STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 06/09/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced COVID19 focused survey was conducted on 6-2-20 through 6-9-20. The facility was found in compliance with CFR 483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# GXEO11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 6-9-20. 2 of 2 complaint allegations were substantiated resulting in deficiency. Event ID# GXEO11	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the	F 561		6/16/20

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

Electronically Signed | 06/17/2020

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F 561	Continued From page 1 facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident representative interviews and physician interviews the facility failed to honor 4 of 5 residents (Resident #1, #2, #3 and #4) choice to remain in the facility after testing positive for COVID19. Findings included: Review of the facility's "Transfer or Discharge Documentation" policy and procedure dated December 2016 revealed the following in part; each resident will be permitted to stay in the facility and not be transferred or discharged unless the resident's needs cannot be met in the facility. 1. Resident #1 was admitted to the facility on 1-10-17 and transferred to another Long-Term Care Facility on 5-28-20 after testing positive for COVID19. Resident #1 also had the following diagnosis chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 4-15-20 revealed Resident #1 was minimally cognitively impaired. Resident #1's care plan dated 4-21-20 revealed a goal that the resident would be given the opportunity to make choices related to her	F 561	The facility failed to honor 4 of 5 residents (Resident #1, #2, #3 and #4) choice to remain in the facility after testing positive for COVID19. All residents have the potential to be affected. Upon review, facility did not provide residents nor resident□s responsible party with a choice to stay in the facility for treatment.The transfer to another facility , was the result of facility not having solid acceptable processes in place to meet Forsyth County Health Departments reccomendations to provide care and acceptable isolation barriers for residents with positive covid-19 test. II. Education was provided from 06/10/20 - 6/15/20 to Nursing Staff and Social Services Department by the Director of Nursing and Assistant Director of Nursing to ensure the residents preferances are honored and notification of any upcoming discharge is provided to the resident and resident representative before any transfers out of the facility not to include any emergency transfer to hospital emergency rooms. Licensed Nurses will record the reasons and notifications for any emergency transfer or discharge in the resident□s medical record. nursing staff and social	

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F 561	Continued From page 2 treatment through collaboration with her responsible party. The interventions associated with the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or another physician's office. Review of Resident #1's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility. The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility. Resident #1's legal representative was interviewed on 6-4-20 at 2:27pm by telephone. The representative said she had received a call on 5-28-20 by the facility social worker that Resident #1 needed to be transferred to another facility "because she tested positive for COVID". She also stated when she spoke with the social worker, she was not given the choice for the resident to remain in the facility "I was told she had to be transferred or discharged." The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #1's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID.	F 561	services staff will have completed education by 6/15/20, As requested by Ombudsman, Social Services Director will maintain Transfer/Discharge log and submit notice of transfer log to Ombudsman monthly. III. Beginning 6/10/20, an audit will be conducted weekly for twelve (12) weeks by the Social Service Director to ensure upon any discharge , a letter of discharge is provided to the resident and resident representative and notice of transfer will be added to the monthly log for the ombudsman notification. V. Social Service Director will report findings and resolution monthly for a minimum of three (3) months to the QAPI Committee. Data results will be reviewed and analyzed for the need for further monitoring beyond the three months with subsequent POC as needed. Social Service Director and Administrator will be responsible for overall compliance.	

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The social worker said "some" of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged. She also stated the choice for the resident to stay in the facility was not an option and said, "we were told by corporate that they had to be transferred or discharged."

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives.

2. Resident #2 was admitted to the facility on 12-28-16 and transferred out of the facility on 5-28-20 due to testing positive for COVID19. Resident #2 was also diagnosed with malignant neoplasm of the colon and diabetes.

The quarterly Minimum Data Set (MDS) dated 5-7-20 revealed Resident #2 was severely cognitively impaired.

Resident #2's care plan dated 5-12-20 revealed a goal that he would be given the opportunity to make choices related to his treatment through collaboration with his responsible part. The interventions for the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if

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treatment is indicated at an outside location i.e., hospital and/or another physician's office.

