25 an Resident sustained a #1 late that same nigh UM called her the nex 4:50 PM when the Re condition. When the Re condition when the Re conditio	4 cm and height of 9.7 cm. compression of the left im midline shift. There is hydrocephalus (a buildup of avities of the brain). The esident's family was ition and because of his bed to provide comfort consult Hospice services. Ucted with the Physician at 2:15 PM and 04/03/25 at blained that she was at the d was informed that the fall and assessed Resident it. The PA reported that the t day on 03/26/25 around sident had a change in PA was asked if she was #1 was lethargic, the PA emember the exact used in describing the condition, but she felt that labs, urine and a chest issue. The PA reported that 3/27/25 she was notified by nt #1's family was at the n sent to the hospital and n order to send Resident #1 as conducted with the ON) on 04/03/25 at 2:40 ed that she was aware that on 03/25/25 and that he he fall. The DON stated that Resident #1 had a change orning of 03/26/25 and	F	580				

Facility ID: 923353

If continuation sheet Page 11 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 05/20/2025 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345283	B. WING				C / 08/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				5	550 GLENWOOD DRIVE		
	DEL MOORESVILLE			Ν	MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	time.	ld have been notified at that	F	580			
	Director on 04/04/25 a Director stated that he #1's situation by the F events that led to the hospital. The Medical Resident #1's comple should have notified t noticed a change in th sent Resident #1 to th	ducted with the Medical at 4:15 PM. The Medical e was notified of Resident PA and was aware of the Resident being sent to the Director stated that given ex medical history, the facility he PA as soon as they ne Resident's condition and he hospital. He indicated that of have changed but the ent him out.					
	The Administrator was Jeopardy on 04/03/25	s notified of Immediate 5 at 4:40 PM.					
	The facility implement Allegation of Immedia	ted the following Credible ate Jeopardy removal.					
		nts who have suffered, or serious adverse outcome as npliance:					
	in condition on 03/26/ AM. Resident #1 had approximately 2:00 P nursing staff to have r transferred back to be Resident #1 had a ch described by staff as consciousness, unabl slow to respond, muc The Medical Provider	en Resident #1 had a change 25 at approximately 8:30 a fall on 03/25/25 at M and was assessed by the no injuries and was ed. On 03/26/25 at 8:30 AM					

Facility ID: 923353

If continuation sheet Page 12 of 41

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 05/20/2025 APPROVED 0. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		345283	B. WING		_		C 08/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE CITA	DEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	 #1's family came to vi unresponsive and call Services (EMS). Resi the Emergency Room subdural hematoma vi #1 was transferred to on 03/31/25. On 4/3/25, the DON ri notification policy and immediately notifying a resident has a chan On 4/3/25, the DON a completed an audit of therapy who have explast 72 hours to ensur Medical Provider if a o occurs. Two residents concerns identified. On 4/4/2025, the facil with changes in condi- immediate notification occurred. Six residents Medical Provider was Specify the action the process or system fai adverse outcome from and when the action vi On 4/3/25, the Admin (DON), Vice President Assurance (VPRQA), Physician Assistant at Ad Hoc QAPI meeting 	 k-ray. On 03/27/25 Resident sit and found him led Emergency Medical dent #1 was transferred to a and diagnosed with a large with midline shift. Resident hospice and passed away e-educated the nurse on the process to include the Medical Provider when ge in condition. and Nurse Consultant is residents on anticoagulant berienced a fall within the retimely notification to the change in resident condition as were identified and no ity reviewed all residents tion in 24 hours to ensure a to the Medical Provider ts were identified, and the notified. entity will take to alter the lure to prevent a serious n occurring or reoccurring, will be complete. istrator, Director of Nursing t of Risk and Quality 	F 580				

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If continuation sheet Page 13 of 41

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345283	B. WING					C 08/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP C	ODE		
THE CITAI	DEL MOORESVILLE				50 GLENWOOD DRIVE 100RESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD B		(X5) COMPLETION DATE
F 580	when Resident #1 ha Root cause analysis of failed to have effective monitoring measures nurse understood the responsibility to notify a resident experience post-fall, especially th On 4/3/2025, the Dire Management, Nurse Nursing, Administrator reviewed the notificat updates were made. Effective 4/3/25, the D Consultant, and Nurs education with all faci nurses and Certified N facility Notification of Fall Prevention Policie licensed nurse's respontify the Medical Pro- change in condition, e history of stoke and p anticoagulant. Certifie immediately commun any change in Reside of Nursing will ensure nurses and Certified N educated during orier educated prior to takin Effective 4/3/25, the A responsible for the im completion of this rem Alleged Date of IJ Re	notify the Medical Provider d a change in condition. determined that the facility e systems in place and to ensure that a licensed seriousness of their the Medical Provider when is a change in condition ose on anticoagulants. ctor of Risk of Quality Consultant, Director of r, and Physician Assistant ion and fall policy. No Director of Nursing, Nurse ing Administration initiated lity and contracted licensed Nursing Assistants on the Changes in Condition and es. Education includes the onsibility to immediately wider of any resident's especially post-fall, with a ulmonary embolism on an ed Nursing Assistants will icate to the licensed nurses ents condition. The Director all newly hired licensed Nursing Assistants will be nation and contracted staff ng their assignment. Administrator is ultimately plementation and noval plan.	F	580				
	UII 04/08/25 the cred	ible allegation of Immediate						

Facility ID: 923353

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 05/20/2025 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		345283	B. WING _			-		C / 08/2025
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE	•	
				550	0 GLENWOOD DRIVE			
THE CITAL	DEL MOORESVILLE			МС	OORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B ICED TO THE APPROPRIA IEFICIENCY)		(X5) COMPLETION DATE
F 580	through staff interview education reviews. The members of administre nursing assistants. The related to the facility's notification of changes how to identify changes how to identify changes notification the provide conditions. The mana procedures in monitor conditions in order to licensed nurses report assess residents whe occur so that timely net the providers, and the responsibility in notify the residents' condition education of Notificati was evident through se education attendances The Immediate Jeopa 04/05/25 was validates Free from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom from Exploitation The resident has the mediate of the neglect, misappropriation and design of the first of the includes but is not lim	h a removal date of d by onsite verification vs, record reviews, and he staff interviewed included ation, licensed nurses and he staff interviews were policy and procedures for s in condition, specifically es in conditions and ers upon changes in gement team reported new ring for changes in notify the providers. The ted their responsibility to n changes in conditions otification can be made to a nurse aides voiced their ing the nurses of changes in ns as soon as possible. The on provided for the staff staff interviews and records. ardy removal date of rd. Neglect m Abuse, Neglect, and right to be free from abuse, tion of resident property, sfined in this subpart. This	F 6	580		PEFICIENCY)		4/30/25
	treat the resident's me	cal restraint not required to edical symptoms.						

