PRINTED: 01/03/2022 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345283	B. WING		C	
	ROVIDER OR SUPPLIER DEL MOORESVILLE	040200		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11/29/2021	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	O BE COMPLETION	
F 000	INITIAL COMMENTS	3	F 00	00		
	was conducted on 11 information was obta	ined through 11/29/21. ate was changed to 11/29/21. s investigated were				
	Past-noncompliance	was identified at:				
	CFR. 483.10 at tag F (J)	580 at a scope and severity				
	CFR. 483.25 at tag F (J)	695 at a scope and severity				
	CFR. 483.35 at tag F (J)	726 at a scope and severity				
	CFR. 483.70 at tag F (J)	835 at a scope and severity				
	Tag F 695 constituted Care.	d Substandard Quality of				
F 580 SS=J	,	was conducted on 11/24/21. jury/Decline/Room, etc.) l)(i)-(iv)(15)	F 58	30	12/22/21	
	consult with the resid consistent with his or representative(s) who (A) An accident invol- results in injury and h physician intervention	nediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which has the potential for requiring				
LABORATORY I	L DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE	

Electronically Signed 12/22/2021

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345283	B. WING		C 11/29/2021	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 580	status in either life-the clinical complications (C) A need to alter to a need to discontinual treatment due to advocmmence a new for (D) A decision to train resident from the fact §483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatics available and proving physician. (iii) The facility must resident and the	cial status (that is, a ch, mental, or psychosocial interaction on psychosocial interaction of sis); eatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or insfer or discharge the cility as specified in tification under paragraph (g) in, the facility must ensure that it ion specified in §483.15(c)(2) wided upon request to the independent in the interaction of the interaction in the	F 58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345283	B. WING		C 11/29/2021		
	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION		
F 580	by: Based on record reviewed for the facility failed to not clarification when a readmitted on 10/18/2 positive airway pressinclude the settings on non-invasive mechan Nurse Manager #1 of when they were not Therapist on 10/18/2 up the BiPaP. The mass approached by who asked why the reventilator was not be attempt to contact the Therapy for assistant Death Certificate reviewed for the findings included Resident #1 was additionally 10/18/21 with diagnor Obstructive Pulmonarespiratory failure. Review of Resident summary dated 10/1 history of COPD chrome oxygen therapy non-invasive mechanical materials.	riews and staff, Respiratory al Director (MD) interviews otify the Physician for resident (Resident #1) was 1 with orders for a bilevel sure (BiPaP) that did not or frequency for the nical ventilator. In addition, iid not contact the Physician able to reach the Respiratory 11 for assistance with setting norning of 10/19/21 Nurse #2 Resident #1's family member non-invasive mechanical sing used. Nurse #2 did not the Physician or Respiratory ce. Review of Resident #1's realed he expired on 10/20/21 see of death was listed as spiratory failure with hypoxia s failure affected 1 of 1 or notification of changes. d: mitted into the facility on oneses which included Chronic ary Disease (COPD) and #1's hospital discharge 8/21 revealed he had a onic respiratory failure on	F 580	Past noncompliance: no plan of correction required.			

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		345283	B. WING _			C 11/29/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115			
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F 580	BiPaP use as needed orders did not include orders did not include with Nurse #1 reveal evening Resident #7 facility. He stated the PM on 10/18/21 and Emergency Medical that the resident's of very quickly when or EMS services had Foon-rebreather mas and Nurse #1 kept to in case his oxygen lestated he then chan cannula on 4 liters of stated Resident #1 values the entire time PM. He stated he womember with Reside invasive mechanical Nurse Manager assist The interview reveal assessed the reside Review of a nursing 10/18/21 at 7:11 PM revealed Resident #1 from the hospital. Reas being on 4 liters would be using a Bil #1 documented she	21 revealed an order for ed. The review revealed the le BiPaP settings. Sted on 11/12/21 at 12:25 PM led he was working the led was admitted into the eresident came after 3:00 led he received report from Services (EMS) who stated axygen level would decrease ff of supplemental oxygen.	F 5	80			
	BiPaP. Resident #1 oriented to person, p	was noted to be alert and place, and time. No vital signs initial assessment of					

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		345283	B. WING			l	29/ 2021
	ROVIDER OR SUPPLIER		1	5	TREET ADDRESS, CITY, STATE, ZIP CODE 50 GLENWOOD DRIVE MOORESVILLE, NC 28115		20/2021
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F 580	who said they would evaluate Resident #1 reveal the exact time Review of a nursing product to the total state of the exact time. Review of a nursing product and the exact time and the exact time and the exact time and the exact time. The exact time are the exact time and the exact time are the exact time. The exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time. The exact time are the exact time are the exact time are the exact time are the exact time. The exact time are the exact t	orogress note dated written by the Nurse I she had contacted and spoke with the ompany Staff Member #1 have someone come 's BiPaP. The note did not the call was placed. orogress note dated I written by the Nurse I she had called Respiratory with the respiratory therapy over #2 who stated an on-call rapist) would contact them dent #1's BiPaP. The note act time the call was placed.	F	580	,		
	them to send someon She stated she hadn' the company, so she 9:30 PM and Resider Non-invasive mechan home. Nurse Manage the machine from his	ne out to assist the resident. It heard anything back from went into the room around int #1 stated he used his inical ventilator machine at er #1 stated she then took bag and laid it onto his bed. ine was in pieces and she					

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F 580	She stated she did when the RT compainterview revealed interview revealed interview revealed interview conduction with one of the night shown signs of responsive conduction with Nurse #6 revealed the night shown signs of responsive conduction in the night shown signs of responsive conduction in the night shown signs of responsive conduction in the night shown signs of the night shown in the	o put it together or turn it on. not contact the Physician any did not respond. The Resident #1 went to sleep asive mechanical ventilator nt of 10/18/21 and had not	F 5	80		
	the shift on 10/19/2 member came to he	1. She stated the family er around 8:45 AM asking why evasive mechanical ventilator				

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	•	1/20/2021	
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F 580	told the family men understanding that respiratory therapy to come set up his went into the residuadministering his nhis non-invasive maying on his bed. It was experiencing I anxious at that time oxygen saturation breathing treatmen able to calm down was sitting at a 90-difficulty breathing. Director was able to Respiratory Therapuilding around 5:0 Resident #1. She sesident #1's oxygen (normal oxygen sa 92%) on 4 liters via Review of a Physic on 10/19/21 at 5:3 non-invasive mechanical ventila BiPaP ventilation. An interview conduction with the Medical Diseen Resident #1 in PM. She stated she #2 earlier in the damechanical ventila mechanical ventila mechanical ventila with the damechanical ventila wentila in the damechanical ventila wentila in the damechanical ventila in the damechanical ventila wentila in the damechanical ventila	ooked up and she stated she nber that it was her another nurse had called , and someone was supposed machine. Nurse #2 stated she ent's room when she was norning medication and saw echanical ventilator machine Nurse #2 stated Resident #1 abored breathing and was very e, but she did not check his level. After administering the t, she stated the resident was Nurse #2 stated the resident degree angle in the bed due to She stated the Medical o get in touch with the post (RT) who entered the 10 PM on 10/19/21 to see stated when the RT checked the saturation level it was 85% turation level greater than	F	580			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 580	Continued From page	e 7	F	580			
	· -	e RT and the RT answered		000			
		and said she would be on					
		. She stated she was told the					
	nurse had tried to cor						
		ed she had no issues					
	getting ahold of them	and them responding. The					
		e had not been informed of					
	Resident #1's non-inv	vasive mechanical ventilator					
	not being set up prior	to Nurse #2 telling her while					
	she was in the facility. The interview revealed for						
	anyone who required	the use of a non-invasive					
	mechanical ventilator	machine, not being on it					
		negative impact. That was					
	· ·	out he needed his machine					
		t on as soon as possible.					
		ed Resident #1 had been					
	_	home prior to admission in					
		ed nobody had contacted					
		ting they couldn't get a RT to					
		hine. The interview revealed					
		ent #1 at 9:00 PM he had his nical ventilator mask on and					
		e stated she stopped the					
		s to speak to him and he					
		in abnormally fast rate with					
	_	MD stated Resident #1 did					
		non-invasive mechanical					
		he stated during the 10					
		is room the resident did not					
	move his arms or try	to move his arms. The MD					
		ed 10/20/21 that Resident #1					
	was found with a neb	ulizer mask on his face and					
	had expired. She stat	ted she felt he had expired					
		oxygen). The interview					
		feel comfortable saying that					
		ely due to not receiving his					
		ical ventilator machine					
	timely.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			5 5	11123/2021	
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F 580	An interview conduct Therapist (RT) on 11 stated she was conta 4:00 PM by the MD t non-invasive mechan RT stated when she 4:30 PM to the facility saturation level was oxygen. She stated soximeters on his fing his heart rate was 12 observed by the RT to lying like a statue. The Resident #1 if he was responded with a yestover exert himself. She Non-invasive mechan set up his heart rate an oxygen saturation. The facility Administrinterview during the to the facility provided Action Plan with the facility Interdisciplina Director of Operation of Clinical Services (red with the Respiratory /12/21 at 12:45 PM she rected on 10/19/21 around o initiate Resident #1's nical ventilator machine. The rearrived on 10/19/21 around by Resident #1's oxygen respectively a state of the had to use two pulse rers to obtain a reading and respectively. Resident #1 was rearrived on 4 liters of respectively. The had to use two pulse rers to obtain a reading and respectively. Resident #1 was rearrively a state of the state of the state of the state of the respectively. The had the respectively a state of the respectively. The had the respectively a state of the respectively. The respectively a state of the respectively. The respectively a state of the respectively. The respectively. The respectively are respectively. The respectively. The respectively are respectively. The r	F 580		