Review of Resident #2's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility.

The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility.

Resident #2's legal representative was interviewed by phone on 6-4-20 at 3:28pm. The representative said he was notified by the facility social worker of the transfer to another facility by telephone on 5-28-20 due to the resident testing positive for COVID. He also stated when he spoke with the social worker, he was not provided the option for Resident #2 to remain in the facility. He stated, "I was just told he had to be transferred and that there were no other options."

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #2's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said "some" of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged. She also stated the

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choice for the resident to stay in the facility was not an option and said, "we were told by corporate that they had to be transferred or discharged."

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives.

3. Resident #3 was admitted to the facility on 10-4-19 and transferred to another facility on 5-28-20 related to testing positive for COVID19. Resident #3 was also diagnosed with encephalopathy.

The quarterly Minimum Data Set (MDS) dated 5-8-20 revealed Resident #3 was moderately cognitively impaired.

Resident #3's care plan dated 5-14-20 revealed a goal that she would have a safe discharge to the community and her discharge arrangements would be completed prior to her discharge date. The interventions associated with the goal were in part; Explain discharge instructions to the resident and her representative.

Review of Resident #3's electronic medical record revealed no documentation of the representative's response of the residents transfer to another facility.

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The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility.

Resident #3's representative was interviewed by telephone on 6-4-20 at 4:02pm. The representative stated he had not received a call from the facility notifying him of the resident's transfer. He said, "I was not told about the positive COVID test or the transfer until I called the facility to speak to her and was told she was moved to another floor due to testing positive and would be transferred to another facility that day (5-28-20)." The representative said he had informed the social worker he did not want Resident #3 transferred to another facility but stated "I was told either she had to be transferred or discharged". The representative stated he was not provided a choice for Resident #3 to remain in the facility.

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #3's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said "some" of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged. She also stated the choice for the resident to stay in the facility was

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not an option and said, "we were told by corporate that they had to be transferred or discharged."

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives.

4. Resident #4 was admitted to the facility on 1-16-17 and was transferred to another facility on 5-28-20 related to testing positive for COVID19. The resident was also diagnosed with diabetes.

The quarterly Minimum Data Set (MDS) dated 5-11-20 revealed Resident #4 was mildly cognitively impaired.

Resident #4's care plan dated 5-18-20 revealed a goal that she would be given the opportunity to make choices related to her care through collaboration with her representative. The interventions associated with the goal were; contact my representative when impactful decisions need to be made, report any changes in my level of consciousness, increased behaviors, or other medical changes to my representative and my physician as needed.

Review of Resident #4's electronic medical record revealed no documentation of the representative's response of the residents

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transfer to another facility.

The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if any of the representatives wanted their loved one to remain in the facility.

Resident #4's representative was interviewed on 6-5-20 at 9:07am by telephone. The representative said she was notified "around" 2:00pm on 5-28-20 by the facility social worker that Resident #4 needed to be transferred to Henderson on 5-29-20 due to testing positive for COVID19. She explained she had informed the social worker; she would rather have Resident #4 remain in the facility and not be transferred. She stated the social worker informed her the resident had to be transferred or discharged.

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #4's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said "some" of the representatives had requested for their loved one to stay in the facility but stated she had informed the representatives the residents had to be transferred or discharged. She also stated the choice for the resident to stay in the facility was not an option and said, "we were told by corporate that they had to be transferred or discharged."

