PRINTED: 05/10/2023 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345008	B. WING			C 04/18/2023	
	ROVIDER OR SUPPLIER DEL AT MYERS PARK, I	LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE ROAD CHARLOTTE, NC 28207	•	5-H 16/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	6	F 00	00			
	through 4/18/23. Inta investigated. One of resulted in immediate						
	(J)	was identified at: 607 at a scope and severity 835 at a scope and severity					
	The tag F607 constit Care.	tuted Substandard Quality of					
		began on 03/17/23 and 3. A partial extended survey					
F 607 SS=K	Develop/Implement / CFR(s): 483.12(b)(1	Abuse/Neglect Policies)-(5)(ii)(iii)	F 60	77		5/5/23	
	§483.12(b) The facili implement written po	ity must develop and plicies and procedures that:					
	§483.12(b)(1) Prohib neglect, and exploita misappropriation of r						
	§483.12(b)(2) Establ to investigate any su	ish policies and procedures ch allegations, and					
	§483.12(b)(3) Includ paragraph §483.95,	e training as required at					
	§483.12(b)(4) Establ QAPI program requii	ish coordination with the red under §483.75.					
ABORATORY	DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/04/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

Electronically Signed

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345008	B. WING		C 04/18/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/10/2023	
				300 PROVIDENCE ROAD		
THE CITA	DEL AT MYERS PARK, L	LC		CHARLOTTE, NC 28207		
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F 607	Continued From page	÷ 1	F 60	7		
F 607	§483.12(b)(5) Ensure occurring in federally-facilities in accordance Act. The policies and but are not limited to a semilous experience (3) of the Act. §483.12(b)(5)(iii) Progretaliation, as defined (2) of the Act. This REQUIREMENT by: Based on record revipely experience when they failed to improve they failed to imp	reporting of crimes funded long-term care e with section 1150B of the procedures must include the following elements. ting a conspicuous notice of efined at section 1150B(d) hibiting and preventing at section 1150B(d)(1) and is not met as evidenced ew, observations, staff and actitioner, Nurse Practitioner failed to follow their abuse in the area of protection aplement measures to be protected from Resident	F 60	On 4/12/23 the Administrator placed Resident #2 with one on one supervis to provide safety to all other residents. One on one supervision remains in place Resident #1 was immediately transfer to the hospital on 3/11/23. After the incident on 3/11/23, Resident #2 was immediately transferred to the hospital and was placed with one on one supervision upon his return on 3/12/23 On 3/11/23 The Administrator submitte 24 hour report for abuse and notified I enforcement and Adult Protective Services. On 3/29/23 the perpetrator moved to a private room beside the Nurses station and one on one supervision was discontinued.	ace. red I 3. ed a aw	
	after the recertification the facility failed to im	n exit date (3/16/23), when plement measures to		On 4/12/23 the Administrator placed the		
	protected from Reside jeopardy was remove facility implemented a	n the unsecured units were ent #2. The immediate d on 04/13/22 when the credible allegation of e facility will remain out of		perpetrator on one-on-one supervisior On 4/12/23 the Administrator assigned Nurse Aide to provide one on one supervision to the Resident with aggressive behaviors to ensure safety	d a	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345008	B. WING _			04/	18/2023
	ROVIDER OR SUPPLIER DEL AT MYERS PARK, L	LC		30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PROVIDENCE ROAD HARLOTTE, NC 28207		
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F 607	actual harm with pote monitoring systems p The findings included A review of the facility "Abuse, Neglect, and date of 10/22/20, read this facility to provide welfare, and rights of and implementing writhat prohibit and prevexploitation, and misa property." The Protect specified, "The facility all residents are protect psychosocial harm duinvestigation. Exampl limited to increased swictim and resident." Resident #2 was adm 01/31/20 with diagnost dementia, and schizotype). Resident #2's quarter dated 01/17/23 reveat cognitively intact and behaviors. He was as	r scope and severity "E" (no ential for harm) to ensure ut into place are effective. r policy and procedure titled Exploitation", with a revised d in part, "it is the policy of protections for the health, each resident by developing then policies and procedures ent abuse, neglect, appropriation of resident tion of Resident: section will make efforts to ensure ected from physical and uring and after the es include but are not upervision of the alleged mitted to the facility on sees which included affective disorder (bipolar led Minimum Data Set (MDS) led Resident #2 was was not coded for ssessed as requiring limited fers and was independent	F	607	all other residents. On 4/12/23 the Director of Nursing educated the Nurse Aide and Licensed Nurse regarding monitoring behaviors that include agitation, yelling, physical aggression a notifying the Director of Nursing and Nurse Manager in the event behavior escalation occurs. On 4/12/23 the Administrator, Director Nursing and Nurse Managers complete an interview with all residents with BIM greater than 10 to identify any allegation of abuse related to the perpetrator. As assessment was conducted for those residents unable to be interviewed to identify any injuries that could have becaused by the perpetrator. Any events identified as a result of this audit will be reported to the state agency, law enforcement and Adult Protective Services. On 4/12/23 the Director of Nursing received a Dietary order for "no knives' the resident's meal tray and educated to Dietary Manager and Dietary staff on "In knives" on the meal tray. On 4/12/23 the Director of Nursing and Nurse Manage assessed the resident's room for other dangerous objects and none were identified.	of ed S on skin	
	03/17/23 revealed Re aggressive and hits re agitation with the resi	2's active care plan as of esident #2 was physically esident's secondary to dent/situation. The care plan dent #2 had a history of			On 4/12/23 the Administrator, Director Nursing and Nurse Managers complete an interview with all residents with BIM greater than 10 to identify any allegatio of abuse related to the perpetrator. On	ed S Ins	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 50.25	_			С