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
THE CITA	DEL MOORESVILLE			550 GLENWOOD DRIVE			
THE CITA	DEL WOOKESVILLE			MOORESVILLE, NC 28	3115		
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F 580		ate immediate action plans	F!	580			
	based on immediate 2) Identification of On 10/24 a completed by the D residents utilizing N which include bi-lev (Bi-Pap), continuous (C-Pap) and non-inv volume assured pre (NIV/AVAPS-AE, br. to ensure that physis settings and frequer identified for order of harm or adverse eff resident remains stat On 10/24/2 by the Director of N clarification for Resi (Non-Invasive Venti orders revised and the Director of Nurs 10/25/21 On 10/25/2 completed a review of current residents settings were accur orders. No further re On 10/25/2 9/18-10/20/21 will b Nursing/designee to NIV devices per hos have appropriate or frequency of use. N identified for correct On 10/22/2	e findings. Others: and 10/25/2021, an audit was irector of Nursing of all current on-Invasive Ventilator (NIV) el positive airway pressure se positive airway pressure vasive ventilation average essure support-auto E-Pap ands such as trilogy) devices cian orders include the device ency of use. Resident #2 clarification. There was no etcts to Resident #2 and able on current NIV settings. 21, the Physician was notified ursing of orders needing dent #2 's NIV/AVAPS-AE lation) device. Resident #2 implemented on 10/24/21 by ing and care plan revised on 2021, the respiratory therapist (and revision as appropriate) on NIV devices to ensure ate based upon physician ecommendations made. 2021, all new admissions from the reviewed by the Director of the ensure any resident requiring spital discharge summary ders to include settings and the additional residents were tion. 21, the VPCS and contracted					
	and revised policy "	Respiratory Therapy reviewed Non-Invasive Ventilation: re" to reflect and further clarify					

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NAME OF PROVIDER OR SUPPLIER	0.10200		STREET ADDRESS, CITY, STATE, ZIP CODE	1	11/29/2021	
THE CITADEL MOORESVILLE			550 GLENWOOD DRIVE MOORESVILLE, NC 28115			
PREFIX (EACH DEFICIENC			(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 580 Continued From pag	e 10	F 5	80			
licensed nurses and and responsibilities in C-Pap and APAPS-A Trilogy) devices. 3) Education/Syste On 10/22/2 education to the facil RDCS on the update Ventilation: IV/AVAPS effective immediately accept NIV/AVAPS-A trilogy) On 10/25/21, Assurance Performa meeting was comple RDO and VPCS a coaction plan was deveranalysis to address For By 10/25/21 including agency lice by the Director of Nuensuring that the phy in implementing physical initiation of NIV device education records to current and newly hir licensed nurses. State until education composition of Nursing/dadmission process in transcription of order the physician if clarification of order the allowed to work under the allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and agency lice allowed to work under the physician if clarification and the physician if the physician if the physician if the physician if the	Respiratory Therapists roles in the management of Bi-Pap, i.E NIV (brands such as emic Change 1, the VPCS provided ity Administrator, DON and id policy "Non-Invasive SA-E feature" to include that if the facility shall no longer in the facility and agency in the management in the facility and agency in the management in the m					

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F 580	regarding the notifical calling the respirator service number to not Therapist of all new adevices and any other current residents. If the company does not refacility will reattempt will be immediately of addition, if the respirator of further eval maintain education recompetency for current and agency licensed allowed to work until the Effective 10 will have the contact contracted Respirator prominently posted. The are available after her spirator on ensuring the respirator of the service of the	Director of Nursing /designee ation process which includes by therapy company customer of the Respiratory admission requiring NIV ar respiratory needs of the respiratory therapy aspond within 10 minutes, the x 1, if no response the MD contacted for further orders. A sident is in any acute distress, all be sent to the emergency unation. The DON will accords to validate staff and newly hired facility and nurses. Staff will not be aducation completed. Divide 25/21, each nursing station information for the cory Therapy company Respiratory therapy services ours and on weekends. Divide 21, the Admission Director he Administrator/ designee directory therapist, unit clerk,	F 58	1		
	admission when resi Education also include longer accept NIV/A' trilogy effective 10/25 Director was also ed 10/25/21 on C-PAP, (Trilogy type) device the settings associated devices. The DON was records to validate so and newly hired facily not be allowed to wood to set in the settings associated to the settings associated to validate so and newly hired facily not be allowed to wood triloger to the settings associated to wood the settings are settings as social the settings as social the settings as social the settings are settings as settings are settings as social the settings are settings as settings are set	el are notified prior to dents require NIV devices. ded for admissions to no VAPS-AE, brands such as 5/21. The Admissions ucated by the DON on Bi-PAP, and AVAPS-AE s to identify the differences in ed with these types of vill maintain education taff competency for current ity Admission staff. Staff will urk until education completed. 0/25/21, the Admission				

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F 580	contracted respirated notified at least 24 k with physician order NIV device will be readmission with the serious devices are available frequency orders with the facility. The DOI records to validate serious and newly hired facility and agency be allowed to work services were educated facility and agency liberal services were educated facility and agency liberal services were educated facility clinical cated facility of the facility policy such as trilogy) in the Director received education facility policy "Non-Invasive Ventito include competer include categories included incl	of Nursing will ensure that the bry therapy company will be hours prior to an admission as for NIV device to ensure eadily available prior to required settings verified. 2021, the Admission Director g staff including agency be educated by the Director ing that ordered equipment/or le with required setting and hen residents are admitted to N will maintain education staff competency for current ility Admissions staff and incensed nurses. Staff will not until education completed. 2021, Licensed Nurses, r., Medical Director and Social stated by the Administrator on apabilities grid which specifies revided by the facility to approval. The DON will records to validate staff and newly hired facility denurses, Admissions staff, d Social Services staff. Staff to work until education 0/25/21, the facility will no AVAPS-AE devices (brands the facility. The Admission ducation on 10/25/21. 2021, Licensed Nurses ensed nurses will be educated revision date 10/22/21 llation: IV/AVAPSA-E feature" incies on the use of all NIV ingoing respiratory assessment	F 5	80				

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	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	Ē		
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F 580	by the Respiratory The Nursing. The DON will records to validate stand newly hired facilin nurses. Staff will not be ducation completed. By 10/25/21 including agency CNADirector of Nursing or including notifying the issues with the NIV in with the resident until and not manipulating DON will maintain ed staff competency for facility and agency Clowork until education be allowed to work until education be allowed to work until saff. These staff will education completed. Effective 10, paperwork and physic by nursing managem to ensure the accurace of physician 's orders notification to physicial discrepancies for clar management was inferenced.	d NIV and oxygen therapy terapist and Director of II maintain education aff competency for current by and agency licensed on allowed to work until and the care of NIV residents of the care of NIV devices and the normal care of the nIV devices and the nIV devic	F 5				
	Administrator. 4) Monitoring Proce Beginning 1 management will revi	•					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345283	B. WING _			C 11/29/2021		
	ROVIDER OR SUPPLIER DEL MOORESVILLE	1		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/20/2021		
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F 580	physician s orders for devices and notificar discrepancies for clawill be communicated clarification and/or or Administrator/designeducation files for ne ensure staff competed NIV devices. Staff we education completed education completed on the "Quality Impropersion on the "Quality Impropersion on the "Quality Impropersion on the "Quality Impropersion on the Adminition on 10/25/2 notified by the Adminition of the Adminitoring responsion on the Adminitoring will be discommittee meeting overseen by the Adminitoring will be discommittee meeting overseen by the Adminiterdisciplinary tear the plan as indicated compliance. Beginning the RDO will review QAPI minutes month ongoing compliance implementation of pland C-Pap NIV deviphysician of any ord clarification.	and timely implementation of or Bi-Pap and C-Pap NIV tion to physician of any order arification. Any discrepancies d to the physician for correction and 2) the nee will review/audit nursing the hires and agency staff to be ence of Bi-Pap and C-Pap ill not be allowed to work until the audits will be documented to be ence of Bi-Pap and C-Pap ill not be allowed to work until the audits will be documented to be ence of Bi-Pap and C-Pap ill not be allowed to work until the audits will be documented to be ence of Bi-Pap and C-Pap ill not be allowed to work until the audits will be documented to be ence of Bi-Pap and C-Pap ill not be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be documented to be allowed to work until the audits will be audits will be audits will be audits and the audits	F	580				
	11/24/21 and conclu	n Plan was validated on ded the facility implemented ctive action plan on 10/26/21.						

NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115 D PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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DEFICIENCY)	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE	COMPLETION
F 580 Continued From page 15 The facility amended the notification process to include calling the respiratory therapy company customer service number to notify the Respiratory Therapist of all new admission requiring NIV devices and any other respiratory needs of current residents. If the respiratory therapy company does not respond within 10 minutes, the facility will reatterpix 1, if no response the MD will be immediately contacted for further orders. The Corrective Action Plan was reviewed during QAPI meeting held on 10/25/21. The weekly monitoring logs residents requiring a BiPaP/ CPAP were reviewed from October 2021 to November 2021 with no concerns identified. Review of the nursing staff find intilated as receiving the in-service training, Interviews conducted with nursing staff find intilated as receiving the in-service training, Interviews conducted with nursing staff for first, second and third shifts revealed they had received the in-service as stated by the facility. The staff verified they had received in-servicing on notification, abuse, neglect, change of condition and use of a BiPap/CPAP machine. F 609 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, the facility must: \$483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609	The facility amended include calling the rescustomer service nur Therapist of all new adevices and any other current residents. If the company does not refacility will reattempt will be immediately of the Corrective Action QAPI meeting held of the Weekly monitoring BiPaP/ CPAP were restored to November 2021 with Review of the nursing non-invasive mechan revealed the nursing receiving the in-service and third shifts revea in-service as stated by verified they had recentification, abuse, not and use of a BiPap/C Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In responsing proceiving abuse, negligible responsing of the process of the proce	the notification process to spiratory therapy company of the property in the respiratory therapy spiratory needs of the respiratory needs of the respiratory therapy spond within 10 minutes, the exit, if no response the MD contacted for further orders. In Plan was reviewed during the 10/25/21. In glogs residents requiring a eviewed from October 2021 of the no concerns identified. In the staff had initialed as the training. Interviews the staff from first, second led they had received the property of the property of the staff second incompanies. Wiolations (4) In the notification of the property of the property, attely, but not later than 2				12/23/21

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			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1	23/2021
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH			(X5) COMPLETION DATE
that cause the allegat serious bodily injury, the events that cause abuse and do not rest the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the addesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revifacility failed to send a Agency for 1 of 2 resirespiratory care (Resepiratory care (Resepiratory care and Corporate Computified of Immediate of necessary care and compromised resider a non-invasive mechal Resident #1's Death of expired on 10/20/21 adeath was listed as a	cion involve abuse or result in or not later than 24 hours if a the allegation do not involve ult in serious bodily injury, to ne facility and to other the State Survey Agency and ches where state law provides at the results of all administrator or his or her ative and to other officials in the law, including to the State in 5 working days of the eged violation is verified a caction must be taken. It is not met as evidenced the wand staff interview, the an initial report to the State dents reviewed for ident #1). PM the Director of Nursing liance Consultant were Jeopardy related to a lack do services for a services for a that was dependent upon anical ventilator. Review of Certificate revealed he at 2:07 AM. The cause of cute and chronic respiratory	F	609	2. On 12/22/21, the Administrator completed a review of grievances from 11/21-12/21/21 to ensure any alleged violations of abuse, neglect, exploitation or mistreatment including injuries of unknown source and misappropriation resident property were reported to the State Agency per guidelines. Two (2) allegations identified were reported accordingly. 3. On 12/22/21, the Regional Director of Operations completed education with the facility Administrator and Director of	n, of NC of he	
An interview conducte	ed on 11/12/21 at 4:54 PM			abuse, neglect, exploitation, or		
	CORRECTION ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page that cause the allegat serious bodily injury, the events that cause abuse and do not res the administrator of the officials (including to adult protective service for jurisdiction in long accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State procedures. §483.12(c)(4) Report investigations to the adesignated represent accordance with State Survey Agency, within incident, and if the all appropriate corrective This REQUIREMENT by: Based on record revifacility failed to send a Agency for 1 of 2 resi respiratory care (Reservice) Findings included: On 11/16/21 at 5:50 Fand Corporate Composition of Immediate of Immediate of necessary care and compromised resident a non-invasive mechanic resident #1's Death of expired on 10/20/21 adeath was listed as a failure with hypoxia (I	CORRECTION 345283 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to send an initial report to the State Agency for 1 of 2 residents reviewed for respiratory care (Resident #1).	A BUILDI ROVIDER OR SUPPLIER DEL MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to send an initial report to the State Agency for 1 of 2 residents reviewed for respiratory care (Resident #1). Findings included: On 11/16/21 at 5:50 PM the Director of Nursing and Corporate Compliance Consultant were notified of Immediate Jeopardy related to a lack of necessary care and services for a compromised resident that was dependent upon a non-invasive mechanical ventilator. Review of Resident #1's Death Certificate revealed he expired on 10/20/21 at 2:07 AM. The cause of death was listed as acute and chronic respiratory failure with hypoxia (lack of oxygen).	A BUILDING A BUILDING B. WING 345283 ROVIDER OR SUPPLIER DEL MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE \$50 GLENWOOD DRIVE MOORESVILLE, NC 28116 SUMMARY STATEMENT OF DEFICIENCIES BURNAMEN STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and not result in serious bodily injury, to the administrator of the facility and to other officials fincluding to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to send an initial report to the State Agency for 1 of 2 residents reviewed for respiratory care (Resident #1). Findings included: On 11/16/21 at 5:50 PM the Director of Nursing and Corporate Compliance Consultant were notified of Immediate Jeopardy related to a lack of necessary care and services for a compromised resident that was dependent upon a non-invasive mechanical ventilator. Review of Resident #15 Death Certificate revealed he expired on 10/20/21 at 2:07 AM. The cause of death was listed as acute and chronic respiratory failure with hypoxia (lack of oxygen). William Agency for 1 of 2 residents ventilator, Review of Resident #15 Death Certificate revealed he expired on 10/20/21 at 2:07 AM. The cause of death was listed as acute and chronic respiratory failure with hypoxia (lack of oxygen).	A BUILDING 345283 B. WING STREET ADDRESS, CITY, STATE, 2IP CODE SO GLENWOOD DRIVE MOORESVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 16 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation of not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. \$483.12(c)(4) Report the results of all involve aduse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with State law through established procedures. \$483.12(c)(4) Report the results of all involves against the administrator or his or her designated representative and to other officials in accordance with State law including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility faliele to send an initial report to the State Agency for 1 of 2 residents reviewed for respiratory care (Resident #1). Findings included: On 11/16/21 at 5:50 PM the Director of Nursing and Corporate Compliance Consultant were notified of Immediate Jeopardy related to a lack of necessary are and services for a compromised resident that was dependent upon a non-invasive mechanical ventilator. Review of Resident #1's Death Certificate revealed he expired on 10/20/21 at 2:07 AM. The cause of death was listed as acute and chronic respiratory failure with hypoxia (lack of oxygen). With the provide of the provide device of Nursing anon-invasive mechanical ventilator. Review

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F 609			F 609		mistreatment including injuries of unknown source and misappropriation of resident property were reported to the NC State Agency per guidelines. The Administrator or Director of Nursing will report alleged violations to NC State Agency immediately but, not later than 2 hours if the allegation involves abuse or results in bodily harm or not later than 24 hours if the events that cause the allegation do not involve abuse or result in bodily harm. Results of the investigation will be submitted within 5 working days of the incident. Newly hired Administrators and Directors of Nursing will receive education upon hire. 4. The Administrator and/or Director of Nursing will monitor grievances weekly for three (3) months to ensure reporting of alleged violations per guidelines. The Administrator will report findings of the monitoring to the Interdisciplinary Team (IDT) during QAPI meetings monthly for three (3) months and will make changes		
F 695 SS=J	CFR(s): 483.25(i) § 483.25(i) Respirato tracheostomy care ar The facility must ensureeds respiratory car care and tracheal succare, consistent with	ry care, including and tracheal suctioning. Ure that a resident who be, including tracheostomy citioning, is provided such professional standards of the ensive person-centered	F	695	compliance with reporting of alleged violations.		12/22/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/29/2021
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F 695	care plan, the resider and 483.65 of this sul This REQUIREMENT by: Based on record rev Therapist, Medical Direspiratory provider in provide necessary reto a resident with a costatus who was depeairway pressure (BiPadmitted on 10/18/21 positive airway pressinclude the settings on non-invasive mechanfailed to clarify orders or involve respiratory BiPaP machine was rof 10/19/21. In additicomplete and documassessments of the reand ensure Resident #revealed he expired cause of death was lirespiratory failure with This failure affected frespiratory care. The findings included Resident #1 was admitional to the settings of the respiratory care. Resident #1 was admitional to the findings included Resident #1 was admitional to the settings of the respiratory care.	nts' goals and preferences, bpart. is not met as evidenced liews and staff, Respiratory rector (MD) and clinical nterviews the facility failed to spiratory care and services ompromised respiratory indent on bilevel positive aP). Resident #1 was with orders for a bilevel ure (BiPaP) that did not in frequency for the ical ventilator. The facility is for the BiPaP on admission therapy and as a result the not set up until the evening on, the facility failed to ent on-going comprehensive esident's respiratory status #1 had continuous oxygen. I's Death Certificate on 10/20/21 at 2:07 AM. The sted as acute and chronic in hypoxia (lack of oxygen).	F 69	Past noncompliance: no plan correction required.	of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 695	therapy and the use ventilator machine. Resident #1's hospin 10/18/21 revealed an needed. The review include BiPaP setting or any orders for a resident #1's Physical 6:23 PM revealed an oxygen at 4 liters condition in the review conduction with the Admissions revealed she had seen hospital. She stated used a non-invasive machine but knew the She stated she usual discharge summary talked about his nor ventilator machine. Supposed to admit remechanical ventilator machine why he was admitted why he was admitted. An interview conduction with Nurse #1 reveal evening Resident #1 facility. He stated the PM on 10/18/21 and Emergency Medical	tal discharge orders dated in order for BiPaP use as revealed the orders did not igs, orders for oxygen therapy nebulizer treatment. cian order dated 10/18/21 at in order for supplemental intinuously via nasal cannula ie Manager #1. cited on 11/15/21 at 2:51 PM Coordinator for the facility ien Resident #1 in the she was unaware that he is mechanical ventilator ie had orders for a BiPaP. The invasive mechanical she stated the facility was not iesidents with a non-invasive or machine. She stated they it on a non-invasive or machine and wasn't sure	F 69			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	' '	COMPLETED		
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F 695	kept the mask on fo oxygen levels decrethen changed the red 4 liters of suppleme Resident #1 wore the entire time he with the entire time he wistated he was not a with Resident #1 hamechanical ventilated Manager assisted hinterview revealed Nassessed the resided Anursing progress PM written by the Nishe had contacted responding the exact Anursing progress PM written by the Nishe had contacted responding the exact Anursing progress PM written by the Nishe had called Responding the exact time An interview conduction with Nurse Manager working during the exact time was admitted on 10 was the hall nurse, admission. She state oriented and talking	red the facility and Nurse #1 r a short period in case his ased. Nurse #1 stated he sident to a nasal cannula on ntal oxygen. He stated e nasal cannula at 4 Liters as working until 11:00 PM. He ware that the family member d brought in a non- invasive or. He stated the Nurse im with the admission. The lurse Manager #1 had ent and obtained vital signs. The dated 10/18/21 at 6:02 curse Manager #1 revealed Respiratory Therapy and ratory therapy company Staff d they would have someone dent #1's BiPaP. The note did time the call was placed. The dated 10/18/21 at 10:13 curse Manager #1 revealed biratory Therapy and spoke therapy company Staff	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 695	liters. She stated the #1 to receive a BiPa the respiratory thera to send someone ou stated she hadn't he company, so she we PM and Resident #1 non-invasive mechal home. Nurse Manag the machine from his She stated the mach did not know how to She stated she did not when the RT compainterview revealed R without the non-invamachine on the nigh shown signs of respiratory in the resident #1's vital si saturation level docu AM by Nurse #6 of 9 saturation level is great An interview conduct with Nurse #6 reveal Resident #1 on 10/1. 11:00 PM. She state his BiPaP in place, so oxygen saturation le at 11:00 PM and it were vealed she could ro oxygen saturation le than 92% on 4 liters nasal cannula. She seem like he was in distress and did not	re was an order for Resident P as needed so she called py company and asked them t to assist the resident. She ard anything back from the nt into the room around 9:30 stated he used his nical ventilator machine at er #1 stated she then took s bag and laid it onto his bed. inine was in pieces and she put it together or turn it on. ot contact the Physician ny did not respond. The esident #1 went to sleep sive mechanical ventilator t of 10/18/21 and had not	F 69				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
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		345283	B. WING _			11/	29/2021
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
THE CITA	DEL MOORESVILLE				0 GLENWOOD DRIVE		
				MC	DORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	e 22	F 6	695			
F 695	she knew Nurse Man Respiratory Therapy someone was coming machine. Nurse #6 stentered on 10/19/21 a indicated oxygen via confirmed the flow me Resident #1's vital sig saturation level docur AM by Nurse #2 of 94 oxygen via nasal can An interview conducte with Nurse #2 reveale Resident #1 at 7:00 A in report Nurse #6 sta a new admission (Rehad sent the incorrect resident. The nurse to had issues with hypotresident's family mem the shift on 10/19/21. member came to her the residents non-invanachine was not hoo told the family member understanding that ar respiratory therapy, at to come set up his may went into the resident administering his morhis non-invasive meclaying on his bed. Nu	ager #1 had contacted the company and thought g to set up Resident #1's cated the vital signs she at 1:07 AM should have masal cannula. Nurse #6 eter was set at 4 L/min. Igns revealed an oxygen mented on 10/19/21 at 10:57 at receiving supplemental mula. The don 11/12/21 at 12:06 PM ed she took over care for at AM on 10/19/21. She stated at the facility had received sident #1) and the hospital at BiPaP machine with the bld Nurse #2 the resident via. Nurse #2 stated the aber was in the room during She stated the family around 8:45 AM asking why asive mechanical ventilator asked up and she stated she er that it was her mother nurse had called and someone was supposed achine. Nurse #2 stated she it's room when she was rning medication and saw hanical ventilator machine rse #2 stated Resident #1	Fé	695			
	was experiencing lab anxious at that time, I oxygen saturation lev breathing treatment,	ored breathing and was very but she did not check his rel. After administering the she stated the resident was urse #2 stated the resident					