Event ID: EPKA11

Facility ID: 923353

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING ___ С 345283 B. WING 04/08/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE THE CITADEL MOORESVILLE MOORESVILLE, NC 28115 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 600 Continued From page 15 F 600 §483.12(a) The facility must-§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced bv: Based on resident and staff interviews, and The facility failed to protect a resident's record reviews, the facility failed to protect a right to be free from abuse on 10/21/2024 resident's right to be free from physical abuse when NA #8 awakened Resident #2 to when a Nursing Assistant woke a resident from provide incontinence care against his will his sleep to provide incontinent care against his and held the resident's arms resulting in a will and held the resident's arms while the skin tear to resident's left lower arm. The resident was fighting for 1 of 3 sampled residents facility completed an initial report to the (Resident #2). A skin tear to the resident's left state agency complaint intake lower forearm was noted after this incident. department, notified local law enforcement and adult protective services The findings included: (APS). On 10/21/24, the licensed nurse completed a comprehensive assessment Resident #2 was admitted to the facility on including skin assessment, notified the 07/09/2024 with diagnoses of chronic obstructive resident's representative and the medical pulmonary disease, pacemaker, type II diabetes provider. New orders were received and implemented for Resident #2 skin tear to mellitus with chronic kidney disease, and major left lower arm. On 10/23/24, the physician depressive disorder. assistant assessed Resident #2. On A review of the 09/26/2024 provider progress 10/28/24, the Administrator submitted a notes on Resident #2 revealed major depression 5-Day investigation report to the state with psychosis with psychiatric features, agency as appropriate. NA #8 is no longer moderate depression with psychosis, intermittent an employee of the facility. unfounded accusations toward staff and facility with paranoid ideations, and that ISIS wanted to Effective 4/29/25, the Social Worker kill him. Psychotherapy and evaluation and completed abuse questionnaires with cognitively intact residents to ensure aggression with paranoid ideations were pending official notes. Lamictal (a drug used for bipolar I residents are free from abuse and only disorder maintenance) and trazodone (a drug receive care as residents allow. No used for depression) were reviewed. Lamictal additional concerns reported. Effective dosing was switched to nighttime dosing due to 4/28/25, licensed nurses completed body daytime fatigue. audits on cognitively impaired residents to identify any signs of abuse or resistance

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: EPKA11

Facility ID: 923353

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PRINTED: 05/20/2025

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		LE CONOTRUCTION		
		IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		DATE SURVEY
		245202	B. WING			С
		345283	B. WING			04/08/2025
IAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	
THE CITAI	DEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28	8115	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	I'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 600	Continued From page	2 16	F 60	0		
	A Discharge (end of F			to care. No conce	erns observed.	
	(MDS) dated 10/19/20	024 revealed that Resident act and had skin tears.		agency staff were	current facility and in-serviced on the nd Exploitation Policy by	
	Resident #2 care plar that he had a skin tea	n dated 10/19/2024 stated Ir to the right hand.		the Director of Nu Managers, and So		
	right hand had a skin	cian orders revealed that the tear on 10/09/2024 with 0/22/2024 to clean right		recognizing what including refrainin	0,1	
	hand with wound clea with dry dressing eve	anser. Apply xeroform. Cover ry day shift for wound		facility and agence education during	y staff will receive orientation and prior to	
	Clean left wrist skin te apply xeroform. Cove	er started on 10/22/2024 to ear with wound cleanser and r with dry dressing every		responsible for en trained by tracking		
	day shift for wound he	-		and agency orient		
		history of abuse without aumatic Stress Disorder.		evidence of abuse The Social Worke complete ongoing	er and/or designee will	
	The report stated that abuse, history of trau	t Resident #2 denied recent matic events, no suicidal or		conducting abuse (5) facility and/or a	questionnaires with five agency staff and with	
		no audio verbal t. Diagnoses of bipolar and nented by the Psychiatric		ensure understan Neglect and Explo	/ intact residents to ding of the Abuse, pitation Policy ensuring free from abuse to	
	A daily skilled assess	ment authored by Nurse #5		include receiving The DON/Unit Ma	care as resident allows. anagers/Designee will	
		/2024 revealed that ave any unhealed pressure he did have a skin tear. It		(5) cognitively imp	ng resident care for five paired residents to remain free from abuse	
		there was no change in his		and care is provid Monitoring will be	led as residents allow. completed three times a eks, bi-weekly for four	
	10/22/2024 was revie	A) #8's written statement on wed and revealed that the sident #2's room earlier that		weeks, then week Administrator will	kly times four weeks. The report audit findings uality Assurance Process	

Facility ID: 923353

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- (X3) DATE SURVEY COMPLETED C O4/08/2025 STATE, ZIP CODE 3115 'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE DEFICIENCY)
STATE, ZIP CODE 3115 S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)
STIS S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
"S PLAN OF CORRECTION (X5) ECTIVE ACTION SHOULD BE COMPLETION ENCED TO THE APPROPRIATE DATE DEFICIENCY) Image: Completion of the
ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE DEFICIENCY)
pliance and/or revision.
pliance and/or revision.