		345008	B. WING _				04/18/2023
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					00 PROVIDENCE ROAD		
THE CITA	DEL AT MYERS PARK	, LLC			CHARLOTTE, NC 28207		
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F 607	Continued From pa	age 3	F	607			
	physical altercation	is with his roommates. The			4/12/23 the Nurse Managers and Wou	nd	
		ent #2 to have fewer episodes			Nurse conducted a skin assessment for		
	-	dents through the review date.			those residents unable to be interviewed		
		ded separate residents having			to identify any injuries that could have		
	altercations, attemp	ot to identify the cause of			been caused by the perpetrator.		
	agitation, attempt to	o redirect and calm resident,					
		ate resident's needs, provide			On 4/12/23 the Director of Nursing		
		I cues to alleviate anxiety; give			educated all Nurse Aides and Licensed		
	·	assist verbalization of source			Nurse regarding monitoring behaviors	that	
		to set goals for more pleasant			include agitation, yelling, physical		
		ge seeking out of staff member			aggression and notifying the Director of		
		monitor/document/report as			Nursing and Nurse Manager in the even behavior escalation occurs.	ent	
		signs and symptoms of nger to self and others.			benavior escalation occurs.		
	resident posing dar	iger to sell and others.			On 4/12/23 the Director of Nursing		
	An interview condu	cted with Nurse #1 on			received a Dietary order for "no knives	on.	
		AM revealed she heard			the meal tray for Resident #2 and	•	
	commotion in Resid	dent #1 and Resident #2's			educated the Dietary Manager, Dietary	/	
	room on 3/10/23 ar	nd went to the room and found			staff and Nursing staff on "no knives" of		
	Resident #2 had hi	t Resident #1 in the right eye.			the meal tray. On 4/12/23 the Director	of	
	**	vealed Resident #2 admitted			Nursing and Nurse Managers assesse		
		#1 because he was trying to			the resident's room for other dangerou	S	
		dent #1 would not be quiet.			objects and none were identified.		
		both residents were separated				_	
		spital for evaluation. Nurse #1			On 4/12/23 the Administrator, Director		
		required one-on-one			Nursing and Nurse Managers re-educa		
		ne returned from the hospital			all facility staff, including agency staff,		
		or two but could not recall any entions put in place on his			the facility policy for abuse prevention, providing safety and protection to		
	,	ndicated Resident #1 was			residents from perpetrators to prevent		
		loor when he returned from the			further abuse by providing one on one		
		revealed she was not			supervision.		
	•	terventions to implement to					
		ents after Resident #2 was			On 4/12/23 the Nursing staff were		
	·	-one supervision. Nurse #2			educated regarding monitoring and		
		#2 was able to continue to be			documenting behaviors in the electron	ic	
	around residents w	ithout any supervision.			medical record and the requirement to		
					report new or escalating behaviors to t	:he	
	An interview condu	cted with Nurse Aide (NA) #1			Director of Nursing or Nurse Managers	s to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION NITIMBED:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2023	
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					CHARLOTTE, NC 28207			
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F 607	Continued From page	e 4	F 6	607				
	on 4/12/23 at 1:30 PM	M revealed she had worked			prevent abuse.			
		Resident #2 and Resident #1			provent albaco.			
		urther revealed she heard			On 4/12/23 the Director of Nursing and	d		
		ud and had entered the room			Nurse Managers educated all staff	_		
		occurred and nursing staff			regarding the requirement to immediate	elv		
		t. NA #1 indicated she rarely			provide safety for any resident in an	,		
	• •	but was never educated			abusive situation including providing or	ne		
	that Resident #2 had previous aggressive on one supervision for the perpetrato							
	behaviors. NA #1 revealed after the incident she provide safety for other residents		provide safety for other residents from					
	was not aware of any safety intervention in place abuse, and then immediately report any observation or allegation of abuse to the				abuse, and then immediately report an	у		
			he					
					Administrator or Director of Nursing for			
		al record revealed Resident			further			
		ne facility on the secured		investigation and interventions prior to				
	-	n 9/2/22 due to wandering	removing the increased supervision.					
		d indicated Resident #1 was						
		ly impaired with diagnoses of			On 4/12/23 the staff were notified that			
		cle weakness, and vascular			contact information for the Administrate			
		1 did receive a blood			and Director of Nursing is posted at ea	ch		
	_	Eliquis. Resident #1 was			Nurses station for after hours and			
		ured Memory Care Unit due			weekend reporting.			
	_	aviors and into a room with						
	Resident #2 on 2/26/				The Director of Nursing will ensure any			
		sing staff found Resident #2			newly hired staff and agency staff rece	ive		
		ent #1 while he was in bed,			this training during orientation.			
	threatening to "whoo				The Director of Numerican will answer			
		ation by sitting with the			The Director of Nursing will ensure			
		tions were put in place and			Behavior monitoring, including any residents with one on one supervision	io		
		dent report completed. On vealed Resident #2 hit			reviewed during the morning Clinical	IS		
		ght eye. Both residents were			meeting 5 times per week for 12 weeks	•		
	_	or evaluation and treatment.			to identify escalating behaviors and	,		
	-	to the facility on 3/12/23,			ensure interventions are in place for			
		one on one for a brief period			prevention of abuse.			
	•	ent #1 returned to the facility			The Administrator will review all			
		other room on a different			allegations of abuse with the			
		2. The incident report			Interdisciplinary team daily during the			
		2 was moved to a private			Morning Meeting and with the Regiona	d		
	room closer to the nu	•			Director of Operations and Regional	•		