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				29/2021
	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	difficulty breathing. Sincector was able to grespiratory Therapist building around 5:00 Resident #1. She star Resident #1's oxygen (normal oxygen satur 92%) on 4 liters via management of the star of	gree angle in the bed due to the stated the Medical get in touch with the it (RT) who entered the PM on 10/19/21 to see ted when the RT checked is saturation level it was 85% ation level greater than asal cannula. Itiated by the RT on 10/19/21 Resident #1's non-invasive machine was to be worn at during naps. The order for non-invasive mechanical deliver the BiPaP ventilation ation Administration Record reder dated 10/19/21 for Solution 0.5-2.5 inhale orally via nebulizer rtness of breath. The review or solution was not 12:00 AM dose. Nurse #3 to #1 was sleeping. Torogress note dated written by Nurse #3 was administered Diltiazem of treat high blood pressure) it is feeding tube. The note as receiving oxygen via his ical ventilator machine. Ident #1 was found with his	F	695			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DEL MOORESVILLE	0.0230		STREET ADDRESS, CITY, STATE, ZIP C 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES SNCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 695	An interview condivith Nurse #3 reversity Nurse #2 on 10/19. She stated the RT she received report the room and tried non-invasive mechanical resident #1 supper so when show the resident's blood sumedications via his revealed she returned per looking for hur oxygen and he was mechanical ventile at midnight she went the resident's med respiratory distress his blood pressure the resident was a room. Nurse #3 state breathing treatmer she didn't administ touch his non-invasity walked by Resider have his non-invasion but had his neb	AM and Resident #1 was bired at 2:07 AM. Jucted on 11/12/21 at 12:21 PM ealed she received report from 1/21 at 7:00 PM for Resident #1. Was not in the building when at, but Nurse #2 took her into to show her how to use the manical ventilator machine. She had taken the mask off to eat the and Nurse #2 entered the applied the residents mask led his supper meal. She stated from at 8:30 PM to check the legar and administer his a feeding tube. The interview fined to the room around 9:00 midification for the resident's set still on the non-invasive for machine. Nurse #3 stated for midnister ication and he was in no set. She stated she administered for midnight however fined the resident had a fine ordered for midnight however fine it because she didn't want to sive mechanical ventilator fine at a fine ordered for midnight or sive mechanical ventilator mask builzer mask on with no	F6	395		
	supplemental oxyg tubing hooked. The nebulizer mask on walked in the room	gen hooked to it and no other e resident just had the his face. She stated when she n, she did not see him breathing pulse. She yelled for another				

AND DIAN OF CORRECTION IN IMPER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	,	11/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 695	they initiated cardiop (CPR) but were unal Nurse #3 stated Reshad been on his bed must have reached of mechanical ventilato with his nebulizer trestated she did not he non-invasive mechanical ventilato incident. She stated anything about the in Resident #1's vital sissaturation level docu AM by Nurse #3 of 9 oxygen via nasal car A follow-up interview 3:24 PM with Nurse vital signs must have She stated at 1:29 A was not 95%. An interview conduct with Nurse #4 reveal 300 hall on the morn Nurse #3 calmly wer stated Resident #1 w Manger #2 then ran responded with Nurse #3 stayed at the nurse stated when she entwas laying in the bed She stated he had a	l come into the room, and ulmonary resuscitation ole to revive the resident. ident #1's nebulizer mask side dresser and the resident over, took his Non-invasive mask off and replaced it atment mask himself. She car an alarm coming from the nical ventilator machine, but on. Nurse #3 stated she had regarding a non-invasive machine before or after the nobody had asked her incident. In gns revealed an oxygen mented on 10/20/21 at 1:29 5% receiving supplemental	F6	95		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRU		(X3) DATE COMP	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	DRESS, CITY, STATE, ZIP CODE	·	
THE OITA	DEL MOODEOV/// LE			550 GLENW	OOD DRIVE		
THE CITA	DEL MOORESVILLE			MOORESV	/ILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	machine running. Resupplemental oxyger and Nurse #5 felt for could feel one. She thought she felt a puniter Nurse Manager #2, She stated they perform a rived. The intervier non-invasive mechalooked like it hadn't along with the mask and didn't remember stated she had to place annula prior to initiate revealed that afterweld discussing what had stated to her she had non-invasive mechal that's why she hadnore breathing treatment. In knew non-invasive machines had an all disconnected from a revealed she had not from Resident #1's resident #1's resident #1's resident's family and together. She stated Resident #1 was lay interview revealed she to disconnected from the stated she told Nurse resident's family and together. She stated Resident #1 was lay interview revealed she or rise or stated she was no rise or supplementations.	She did not hear the nebulizer esident #1 had no en on. Nurse #4 stated she rapulse but neither nurse stated Nurse #3 had said she alse when she reported it to so they began to initiate CPR. formed CPR unit EMS we revealed she saw the unical ventilator machine, but it been on the resident stating it was on his bedside dresser reseing it turned on. She acce oxygen on him via nasal eating CPR. The interview ards the nurses were if happened and Nurse #3 depended by the stated in the past she mechanical ventilator.	F	595			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	ODE	11/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA	DATE
F 695	she see his non-invasion machine. She stated touch. Nurse Manage (Automated External initiated CPR. The number of the EMS arrived and property of the EMS arrived and she stated alarms coming from the nebulizer machine rule. A voicemail was left for the Working on 10/19/21 during third call. A voicemail was left for the Working on 10/19/21 death was listed as a failure with hypoxia (In EMS). An interview conduct with the Medical Direst of the EMS arrived with the Medical Direst of the MS arrived was informed it had responsive mechant was informed it had responding the MD that the facility did no non-invasive mechant management of the EMS arrived and was unsuccessful issues getting ahold or responding. The MD that the facility did no non-invasive mechant.	sive mechanical ventilator the resident was cool to the er #2 obtained the AED Defibrillator) while Nurse #4 urses continued CPR until nounced the resident expired ed she did not hear any his room or hear the nning. Or Nurse #5 who worked on shift with no return phone Or the third shift Nurse Aide with no return phone call. Certificate revealed he at 2:07 AM. The cause of cute and chronic respiratory ack of oxygen). ed on 11/12/21 at 3:10 PM ctor (MD) revealed she had his room on 10/19/21 at 9:00 had an interaction with the he day regarding his hical ventilator machine and not been set up. She stated ed RT in which the RT right away and said she to the facility. She stated he had no of them and them stated she was originally told	F	695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DEL MOORESVILLE			550 GLENW	DRESS, CITY, STATE, ZIP CODE VOOD DRIVE VILLE, NC 28115		,,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 695	non-invasive mechal being on it could have That was why when machine initiated she possible. The intervible of the number of the	who required the use of a nical ventilator machine, not ve a serious negative impact. she found out he needed his e wanted it on as soon as ew revealed Resident #1 had	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD	NG _		Ι,	c	
		345283	B. WING				29/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	50 GLENWOOD DRIVE			
THE CITA	DEL MOORESVILLE			N	OORESVILLE, NC 28115			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 695	lying like a statue. The Resident #1 if he was responded with a year overexert himself. She non-invasive mechaniset up his heart rate an oxygen saturation she educated Nurse and had asked her to She stated she asked oncoming nurses be staff was not familiar mechanical ventilatorshe stayed in the fact and orders into the Fishe always did and I the RT contacted the how Resident #1 was expired during the ninhe was found with a and knew he had order at midnight. She stated the nurse on duty has supplemental oxygen treatment when she stated when she loggenter than the breathing treatment saleep. The RT states because she had see he could not have check the stated with his belasted 2 minutes with oxygen and the nonventilator machine shad been removed.	e RT to be short of breath and he RT stated she asked is afraid to move and he is due to being afraid to he stated after the inical ventilator machine was was 68 beats per minute with in level of 92%. The RT stated #2 on use of the machine of demonstrate how to use it. If the the cause she knew the facility is with use of a non-invasive in machine. The RT stated colinity and placed her notes from the building. The next day is and was told he had ght. She stated she was told inebulizer mask on his face deers for a breathing treatment and she immediately thought and not hooked his in up with his nebulizer administered it. The RT ged into the system, she saw mented she did not administer ent because the resident was ed it didn't make sense to her en the resident prior and felt anged the mask himself.	F	695				