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 05/20/2025 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345283	B. WING _				C 108/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE		
				M	NOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 600	metformin, an antidiad issues with his bowels During an interview w on 04/02/2025, he rep to change me when I twisted my hands, and into my skin. He nippe fingernails. I told him He didn't mean to hur his job done. He chan him out of my room. If I didn't want to hurt hi me. Just the situation An interview with Res 04/02/2025 revealed to situation we talked ab him was abuse. Resi didn't think so, but "he I resisted. I didn't nee Nurse #8's written sta revealed that no obse reported to him on the Nurse #8 worked on to was assigned. Nurse interviewed. A review of Nurse #7' 10/24/2024 about her revealed that the resid grabbing him while he him. The nurse obser Resident #2 at both th resident reported that Resident #2 reported	recalled Resident #2 was on betic drug, and was having s. with Resident #2 at 1:55 PM ported that NA #8 was "trying didn't need it. I resisted. He d his long fingernails went ed my skin with my he better not do that again. t me. He was trying to get nged me. I told them to keep t's better for us to stay apart. m, and he didn't want to hurt in just gets out of hand." Sident #2 at 4:23 PM on that he didn't think the boot with NA #8 changing ident #2 reported that he e should have stopped when id changing." Attement dated 10/25/2024 ervations from NA #8 were e night shift of 10/21/2024. the same hallway as NA #8 #8 was not able to be s written statement dated to interview with Resident #2 dent reported NA #8's e was sleeping thus startling	F	500			

Facility ID: 923353

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345283	B. WING					。 08/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITAI	DEL MOORESVILLE				50 GLENWOOD DRIVE IOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 600		ory of being rough with him. nit Manager who worked on	F	600				
	10/22/2024 at 3:36 Pl revealed that Resider right hand and a skin Documentation revea	in condition assessment on M authored by Nurse #5 at #2 had a skin tear on the tear on the left lower arm. led that the nurse was 2's family representative a the night NA.						
	3:55 PM on 04/03/202 the NAs to provide ca							
F 684 SS=J	with the Administrator must explain to the nu- refuses care. Then the resident was still resis resident's history of b not a reason to not se reported that the expe- every resident to be more resident's brief must b	e NA must report on why the stant if applicable. A ehavior like Resident #2 is ee about his care. She ectation has been set for ounded on and clean. Each be opened and cleaned if d the NAs to complete a	F	684				4/30/25
	-	are ndamental principle that nt and care provided to						

Facility ID: 923353

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATI	0. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	i		PLETED
		345283	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	040200		STREET ADDRESS, CITY, STATE, ZIP CODE		/08/2025
				550 GLENWOOD DRIVE		
THE CITA	DEL MOORESVILLE			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From page	a 20	F 68	4		
1 004		e 20 sed on the comprehensive		4		
		dent, the facility must ensure				
		e treatment and care in				
	accordance with prof	essional standards of				
		nensive person-centered				
	care plan, and the rea					
		Γ is not met as evidenced				
	by:					
		iews, Emergency Medical		The facility failed to recognize of a change in condition for Re		
		rds, facility staff, Emergency ysician, Physician Assistant		who sustained a fall from bed		
		ector interviews, the facility		at approximately 2:00 PM. Res		
	. ,	e severity of an acute		had a past medical history sign		
		after a fall for Resident #1.		history of stroke, recent pulmo		
	-	ast medical history that		embolism, recent COVID-19, a		
		ion with anticoagulation,		fibrillation, and traumatic brain	injury, who	
		bolism, recent COVID-19,		was prescribed Apixaban (anti	- ,	
		rain injury (TBI), history of		5 milligram (mg) via gastrostor		
		s on one side of body)		twice a day for atrial fibrillation	. In the	
		nfarction, and history of matoma. Resident #1 was		morning hours of 03/26/25 at approximately 8:30 AM, Reside	opt #1 woo	
	prescribed an anticoa			noted by staff with a change in		
		s (mg) via gastrostomy tube		as described by staff as having		
		fibrillation. On 03/25/25		decreased level of consciousn		
	-	2:30 PM Resident #1 had an		easily aroused, lethargic slow		
	unwitnessed fall from	the bed and was assessed		much different than his baselin	e. On	
	to have no visible inju	uries and transferred back to		3/26/25 at approximately 4:50	PM the Unit	
	-	ecks were initiated. Resident		Manager notified the Physiciar		
	-	hat he did not hit his head.		(PA) and orders obtained for b		
		oximately 8:30 AM Resident		urinalysis, and Chest Xray. Vit	-	
		f to be hard to arouse,		neurological checks remained throughout the night.	sladie	
		sive, and lethargic. At 4:50 Jnit Manager (UM) notified		On 03/27/25 at approximately	9·58 AM	
		#1 was "lethargic" and		Resident #1 became non-resp		
		loodwork, urinalysis, culture		Emergency Medical Services (
		chest x-ray. On 03/27/25 at		called by the licensed nurse ar	•	
	-	's family came to the facility		ordered by the Physician Assis		
	and found him unresp			Resident #1 was diagnosed wi		
	Emergency Medical S		1	and a left subdural hematoma		1

Facility ID: 923353

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		י יחוד		OMB NC (X3) DATE	
	CORRECTION	IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· /	LETED
			A. BUILDI	ING _			C
		345283	B. WING				。 08/2025
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	04/	00/2025
					50 GLENWOOD DRIVE		
THE CITA	DEL MOORESVILLE				NOORESVILLE, NC 28115		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETIO
F 684	Continued From page	e 21	F	684			
		sported to the Emergency			transferred and placed on Hospice		
		d diagnosed with a "huge left			services where he passed away on		
		with a midline shift" (shifting			03/31/25.		
	of brain past its cente				On 4/3/25, the DON and Nurse		
		ce services and passed			Consultant completed an audit of		
		his affected 1 of 3 residents			residents on anticoagulant therapy who		
	reviewed for change	in condition.			have experienced a fall within the last 7	2	
					hours to ensure timely recognition and		
		began on 03/26/25 when			response occurred if the resident		
		ed to have had an acute			experienced a change in condition. Two residents were identified and no concer		
		condition and was not red to a higher level of care			identified.	ns	
		diate Jeopardy was removed			On 4/4/2025, the DON and Unit Manag	ore	
		e facility implemented an			reviewed all residents with changes in	013	
		allegation of immediate			condition in 24 hours to ensure immedia	ate	
	-	le facility will remain out of			notification to the Medical Provider		
		r scope and severity D			occurred. Six residents were identified,		
		al harm with potential for			assessed and the Medical Provider was	6	
		arm that is not immediate			notified.		
	jeopardy) to complete	e education and ensure			On 4/3/25, the Administrator, Director o	f	
	monitoring systems p	out into place are effective.			Nursing (DON), Vice President of Risk		
					and Quality Assurance (VPRQA), Nurse		
	The findings included	l:			Consultant, PA and Medical Director he		
					an Ad Hoc QAPI meeting to discuss the		
		nitted to the facility on			incident to determine root cause analys	IS	
		ses that included atrial			of the facility's failure to recognize the		
	of cerebral infarction	pulmonary embolism, history			severity of a change in condition for Resident #1. Root cause analysis		
	traumatic brain injury				determined that the facility failed to hav	e	
					effective systems in place and monitorin		
	Review of a physiciar	n order dated 02/28/25 read;			measures to ensure timely response an		
		s (mg) via gastrostomy tube			notification is made to a medical provide		
	two times a day	· -· - ·			for proper intervention up to and includi		
	for atrial fibrillation.				transfer to a higher level of care.	-	
					On 4/3/2025, the Director of Risk and		
	A review of Resident	-			Quality Assurance, Nurse Consultant,		
		e Resident received an			Director of Nursing, Administrator, and		
		ation related to a diagnosis of			Physician Assistant reviewed the chang	e	
	atrial fibrillation. The	goal that Resident #1 will be			in condition and fall policy. No changes		