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		345008	B. WING_				C	
NAME OF D	DOVIDED OD CLIDDLIED	343000	<u> </u>		TREET ADDRESS CITY STATE ZID CODE	<u> </u>	04/18/2023	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
THE CITA	DEL AT MYERS PARK	LLC			00 PROVIDENCE ROAD			
		,		С	HARLOTTE, NC 28207			
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F 607	Continued From pa	age 5	F 6	507				
F 007	Protective Services notified by the facil Review of the hosp 3/15/23 revealed R Neuro Intensive Ca a traumatic subdur receiving Eliquis, a medical history of a dementia and pres department after be resident at his skille computed tomograr results of a moderar resident was dischaursing facility on 3 An interview condu Practitioner (NP) or revealed Resident to the right eye on sustained a traumalt was revealed after unable to feed him.	s and Law Enforcement were ity. Dital discharge summary dated Resident #1 was admitted to the Pare Unit service on 3/12/23 for Pal hematoma (SDH), and was a blood thinner. He had a past Patrial fibrillation, and vascular Patr		507	Director of Clinical Services to include review of safety measures put in place prevent further abuse from perpetrator escalating behaviors identified with behavior monitoring, and any events reported to the state agency, law enforcement and Adult Protective Services. The Regional Director of Operations of Regional Director of Clinical Services of review all incidents weekly for 12 week ensure interventions are in place to provide safety interventions to protect residents. The Director of Nursing and Administrativill report the results of these audits monthly for 3 months during the QAPI committee meeting and the committee make recommendations. Date of Completion: 5/5/23	e to rs, r will ks to		
	passed and she be #1's head injury su could have played The NP further reve altercations with re unsafe for Residen residents. She indi	elieved it was possible Resident stained from Resident #2 part to Resident #1's death. ealed Resident #2 had other sidents previously and it was at #2 to be placed with other cated she was unsure what the ensure the safety of other						
	An interview condu 04/12/23 at 9:45 Al ongoing aggressive	icted with Nurse #2 on M revealed Resident #2 had e physical and verbal behavior and staff. Nurse #2 indicated						

