STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	300 PROVIDENCE ROAD CHARLOTTE, NC 28207

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F 000	INITIAL COMMENTS A complaint investigation was completed from 09/10/24 through 9/11/24. The following intakes were investigated: NC00221679, NC00221490, and NC00221488. Event ID# 54YQ11 3 of the 5 allegations resulted in a deficiency.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff, resident, Medical Director interviews, the facility failed to monitor the whereabouts of a cognitively intact resident who had a diagnosis of dementia when he left the facility unannounced, and walked, by himself, to a convenience store located 0.8 of a mile from the facility to buy a pack of cigarettes. Resident #1 stated he got "turned around" upon his attempted return and called for a ride service. He was dropped off at a behavioral health emergency clinic not far from the facility and was returned to the facility by the police. This affected 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1). The findings included: Resident #1 was admitted to the facility on	F 689	1.Resident #1 was immediately assessed by staff nurse upon return to the facility. The resident denied issues of any kind and no negative findings were observed upon assessment. Resident was re-educated on 9/7/24 regarding signing in and out and the importance of notifying staff if going on LOA. 2.Alert and oriented residents going on LOA have the potential to be affected. Residents will be provided education on LOA process by the LNHA/designee. Education will be completed by 10/4/2024. 3.All staff will be re-educated by the LNHA/designee regarding the resident sign out/LOA process. Education will be	10/4/24

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

Electronically Signed | 10/04/2024

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F 689	Continued From page 1 08/29/23 with diagnoses that included epilepsy, muscle weakness, difficulty walking, cognitive communication deficit, dementia with behaviors, and bipolar disorder. A review of Resident #1's annual Minimum Data Set assessment dated 06/11/24 revealed he was cognitively intact with no delusions, behaviors, rejection of care, or instances of wandering. Resident #1 was independent with bed mobility, transfers, and was coded as independent with walking 10 feet, walking 50 feet, and walking 150 feet. A review of Resident #1's most recent smoking assessment dated 08/15/24 revealed he had a history of smoking related incidents that included burning himself and his clothing and smoking in a non-smoking area. The assessment indicated that Resident #1 smoked 10 or more times a day and determined that he required supervision while smoking to remain safe. An interview with Nurse Aide #1 on 09/10/24 at 2:24 PM revealed she was assigned to Resident #1's hall on 09/07/24, the day he left the facility. She reported she had seen Resident #1 throughout her shift and stated Resident #1 was alert and oriented and "was his typical self". She reported she took a short break around 8:30 PM and when she left, Resident #1 was still on the hall. Nurse Aide #1 reported she returned to the hall around 8:40 PM, she noted that Resident #1 was on the hall by the vending machine, and it appeared to her as though he was planning on buying himself a drink because he had some cash out in his hand, and it looked as though he was counting it. Nurse Aide stated around 9:00 PM Unit Manager #1 came to her and stated that	F 689	completed by 10/4/24 with no employee, agency staff, or new hire working after 10/4/24 without having above referenced education. 4.LNHA/designee will interview 5 alert/oriented residents weekly for 4 weeks to validate understanding of sign out process when going LOA. Resident LOA sheets will be audited for compliance 3x/week for 4 weeks followed by weekly for 4 weeks. Audits and interviews will be reviewed in QAPI and adjustments made as indicated to maintain ongoing compliance.	

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F 689	Continued From page 2	F 689		

Resident #1 was missing and that his wheelchair was found empty by the elevator. She stated she and the other staff looked for Resident #1 in and around the facility with no luck and that several staff, including herself walked around the exterior of the facility and even went a block down the street but was unable to locate him. She continued, stating sometime later, before the end of her shift, she received word that Resident #1 had been found at a behavioral health center not far from the facility and had returned. Nurse Aide #1 stated she spoke with Resident #1 before she left, and he stated he was mad that the facility would not take him to go smoke and that he decided he would take himself to the store and buy his own cigarettes. She reported Resident #1 was a supervised smoker due to past safety concerns. Nurse Aide #1 stated she did not believe Resident #1 was injured and was wearing a plaid long sleeve shirt, blue jeans, tennis shoes, and a blue hat when he left the facility.

