STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted on 04/02/25 through 04/03/25. The team returned onsite on 04/08/25 to validate the credible allegations, therefore, the exit date was changed to 04/08/25. The following intakes were investigated: NC00228886, NC00227180, NC00226699, NC00223333, and NC00222925. 1 of 6 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.10 at tag F580 at a scope and severity of J. CFR 483.25 at tag F684 at scope and severity of J. Tag F684 constitued Substandard Quality of care. Immediate jeopardy began on 03/26/25 and was removed on 04/05/25. A partial extended survey was completed.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 580		4/30/25

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

Electronically Signed | 04/30/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, and facility staff, Physician Assistant (PA) and Medical Director interviews, the facility failed to immediately notify the PA when Resident #1 had an acute change in	F 580	The facility failed to immediately notify the Medical Provider when Resident #1 had a change in condition on 03/26/25 at approximately 8:30 AM. Resident #1 had	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 condition after a fall. On 03/25/25 between 2:00 PM to 2:30 PM Resident #1 had an unwitnessed fall from the bed and was assessed to have no visible injuries and transferred back to bed. Resident #1 was prescribed an anticoagulant medication of apixaban 5 milligrams (mg) via gastrostomy tube twice a day for atrial fibrillation. Neurological checks were initiated. Resident #1 reported to staff that he did not hit his head. On 03/26/25 at approximately 8:30 AM Resident #1 was noted by staff to be hard to arouse, nonverbal, unresponsive, and lethargic. The PA was not notified until 4:50 PM on 03/26/25 of the acute change in condition. The PA ordered bloodwork, urinalysis with culture and sensitivity, and a chest x-ray for reports of lethargy. On 03/27/25 at 9:58 AM Resident #1's family came to the facility and found him unresponsive and called Emergency Medical Services (EMS) and Resident #1 was transported to the Emergency Department (ED) and diagnosed with a "huge left subdural hematoma with a midline shift" (shifting of brain past its center). Resident #1 was transitioned to Hospice services and passed away on 03/31/25. This affected 1 of 3 residents reviewed for notification. Immediate Jeopardy began on 03/26/25 when the medical provider was not immediately notified that Resident #1 had an acute significant change in condition. Immediate Jeopardy was removed on 04/05/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective.	F 580	a fall on 03/25/25 at approximately 2:00 PM and was assessed by the nursing staff to have no injuries and was transferred back to bed. On 03/26/25 at 8:30 AM Resident #1 had a change in condition as described by staff as having a decreased level of consciousness, unable to be awakened, lethargic slow to respond, much different than his baseline. The Medical Provider was not notified until 4:50 PM on 03/26/25 and gave orders for blood work, urinalysis, and chest x-ray. On 03/27/25 Resident #1's family came to visit and found him unresponsive and called Emergency Medical Services (EMS). Resident #1 was transferred to the Emergency Room and diagnosed with a large subdural hematoma with midline shift. Resident #1 was transferred to hospice and passed away on 03/31/25. On 4/3/25, the Director of Nursing (DON) re-educated the nurse on the notification policy and process to include immediately notifying the Medical Provider when a resident has a change in condition. On 4/3/25, the DON and Nurse Consultant completed an audit of residents on anticoagulant therapy who have experienced a fall within the last 72 hours to ensure timely notification to the Medical Provider if a change in resident condition occurs. Two residents were identified and no concerns identified. On 4/4/2025, the facility reviewed all residents with changes in condition in 24 hours to ensure immediate notification to the Medical Provider occurred. Six residents were identified, and the Medical Provider was notified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 The findings included: Resident #1 was admitted to the facility on 02/28/25 with diagnoses that included atrial fibrillation, history of pulmonary embolism, history of cerebral infarction with hemiplegia and traumatic brain injury. Review of a physician order dated 02/28/25 read; apixaban (anticoagulant) 5 milligrams (mg) via gastrostomy tube two times a day for atrial fibrillation. A review of Resident #1's Medication Administration Record (MAR) for 02/2025 and 03/2025 indicated the Resident had received an anticoagulant medication apixaban 5 mg via gastrostomy tube twice a day for atrial fibrillation. The MARs indicated Resident #1 received the anticoagulant as ordered since his admission date of 02/28/25. An incident report dated 03/25/25 at 2:00 PM and written by Nurse #1 revealed Resident #1 was in bed after lunch when Nurse #1 was called to the