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 11/29/2021	
	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 695	following the incident meeting with the Dire Corporate team when were not educated to non-invasive mechan stated she was asked in-service to staff followeekend. A follow-up interview 11:15 AM with the Rethe settings were for non-invasive mechan stated she always wright and as needed not be on longer than RT stated she had spfamily member who the more frequently at hosick. The Respiratory told the facility to not BiPaP settings included ischarge summary, to the facility without settings. She stated was setting up the more frequently at hosick argues it was not you once it was on his fact to of hit the silence be alarming. The Respir facility did not have a accepting admissions mechanical ventilator revealed the RT felt for the silence of the sile	de dresser. She stated ashe was asked to have a actor of Nursing and re she told them the nurses of care for a resident with a nical ventilator machine. She did to provide a 4-day owing the incident on the conducted on 11/16/21 at respiratory Therapist revealed the BiPaP mode of the nical ventilator machine. She rote for BiPaP to be on at for naps because they could in 12 hours consistently. The rocken with the resident's rold her he was wearing it to me since he had become of Therapist stated she had accept residents without led on their hospital but that Resident #1 came an order including his BiPaP she remembered when she archine and showing Nurse archine it kept alarming, and rest the silence button at on his face. She stated the policy prior to 10/22/21 for	F6	595			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345283	B. WING		C 11/29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE		:	STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11723/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 695	conducted with the Respiratory Therapy was notified by the fin touch with the RT had expired, so she all of the call logs for 10/19/21. She state the agency on 10/19 resident in which the notified about Resident in which the notified about Resident the company we The interview revea record of the facility Resident #1 except had directly called the 4:30 PM no prior can she stated the RTs respond after they conduct with the Director of facility had a policy non-invasive mechal long as the machine setting. The DON state the hospital with ord she stated Nurse Manager said she has the felt that the call region incorrectly by the order is as need initiates the machine normal for a resident half for initiation of a state of the she felt that the call region incorrectly by the order is as need initiates the machine normal for a resident half for initiation of a state of the she felt that the call region incorrectly by the order is as need initiates the machine normal for a resident half for initiation of a state of the she felt that the call region incorrectly by the order is as need initiates the machine normal for a resident half for initiation of a state of the she felt that the call region incorrectly by the order is as need initiates the machine normal for a resident half for initiation of a state of the she felt that the call region incorrectly by the order is an expectation.	PM an interview was District Manager from the y company. She stated she facility that they could not get company after Resident #1 had the corporate team pull om the dates of 10/18/21 and d the facility had contacted 0/21 at 2:24 PM for a different e RT responded and was not tent #1. She stated prior to as contacted on 10/16/21. led the company had no contacting them regarding for when the Medical Director ne RT on her cell phone at lls were seen on the call log. only have 10 minutes to	F 695		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		()	` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/23/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 695	normal. She stated shappened to Residen any farther. The interstarted an in-service oventilator machines at taught by the Respiral District Manager of the A follow up interview 4:36 PM with the Direction of the Aid on the Aid of th	the had asked Nurse #3 what the #1 and did not question it wiew revealed the facility had on non-invasive mechanical fiter the incident for 4 days tory Therapist and the eRT company. Conducted on 11/16/21 at ector of Nursing revealed she unicate with the Admissions of new admissions in the ewas unaware Resident #1 con-invasive mechanical the DON stated she had not cospital discharge summary. It is a bipaper or non-invasive machine. She stated	F	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			(0
		345283	B. WING			11/	29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE			55	REET ADDRESS, CITY, STATE, ZIP CODE 60 GLENWOOD DRIVE OORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	AM with a representative respiratory provider at the rapy. He explained which was non-react needs. On the other Volume Assured Premode automatically a breathing patterns, to over time. The interval higher level of sup. The non-invasive mend expiratory press function to sense if the air in order to prever delivered prematured way to disable the lopatient was disconnehowever staff could at the button on the frowould only stop the astated if the machine battery back-up and got down to 20 minumore aggressive ala at 10 minutes remain alarm would sound the alarm silence but the alarm silence but there would be no al turned off. An interview conduct with Family Member facility on 10/19/21 afacility only allowing #1. Resident #1 was admission. She state the room with the resident state of the resident was admission. She state the room with the resident was admission.	nducted on 11/19/21 at 10:45	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE C	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER DEL MOORESVILLE			550	EET ADDRESS, CITY, STATE, ZIP CODE GLENWOOD DRIVE ORESVILLE, NC 28115		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	the night prior withou also had no breathin revealed the family of Resident #1 was so extremely short of bit 10/18/21 and on 10/facility, but Family Macility until 6:00 PM at 1:30 AM she recestating Resident #1 called Family Memb to the facility. She st call shortly after stat Family Member #1 shad just given him him stating he had of Member #1 confirmed that Resident #1 was prior to the Respirate building and applying mechanical ventilator #1 stated Resident #1 ventilator mask had entering the hospital She stated she stated remove his mask by was in. The facility provided Action Plan with the 1) Immediate Action Plan with the Physician and Respino/20/2021. On 10/20/2021.	why Resident #1 had gone at his BiPaP machine and a greatments. The interview was on high alert because weak and had been reath the day before on 19/21. She stated she left the lember #2 stayed in the with Resident #1. She stated ived a call from Nurse #3 was unresponsive, so she er #2 and they began to drive ated she received a second ing Resident #1 had expired. Stated Nurse #3 told her she is medication and then found hanged his mask. Family ed with Family Member #2 is short of breath on 10/19/21 bry Therapist entering the	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	 	11/23/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 695	facility Interdisciplina Director of Operation of Clinical Services (VF of event and to initial based on immediate 2) Identification of On 10/24 a completed by the Diresidents utilizing Nowhich include bi-leve (Bi-Pap), continuous (C-Pap) and non-involume assured presequence (NIV/AVAPS-AE, brato ensure that physic settings and frequence identified for order of harm or adverse efferesident remains state On 10/24/2 by the Director of Nuclarification for Resid (Non-invasive Ventillorders revised and in the Director of Nursi 10/25/21. On 10/25/2 completed a review	eted via conference call with ary Team (IDT) and Regional as (RDO), Regional Director (RDCS) and Vice President of (PCS) to discuss initial findings the immediate action plans findings.	F	695		
	settings were accurate orders. No further recorders. No further recorders. No 10/25/2 9/18-10/20/21 will be Nursing/designee to NIV devices per hos have appropriate order.	ate based upon physician commendations made. 021, all new admissions from e reviewed by the Director of ensure any resident requiring pital discharge summary ders to include settings and o additional residents were				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE		,	STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	'	11/29/2021
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	District Director of R and revised policy "I IV/AVAPSA-E featur licensed nurses and and responsibilities in C-Pap and APAPS-A Trilogy) devices. 3) Education/Syste On 10/22/2 education to the faci RDCS on the update Ventilation: IV/AVAP effective immediately accept NIV/AVAPS-A trilogy) On 10/25/21. Assurance Performan meeting was comple RDO and VPCS a control of the properties of the Director of Nursel of the Director of Nursel of NIV deviced ucation records to current and newly hilicensed nurses. Startled ucation complements of the Director of NIV deviced ucation complements. Startled ucation complements of NIV/25/2 including agency startled ucation complements. Startled ucation complements of NIV/25/2 including agency startled ucation complements.	1, the VPCS and contracted espiratory Therapy reviewed Non-invasive Ventilation: e" to reflect and further clarify Respiratory Therapists roles in the management of Bi-Pap, AE NIV (brands such as emic Change 1, the VPCS provided lity Administrator, DON and ed policy "Non-invasive SA-E feature" to include that by the facility shall no longer AE devices (brands such as an Ad Hoc Quality ance Improvement (QAPI) eted by the IDT and RDCS, comprehensive corrective eloped based on root cause F580, F695, F726, and F835. 1, all licensed nursing staff ensed nurses will be educated ursing (DON)/ designee on sysician is notified of any delay sician orders including ces. The DON will maintain ovalidate staff competency for red facility and agency ff will not be allowed to work	F	695		
	admission process in transcription of orde the physician if clarit	ncluding verification and rs and immediately contacting fications are needed. The ducation records to validate				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C 1/29/2021	
	ROVIDER OR SUPPLIER DEL MOORESVILLE	0,020		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1/25/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 695	facility and agency lice be allowed to work under the By 10/25/20 licensed nursing staff be educated by the Experience and appropriate the service number to not a calling the respiratory service number to not a current residents. If the company does not refacility will reattempt will be immediately on addition, if the resimple he/she will immediate room for further evaluation and agency licensed allowed to work until Effective 10 will have the contact contracted Respiratory prominently posted. If are available after how By 10/25/20 will be educated by the	current and newly hired bensed nurses. Staff will not ntil education completed. 121, the unit clerk and all fincluding agency staff will Director of Nursing /designee Ition process which includes witherapy company customer of the Respiratory admission requiring NIV for respiratory needs of the respiratory therapy respond within 10 minutes, the fince in any acute distress, and the sent to the emergency function. The DON will records to validate staff for the and newly hired facility nurses. Staff will not be reducation completed. 125/21, each nursing station information for the ry Therapy company Respiratory therapy services outside the Admission Director ne Administrator/ designee intatory therapist, unit clerk,	F 6				
	Education also include longer accept NIV/AV trilogy effective 10/25 Director was also edu 10/25/21 on C-PAP, (Trilogy type) devices	dents require NIV devices. ded for admissions to no /APS-AE, brands such as 5/21. The Admissions ucated by the DON on Bi-PAP, and AVAPS-AE is to identify the differences in ed with these types of					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C I1/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/23/2021
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	and newly hired facili not be allowed to work in the facility and agency lice allowed to work and newly hired facility and agency lice allowed to work under the facility clinical capthe care services prodetermine admission maintain education recompleted. By 10/25/20 and licensed nursing licensed nurses will be of Nursing on ensuring devices are available frequency orders when the facility. The DON records to validate stand newly hired facility and agency lice be allowed to work under the facility of the care services prodetermine admission maintain education recompetency for current and agency licensed Medical Director and will not be allowed to completed. Effective 10 longer accept NIV/ AV	Ill maintain education aff competency for current ty Admission staff. Staff will k until education completed. (25/21, the Admission f Nursing will ensure that the y therapy company will be ours prior to an admission for NIV device to ensure adily available prior to equired settings verified. 21, the Admission Director staff including agency be educated by the Director of that ordered equipment/or with required setting and en residents are admitted to will maintain education aff competency for current ty Admissions staff and bensed nurses. Staff will not not education completed. 21, Licensed Nurses, Medical Director and Social ted by the Administrator on coabilities grid which specifies wided by the facility to approval. The DON will ecords to validate staff and newly hired facility nurses, Admissions staff, Social Services staff. Staff work until education	F 6	95		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345283	B. WING		C 11/29/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11723/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 695	on the facility policy "Non-invasive Ventil to include competen devices, required on documentation relate by the Respiratory T Nursing. The DON were cords to validate sand newly hired facil nurses. Staff will not education completed. By 10/25/2 including agency CN Director of Nursing of including notifying the issues with the NIV i with the resident untand not manipulating DON will maintain education and agency for facility and agency for facility and agency for facility and to work until education be allowed to work until education include new hire fagency licensed nur staff. These staff will education completed	ensed nurses will be educated revision date 10/22/21 ation: IV/AVAPSA-E feature" cies on the use of all NIV going respiratory assessment ed NIV and oxygen therapy herapist and Director of vill maintain education taff competency for current lity and agency licensed be allowed to work until d. 1, Certified Nurse Aides (CNA) IA will be educated by the on the care of NIV residents e Licensed Nurses of any il licensed nurse responds grachine in any way. The ducation records to validate current and newly hired CNAs. Staff will not be allowed on completed. Staff will not until education completed. 0/25/2021, all education for ed in the orientation process accility licensed nurses, ses, CNAs, and admission not be allowed to work until	F 69	,	
	by nursing managen to ensure the accura of physician 's order notification to physic discrepancies for cla management was in	•			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345283	B. WING _				C 29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE		,	550 GLEI	ADDRESS, CITY, STATE, ZIP CODE NWOOD DRIVE SVILLE, NC 28115	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 695	management will rev paperwork during more ensure the accuracy physician 's orders for devices and notificated discrepancies for clarification and/or condition and and and and and and and and and an	ess: 0/25/21, 1) nursing iew/audit new admission orning clinical report to and timely implementation of or Bi-Pap and C-Pap NIV ion to physician of any order rification. Any discrepancies d to the physician for orrection and 2) the ee will review/audit nursing w hires and agency staff to ence of Bi-Pap and C-Pap II not be allowed to work until the audits will be documented ovement Data Collection ed in the plan of correction etrator 's office. If, the QAPI Committee was eistrator of delegation of QA eilities. The results of the eccussed in the monthly QAPI or at least three months, einistrator, Director of dical Director. The en will recommend revisions to en to maintain substantial 10/25/21, the RDCS and/or results of facility audits and ely for three months to ensure with accuracy and timely eysician 's orders for Bi-Pap ess and notification to	F	695			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C
	ROVIDER OR SUPPLIER DEL MOORESVILLE	340203		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	1	11/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
F 695	The facility alleges con The Corrective Action 11/24/21 and conclude an acceptable correct The facility amended include calling the rescustomer service number Therapist of all new adevices and any other current residents. If the company does not refacility will reattempt to will be immediately contract the correct treatment of the current residents.	Plan was validated on led the facility implemented tive action plan on 10/26/21. The notification process to epiratory therapy company of the respiratory needs of the respiratory therapy spond within 10 minutes, the k 1, if no response the MD ontacted for further orders.	F6	595		
F 726 SS=J	BiPaP/ CPAP were reto November 2021 will Review of the nursing non-invasive mechan revealed the nursing receiving the in-service conducted with nursing and third shifts reveal in-service as stated by verified they had recentification, abuse, not and use of a BiPap/C Competent Nursing SCFR(s): 483.35(a)(3) §483.35 Nursing Service The facility must have the appropriate comperovide nursing and reservices.	staff had initialed as be training. Interviews and staff from first, second led they had received the y the facility. The staff sived in-servicing on eglect, change of condition PAP machine.	F7	726		12/22/21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345283	B. WING		C 11/29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE	1 0,020		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11/23/2021
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 726	practicable physical, well-being of each re resident assessment and considering the r diagnoses of the facil accordance with the at §483.70(e). §483.35(a)(3) The fallicensed nurses have and skill sets necessineeds, as identified the assessments, and defended by the facility must enside to resident's needs. §483.35(a)(4) Providibilitied to assessing, implementing resider to resident's needs. §483.35(c) Proficiency The facility must ensite to demonstrate compite to the facility must ensite to demonstrate compite the facility failed to endemonstrate competence the respiratory of a compromised respiratory of a compromi	mental, and psychosocial sident, as determined by and individual plans of care number, acuity and ity's resident population in facility assessment required cility must ensure that the specific competencies ary to care for residents' hrough resident escribed in the plan of care. Ing care includes but is not evaluating, planning and at care plans and responding ey of nurse aides. The plan of care are that nurse aides are able tetency in skills and y to care for residents'	F 72	Past noncompliance: no plan of correction required.	