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TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE	CONSTRUCTION	OMB NC (X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMP	PLETED
							С
		345283	B. WING			04/	08/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE		
				IV	IOORESVILLE, NC 28115		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIC DATE
F 684	Continued From page	2.22	F 6	201			
1 001	free from adverse sid		FU	04	were made.		
		cation would be attained by			Effective 4/3/25, the Director of Nursing	r	
	-	such as administering the			Nurse Consultant, and Nursing	1,	
		cation as ordered and			Administration initiated education with	all	
	-	fects specifically for bleeding			facility and contracted licensed nurses		
	-	s a history of gastrointestinal			and Certified Nursing Assistants on the	•	
	bleed.	, C			facility Notification of Changes in		
					Condition and Fall Prevention policies.		
	Further Review of Re				Education includes recognizing the		
		re plan for falls prior to the			severity of a change in condition status		
	fall on 03/25/25.				post fall to include post fall assessment		
		<i></i>			changes for 72 hours, changes in level		
		#1's admission Minimum			consciousness, and altered mental stat	tus	
		t dated 03/07/25 revealed he			away from baseline. Upon licensed		
		. The Resident was coded ial to maximal assistance			nurse's assessment recognizing the severity of the residents change in		
		daily living except eating. It			condition away from baseline post fall,	the	
	was documented that				Medical Provider will be immediately		
	admission and receiv				notified. Certified Nursing Assistants wi	ill	
		5			communicate any residents change in		
	A review of Resident	#1's Medication			condition away from baseline to the		
	Administration Record	d (MAR) for 02/2025 and			licensed nurses. The Director of Nursin	ıg	
		Resident had received an			and/or Unit Managers will ensure all ne	wly	
		tion apixaban 5 mg via			hired facility and contracted licensed		
	•	ce a day for atrial fibrillation.			nurses and certified nursing assistants		
		Resident #1 received the			receive education during orientation an	d	
		ered since his admission			prior to accepting their assignment.		
	date of 02/28/25.				As of 4/5/25, the DON/Unit		
	An incident report dat	ted 03/25/25 at 2:00 PM and			Manager/Nurse Supervisor will monitor using a Quality Assurance tool. The		
		evealed Resident #1 was in			monitoring will ensure licensed nurses'		
	-	Nurse #1 was called to the			assessment, timely notification to the		
		upon arrival Resident #1			medical provider, and follow-up		
		next to his bed. Resident #1			interventions are implemented for		
		and he did not know what he			residents with a change in condition		
	was trying to do. A he	ead-to-toe assessment was			post-fall on anticoagulation therapy. Th	e	
		1 was moving all extremities			QA monitoring will be conducted three		
		. The Resident complained			times a week x 4 weeks, biweekly x 4		
	of back pain which he	e does most of the time and			weeks, and then weekly x 4 weeks. The	0	1

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	F DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	PLE CONSTRUCTION		O. 0938-039 E SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	· · ·	G	Сом	IPLETED
		345283	B. WING			С
	ROVIDER OR SUPPLIER	545205		STREET ADDRESS, CITY, STATE, ZIP		/08/2025
				550 GLENWOOD DRIVE	00DL	
THE CITAI	DEL MOORESVILLE			MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	23	F 68	34		
		medication for pain. No		DON/Administrator will re	port the results	
	injuries were noted, a	nd Resident #1 was		of the QA monitoring mor	ithly to the	
	assisted back to bed			Quality Assurance Proces		
		ere initiated, and all vital		(QAPI) committee for con		
	do frequent rounding	normal limits. Staff were to		compliance and/or revision	on.	
	positioning while in be					
	A nursing progress no	ote written by Nurse #1 on				
		indicated Resident #1 was				
		e his needs known. The				
		after lunch when Nurse #1				
		nt #1's room (by Nurse Aide rival the Resident was lying				
		s bed. When Resident #1				
	was asked what he w	as trying to do, the Resident				
		hot know what he was				
		o-toe assessment was				
	-	lent #1 being able to move hout any problems. No				
		esident was transferred to				
		2 person assist (Nurse #1				
		#1 complained of back pain				
	and a pain medication					
	-	checks were initiated, and gns were within normal				
	limits.					
		logic checks with vital signs				
		were initiated on 03/25/25 at				
		ed through 03/27/25 at 9:00 check assessment dated				
		was not documented. The				
		gic checks indicated the vital				
	signs were within nor	mal limits and the grips were				
		r and lower motor function				
	of the extremities wer	e present.				