Facility ID: 953418

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED			
		345008	B. WING _			C 04/18/2023
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F 607	Resident #2 had phy during his stay at the recall the dates of the further revealed Reseronmate with a burn Resident #1, and ha #1. Nurse #2 further previous safety interedirect him if he go Resident #2 had one was a safety concern he was allowed to grare a of the facility arother residents. Review of Resident on 2/14/23 nursing sthreatening his form Resident #1 stating room and if he did, he Staff retrieved a butt and the resident statiothering him. Staff violent threats and of the roommate from the incident report compowers not notified. No into place. An interview conduct Psychiatric Nurse Prat 11:55 AM revealed the altercation betwee #2. The Psychiatric Resident #2 prior to 03/10/23 but nursing the state of the roommate from the state of the s	visically hit two other residents of facility. He was unable to see incidents. Nurse #2 sident #2 had threatened a ster knife, threatened to hit decently assaulted Resident revealed he did not recall eventions other than to see a sident of a gitated. Nurse #2 stated going physical behaviors and into other residents because to wherever in the unsecured and was not supervised around was not supervised around was not supervised around was not come in the see was going to stab him. Her knife from Resident #2 feet his roommate was educated the resident about consequences. Staff removed the room. There was not seleted and law enforcement new interventions were put ted with the facility factitioner (NP) on 04/12/23 deshe visited the facility after the resident #1 and Resident NP indicated she had seen the incident that occurred on a staff had failed to inform her	F	507		
	03/10/23 but nursing of previous physical Resident #2 and oth					

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F 607	Continued From page	e 7	F 6	607				
F 607	altercations he should room with another reservealed Resident #2 because he was a sa and had access to oth felt the facility could in the residents. The PS Resident #2 was alert harm to Resident #1. believed Resident #2 explained this meant easily. An interview conducted on 04/12/23 at 1:15 PResident #2 had prevand had made verbal other residents. The NO2/14/23 Resident #2 tray and threatened to roommate. She repoincluded the facility to deescalated the situate further revealed on 03 on one-to-one supervitime after hitting Resi Resident #2 would not other residents due to himself. It was revealed longer supervised and other residents without An interview conducted Nursing (DON) and the at 2:45 PM revealed to #2 had physical altered	d not have been placed in a sident. The Psychiatric NP should not be in the facility fety concern to all residents her residents and staff and not ensure the safety of all sychiatric NP indicated and knew he had caused She reported that she was triggered easily. She Resident #2 got agitated and with Nurse Supervisor #1 and Nurse Supervisor stated on the had a butter knife on his to stab his previous red the only interventions work the knife away and tion. The Nurse Supervisor 3/10/23 Resident #2 was put rision for a short period of dent #1 and felt that to be a safety concern to be being placed in a room by led Resident #2 was no d was able to be around	F	507				
	Resident #1 and othe	#2 had made threats to r residents prior. The						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345008	B. WING			04/	18/2023
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F 607	Resident #2 had three roommate with a butter included to de-escalar Resident #2's roomm 03/02/23 Resident #2's threatening to hit Resinterventions included situation. The Admin when Resident #2 ret 3/12/23 he was place and he was moved cloon 03/29/23. When attaken off of one to on no longer had staff as they also felt like he radministrator reporter Resident #1 that the situation by separatin when Resident #2 be had calmed down. No put in place. The Admin the safety of other resimoved closer to the radmined had not shown any sissince he had been more than the safety of other resident #2 the had calmed down and the safety of other resident. The Administrator was jeopardy on 04/14/23. The facility provided the limmediate Jeopardy completion date of 4/1.	atened his previous er knife and interventions ate the situation and move ate to another room. On a was observed by staff sident #1 in his bed. Safety at to de-escalate the istrator further revealed aturned to the facility on ad one-on-one for over a day, toser to the nurses' station sked why Resident #2 was the they reported the facility vallable to watch him, and no longer needed it. The dibefore the incident with facility would de-escalate the agresident #2 from others came aggressive until he to other interventions were esidents Resident #2 was nurses' station so he could istrator stated Resident #2 gns of physical aggression oved into a room by himself. Is notified of immediate at 3:45 PM. Ithe following the following removal plan with 13/2023. Iccipients who have suffered, a serious adverse outcome	F	607			