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		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	I	11/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	respiratory failure w This failure affected competent nursing s The findings include This tag is cross reform F 580: Based on rece Respiratory Therapi interviews the facility for clarification where was admitted on 10, positive airway prese include the settings non-invasive mechan Nurse Manager #1 of when they were not Therapist on 10/18/2 up the BiPaP. The reform was approached by who asked why the ventilator was not be attempt to contact the Therapy for assistan Death Certificate reform at 2:07 AM. The cau acute and chronic reform (lack of oxygen). The resident reviewed for F 695: Based on rece Respiratory Therapi clinical respiratory p failed to provide nece services to a resider respiratory status with positive airway pres	th hypoxia (lack of oxygen). 1 of 2 resident reviewed for staff. d: erred to: cord reviews and staff, st and Medical Director (MD) y failed to notify the Physician a resident (Resident #1) (18/21 with orders for a bilevel sure (BiPaP) that did not	F7	726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C 11/29/2021
	ROVIDER OR SUPPLIER DEL MOORESVILLE	1.000		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	l	11/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	include the settings non-invasive mecha failed to clarify orde or involve respirator BiPaP machine was of 10/19/21. In add complete and docur assessments of the and ensure Resident revealed he expired cause of death was respiratory failure w This failure affected respiratory care. The facility provided Action Plan with the	sure (BiPaP) that did not or frequency for the inical ventilator. The facility rs for the BiPaP on admission by therapy and as a result the strong and strong and as a result the strong and strong	F 72	26		
	10/20/2021. On 10/20/2 Assurance Performs meeting was completed by the Dresidents utilizing N					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345283	B. WING		C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11125/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 726	(C-Pap) and non-involume assured pre (NIV/AVAPS-AE, brato ensure that physic settings and frequer identified for order or harm or adverse effiresident remains state. On 10/24/2 by the Director of Niclarification for Resic (Non-invasive Ventil orders revised and ithe Director of Nursi 10/25/21. On 10/25/2 completed a review of current residents settings were accuratorders. No further residents settings were accuratorders. No further residents settings were accuratorders. No further residents orders. No further residents ordered in 10/25/2 bits of the control of	s positive airway pressure rasive ventilation average sure support-auto E-Pap ands such as trilogy) devices cian orders include the device rocy of use. Resident #2 larification. There was no rects to Resident #2 and able on current NIV settings. P1, the Physician was notified ursing of orders needing dent #2 s NIV/AVAPS-AE ation) device. Resident #2 mplemented on 10/24/21 by ng and care plan revised on NIV devices to ensure ate based upon physician recommendations made. P021, all new admissions from the reviewed by the Director of the ensure any resident requiring spital discharge summary ders to include settings and to additional residents were sion. 11. the VPCS and contracted respiratory Therapy reviewed Non-invasive Ventilation: The remanagement of Bi-Pap, AE NIV (brands such as	F 72	6	
	3) Education/System On 10/22/2	emic Change 11, the VPCS provided lity Administrator, DON and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	'	11/29/2021
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 726	Continued From pag	ge 46	F 7	26		
	RDCS on the update Ventilation: IV/AVAP effective immediately accept NIV/AVAPS-A trilogy) On 10/25/21, Assurance Performa meeting was comple RDO and VPCS a concion plan was devianalysis to address and by the Director of Nuensuring that the physical including agency lice by the Director of NIV deviceducation records to current and newly hillicensed nurses. Stauntil education composition of NIV deviceducation records to current and newly hillicensed nurses. Stauntil education composition of NIV deviceducation records to current and newly hillicensed nurses. Stauntil education composition of NIV deviceducation records to current and newly hillicensed nurses. Stauntil education composition of NIV devices and agency states and any other physician if clariff DON will maintain education of order the physician if clariff DON will maintain education to order the physician if clariff DON will maintain education agency libe allowed to work updated by the liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency liberal physician in clariff competency for facility and agency	ed policy "Non-invasive SA-E feature" to include that by the facility shall no longer AE devices (brands such as an Ad Hoc Quality ance Improvement (QAPI) eted by the IDT and RDCS, comprehensive corrective eloped based on root cause F580, F695, F726, and F835. 1, all licensed nursing staff ensed nurses will be educated ursing (DON)/ designee on sysician is notified of any delay sician orders including ces. The DON will maintain evalidate staff competency for red facility and agency off will not be allowed to work obleted. 2021, all licensed nursing staff off will be educated by the designee related to the including verification and res and immediately contacting fications are needed. The ducation records to validate a current and newly hired censed nurses. Staff will not until education completed. 2021, the unit clerk and all off including agency staff will corrector of Nursing /designee ation process which includes by therapy company customer				