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	MENT OF HEALTH AN						FORM): 05/20/2025 MAPPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345283	B. WING			_		08/2025	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE			
	DEL MOORESVILLE			(550 GLENWOOD DRIVE				
	DEL MOORESVILLE			!	MOORESVILLE, NC 28	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	of 03/25/25. No injurie were reported. The ne baseline and no acute The Resident was sta hospitalization with a cerebral vascular acc hemiparesis, pulmona gastrointestinal bleed apixaban 5 mg two tir 119/76, 73, 18, 97.6 a 96%. Assessment Pla measures and neuro and continue to monitor continue to monitor of provider as needed. During an interview w 2:40 PM the Nurse co from 7:00 AM to 7:00 explained that she wa was on the floor in his went to the Resident's the floor and when the how he got on the floo guessed he turned ov remember. The Resic pain, and she gave hi that was effective. Th explain that they (Nur Resident #1 back in th Nurse #1 stated she a his head, and he mad funny which was his r indicated she specific head because it was there were no visible	led Resident #1 was ning a fall earlier in the day es or cognition changes eurologic exam was at a distress was appreciated. tus post recent complicated history of atrial fibrillation, ident with residual left ary embolism and recent . Medications include nes a day. Vital signs and oxygen saturation of an: continue post fall checks per the facility policy or for bleeding. Nursing will hanges and inform the ith Nurse #1 on 04/02/25 at onfirmed that she worked PM on 03/25/25. The Nurse is notified that Resident #1 is room by NA #1. Nurse #1 is room to find him lying on e Nurse asked Resident #1 or, he stated that he ter, but he could not lent complained of back m some pain medication e Nurse continued to	F	684					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		345283	B. WING			_		08/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	continued the neurolo rest of the shift and the remained within norm was alert and talkative demeanor. The Nurse off to Nurse #3 at the continued to explain the work on 03/27/25 for informed her that Ress she did not think to as lethargic. Nurse #1 ex assess Resident #1, a when she tried to wak would not wake up an stated she reviewed h indicated he had labs and a chest x-ray was reported that the UM was doing that day an that he was lethargic, Resident had labs dra #1 reported that while morning medications arrived to obtain a che Resident #1's family of her that Resident #1 v and was aware that h stated that Resident # bleeds. The Nurse inf that were ordered, an done but the family in transferred to the hos the PA and was given Resident #1 to the ho On 04/02/25 at 12:55 AM interviews were or	Jurse #1 explained that she begic checks throughout the re neurologic checks al limits and Resident #1 e, which was his normal e indicated that she reported change of shift. Nurse #1 hat when she returned to the 7:00 AM shift, Nurse #3 ident #1 was lethargic, but sk how long he had been cplained that she went to and he was sleeping and the was sleeping and the was lethargic. She his progress notes which drawn and a urine sample a due to be done. Nurse #1 asked her how Resident #1 hot Nurse #1 informed her and the UM stated that the awn the day before. Nurse e she was passing her the radiology technician est x-ray. Shortly after that, came to visit and informed was not acting like himself e had a fall on 03/25/25 and 41 had a history of two brain formed the family of the labs d the chest x-ray had been sisted that Resident #1 be pital, so Nurse #1 notified an order to transfer	F	684				

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DEPARTMENT OF HE							FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<u>, , , , , , , , , , , , , , , , , , , </u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			-		C 08/2025
NAME OF PROVIDER OR SUP	PLIER	-		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE CITADEL MOORESV	ILLE				550 GLENWOOD DRIVE	15		
PREFIX (EACH [EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
after lunch sh Resident #1's on the floor of his roommate the call light f explain that s or if he hit his Resident told of injury or bl informed the Nurse #1 whi assessed Re put him back checked on F she went off trying to do w responded, " NA explained demeanor to to explain tha PM on 03/26, assignment, #1 and found responding a she helped N for therapy at was limp like a change in t NA #1 reports Physical The how the Resi 03/25/25 and the bed.	n 03/25/2 he answer s room a n his left or Resident che asker s head di her no a eeding fi Resident ch she of sident # in bed. I Resident ch she of sident # in bed. I Resident ch she of shift and then he fi I don't kr I that it w joke with t she woo but she woo him to b s his usu (25 but she but she woo him to b s his usu a rag do he Resident a rag do he Resident they bo was con at 10:15 7:00 AM	2 26 25. The NA explained that ered the call light for and found Resident #1 lying is side between his bed and The roommate had pushed lent #1. NA #1 continued to d Resident #1 if he was hurt uring the fall and the and she saw no visible signs rom Resident #1. NA #1 t that she was going to get lid and after Nurse #1 1 they used the total lift to NA #1 reported that she #1 one more time before asked him what he was fell and the Resident now, dancing I guess." The vas Resident #1's usual in the staff. NA #1 continued orked from 7:00 AM to 3:00 whe worked on a different went to check on Resident to e lethargic and basically not ual self. The NA stated that t Resident #1 out of the bed d-morning and the Resident of and lethargic and that was dent since the day before. he went and got the ustant (PTA) and reported is acting since the fall on th put Resident #1 back in	F	684				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM): 05/20/2025 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING _				(04/	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER		· ·	ST	TREET ADDRESS, CITY, STATE,	ZIP CODE		
				55	50 GLENWOOD DRIVE			
	DEL MOORESVILLE			M	OORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE CROSS-REFERENCEL	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 684	Resident #1 one time was alert and converse daughter with her nam when she went in to co- morning (03/26/25) ar immediately that he we their previous encoun- response was slower, with her like he norma- explain that around 10 get Resident #1 out o went to inform therapy acting and therapy an back to bed. NA #2 re- notify Nurse #2 of Res Nurse #2 went to his explained that Reside throughout the rest of into care for him. During an interview we Assistant (PTA) on 04 explained that she ha since his admission, a participate in therapy. morning of 03/26/25 N go to Resident #1's ro- had a fall out of bed th gotten him out of bed he was not behaving The PTA stated she we and could see that he responding to her as I and NA #1 put the Re explained that she rep #2 and the Nurse info- reported to her that R PTA continued to expl	before 03/26/25, and he sed with her about having a ne. NA #2 reported that are for Resident #1 on that ound breakfast, she knew vas acting differently from ter because the Resident's and he was not conversing ally did. NA #2 continued to 0:00 AM NA #1 helped her f bed for therapy and NA #1 y of how Resident #1 was d NA #1 put the Resident ported that she went to sident #1's condition and room to assess him. NA #2 nt #1 acted the same the shift when she went ith the Physical Therapy /02/25 at 11:45 AM the PTA d worked with Resident #1 and he was able to She reported that on the NA #1 came and got her to nom because the Resident ne day before and they had for his therapy session, but like his normal behavior. vent into Resident #1's room was lethargic and not ne normally did, and she sident back to bed. The PTA ported her concern to Nurse	F 6	84				