Resident's room and upon arrival Resident #1 was lying on the floor next to his bed. Resident #1 stated he rolled over and he did not know what he was trying to do. A head-to-toe assessment was done, and Resident #1 was moving all extremities without any problems. The Resident complained of back pain which he does most of the time and was given some pain medication for pain. No injuries were noted, and Resident #1 was assisted back to bed using the total lift. Neurologic checks were initiated, and all vital signs were within the normal limits. Staff were to do frequent rounding and ensure correct	F 580	On 4/3/25, the Administrator, DON, Vice President of Risk and Quality Assurance (VPRQA), Nurse Consultant, Physician Assistant and Medical Director held an Ad Hoc QAPI meeting to discuss the incident to determine root cause analysis of the facility's failure to immediately notify the Medical Provider when Resident #1 had a change in condition. Root cause analysis determined that the facility failed to have effective systems in place and monitoring measures to ensure that a licensed nurse understood the seriousness of their responsibility to notify the Medical Provider when a resident experiences a change in condition post-fall, especially those on anticoagulants. On 4/3/2025, the VPRQA, Nurse Consultant, DON, Administrator, and Physician Assistant (PA) reviewed the notification and fall policy. No updates were made. Effective 4/3/25, the DON, Nurse Consultant, and Nursing Administration initiated education with all facility and contracted licensed nurses and Certified Nursing Assistants on the facility Notification of Changes in Condition and Fall Prevention Policies. Education includes the licensed nurse's responsibility to immediately notify the Medical Provider of any resident's change in condition, especially post-fall, with a history of stoke and pulmonary embolism on an anticoagulant. Certified Nursing Assistants will immediately communicate to the licensed nurses any change in Residents condition. The DON will ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 positioning while in bed. During an interview with Nurse #1 on 04/02/25 at 2:40 PM the Nurse confirmed that she worked the 7:00 AM shift on 03/27/25 after his fall on 03/25/25. Nurse #1 explained that when she returned to work on 03/27/25 for the 7:00 AM shift, Nurse #3 informed her that Resident #1 was lethargic, but she did not think to ask how long he had been lethargic. Nurse #1 explained that she went to assess Resident #1, and he was sleeping and when she tried to wake him up, the Resident would not wake up and he was lethargic. She stated she reviewed his progress notes which indicated he had labs drawn and a urine sample and a chest x-ray was due to be done. Nurse #1 reported that the Unit Manager (UM) asked her how Resident #1 was doing that day and Nurse #1 informed her that he was lethargic, and the UM stated that the Resident had labs drawn the day before. Nurse #1 reported that while she was passing her morning medications the radiology technician arrived to obtain a chest x-ray. Shortly after that, Resident #1's family came to visit and informed her that Resident #1 was not acting like himself and was aware that he had a fall on 03/25/25 and stated that Resident #1 had a history of two brain bleeds. The Nurse informed the family of the labs that were ordered, and the chest x-ray had been done but the family insisted that Resident #1 be transferred to the hospital, so Nurse #1 notified the PA and was given an order to transfer Resident #1 to the hospital. On 04/02/25 at 12:55 PM and 04/03/25 at 10:45 AM interviews were conducted with Nurse Aide (NA) #1 who confirmed she worked from 7:00 AM to 3:00 PM on 03/26/25 on a different assignment, but she went to check on Resident	F 580	all newly hired facility and contracted licensed nurses and certified nursing assistants will be educated during orientation and/or prior to taking assignment. As of 4/5/25, the DON/Unit Manager/Nurse Supervisor will monitor using a Quality Assurance tool. The monitoring will ensure timely notification to the medical provider residents with a change in condition post-fall on anticoagulation therapy. The QA monitoring will be conducted three times a week x 4 weeks, biweekly x 4 weeks, and then weekly x 4 weeks. The DON/Administrator will report the results of the QA monitoring monthly to the Quality Assurance Process Improvement (QAPI) committee for continued compliance and/or revision.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5	F 580		

#1 because he had fallen on 03/25/25 and found him to be lethargic and basically not responding as his usual self. The NA stated that she helped NA #2 get Resident #1 out of the bed for therapy around mid-morning and the Resident was limp like a rag doll and lethargic and that was a change in the Resident since the day before. NA #1 reported that she went and got the Physical Therapy Assistant (PTA) and reported how the Resident was acting since the fall on 03/25/25 and they both put Resident #1 back in the bed.