An interview with Nurse #1 on 09/11/24 at 11:52 AM revealed she felt Resident #1 was alert and oriented, but she did not think he was safe to ambulate by himself to the convenience store, located almost a mile from the facility due to his unsteady gait and history of seizures. Nurse #1 reported on the evening of 09/07/24, he was calm and collected with no concerning behaviors. She stated around 8:15 PM, Resident #1 came to her and stated that he wanted to go back outside to smoke. She continued reporting that she called Nurse Aide #2, who was assigned to take supervised smokers to outside to smoke, and was informed that she would take him but that she needed to wait until her coworker returned from her break. Nurse #2 relayed that information to Resident #1 and stated he

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F 689	Continued From page 3	F 689		

responded "ok, ok" and did not appear frustrated or angry. She reported around 8:45 she saw Resident #1 in the hallway coming from the vending machine room. Approximately 10 minutes later, his empty wheelchair was found by the elevator, and she initiated the missing resident protocol. She began looking for resident in all the facility rooms and common areas with no luck. She reported she ended up leaving early that evening and passed Resident #1 being escorted back into the facility as she was leaving around 10:00 PM. She reported he did not appear injured. Nurse #2 reported she spoke with Resident #1 the following day and he reported to her that he left the facility to buy his own cigarettes since he felt no one would take him to smoke and that he did not understand why he could not have control over his own smoking materials.

An interview with Nurse Aide #2 on 09/10/24 at 4:34 PM revealed she was working on the 300-hall on 09/07/24 and was the nurse aide assigned to take supervised smokers out to smoke. She reported around 8:15 PM, she received a telephone call from the nurse on the 200 hall (Nurse #1) who asked if she would take Resident #1 back out to smoke (the final supervised smoking time was 8:00 PM). Nurse Aide #2 reported to Nurse #1 that she had already taken the supervised smokers out to smoke, but she would take Resident #1 back out to smoke when her coworker returned from being on break. Nurse Aide #2 stated she fully intended to take Resident #1 out to smoke once her coworker returned. Nurse Aide #2 reported a little before 9:00 PM, a staff member whom she could not recall, came up to the 3rd floor and informed her that Resident #1 was missing. She reported it

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F 689	Continued From page 4	F 689		

was her understanding that Resident #1 was found and returned to the facility between 10:00 PM and 10:30 PM. She also stated she was unfamiliar with Resident #1's care needs but was aware that he would become belligerent when he was told he could not go smoke when he wanted to.

An interview with Unit Manager #1 on 09/10/24 at 1:52 PM revealed on 09/07/24, she was made aware around 8:45 PM that Resident #1's empty wheelchair was found by the elevator. She reported she immediately began a quick search to try and find Resident #1 by looking on each floor and could not locate him. She stated at that time, she called a code silver (missing resident) and notified the Director of Nursing. She reported a code silver, were steps the facility took when a resident was unable to be found. Theses steps included recording the time the resident was discovered missing and when they were last seen, ensure the resident had not discharged or signed out, perform a resident roll call, search the facility grounds, call 911 and report the missing resident, notify next of kin, and coordinate with public safety agencies to locate the resident. She stated she gathered more staff, and they completed a more extensive search of the facility grounds including outside the facility. She stated the Administrator along with the police department, Resident #1's family, and the medical director were notified. The police department came to the facility and helped the staff search for Resident #1 in the surrounding residential area. Around 10:00 PM, the facility received a telephone call from a local behavioral health facility stating that Resident #1 had been dropped off there. Unit Manager #1 stated she immediately contacted the Director of Nursing for

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F 689	Continued From page 5	F 689		

guidance and was instructed to see if Resident #1 wanted to be assessed while he was there to which Resident #1 declined. The police department ended up transporting Resident #1 back to the facility at which time she completed a complete head to toe assessment which revealed no injuries to Resident #1. Unit Manager #1 reported she questioned Resident #1 why he left the facility without notifying them or signing out and he reported he was mad that no one would take him outside to smoke and he decided he would just take himself to get his own cigarettes. She reported Resident #1 was a supervised smoker but was able to exit the facility on his own as he liked to sit on the front porch of the facility. She stated he had never left the facility on his own before without notifying them or signing out and stated this behavior was unusual for him.

An interview with Resident #1 on 09/10/24 at 10:32 AM found him in his room packing his belongings. Resident #1 reported several days ago, he left the facility and went to a convenience store to get cigarettes after requesting them at the facility. Resident #1 stated "No one would give them to me, so I left and went to buy some, I had the money and the ability to go". He reported that he walked down a sidewalk to get to the convenience store. When asked if he used crosswalks and initiated the traffic signal to cross the roads safely, he reported he was going to but there was no traffic, so he didn't. Resident #1 also stated once he walked to the convenience store, he was turned around, so he called a driving service which came and picked him up and took him to a "mental health place". When asked why he had them drive him to a "mental health place" Resident #1 stated "that's where I live, a mental health place." Resident #1 reported

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F 689	Continued From page 6	F 689		

he did not feel like he was gone long before the police department transported him back home. Resident #1 could not recall what driving service he used or how he contacted them. Resident #1 also reported he knew he was supposed to notify the facility staff of his intentions to leave so they know where he was going and how long to expect him to be gone. Resident #1 stated he would make sure he signed out in the future.