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATE SURVEY	8-03
	CORRECTION	IDENTIFICATION NUMBER:			COMPLETED	Ŷ
			A. BUILDIN	NG		
		245002	P MINC		С	
		345283	B. WING		04/08/202	25
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE	
	DEL MOORESVILLE			550 GLENWOOD DRIVE		
				MOORESVILLE, NC 28115		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION (X	X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	C (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE DA	ATE
F 684	Continued From page	28	F 6	84		
		y made eye contact with the		-		
		e Resident made "groaning				
		" while he was sleeping.				
	and meaning counds					
	Interviews were cond	ucted with Nurse #3 on				
		and 04/04/25 6:55 AM. The				
		she worked with Resident				
		gh 03/26/25 for the 7:00 PM				
		7:00 PM to 7:00 AM for				
	03/26/25 through 03/2	27/25. Nurse #3 explained				
	-	ne report on 03/25/25 that				
		d a fall from the bed and the				
	neurologic checks we	ere on going. When the				
		ss Resident #1, he was alert				
	and talkative and info	rmed her that he had a fall				
	before she asked the	Resident about the fall. The				
	Nurse indicated that e	every time she went into				
	assess Resident #1, I	he spoke with her and his				
	neurologic checks an	d vital signs were within				
	normal limits and rem	ained within normal limits				
	throughout the rest of	the shift. Nurse #3				
	continued to explain t	hat she reported off to				
	Nurse #2 the morning	of 03/26/25 and informed				
	the Nurse that Reside	ent #1 had a fall and that his				
	neurologic checks we	ere on going and she				
		24-hour report sheet. Nurse				
		ame on duty at 7:00 PM on				
	•••=•	d on the residents and found				
		lethargic. Nurse #3 was				
	•	Manager (UM) that labs,				
		ay had been ordered for				
		she had to collect the urine				
	•	the lab to pick up. The				
		ained the urine, and the lab				
		around 4:00 AM in the				
	÷	Resident's labs so that just				
	left the chest x-ray wh	hich she reported to Nurse				
	-	r report that morning. Nurse				

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391	
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 345283		· /		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C		
		345283	B. WING			_		08/2025	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	DEL MOORESVILLE				550 GLENWOOD DRIVE				
	DEL MOORESVILLE				MOORESVILLE, NC 287	115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORREC CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page night, and she was at checks except the gri sleeping. The Nurse i signs were stable. Nu was able to connect h medicate him through clean the gastrostomy the external tube feed that was not unusual could be a "hard sleep had been during the o the provider, but she h already been informer and his lab work was Interviews were cond 04/02/25 at 11:30 AM Nurse #2 confirmed th Resident #1 on 03/26 PM and it was the firs the Resident. Nurse # receive in report from had fallen but she did about the Resident. N	e 29 ble to perform the neurologic ps because he was ndicated the Resident's vital rse #3 reported that she his external tube feeding, his gastrostomy tube, y tube site and disconnect ling without waking him but for the Resident because he per." Nurse #3 reported if it day she would have called knew the provider had d of Resident #1's condition pending. ucted with Nurse #2 on and 04/03/25 at 11:35 AM.		684]				
	(PTA) member inform a fall and was not acti went to assess him. N	ed her that Resident #1 had ing like himself and she lurse #2 stated Resident #1							
	but he would not resp indicated that she obt signs which were with completed a change i reported the change i the UM got out of a m 10:30 AM and the UM would call the PA. The	when she called his name, ond to her. The Nurse ained the Resident's vital nin normal limits and n condition assessment and n condition to the UM after weeting which was around 1 informed Nurse #2 that she e Nurse explained that they ome blood work, urine and a							
		e #2 called the Resident's							

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	-	D HUMAN SERVICES					FORM	05/20/2025
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		345283	B. WING			_	(04/	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
				550	GLENWOOD DRIVE			
THE CITA	DEL MOORESVILLE			МС	ORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	responsible party twice message on the cell p if the responsible part left off shift around 3:0 asked why she did no Nurse indicated that s Resident and wanted condition to her Unit M A review of a Change completed by Nurse # revealed Resident #1 very less responsive. Pulse 64, Respiration via forehead and rece Decreased level of co lethargic). The assess the responsible party A review of Resident # 03/26/25 written aroun for a Complete Blood (CBC/Diff) in AM, Urir and Sensitivity (UA/C X-Ray (CXR) for coug orders were written by Interviews were conde on 04/02/25 at 5:00 P AM. The UM explaine Resident #1's fall by N after the fall happened Resident did not susta Nurse #1 initiated the included vital signs as The UM continued to 03/26/25 at approxima out of the Risk Manage	te but had to leave a bhone and she did not know y called back because she D0 PM. When Nurse #2 was t call the PA herself the she was not familiar with to report the Resident's Manager. in Condition Assessment 42 on 03/26/25 at 2:35 PM was drowsy, lethargic and Blood Pressure 115/62, s 18 and Temperature 97.7 ent oxygenation 95%. Insciousness (sleepy, sment indicated the PA, and were notified. #1's physician orders on and 5:40 PM indicated orders Count with Differential the for Urinalysis and Culture &S) if indicated and a Chest gh were obtained. The	F 6	84				