An interview was conducted with Nurse Aide #2 on 04/03/25 at 10:15 AM who confirmed she worked from 7:00 AM to 3:00 PM on 03/26/25. The NA explained that she had only worked with Resident #1 one time before 03/26/25, and he was alert and conversed with her about having a daughter with her name. NA #2 reported that when she went in to care for Resident #1 on that morning (03/26/25) around breakfast, she knew immediately that he was acting differently from their previous encounter because the Resident's response was slower, and he was not conversing with her like he normally did. NA #2 continued to explain that around 10:00 AM NA #1 helped her get Resident #1 out of bed for therapy and NA #1 went to inform therapy of how Resident #1 was acting and therapy and NA #1 put the Resident back to bed. NA #2 reported that she went to notify Nurse #2 of Resident #1's condition and Nurse #2 went to his room to assess him. NA #2 explained that Resident #1 acted the same throughout the rest of the shift when she went into care for him.

During an interview with the Physical Therapy Assistant (PTA) on 04/02/25 at 11:45 AM the PTA explained that she had worked with Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6	F 580		

since his admission, and he was able to participate in therapy. She reported that on the morning of 03/26/25 NA #1 came and got her to go to Resident #1's room because the Resident had a fall out of bed the day before (03/25/25) and they had gotten him out of bed for his therapy session, but he was not behaving like his normal behavior. The PTA stated she went into Resident #1's room and could see that he was lethargic and not responding to her as he normally did, and she and NA #1 put the Resident back to bed. The PTA explained that she reported her concern to Nurse #2 and the Nurse informed her that no one reported to her that Resident #1 had a fall. The PTA continued to explain that she periodically checked on Resident #1 throughout the rest of the shift and he barely made eye contact with the PTA. She indicated the Resident made "groaning and moaning sounds" while he was sleeping.

Interviews were conducted with Nurse #3 on 04/02/25 at 9:20 PM and 04/04/25 6:55 AM. The Nurse confirmed that she worked with Resident #1 on 03/25/25 through 03/26/25 for the 7:00 PM to 7:00 AM shift and 7:00 PM to 7:00 AM for 03/26/25 through 03/27/25. Nurse #3 explained that she received in the report on 03/25/25 that Resident #1 sustained a fall from the bed and the neurologic checks were on going. Nurse #3 continued to explain that she reported off to Nurse #2 on the morning of 03/26/25 and informed the Nurse that Resident #1 had a fall and that his neurologic checks were on going and had been stable throughout the night and she documented it on the 24-hour report sheet. Nurse #3 stated when she came on duty at 7:00 PM on 03/26/25 she checked on the residents and found that Resident #1 was lethargic. Nurse #3 was then told by the UM that labs, urine and a chest

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7	F 580		

x-ray had been ordered for Resident #1 and that she had to collect the urine and have it ready for the lab to pick up. The Nurse stated she obtained the urine, and the lab phlebotomist came in around 4:00 AM in the morning to obtain the Resident's labs so that just left the chest x-ray which she reported to Nurse #1 when she gave her report that morning. Nurse #3 continued to explain that Resident #1 slept all night, and she was able to perform the neurologic checks except the grips because he was sleeping. The Nurse indicated the Resident's vital signs were stable. Nurse #3 reported if it had been during the day she would have called the provider, but she knew the provider had already been informed of Resident #1's condition and his lab work was pending.