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F 561	Continued From page 9 During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives, so she was not sure how the reason for the transfers were communicated to the representatives.	F 561		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		6/16/20

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before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 11 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff and Resident Representative interviews, physician interview, Ombudsman interview and record review the facility failed to provide written notification to resident representatives and the Ombudsman of facility-initiated resident transfers to another Long Term Care Facility for 4 of 5 residents reviewed for transfers (Residents #1, #2, #3 and #4).	F 623	I. The facility did not provide required notice before transfer for 4 of 5 residents (Resident #1, #2, #3 and #4). All residents have the potential to be affected. (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in	

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F 623	Continued From page 12 Findings included: Review of the facility's "Transfer or Discharge Documentation" policy and procedure dated December 2016 revealed the following in part; each resident will be permitted to stay in the facility and not be transferred or discharged unless the resident's needs cannot be met in the facility. When a resident is transferred or discharged from the facility, notice would be provided to the resident and/or legal representative. 1.Resident #1 was admitted to the facility on 1-10-17 and transferred to another Long-Term Care Facility on 5-28-20 after testing positive for COVID19. Resident #1 also had the following diagnosis chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 4-15-20 revealed Resident #1 was minimally cognitively impaired. Resident #1's care plan dated 4-21-20 revealed a goal that the resident would be given the opportunity to make choices related to her treatment through collaboration with her responsible party. The interventions associated with the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or other physician's office, Report any changes in my level of consciousness, increased behaviors, or other medical changes to my responsible party and my physician as needed. Review of the facility's progress note from	F 623	writing and in a language and manner they understand. The facility did not send a copy of the notice to a representative of the Office of the State Long-Term Care resident nor resident□s responsible party with a choice before transfer to another facility , the transfer was a result of the facility not having processes in place to provide care and required isolation barriers for residents with positive covid-19 test. II. Education was provided from 06/10/20 - 6/15/20 to Nursing Staff and Social Services Department by the Director of Nursing and Assistant Director of Nursing on ensuring the notification of any discharge is provided to the resident and resident representative upon any transfers out of the facility. Licensed Nurses will record the reasons for the transfer or discharge in the resident□s medical record. Any nursing staff or social services staff will have completed education by 6/15/20. As requested by Ombudsman, Social Services Director will maintain Transfer/Discharge log and submit notice of transfer log to Ombudsman monthly. III. Beginning 6/10/20, an audit will be conducted weekly for twelve (12) weeks by the Social Service Director to ensure upon any discharge , a letter of discharge is provided to the resident and resident representative and notice of transfer will be added to the monthly log. V. Social Service Director will report	

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F 623	Continued From page 13 5-28-20 revealed Resident #1's representative was notified by phone of Resident's transfer to "Pelican Health Henderson" on 5-29-20 by the facility's social worker. Another progress note written by Nurse #2 dated 5-28-20 was reviewed stating Resident #1's representative was notified of the residents transfer to Henderson and "that it would take about 2 hours". The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer. Resident #1's legal representative was interviewed on 6-4-20 at 2:27pm by telephone. The representative said she had received a call from the facility social worker on 5-28-20 that Resident #1 needed to be transferred to another facility "because she tested positive for COVID" but stated she had not received anything in writing or a plan to have the resident return to the facility. The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #1's legal representatives by telephone on 5-28-20 and explained the resident was being transferred to another facility due to testing positive for COVID. The social worker said she had informed the	F 623	findings and resolution monthly for a minimum of three (3) months to the QAPI Committee. Data results will be reviewed and analyzed for the need for further monitoring beyond the three months with subsequent POC as needed. Social Service Director and Administrator will be responsible for overall compliance.	

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representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives.

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing.

Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 to another facility. She specified, "they usually send me an email when there had been a discharge or transfer, but I have not received anything." She also stated she had not received a phone call about the transfer from anyone in the facility.

2. Resident #2 was admitted to the facility on 12-28-16 and transferred out of the facility on 5-28-20 due to testing positive for COVID19. Resident #2 was also diagnosed with malignant neoplasm of the colon and diabetes.

The quarterly Minimum Data Set (MDS) dated 5-7-20 revealed Resident #2 was severely cognitively impaired.