An observation made of the alleged path of travel Resident #1 used to get to the convenience store included walking down a sidewalk for 0.8 of a mile in which he had to cross 6 side streets and two intersections that were 4 lanes of travel. The posted speed limits for the roads Resident #1 traveled were 35 mph and had moderate traffic.

A review of the archived weather report for Charlotte on 09/07/24 at 9:00 PM revealed it was 4 degrees Fahrenheit with mostly cloudy skies.

A review of Resident #1's progress notes revealed a note dated 09/08/24 at 2:11 PM that read, in part: "During tour patient stated he was going out to smoke. Writer notified patient that because of past elopement he is currently on a 1:1 watch, and the [nurse] aide will be with him in a minute to take him outside."

An interview with the Director of Nursing on 09/11/24 at 1:01 PM revealed she was notified around 9:00 PM on 09/07/24 that Resident #1's wheelchair was found empty near the elevator and that the staff were unable to locate him. She reported she told the staff to initiate the elopement protocol by having Unit Manager #1 contact the local police department and begin calling the local hospitals. She stated she also

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F 689	Continued From page 7	F 689		

notified the Administrator who reported to the facility to assist in locating Resident #1. She reported she stayed in contact with the facility and was informed around 10:00 PM that Resident #1 was found and had been returned to the facility unharmed. The Director of Nursing stated she spoke with Resident #1 who stated he was unhappy being a supervised smoker, so he left the facility and walked to a convenience store to buy cigarettes. He reported to her that once he got to the convenience store, he became disoriented and had someone help call him a driving service who he told he lived "at a mental health facility" and that the driving service "probably google searched" area mental health facilities and took him to the behavioral health center located not far from the facility. She stated Resident #1 had been educated on the sign out procedure and he reported to her that he did not sign out because he felt he would not be gone too long and that "he wouldn't be missed". The Director of Nursing reported she re-educated Resident #1 along with the staff on the sign out policy and procedures and placed Resident #1 on 1:1 supervision. She also reported she felt Resident #1 became disoriented because it was dark outside and that they determined he walked in a straight line, on a sidewalk to the convenience store. She reported he was fully assessed upon his return and found to be without injury. The Director of Nursing reported Resident #1 was his own responsible party and did not have a guardian or power of attorney. The Director of Nursing also reported the facility had also implemented the use of laminated cards with the facility's name, address, and telephone number on them and they were given to residents when they sign out by themselves or with family should the resident become disoriented or lost so

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F 689	Continued From page 8	F 689		

the resident, police, or citizens can call the facility to come get them. The Director of Nursing reported she felt Resident #1 was alert and oriented and would have been a resident that the facility would have let sign himself out if they knew where he was going, how long to expect him to be gone, and the reason he wanted to leave.

An interview with the Administrator on 09/11/24 at 1:31 PM revealed she felt Resident #1 was alert and oriented and would have been a resident that the facility would have let sign himself out as long as they knew where he was going, how long to expect him to be gone, and the reason he wanted to leave. She stated she was alerted around 9:00 PM on 09/07/24 that Resident #1 was missing. She stated the facility's elopement protocol and code silver were initiated. She stated the facility staff and police department looked for Resident #1 for approximately an hour before they were contacted by a behavioral health facility letting them know that Resident #1 had been dropped off. She reported the police department brought Resident #1 back to the facility and he was assessed and found without injury. She stated Resident #1 was placed on 1:1 supervision and when she spoke to him, he informed her that he was mad that he was a supervised smoker, and he decided he would walk to the convenience store and buy his own cigarettes. She reported Resident #1 had been educated on the sign out policy and she expected her alert and oriented residents to sign out and notify their nurse where they were going and how long they would be gone.

An interview with the Medical Director on 09/11/24 at 12:45 PM revealed he was aware of

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F 689	Continued From page 9 Resident #1 leaving the facility without signing out. He stated he believed Resident #1 was alert and oriented and had the ability to make appropriate and safe decisions regarding his wellbeing. The Medical Director stated he last saw Resident #1 on 07/12/24 and that he was ambulatory and felt Resident #1 had the ability to ambulate safely without assistance. He indicated he would prefer all residents to notify the facility if they planned on leaving the grounds so the facility would be aware of their whereabouts.	F 689		