Interviews were conducted with Nurse #2 on 04/02/25 at 11:30 AM and 04/03/25 at 11:35 AM. Nurse #2 confirmed that she worked with Resident #1 on 03/26/25 from 7:00 AM to 3:00 PM and it was the first time she had worked with the Resident. Nurse #2 stated between 8:00 AM and 8:30 AM a therapy staff (PTA) member informed her that Resident #1 had a fall the previous day (03/25/25) and was not acting like himself and she went to assess him. Nurse #2 stated Resident #1 would open his eyes when she called his name, but he would not respond to her. The Nurse indicated that she obtained the Resident's vital signs which were within normal limits and completed a change in condition assessment and reported the change in condition to the UM after the UM got out of a meeting which was around 10:30 AM and the UM informed Nurse #2 that she would call the PA. The Nurse explained that they received orders for some blood work, urine and a chest x-ray. When Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8	F 580		

#2 was asked why she did not call the PA herself the Nurse indicated that she was not familiar with Resident and wanted to report the Resident's condition to her Unit Manager.

A review of a Change in Condition Assessment completed by Nurse #2 on 03/26/25 at 2:35 PM revealed Resident #1 was drowsy, lethargic and very less responsive. Blood Pressure 115/62, Pulse 64, Respirations 18 and Temperature 97.7 via forehead and recent oxygenation 95%. Decreased level of consciousness (sleepy, lethargic). The assessment indicated the PA, and the responsible party were notified.

A review of Resident #1's physician orders on 03/26/25 written around 5:40 PM indicated orders for a Complete Blood Count with Differential (CBC/Diff) in AM, Urine for Urinalysis and Culture and Sensitivity (UA/C&S) if indicated and a Chest X-Ray (CXR) for cough were obtained. The orders were written by the Unit Manager.

Interviews were conducted with the Unit Manager on 04/02/25 at 5:00 PM and 04/03/25 at 10:45 AM. The UM explained that she was notified of Resident #1's fall by Nurse #1 on 03/25/25 shortly after the fall happened and was told that the Resident did not sustain any injuries from the fall. The UM continued to explain that the next day on 03/26/25 at approximately 4:30 PM after she got out of the Risk Management meeting, Nurse #2 informed her that Resident #1 had a change in condition and was lethargic and she was going to document a change in condition and call the responsible party. The UM stated that she stepped into Resident #1's room and laid eyes on him but the Resident did not appear to her to be lethargic. She indicated that she did not complete

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9	F 580		

an assessment on Resident #1. The UM continued to explain that since she had to call the PA about other residents, she decided to call the PA at that time and reported that Resident #1 had a change in condition and was lethargic. The UM stated she received orders for lab work, urine for culture and sensitivity and a chest x-ray which she put in the computer. The UM reported that Nurse #3 was to collect the urine, and the phlebotomist was to obtain the blood when they made their next round to the facility. The UM indicated Resident #1's vital signs were stable, and they were trying to rule out infection.

Review of a progress note made by Nurse #1 on 03/27/25 at 10:52 AM indicated Resident #1 continued to appear lethargic, family at the facility at the time, requested Resident #1 to be sent out to ED for more evaluation. The PA was notified, and an order was received. Resident #1 left with EMS at around 10:19 AM. Vital Signs: 133/94, T97.3, R18, P112, 02 saturation 97% on room air.

A review of Resident #1's hospital records dated 03/27/25 revealed Resident #1 arrived at the ED with a history of intracranial hemorrhage, altered mental status and subdural hematoma. The Resident received apixaban 5 mg twice a day. Resident #1's vital signs rose to 212/108, 124, 40 but remained negative for fever. The Glasco Coma Scale (GCS) (a neurological assessment tool used to measure a person's level of conscientious especially in traumatic brain injury) was a 3 meaning the lowest possible level of consciousness and is usually associated with the deep coma or death meaning the person is wholly unresponsive. The computed tomography (CT) results of the brain revealed a huge left subdural hematoma measuring 15.1 centimeters (cm) in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10	F 580		

length, thickness of 3.4 cm and height of 9.7 cm. This results in severe compression of the left hemisphere with 1.5 cm midline shift. There is developing right side hydrocephalus (a buildup of fluid deep within the cavities of the brain). The report indicated the Resident's family was consulted on his condition and because of his condition the family opted to provide comfort measures only and to consult Hospice services.