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Resident #2's care plan dated 5-12-20 revealed a goal that he would be given the opportunity to make choices related to his treatment through collaboration with his responsible part. The interventions for the goal were; If a medical need arises, I have the right with the assistance of my physician and responsible party to decide if treatment is indicated at an outside location i.e., hospital and/or other physician's office, Report any changes in my level of consciousness, increased behaviors, or other medical changes to my responsible party and my physician as needed.

Review of the facility's progress note from 5-28-20 revealed Resident #1's representative was notified by phone of Resident #2's transfer to "Pelican Health Henderson" on 5-29-20 by the facility's social worker.

Another progress note written by Nurse #2 dated 5-28-20 was reviewed stating Resident #2's representative was notified of the residents transfer to Henderson and "that it would take about 2 hours".

The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer.

Resident #2's legal representative was

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interviewed by phone on 6-4-20 at 3:28pm. The representative said he was notified by the facilities social worker of the transfer to another facility by telephone on 5-28-20 due to the resident testing positive for COVID and was originally told the resident would not be transferred until 5-29-20 but then stated he received a call "later that night" (5-28-20) the resident was going to be transferred 5-28-20. The representative stated he had not received anything in writing about the transfer or the plan to have the resident return to the facility.

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #2's legal representatives by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives.

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing.

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Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 another facility. She specified, "they usually send me an email when there had been a discharge or transfer, but I have not received anything." She also stated she had not received a phone call about the transfer from anyone in the facility.

3. Resident #3 was admitted to the facility on 10-4-19 and transferred to another facility on 5-28-20 related to testing positive for COVID19. Resident #3 was also diagnosed with encephalopathy.

The quarterly Minimum Data Set (MDS) dated 5-8-20 revealed Resident #3 was moderately cognitively impaired.

Resident #3's care plan dated 5-14-20 revealed a goal that she would have a safe discharge to the community and her discharge arrangements would be completed prior to her discharge date. The interventions associated with the goal were in part; Provide written discharge instructions to me and my representative.

Review of the facility's progress note written by Nurse #2 dated 5-28-20 revealed documentation that Resident #3's representative was notified of the transfer "to the facility in Henderson NC and that it will take about 2 hours."

The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for

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those residents here" and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer.

Resident #3's representative was interviewed by telephone on 6-4-20 at 4:02pm. The representative stated he had not received a call from the facility notifying him of the resident's transfer. He said, "I was not told about the positive COVID test or the transfer until I called the facility to speak to her and was told she was moved to another floor due to testing positive and would be transferred to another facility that day (5-28-20)." The representative said he had not received anything in writing about the transfer or made aware of the facility's plan to have the resident return.

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #3's legal representative by telephone on 5-28-20 and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20. She also stated she had not contacted the Ombudsman or sent written notification to the representatives.

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision

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was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing.

Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 4 residents that were transferred on 5-28-20 to another facility. She specified, "they usually send me an email when there had been a discharge or transfer, but I have not received anything." She also stated she had not received a phone call about the transfer from anyone in the facility.

4. Resident #4 was admitted to the facility on 1-16-17 and was transferred to another facility on 5-28-20 related to testing positive for COVID19. The resident was also diagnosed with diabetes.

The quarterly Minimum Data Set (MDS) dated 5-11-20 revealed Resident #4 was mildly cognitively impaired.

Resident #4's care plan dated 5-18-20 revealed a goal that she would be given the opportunity to make choices related to her care through collaboration with her representative. The interventions associated with the goal were; contact my representative when impactful decisions need to be made, report any changes in my level of consciousness, increased behaviors, or other medical changes to my representative and my physician as needed.

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Review of the facility progress note written by the social worker dated 5-28-20 revealed the resident's represented was notified of the residents transfer to "Pelican Health Henderson" to take place on 5-29-20.

There was no further documentation regarding Resident #4's transfer.

The facility's medical director was interviewed on 6-2-20 at 1:04pm. The medical director said he did not understand why the residents had been transferred "we have the capability to care for those residents here" and stated he was not involved in speaking with the representatives so he did not know if they had been contacted regarding the transfer but expected the facility staff to notify the representatives prior to the residents transfer.