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 1/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN O X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 726	facility will reattemy will be immediately In addition, if the rehe/she will immediate room for further everage and agency license allowed to work under the contracted Respirate prominently posted are available after a will be educated by on ensuring the result and supply personal admission when reeducation also inclonger accept NIV/ trilogy effective 10/Director was also en 10/25/21 on C-PAF (Trilogy type) devices. The DON records to validate and newly hired factor to be allowed to well as the contracted respirate notified at least 24 with physician order NIV device will be admission with the	respond within 10 minutes, the of x 1, if no response the MD contacted for further orders. It is in any acute distress, ately be sent to the emergency aluation. The DON will records to validate staff that and newly hired facility and nurses. Staff will not be till education completed. 10/25/21, each nursing station at information for the tory Therapy company 1. Respiratory therapy services thours and on weekends. 10/25/21, the Admission Director of the Administrator designee spiratory therapist, unit clerk, and are notified prior to sidents require NIV devices. 10/25/21. The Admissions to no AVAPS-AE, brands such as 25/21. The Admissions to no AVAPS-AE, brands such as 25/21. The Admissions and with these types of will maintain education staff competency for current callity Admission staff. Staff will work until education completed. 10/25/21, the Admission of Nursing will ensure that the cory therapy company will be hours prior to an admission are for NIV device to ensure readily available prior to required settings verified.	F	726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345283	B. WING				29/ 2021
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			5	TREET ADDRESS, CITY, STATE, ZIP CODE 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	licensed nurses will be of Nursing on ensuring devices are available frequency orders when the facility. The DON records to validate stand newly hired facility and agency lice be allowed to work urgo By 10/25/20. Admissions Director, Services were educated the facility clinical capted the care services productermine admission maintain education recompetency for curre and agency licensed Medical Director and will not be allowed to completed. Effective 10/10 longer accept NIV/ Avanch as trilogy) in the Director received educed in the facility policy reconsidered include competency documentation related by the Respiratory The Nursing. The DON wirecords to validate stand newly hired facility	staff including agency e educated by the Director g that ordered equipment/or with required setting and en residents are admitted to will maintain education aff competency for current ty Admissions staff and ensed nurses. Staff will not ntil education completed. 21, Licensed Nurses, Medical Director and Social ted by the Administrator on pabilities grid which specifies wided by the facility to approval. The DON will ecords to validate staff int and newly hired facility nurses, Admissions staff, Social Services staff. Staff work until education (25/21, the facility will no /APS-AE devices (brands facility. The Admission facility. The Admission facility. The Admission facility. The Admission facility in the second of the s	F	726			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
	345283		B. WING _			C 11/29/2021	
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP COL 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1/25/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 726	including agency CN. Director of Nursing of including notifying the issues with the NIV ir with the resident until and not manipulating DON will maintain ed staff competency for facility and agency C to work until educatio be allowed to work until educatio be allowed to work until educatio to include new hire fa agency licensed nurs staff. These staff will education completed Effective 10 paperwork and physi by nursing managem to ensure the accuracy of physician 's orders notification to physici discrepancies for clar management was infiduring Ad Hoc QAPI Administrator. 4) Monitoring Processing Beginning 1 management will revipaperwork during more ensure the accuracy physician 's orders for devices and notification discrepancies for clar will be communicated clarification and/or collar collar fication and/or collar collar fication and/or collar collar fication and/or collar fication and fi	A will be educated by the note care of NIV residents and Licensed Nurses of any including alarms, remaining allicensed nurse responds machine in any way. The ducation records to validate current and newly hired NAs. Staff will not be allowed on completed. Staff will not intil education completed. /25/2021, all education for d in the orientation process acility licensed nurses, ses, CNAs, and admission not be allowed to work until . /25/21, new admission cian orders will be reviewed eight in morning clinical report by and timely implementation is for NIV devices and an of any order rification. Nursing ormed of review process meeting on 10/25/21 by the sess: 0/25/21, 1) nursing iew/audit new admission or ing clinical report to and timely implementation of or Bi-Pap and C-Pap NIV on to physician of any order rification. Any discrepancies d to the physician for	F7	26			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C 1/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	'	1/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 726	ensure staff compete NIV devices. Staff we education complete. Results of to on the "Quality Improsheet" and maintain binder in the Adminis. On 10/25/2 notified by the Admir monitoring responsite monitoring will be discommittee meeting foverseen by the Adm Nursing, and the Meinterdisciplinary teans the plan as indicated compliance. Beginning the RDO will review QAPI minutes month ongoing compliance implementation of prand C-Pap NIV device physician of any ordicarification. The facility alleges of the Corrective Action 11/24/21 and concludant acceptable corrective acceptable corrective and conclude calling the recustomer service nutral transpist of all new devices and any othe current residents. If the corrective includes and the current residents.	w hires and agency staff to ence of Bi-Pap and C-Pap II not be allowed to work until the audits will be documented everent Data Collection ed in the plan of correction estrator 's office. 1, the QAPI Committee was anistrator of delegation of QA solities. The results of the excussed in the monthly QAPI for at least three months, ministrator, Director of dical Director. The en will recommend revisions to to maintain substantial 10/25/21, the RDCS and/or results of facility audits and ally for three months to ensure with accuracy and timely exiscian 's orders for Bi-Pap ces and notification to	F 72	26		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		2.45202			С	
NAME OF PR	ROVIDER OR SUPPLIER	345283	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	11/	29/2021
THE CITAL	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 PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	will be immediately control of the Corrective Action QAPI meeting held on The weekly monitorin BiPaP/ CPAP were restoned to November 2021 wind Review of the nursing non-invasive mechan revealed the nursing receiving the in-service conducted with nursing and third shifts reveal in-service as stated be verified they had recentification, abuse, not and use of a BiPap/C Administration CFR(s): 483.70 §483.70 Administration A facility must be admenables it to use its refficiently to attain or practicable physical, in well-being of each restriction that it is resulted in the provide oversight for a procedures and decise effective and necessaresident with a comprise the control of the control o	x 1, if no response the MD ontacted for further orders. In Plan was reviewed during in 10/25/21. If glogs residents requiring a eviewed from October 2021 of the no concerns identified. In staff in-service sheets on itical ventilator training staff had initialed as one training. Interviews and staff from first, second led they had received the young the facility. The staff elived in-servicing on eaglect, change of condition and part of the property and maintain the highest mental, and psychosocial sident. In initial the initial of the property is not met as evidenced in the second of the property is not met as evidenced in the property is not met as evidence in the property is not	F 7	726		12/22/21
		BiPap ventilation using a ical ventilator. Review of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	'	11/20/2021
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 835	expired on 10/20/21 death was listed as failure with hypoxia affected 1 of 2 resid Administration. The findings include This tag is cross reference of the facility for clarification where was admitted on 10 positive airway presinclude the settings non-invasive mechan Nurse Manager #1 owhen they were not Therapist on 10/18/2 up the BiPaP. The result was approached by who asked why the ventilator was not be attempt to contact the Therapy for assistant Death Certificate result acute and chronic residence.	a Certificate revealed he at 2:07 AM. The cause of acute and chronic respiratory (lack of oxygen). This failure ents reviewed for d: erred to: cord reviews and staff, st and Medical Director (MD) y failed to notify the Physician n a resident (Resident #1) /18/21 with orders for a bilevel sure (BiPaP) that did not	F 8	·		
	resident reviewed for F 695: Based on reconstruction Respiratory Therapic clinical respiratory provide neconstruction and the second respiratory provides a	or notification of changes. cord reviews and staff, st, Medical Director (MD) and rovider interviews the facility sessary respiratory care and nt with a compromised				