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F 607	place to protect all reresident known to have aggressive behaviors. After the incident on 3 discontinued on 3/24/4/10/2023 a new order twice a day was obtain order for monthly aminomatic and adjusted provided and ordered and adjusted provided and ordered and adjusted provided p	ut safety interventions in sidents from another ve previously exhibited 3/11/23, Clonazepam was 23 due to a fall. On er for Oxcarbazepine 150mg ned and on 4/13/2023 a new monia levels was started. actitioner completed med psych medications. actitioner recommended to of care and to continue to endations and adjust meds assessed resident due to assessed resident due to rectitioner from psych d new medication. trator was moved to the ses station and remains in a	F	607			

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	e 10	F	507				
F 607	Nurse Aides and Lice monitoring behaviors yelling, physical aggreunt behavior escalar on 4/12/23 the Admir and Nurse Managers all residents with BIM any allegations of aboperpetrator. On 4/12/23 the Nurse Nurse conducted a stresidents unable to be injuries that could have perpetrator. On 4/12/23 the Direct Dietary order for "no limit meal tray and educat Dietary staff and Nurse the meal tray. On 4/1 and Nurse Managers room for other dange identified. Specify the action will be added to the process or system adverse outcome from when the action will be	that include agitation, ession and notifying the nd Nurse Manager in the ation occurs. Inistrator, Director of Nursing completed an interview with S greater than 10 to identify use related to the Managers and Wound kin assessment for those interviewed to identify any we been caused by the tor of Nursing received a knives" on the resident 's ed the Dietary Manager, sing staff on "no knives" on 2/23 the Director of Nursing assessed the resident 's rous objects, and none were on the entity will take to alter in failure to prevent a serious moccurring or recurring, and	F	607				
	and Nurse Managers including agency staf preventing abuse, pro to residents from perp	re-educated all facility staff, f, on the facility policy for oviding safety and protection petrators to prevent further on one supervision.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345008	B. WING		C 04/18/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE ROAD CHARLOTTE, NC 28207	1 04/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 607	regarding monitoring in the electronic med requirement to report to the Director of Nurprevent abuse. On 4/12/23 the Director Managers educated requirement to immeresident in an abusive providing one on one perpetrator to providing one on one perpetrator or allegated Administrator or Director investigation and intensive the increased supervention of the Annursing is posted at hours and weekend On 4/12/23 the Admit of Nursing of her reseducation and maintensure no staff are a receiving training. The ensure any newly him receive this training of Director of Nursing of maintaining the one-On 4/12/23 the Director of Nursing of Manager in the one-On 4/12/23 the Director of	ing staff were educated and documenting behaviors dical record and the to new or escalating behaviors raing or Nurse Managers to extor of Nursing and Nurse all staff regarding the ediately provide safety for any resituation including esupervision for the esafety for other residents immediately report any ation of abuse to the extor of Nursing for further erventions prior to removing vision. Were notified that the contact diministrator and Director of each Nurses station for after reporting inistrator notified the Director ponsibility to provide the ain the tracking tool to allowed to work without the Director of Nursing will red staff and agency staff during orientation. The will be responsible for	F 60	7	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUILI		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345008	B. WING _			C 04/18/2023		
	ROVIDER OR SUPPLIER DEL AT MYERS PARK, L	rc		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE ROAD CHARLOTTE, NC 28207	•	0 1 10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 607	allegations of abuse team during the Morr Regional Director of Clinical Se safety measures put abuse from perpetrat On 4/12/23 the Regional Regional Director	nistrator began reviewing all with the Interdisciplinary ning Meeting and with the Operations and Regional ervices to include a review of in place to prevent further ors. In all Director of Operations of Clinical Services will wo fall incidents to ensure lace to provide safety ct residents.	F	607				
	immediate jeopardy r non-compliance. Alleged Date of IJ Re On 04/18/23, the faci for immediate jeopard 04/13/23 was validate Interviews with facility was completed and e preventing abuse, pro to residents from per abuse by providing o nursing staff were ed and documenting bet medical record, to im any resident in an ab providing one on one perpetrator to provide from abuse, and the observation or allega	lity's corrective action plan dy removal effective ed by the following: y staff revealed in-service educated on policy for oviding safety and protection petrators to prevent further ne on one supervision, ucated regarding monitoring naviors in the electronic mediately provide safety for usive situation including supervision for the e safety for other residents in immediately report any						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345008	B. WING				C 18/2023
NAME OF PROVIDER OR SUPPLIER THE CITADEL AT MYERS PARK, LLC				30	TREET ADDRESS, CITY, STATE, ZIP CODE 00 PROVIDENCE ROAD HARLOTTE, NC 28207	1 0-11	10/2020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
F 835 SS=K	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			835	On 4/12/23 the Administrator placed Resident #2 with one on one supervision to provide safety to all other residents. One on one supervision remains in place Resident #1 was immediately transferred to the hospital on 3/11/23. After the incident on 3/11/23, Resident #2 was immediately transferred to the hospital and was placed with one on one supervision upon his return on 3/12/23. On 3/11/23 The Administrator submitted 24 hour report for abuse and notified latenforcement and Adult Protective Services. On 3/29/23 the perpetrator with moved to a private room beside the Nurses station and one on one supervision was discontinued.	ce. ed d a w	5/5/23