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	MENT OF HEALTH AN					FORM	05/20/2025
STATEMENT (S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	
		345283	B. WING		_	(04/0	C 08/2025
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
THE CITA	DEL MOORESVILLE			50 GLENWOOD DRIVE	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	document a change in responsible party. The stepped into Resident him but the Resident of lethargic. She indicate an assessment on Re- continued to explain the PA about other reside PA at that time and re- a change in condition stated she received of culture and sensitivity she put in the comput Nurse #3 was to colle phlebotomist was to co- made their next round indicated Resident #1 and they were trying the During an interview we 11:40 AM the NA confi Resident #1 on 3:00 F 03/26/25. The NA exp remembered Resident refusing his supper. So only answer her quest responses and slept re- stated she had not we enough to determine if demeanor, so she did to report his behavior. An interview was configured 04/03/25 at 8:15 AM we worked with Resident PM to 7:00 PM. The No only worked with the F	hargic and she was going to a condition and call the a UM stated that she a UM stated that she a this room and laid eyes on did not appear to her to be ad that she did not complete sident #1. The UM hat since she had to call the ported that Resident #1 had and was lethargic. The UM rders for lab work, urine for and a chest x-ray which er. The UM reported that ct the urine, and the btain the blood when they to the facility. The UM 's vital signs were stable, o rule out infection. ith NA #3 on 04/04/25 at irmed that she worked with PM to 11:00 PM on lained that she t #1 being quiet and he indicated that he would tions with one-word nost of the shift. NA #3 orked with Resident #1 f it was his normal not think it was abnormal	F 684				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/20/2025 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_	(04/	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
THE CITAI	DEL MOORESVILLE			550 GLENWOOD DRIVE	115		
			I				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page stated she did not get or she would have con- checks. Nurse #4 repri- would answer her que give him his enteral fe she had known or sus had a change in cond the provider on call. An interview was cond on 04/03/25 at 10:30 a she worked with Resid PM through 03/27/25 explained that she nor not acting like his nor 03/26/25 and reported working with her that her that Resident #1 h they had notified the F lab work. NA #5 state and reposition Reside and basically sleep th unusual because the grunt and moan when Review of a progress 03/27/25 at 10:52 AM continued to appear le at the time, requested to ED for more evalua and an order was reca EMS at around 10:19 T97.3, R18, P112, 02	e 32 in report that he had a fall, impleted the neurologic orted that the Resident estions and allowed her to beding. The Nurse stated if spected that Resident #1 ition she would have notified ducted with Nurse Aide #5 AM. The NA confirmed that dent #1 on 03/26/25 3:00 to 7:00 AM. The NA ticed that Resident #1 was mal self on the evening of d it to Nurse #3 who was night. The Nurse informed had a fall the day before and PA and were given orders for d that she was able to check ent #1 throughout the night rough it all which was Resident would normally	F 684				
	to find Resident #1 lyi	at the facility at 10:10 AM ng in the bed unresponsive, thing approximately 40					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING					C 08/2025
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE,	ZIP CODE		
				5	550 GLENWOOD DRIVE			
	DEL MOORESVILLE			r	MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVI CROSS-REFERENCE	AN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
F 684	times a minute. They that he had fallen 2 da indicate how the Resi the Resident was par- cerebral vascular acc at bedside and advise normally alert and ver conversation, so they Resident was unrespo- obtained at 100.6 axil access was establish given. The Resident r throughout the transp A review of Resident r 03/27/25 revealed Re with a history of intrace mental status and suf Resident received ap Resident #1's vital sig but remained negative Coma Scale (GCS) (a tool used to measure conscientious especia was a 3 meaning the consciousness and is deep coma or death r unresponsive. The co results of the brain re hematoma measuring length, thickness of 3 This results in severe hemisphere with 1.5 of developing right side fluid deep within the of report indicated the R consulted on his cond condition the family of	were advised by facility staff ays prior but could not dent fell as it was noted that alyzed from previous idents. The family was also ad that the Resident was rbal and could carry a called EMS because the onsive. His temperature was lary, and intravenous ed, and a fluid bolus was remained unresponsive ort. #1's hospital records dated esident #1 arrived at the ED cranial hemorrhage, altered odural hematoma. The ixaban 5 mg twice a day. gns rose to 212/108, 124, 40 e for fever. The Glasco a neurological assessment a person's level of ally in traumatic brain injury) lowest possible level of usually associated with the meaning the person is wholly imputed tomography (CT) vealed a huge left subdural g 15.1 centimeters (cm) in .4 cm and height of 9.7 cm. compression of the left cm midline shift. There is hydrocephalus (a buildup of cavities of the brain). The	F	684				

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						FORM	05/20/2025
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE COMP	
		345283	B. WING		_	(04/	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER	1	s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
THE CITAI	DEL MOORESVILLE			MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	34	F 684				
	Physician explained F the ED by EMS who r one and a half days p level of consciousness vital signs were not te pressure was 208/100 The ED Physician cor CT results showed a 1 hemorrhage of a subor midline shift and after about the probable pr Hospice services whe day. The ED Physicia signs of injuries to acc hematoma, but it wou there not to be visible was that the hematom not be sure when it st was different and it co the fall. He indicated i bleed and when it cro when Resident #1 sta level of consciousness asked if he thought R diagnosis of COVID-1 the ED Physician stat Interviews were cond Assistant on 04/02/25 12:45 PM. The PA ex facility on 03/25/25 ar Resident sustained a #1 late that same night	5 at 10:20 PM. The ED Resident #1 was brought to reported he had a fall one to virior and had a decreased s. He stated the Resident's errible, but his blood 0 and his pulse was 124. Intinued to explain that the huge intracranial dural hematoma that had a discussion with the family ognosis the family opted for ere he was sent that same in reported that he saw no count for the subdural ild not be uncommon for signs. He stated his opinion ha was acute, but he could arted because everyone build have even been before it could have been a slow ssed the midline shift was erited having a decreased s. The ED Physician was esident #1's recent 19 affected his outcome and ded probably not.					
	•	which made his condition					

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	-	ID HUMAN SERVICES				FORM	05/20/2025
STATEMENT	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			(X3) DATE COMP	LETED
		345283	B. WING		_	04/	C 08/2025
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
			5	50 GLENWOOD DRIVE			
THE CITA	DEL MOORESVILLE		N	OORESVILLE, NC 281	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	worse since he had a PA continued to explat the Resident, she did continue the facility's neurologic checks. The called her the next da PM when the Resider When the PA was ask Resident #1 was lether could not remember to UM used in describing condition, but she felt labs, urine and a chest issue. The PA reporte 03/27/25 she was not Resident #1's family w wanted him sent to th Nurse an order to ser hospital. The PA state Resident #1 had a su could show up in 72 h injury and as soon as in condition, they calle PA stated it was poss have had a slow hem bleed. During an interview w Director of Nursing (D PM. The DON explain Resident #1's fall sho could not remember w told her that there we hit his head. The DON about Resident #1 in meeting, and she spe neurologic checks that there were no problem	neurological condition. The ain that when she assessed not order anything but to protocol for post fall ne PA reported that the UM ay on 03/26/25 around 4:50 nt had a change in condition. We dif she was notified that argic, the PA stated she he exact verbiage that the g the Resident's change in that she needed to obtain st x-ray to diagnose the ed that the next morning on iffied by Nurse #1 that was at the facility and he hospital and she gave the no Resident #1 out to the ed she now knew that bdural hematoma which hours after a fall with head the facility noticed a change ed the PA for guidance. The ible that Resident #1 could orrhage from a previous was conducted with the DON) on 04/03/25 at 2:40 hed that she was notified of rtly after it happened but who notified her, but they re no injuries, and he did not N reported that they talked the Risk Management	F 684				