Nurse #2 was interviewed by phone on 6-4-20 at 3:35pm. The nurse stated he was the shift supervisor for the 3:00pm to 11:00pm shift. He confirmed nursing staff were to contact the residents' representatives to inform them of the transfer occurring in the evening of 5-28-20. He also stated he could not remember if the representative for Resident #4 was contacted but stated "each representative was supposed to be contacted."

Resident #4's representative was interviewed on 6-5-20 at 9:07am by telephone. The representative said she was notified "around" 2:00pm on 5-28-20 by the facility social worker that Resident #4 needed to be transferred to Henderson on 5-29-20 due to testing positive for COVID19. She stated, "a days' notice was ok with me because that gave me time to speak with her

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and make sure she was ok with the transfer and understood what was going on" but then said she had received a call at 11:00pm on 5-28-20 from "Pelican Health Henderson" that Resident #4 was in their facility. The representative stated she had not received a phone call from the facility informing her the resident was being transferred on 5-28-20 nor had she received anything in writing about the transfer or the plan to have the resident return to the facility.

The facility's social worker was interviewed on 6-5-20 at 9:35am by telephone. The social worker stated she had contacted Resident #4's legal representatives by telephone and explained the residents were being transferred to another facility due to testing positive for COVID. The social worker said she had informed the representatives that the residents would be transferred on 5-29-20 but had not re-contacted the representatives when the decision was made to transfer the residents on 5-28-20, she stated "the nursing staff were supposed to contact each representative". She also stated she had not contacted the Ombudsman or sent written notification to the representatives.

During an interview with the Administrator on 6-5-20 at 10:24am by telephone, the Administrator stated after speaking with the facility's cooperate office on 5-28-20, the decision was made to transfer the residents to a "sister facility" because that facility already had COVID positive residents. She also said she was not present when the social worker spoke to the residents' legal representatives but felt all the representatives were notified by telephone but not in writing.

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F 623	Continued From page 22 Forsyth Counties Long Term Care Ombudsman was interviewed by telephone on 6-9-20 at 11:23am. The Ombudsman stated she had not been informed of the 5 residents that were transferred on 5-28-20 to another facility. She specified "they usually send me an email when there had been a discharge or transfer, but I have not received anything." She also stated she had not received a phone call about the transfer from anyone in the facility.	F 623		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		6/16/20

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but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, review of the facility's Handwashing/Hand Hygiene policy and procedure, Infection Control policy and procedure and the facility's COVID19 policy and procedures, staff interviews and physician interview the facility failed to perform hand hygiene when a housekeeper entered and exited 2 of 2 resident rooms (Residents #1 and #2) who were on droplet precautions. This failure occurred during a COVID19 pandemic. Findings included: Review of the facility's Handwashing/Hand Hygiene policy and procedure dated August 2015 revealed in part; all personal shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections, use alcohol hand rub after contact with objects in the immediate vicinity of the resident and before and after entering isolation precaution setting. The facility's Infection Control policy and procedure, Transmission Based Precautions dated 4-24-20, was reviewed and revealed in part; remove gloves before leaving the resident room and perform hand hygiene. Review of the facility's COVID19 policy and procedure dated 5-6-20 was reviewed and revealed in part; remind staff that handwashing is the most important and effective preventive strategy. The Administrator was interviewed on 6-2-20 at 10:30am. The Administrator stated the facility had 5 residents' that had tested positive for COVID19	F 880	The facilitys contracted enviromental services staff failed to perform hand hygiene when a housekeeper entered and exited 2 of 2 resident rooms (Residents #1 and #2) who were on droplet precautions. The Corrective action will be accomplished for those residents found to have been affected, All residents have the potential to be affected. The housekeeping aide was educated immediatly on infection control,handwashing,doning and doffing gloves when moving from room to room.the housekeeper ws also inserviced about coming out of the isolation area without removing or changing gloves or washing her hands. All residents having the potential to be affected by the same deficient practice All Residents who reside on the hallway have the potential to be affected. "Systemic changes made to ensure that the deficient practice will not recur; The director of nursing and housekeeping director began Education related to hand washing on 6/12/2020 for nursing staff, environmental staff and ancillary staff providing services to the residents. Staff that have not been educated by 6/13/2020 will be removed from the schedule until education is completed. This education has been added to the general orientation of new employees. The Director of environmental Services, Nurse Management, Administrator and/or Department	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345092	A. BUILDING _____ B. WING _____	C 06/09/2020