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345008 B. WING				С	
			B. WING _			04/18/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
THE CITADEL AT MYERS PARK, LLC				300 PROVIDENCE ROAD			
IIIE OIIA	JEE AT MITEROTAIN, E			CHARLOTTE, NC 28207			
(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 (EACH CORREC CROSS-REFEREN D	(X5) COMPLETION DATE		
F 835	F 835 Continued From page 14		F 8	35			
	jeopardy removal. Th	e facility will remain out of					
		r scope and severity "E" (no		On 4/12/23 the Adn	ministrator, Director o	f	
		ential for harm) to ensure			Managers completed		
	monitoring systems a				I residents with BIMS		
	effective.	' '			dentify any allegation		
				•	the perpetrator. A sk		
	Findings included:			assessment was co			
	J			residents unable to	be interviewed to		
	This tag is cross refe	rred to F 607.		identify any injuries	that could have beer	n	
	-			caused by the perp	etrator. Any events		
	Based on record revi	ew, staff and Psychiatric		identified as a resul	It of this audit will be		
	Nurse Practitioner, N	urse Practitioner interviews		reported to the state	e agency, law		
	the facility failed to fo	llow their abuse policy and		enforcement and A	dult Protective		
	procedure in the area of protection when they			Services.			
	failed to implement measures to ensure residents						
	were protected from I	Resident #2 who had known		On 4/12/23 The Re	gional Director of		
	physically aggressive	behaviors that included		Operations re-educ	cated the Administrate	or	
	hitting Resident #1 in	the eye resulting in a		on the requirements	s of F835 including th	ne	
	traumatic subdural he	ematoma. This failure put 89		responsibility to follo	ow and oversee the		
	residents who resided	d on the unsecured units at		abuse policy, includ	ding immediate		
		ering serious physical and			separation and one on one supervision for		
	psychosocial harm er	nacted by Resident #2.			ensure residents are		
				safe from physically	y abusive residents.		
		tified of immediate jeopardy					
	on 04/14/23 at 3:45 F	PM.		On 4/12/23 the Reg			
					cated the Administrate	or	
		the following the following		and Director of Nur			
		emoval plan with completion			ting and the Weekly A		
	date of 4/13/23.				ding the discussion ar		
				1	ted incidents of abus		
		ecipients who have suffered,			ncluding separation a		
		a serious adverse outcome			ision of the perpetrato		
	as a result of the non	compliance			ure residents are safe		
					isive residents. Thes	e	
	Administration failed			meetings are held v			
		ight to ensure effective			am which includes the	e	
		e to protect residents from		Director of Nursing,			
	physically abusive re	sidents.		Social Service Dire			
				Director, Dietary Ma	anager and Rehab		