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	_		44!	
NAME OF P	ROVIDER OR SUPPLIER	343203	D. Wiite	s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/2	29/2021
THE CITA	DEL MOORESVILLE				50 GLENWOOD DRIVE IOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 835	positive airway press was admitted on 10/1 positive airway press include the settings on non-invasive mechan failed to clarify orders or involve respiratory BiPaP machine was of 10/19/21. In additicomplete and docum assessments of the mand ensure Resident revealed he expired of cause of death was light respiratory failure with This failure affected frespiratory care. F 726: Based on reconstruction of the respiratory of the res	o was dependent on bilevel ure (BiPaP). Resident #1 (8/21 with orders for a bilevel ure (BiPaP) that did not or frequency for the sical ventilator. The facility of for the BiPaP on admission therapy and as a result the not set up until the evening on, the facility failed to ent on-going comprehensive esident's respiratory status #1 had continuous oxygen. Et's Death Certificate on 10/20/21 at 2:07 AM. The sted as acute and chronic in hypoxia (lack of oxygen). It of 2 resident reviewed for ord reviews and staff, and Medical Director (MD) failed to ensure nursing staff ompetency to provide for and respiratory status. Resident the facility on 10/18/21 with ded chronic obstructive COPD) and respiratory status are expired on 10/20/21 at of death was listed as acute ry failure with hypoxia (lack re affected 1 of 2 resident	F	835			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C / 29/2021
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	Continued From pag	ge 54	F 83	5		
	Physician and Resp 10/20/2021. On 10/20/2 Assurance Performs meeting was comple facility Interdiscipling Director of Operation of Clinical Services (Viorial	<u> </u>				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345283	B. WING _			C 11/29/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	Continued From pag	e 55	F 8	35		
	9/18-10/20/21 will be Nursing/designee to NIV devices per hosp have appropriate ord frequency of use. No identified for correction On 10/22/2. District Director of Reand revised policy "NIV/AVAPSA-E feature licensed nurses and and responsibilities in C-Pap and APAPS-A Trilogy) devices. 3) Education/System On 10/22/2 education to the facil RDCS on the update Ventilation: IV/AVAPS effective immediately accept NIV/AVAPS-A trilogy) On 10/25/21, Assurance Performa meeting was comple RDO and VPCS a control of the complex of the property of the Director of Nursensuring that the phy in implementing physinitiation of NIV device education records to current and newly hir	I, the VPCS and contracted espiratory Therapy reviewed don-invasive Ventilation: It to reflect and further clarify Respiratory Therapists roles in the management of Bi-Pap, E NIV (brands such as mic Change I, the VPCS provided ity Administrator, DON and d policy "Non-invasive SA-E feature" to include that if the facility shall no longer as an Ad Hoc Quality ince Improvement (QAPI) ted by the IDT and RDCS, imprehensive corrective eloped based on root cause F580, F695, F726, and F835. I, all licensed nursing staff insed nurses will be educated ring (DON)/ designee on visician is notified of any delay sician orders including ites. The DON will maintain validate staff competency for red facility and agency if will not be allowed to work				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345283	B. WING		C 11/29/2021
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	11/25/2521
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE COMPLETION
F 835	including agency state Director of Nursing/admission process is transcription of order the physician if clarid DON will maintain estaff competency for facility and agency libe allowed to work and be educated by the regarding the notific calling the respirato service number to not Therapist of all new devices and any officurrent residents. If company does not refacility will reattemp will be immediately In addition, if the respiration of facility will reattemp will be immediately In addition, if the respiration of the res	on 21, all licensed nursing staff aff will be educated by the designee related to the ncluding verification and are and immediately contacting fications are needed. The ducation records to validate are current and newly hired icensed nurses. Staff will not until education completed. 1021, the unit clerk and all off including agency staff will Director of Nursing /designee ation process which includes are the respiratory of the Respiratory admission requiring NIV over respiratory therapy espond within 10 minutes, the tax 1, if no response the MD contacted for further orders. Sident is in any acute distress, tely be sent to the emergency luation. The DON will records to validate staff erent and newly hired facility dinurses. Staff will not be I education completed. 10/25/21, each nursing station	F 835		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345283	B. WING			C	
NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115	I	11/29/2021	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
longer accept NIV/AV trilogy effective 10/25 Director was also ed 10/25/21 on C-PAP, (Trilogy type) devices the settings associat devices. The DON w records to validate st and newly hired facil not be allowed to wo Effective 10 Director or Director or contracted respirator notified at least 24 he with physician orders NIV device will be re admission with the re By 10/25/20 and licensed nurses will be of Nursing on ensurin devices are available frequency orders wh the facility. The DON records to validate st and newly hired facil facility and agency lic be allowed to work u By 10/25/20 Admissions Director, Services were educat the facility clinical ca the care services pro determine admission maintain education re competency for curre	ded for admissions to no VAPS-AE, brands such as 5/21. The Admissions ucated by the DON on Bi-PAP, and AVAPS-AE is to identify the differences in ed with these types of will maintain education taff competency for current ity Admission staff. Staff will with until education completed. 10/25/21, the Admission of Nursing will ensure that the ry therapy company will be ours prior to an admission of for NIV device to ensure adily available prior to equired settings verified. 10/21, the Admission Director is staff including agency be educated by the Director ing that ordered equipment/or exist with required setting and en residents are admitted to a will maintain education taff competency for current ity Admissions staff and censed nurses. Staff will not intil education completed. 10/21, Licensed Nurses, Medical Director and Social ated by the Administrator on pabilities grid which specifies by ided by the facility to approval. The DON will ecords to validate staff ent and newly hired facility in nurses, Admissions staff,	F 83	35			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	IPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED	
		345283	B. WING			C
	ROVIDER OR SUPPLIER DEL MOORESVILLE	0.40200		STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		11/29/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	will not be allowed to completed. Effective 10 longer accept NIV/ A such as trilogy) in the Director received ed. By 10/25/20 including agency lice on the facility policy "Non-invasive Ventile to include competendevices, required on documentation relate by the Respiratory Toursing. The DON were cords to validate sand newly hired facil nurses. Staff will not education completed. By 10/25/2 including agency Conditional properties with the NIV is with the resident untand not manipulating DON will maintain education agency for facility and facility for facility f	o work until education 0/25/21, the facility will no AVAPS-AE devices (brands e facility. The Admission ucation on 10/25/21. 021, Licensed Nurses ensed nurses will be educated revision date 10/22/21 ation: IV/AVAPSA-E feature" cies on the use of all NIV going respiratory assessment ed NIV and oxygen therapy therapist and Director of vill maintain education taff competency for current lity and agency licensed be allowed to work until d. 1, Certified Nurse Aides (CNA) IA will be educated by the on the care of NIV residents the Licensed Nurses of any including alarms, remaining il licensed nurse responds of machine in any way. The ducation records to validate fournent and newly hired CNAs. Staff will not be allowed on completed. Staff will not until education completed. 0/25/2021, all education for ed in the orientation process acility licensed nurses, ses, CNAs, and admission I not be allowed to work until	F	335		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345283		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345283	B. WING _		C 11/29/2021		
	NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE			STREET ADDRESS, CITY, STATE, ZIP COD 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		1/29/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 835	to ensure the accuracy of physician 's orders notification to physici discrepancies for clar management was infuring Ad Hoc QAPI Administrator. 4) Monitoring Processing Beginning 1 management will rever paperwork during more ensure the accuracy physician 's orders for devices and notification discrepancies for clar will be communicated clarification and/or conduction files for necessing education files for necessing education complete. NIV devices. Staff wire deducation complete.	tent in morning clinical report cy and timely implementation is for NIV devices and an of any order rification. Nursing ormed of review process meeting on 10/25/21 by the ress: 10/25/21, 1) nursing iew/audit new admission orning clinical report to and timely implementation of or Bi-Pap and C-Pap NIV on to physician of any order rification. Any discrepancies d to the physician for	F 8	,			
	binder in the Adminis On 10/25/2 notified by the Admin monitoring responsib monitoring will be dis committee meeting fo overseen by the Adm Nursing, and the Med interdisciplinary team the plan as indicated compliance. Beginning	I, the QAPI Committee was istrator of delegation of QA ilities. The results of the cussed in the monthly QAPI or at least three months, inistrator, Director of					

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 11/29/2021
NAME OF PROVIDER OR SUPPLIER THE CITADEL MOORESVILLE				STREET ADDRESS, CITY, STATE, ZIP CODE 550 GLENWOOD DRIVE MOORESVILLE, NC 28115		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETI DATE	
F 835	ongoing compliance implementation of pland C-Pap NIV device physician of any ord clarification. The facility alleges of the Corrective Actions 11/24/21 and conclusion acceptable corrective facility amended include calling the recustomer service nutre The facility amended include calling the recustomer service nutre apist of all new devices and any oth current residents. If company does not refacility will reattempt will be immediately of the Corrective Action QAPI meeting held of the Weekly monitoring BiPaP/ CPAP were not to November 2021 with Review of the nursing receiving the in-service and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing and third shifts reveal in-service as stated verified they had receiving the conducted with nursing	nly for three months to ensure with accuracy and timely hysician 's orders for Bi-Pap ces and notification to er discrepancies for sompliance on 10/26/2021 In Plan was validated on ded the facility implemented ctive action plan on 10/26/21. If the notification process to espiratory therapy company mber to notify the Respiratory admission requiring NIV er respiratory needs of the respiratory therapy espond within 10 minutes, the x 1, if no response the MD contacted for further orders. In Plan was reviewed during on 10/25/21. Ing logs residents requiring a reviewed from October 2021 with no concerns identified. In g staff in-service sheets on nical ventilator training is staff had initialed as ice training. Interviews ing staff from first, second alled they had received the by the facility. The staff elived in-servicing on neglect, change of condition	F 83	35		