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

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F 880	Continued From page 25 and had been discharged to a sister facility. She said the facility was using "part" of the 2nd floor for an "observation unit" and an Isolation unit. She explained the "observation unit" was sealed off from the rest of the 2nd floor by the fire doors and was used to monitor residents who had returned from the hospital, waiting for their COVID test results or new admissions needing to be observed for signs and symptoms of COVID19. The Administrator further explained, the facility had placed a door to divide the "observation unit" from the isolation unit which was located at the end of the hall. During a continuous observation on 6-2-20 from 11:30am to 11:40am of the facility's "observation unit", the observation revealed housekeeper (HK) #1 entered room number 200 that was designated as a droplet precaution room as evidenced by a "droplet precaution isolation" sign on the residents door, without changing her gloves or performing hand hygiene and began cleaning room number 200 by wiping down the dresser, over the bed table, cleaning the bathroom and moping the floor. When the HK was done in room number 200, she exited the room without performing hand hygiene. HK #1 was then observed to walk across the hall and enter resident room number 209, where another resident who was on droplet precautions resided and had a "droplet precaution isolation" sign posted on the door. HK #1 entered the room without changing her gloves or performing hand hygiene and began wiping down the dresser, over the bed table, bathroom and moping the floor. Once the HK completed her work in room number 209, she then took her gloved hand and pushed on the door bar to exit the "observation unit", walked onto the resident hall, walked	F 880	Managers are monitoring hand washing daily for one week, then weekly for four weeks, then monthly thereafter to ensure continued compliance. The Administrator, Director of Health Services and Department Managers are observing the staff in the hallways to ensure their following our infection control policys. The Administrator and/or Director of Health Services are correlating the data from the handwashing reviews. They are presenting the analysis of the data to the Quality Assurance and Performance Improvement Committee monthly until three consecutive months of negative findings are sustained, then quarterly thereafter.	

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F 880	Continued From page 26	F 880		

approximately 25 feet to the housekeeping closet and opened the closet door without removing her gloves or performing hand hygiene.

HK #1 was interviewed on 6-2-20 at 11:40am. The HK stated she had received training on proper hand hygiene in May 2020, which included removing her gloves and performing hand hygiene when she left a resident room that was on droplet precautions. The HK said she saw the droplet precaution signs on the resident's door, and she was aware she had not followed the training but stated "I got distracted and needed to get new mop water and just did not think about it."

The housekeeping manager was interviewed on 6-2-20 at 11:42am. The manager stated all the housekeeping staff had been in-serviced on COVID19 and how the virus is spread, infection control, isolation precautions, masks, gloves and hand hygiene. He said, "they have been in-serviced about this at least 3 times in the last month."

The Administrator was interviewed on 6-2-20 at 12:55pm. The Administrator stated the housekeeping manager had met with all the housekeepers that morning (6-2-20) in the lobby and reminded them of proper hand hygiene. She stated she would follow up with the housekeeping manager.

During an interview with the facility physician on 6-2-20 at 1:04pm, the physician stated he did not feel the staff were not following proper infection control policies because of a lack of knowledge but rather trying to learn new behaviors. He also stated he did expect staff to follow proper procedure and perform hand hygiene when they

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F 880	Continued From page 27 exit a resident's room to prevent the spread of COVID19.	F 880		