Facility ID: 953418

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ELE CONSTRUCTION	, ,	TE SURVEY MPLETED	
		345008	B. WING			С	
NAME OF D		345006	D. WING _	OTDEET ADDRESS SITV STATE 71D SODI		4/18/2023	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	=		
THE CITAL	DEL AT MYERS PARK, L	LC		300 PROVIDENCE ROAD			
	,			CHARLOTTE, NC 28207			
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 835	Continued From page	e 15	F 83	35			
	On 4/12/23 the Administrator, Director of Nursing and Nurse Managers completed an interview with all residents with BIMS greater than 10 to identify any allegations of abuse related to the perpetrator. The Nurse Managers and Wound Nurse conducted skin assessments for those residents unable to be interviewed to identify any injuries that could have been caused by the perpetrator. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete On 4/12/23 The Regional Director of Operations re-educated the Administrator on the requirements of F835 including the responsibility to follow and oversee the abuse policy, identifying situations that create a danger for abuse to other residents such as physical and verbal aggression and threatening behaviors that would require providing safety to other residents from the perpetrator by immediate separation and monitoring of the perpetrator and by assigning trained staff for one on one supervision for the perpetrator. On 4/12/23 the Regional Director of Operations re-educated the Administrator and Director of Nursing regarding the Daily Morning Meeting and the Weekly At-Risk Meeting including the			Manager. The Regional Director of Oper Regional Director of Clinical S review all incidents weekly for ensure interventions are in pla provide safety interventions to residents. On 4/12/23 the Adm will review all allegations of ab Interdisciplinary team daily du Morning Meeting and with the Director of Operations or Region Director of Clinical Services to review of safety measures put prevent further abuse from peescalating behaviors identified	dervices will 12 weeks to ace to protect ninistrator buse with the ring the Regional conal conclude a t in place to rpetrators,		
				behavior monitoring, and any reported to the state agency, I enforcement and Adult Protect Services. On 4/12/23 the Regional Direct Operations or Regional Direct Services will begin a weekly reincidents to ensure interventio place to provide safety interve protect residents from abuse, includes a review of current rereceiving one on one supervis Regional Director of Operation Regional Director of Clinical Sprovide weekly visits for 12 we review allegations of abuse ar	events aw tive ctor of or of Clinical eview of all ens are in entions to this esidents eion. The ens and dervices will eeks to		
	discussion and review of abuse and interver and one on one supe in place to ensure res	w of any reported incidents ntions including separation rvision of the perpetrator are sidents are safe from sidents. These meetings are		interventions remain in place the residents. The Administrator will report the these audits monthly for 3 monthly for QAPI committee meeting a	to protect ne results of nths during		

Facility ID: 953418

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345008	B. WING				C 18/2023	
	ROVIDER OR SUPPLIER	LC		STREET ADDRESS, CITY, STATE, ZIP CODE 300 PROVIDENCE ROAD CHARLOTTE, NC 28207			10/2020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR 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 835	Continued From page includes the Director Managers, Social Ser Director, Dietary Man On 4/12/23 the Admir allegations of abuse viteam during the Morn Regional Director of Clinical Sesafety measures put in abuse from perpetrate Regional Director of Clinical Serview of all incidents in place to provide saresidents from abuse. The Regional Director of Clinical Serview of all incidents in place to provide saresidents from abuse. The Regional Director of Clinical Serview of all incidents in place to provide saresidents from abuse. The regional Director of Clinical Serview of all incidents in place to provide saresidents from abuse. The regional Director of Clinical Serview of all incidents in place to provide saresidents from abuse.	e 16 of Nursing, Nurse rvice Director, Maintenance ager and Rehab Manager. histrator began reviewing all with the Interdisciplinary ing Meeting and with the Departions and Regional revices to include a review of n place to prevent further ors. On 4/12/23 the Departions and Regional revices will begin a weekly to ensure interventions are fety interventions to protect or of Operations and Clinical Services will provide wallegations of abuse and remain in place to protect or residents currently supervision to determine		835	committee will make recommendations Date of Completion 5/5/23			
		Administrator will be ing implementation of this emoval for this alleged						
	Alleged Date of IJ Re On 04/18/23, the facil for immediate jeopard 04/13/23 was validate	ity's corrective action plan ly removal effective						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345008	B. WING	_			2
NAME OF P	ROVIDER OR SUPPLIER	345006	B. WING	s	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	18/2023
THE CITADEL AT MYERS PARK, LLC				30	00 PROVIDENCE ROAD HARLOTTE, NC 28207		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	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	and oversee the abus situations that create residents such as phy The Administrator rep meetings were held w to discuss incidents o be followed. The Adm Regional Director of Courector of	w revealed she had in the responsibility to follow se policy, identifying a danger for abuse to other vsical and verbal aggression. Forted morning and weekly vith the interdisciplinary team of abuse and interventions to inistrator indicated the Departions and Regional ervices has provided weekly tions of abuse and ensure in place to protect the sidents currently receiving on to determine ins prior to removal,	F	835			