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		-	(X3) DATE COMP	SURVEY LETED
		345283	B. WING		_		C 08/2025
NAME OF P	ROVIDER OR SUPPLIER		· ·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE CITA	DEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28	115		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	03/26/25 she went int in bed and asked him Resident told her that and that he was not h not usually have. The thing she knew was th sent to the emergency the family's request. T know that Resident # on 03/26/25. On 04/03/25 at 3:10 F conducted with the Ac Administrator explaine the fall protocol and c with vital signs and th stable until Resident # on 03/26/25. At that ti was notified, and orde urine and a chest x-ra the family insisted that hospital. She indicate on the residents to be facility accommodated Administrator acknow hospital admission dia subdural hematoma v indicated it could have Resident's last trauma An interview was com Director on 04/04/25 a Director stated that he #1's situation by the F events that led to the hospital. The Medical Resident #1's comple	er falls and on Wednesday o see Resident #1 who was how he fell, and the he did not know how he fell aving any pain that he did DON reported that the next hat Resident #1 was being y department on 03/27/25 at The DON stated she did not 1 had a change in condition PM an interview was dministrator. The ed that the facility followed onducted neurologic checks e neurologic checks were #1 had a change in condition me the Physician Assistant ers were received for labs, y which were pending when t Resident #1 be sent to the d that when families insist sent to the hospital the d the request. The ledged Resident #1's agnosis of a huge left <i>v</i> ith a midline shift and e been growing since the	F 68	4			

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		D HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 MAPPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345283	B. WING			-		C 08/2025
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
	DEL MOORESVILLE			5	50 GLENWOOD DRIVE			
				N	MOORESVILLE, NC 281	15		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
TAG F 684	Continued From page when they noticed a c indicated that the outo changed but the facilit The Administrator was Jeopardy on 04/03/25 The facility implement Allegation of Immedia Identify those recipier are likely to suffer, a s a result of the noncon The facility failed to re change in condition for sustained a fall from t approximately 2:00 PI medical history signifi recent pulmonary emil atrial fibrillation, and t was prescribed Apixa milligram (mg) via gas for atrial fibrillation. In 03/26/25 at approximation was noted by staff wit described by staff as consciousness, not ea to respond, much diffe 3/26/25 at approximation Manager notified the fand orders obtained for	e 37 change in his condition. He come might not have ty should have sent him out. s notified of Immediate 5 at 4:40 PM. ted the following Credible te Jeopardy removal. the who have suffered, or serious adverse outcome as apliance: ecognize the severity of a or Resident #1 who bed on 03/25/25 at M. Resident #1 had a past cant for history of stroke, bolism, recent COVID-19, raumatic brain injury, who ban (anticoagulant) 5 strostomy tube twice a day the morning hours of ately 8:30 AM, Resident #1 h a change in condition as having a decreased level of asily aroused, lethargic slow erent than his baseline. On		684			TE	DATE
	checks remained stat On 03/27/25 at appro #1 became non-responded to the comparison of the comparison	ble throughout the night. ximately 9:58 AM Resident onsive and Emergency						

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	-	ID HUMAN SERVICES				FORM	: 05/20/2025 APPROVED			
CENTERS FOR MEDICARE & MI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED				
		345283	B. WING			C 04/08/2025				
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE					
THE CITA	DEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28115						
(X4) ID PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE			
TAG	REGULATORY OR L	SCIDENTIFYING INFORMATION)	TAG		NCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE			
F 684	SUMMARY STATEMENT OF DEFICIENCIES		F 684							

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		D HUMAN SERVICES				FORM): 05/20/2025 1 APPROVED	
CENTERS FOR MEDICARE & STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		345283	B. WING			C 04/08/2025		
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE	_		
THE CITA	DEL MOORESVILLE		550 GLENWOOD DRIVE MOORESVILLE, NC 28115					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	DEL MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 On 4/3/2025, the Director of Risk and Quality Assurance, Nurse Consultant, Director of Nursing, Administrator, and Physician Assistant reviewed the change in condition and fall policy. No changes were made. Effective 4/3/25, the Director of Nursing, Nurse Consultant, and Nursing Administration initiated education with all facility and contracted licensed nurses and Certified Nursing Assistants on the facility Notification of Changes in Condition and Fall Prevention policies. Education includes recognizing the severity of a change in condition status post fall to include post fall assessment changes for 72 hours, changes in level of consciousness, and altered mental status away from baseline. Upon licensed nurse's assessment recognizing the severity of the residents change in condition away from baseline post fall, the Medical Provider will be immediately notified. Certified Nursing Assistants will communicate any residents change in condition away from baseline to the licensed nurses. The Director of Nursing and/or Unit Managers will ensure all newly hired licensed nurses and Certified Nursing Assistants will be educated during orientation and contracted staff educated prior to taking their assignment. Effective 4/3/25, the Administrator is ultimately responsible for the implementation and completion of this removal plan. Alleged Date of IJ Removal: 04/05/2025 On 04/08/25 the credible allegation of Immediate Jeopardy removal with a removal date of 04/05/25 was validated by onsite verification through staff interviews, record reviews, and		F 68					

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 05/20/2025 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C 04/08/2025		
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE NOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	Ē	(X5) COMPLETION DATE
F 684	nursing assistants. The related to the facility's changes in conditions changes in conditions changes in conditions reported new proceduc changes in conditions reported their response when changes in con- aides voiced their reside changes in the reside was noticed to the nu	ration, licensed nurses and ne staff interviews were s policy and procedures for specifically how to identify a and notification upon s. The management team ures in monitoring for s, the licensed nurses sibility to assess residents ditions occur and the nurse ponsibility in reporting ents' conditions as soon as it rse responsible for the tion provided for the staff staff interviews and e records.	F	684				

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