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 _____	R-C 02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL AT MYERS PARK, LLC	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 01/14/25 through 01/17/25 to conduct an unannounced recertification, complaint investigation and revisit survey. A repeat tag was cited. The survey team returned onsite on 01/29/25 for a new complaint investigation and collected additional information offsite 01/30/25 through 01/31/25. The survey team returned onsite on 02/06/25, 02/07/25, and 02/10/25 to conduct a new complaint investigation, collect additional information offsite on 02/11/25 and 02/12/25 and perform an extended survey. Therefore, the exit date was changed to 02/12/25. The facility is still out of compliance.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		

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

Electronically Signed

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F 578	Continued From page 1	F 578		

facility's policies to implement advance directives and applicable State law.
(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.
(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.
(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.
Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews and record review, failed to have effective systems in place for communicating changes in resident code status for 1 of 22 residents reviewed for advanced directives (Resident #25).

The findings included:

Resident #25 was admitted to the facility on 7/10/23. His diagnoses included cerebral infarction due to unspecified occlusion or stenosis of bilateral carotid arteries, diabetes mellitus due to an underlying condition with hypoglycemia, and chronic obstructive pulmonary disease.

Resident #25 resided on the second floor of the facility and a review of his physical advance directive, a Medical Orders for Scope of

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F 578	Continued From page 2	F 578		

Treatment (MOST) form stored in a folder in a filing cabinet at the second-floor nurse's station, dated 12/13/24 indicated cardiopulmonary resuscitation (CPR/Full Code) status.

A review of Resident #25's physical Do Not Resuscitate (DNR) form, signed on 1/3/25 was completed. The DNR form was stored with the MOST form, signed on 12/13/24, in a folder in a filing cabinet at the second-floor nurse's station.

The electronic medical record (EMR) resident profile indicated Resident #25's code status as DNR.

A review of Resident #25's EMR nursing progress notes revealed he transitioned to Hospice/end of life care on 1/3/25 and his code status was changed from a CPR/Full Code to DNR on the same date.

An interview was conducted on 1/16/25 at 3:39 PM with the Medical Records Coordinator. He stated when a code status changed for a current resident, he would receive the information after a care plan meeting occurred and the care plan was updated. He stated he did not update the EMR for Resident #25's code status change and he was unaware of the change in status and was unaware a care plan meeting occurred.

An interview on 1/17/25 at 9:55 AM with the Social Worker (SW) revealed she was responsible for updating the care plan when a code status changed for a current resident in the facility. She stated Resident #25's MOST form on file indicated a CPR/Full Code status and there had been discussion about transitioning his care to Hospice. The SW was unaware Resident

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#25 had transitioned to Hospice on 1/3/25 and was unaware of the code change status to DNR and did not have a care plan meeting. She stated she did not have the ability to change any code status alerts in the EMR and nursing was responsible for updating that information.

An interview was conducted on 1/17/25 at 11:31 AM with the Director of Nursing (DON). She stated the DNR order took effect on 1/3/25 for Resident #25 and the MOST form was not rewritten to reflect the code status change. She stated the Medical Records Coordinator, and the SW were responsible for updating the documents in the chart and the care plan, respectively and she was unsure why they were not informed of Resident #25's code status change. The DON explained Unit Manager #1 updated Resident #25's resident profile code status to DNR in the EMR. She stated nurses typically looked at the alert banner profile in the EMR for code status.

An interview with Unit Manager #1 on 1/17/25 12:11 PM revealed she updated the alert banner profile in the EMR to reflect the DNR code status for Resident #25, but the Medical Records Coordinator was responsible for uploading the copies of any new MOST or DNR form to the EMR and was unsure if that had been completed.

An interview with the Administrator on 1/17/25 at 2:07 PM revealed she expected the physical DNR and MOST forms to reflect the same code status and was not sure how the physical MOST and DNR forms did not reflect the same status.