Interviews were conducted with the Physician Assistant on 04/02/25 at 2:15 PM and 04/03/25 at 12:45 PM. The PA explained that she was at the facility on 03/25/25 and was informed that the Resident sustained a fall and assessed Resident #1 late that same night. The PA reported that the UM called her the next day on 03/26/25 around 4:50 PM when the Resident had a change in condition. When the PA was asked if she was notified that Resident #1 was lethargic, the PA stated she could not remember the exact verbiage that the UM used in describing the Resident's change in condition, but she felt that she needed to obtain labs, urine and a chest x-ray to diagnose the issue. The PA reported that the next morning on 03/27/25 she was notified by Nurse #1 that Resident #1's family was at the facility and wanted him sent to the hospital and she gave the Nurse an order to send Resident #1 out to the hospital.

During an interview was conducted with the Director of Nursing (DON) on 04/03/25 at 2:40 PM. The DON explained that she was aware that Resident #1 had a fall on 03/25/25 and that he had no injuries from the fall. The DON stated that she did not know that Resident #1 had a change in condition on the morning of 03/26/25 and indicated that when the change in condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 11	F 580		

occurred the PA should have been notified at that time.

An interview was conducted with the Medical Director on 04/04/25 at 4:15 PM. The Medical Director stated that he was notified of Resident #1's situation by the PA and was aware of the events that led to the Resident being sent to the hospital. The Medical Director stated that given Resident #1's complex medical history, the facility should have notified the PA as soon as they noticed a change in the Resident's condition and sent Resident #1 to the hospital. He indicated that the outcome might not have changed but the facility should have sent him out.

The Administrator was notified of Immediate Jeopardy on 04/03/25 at 4:40 PM.

The facility implemented the following Credible Allegation of Immediate Jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to immediately notify the Medical Provider when Resident #1 had a change in condition on 03/26/25 at approximately 8:30 AM. Resident #1 had a fall on 03/25/25 at approximately 2:00 PM and was assessed by the nursing staff to have no injuries and was transferred back to bed. On 03/26/25 at 8:30 AM Resident #1 had a change in condition as described by staff as having a decreased level of consciousness, unable to be awakened, lethargic slow to respond, much different than his baseline. The Medical Provider was not notified until 4:50 PM on 03/26/25 and gave orders for blood work,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 12	F 580		

urinalysis, and chest x-ray. On 03/27/25 Resident #1's family came to visit and found him unresponsive and called Emergency Medical Services (EMS). Resident #1 was transferred to the Emergency Room and diagnosed with a large subdural hematoma with midline shift. Resident #1 was transferred to hospice and passed away on 03/31/25.

On 4/3/25, the DON re-educated the nurse on the notification policy and process to include immediately notifying the Medical Provider when a resident has a change in condition.

On 4/3/25, the DON and Nurse Consultant completed an audit of residents on anticoagulant therapy who have experienced a fall within the last 72 hours to ensure timely notification to the Medical Provider if a change in resident condition occurs. Two residents were identified and no concerns identified.

On 4/4/2025, the facility reviewed all residents with changes in condition in 24 hours to ensure immediate notification to the Medical Provider occurred. Six residents were identified, and the Medical Provider was notified.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring, and when the action will be complete.

On 4/3/25, the Administrator, Director of Nursing (DON), Vice President of Risk and Quality Assurance (VPRQA), Nurse Consultant, Physician Assistant and Medical Director held an Ad Hoc QAPI meeting to discuss the incident to determine root cause analysis of the facility's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 13	F 580		

failure to immediately notify the Medical Provider when Resident #1 had a change in condition. Root cause analysis determined that the facility failed to have effective systems in place and monitoring measures to ensure that a licensed nurse understood the seriousness of their responsibility to notify the Medical Provider when a resident experiences a change in condition post-fall, especially those on anticoagulants.
On 4/3/2025, the Director of Risk of Quality Management, Nurse Consultant, Director of Nursing, Administrator, and Physician Assistant reviewed the notification and fall policy. No updates were made.

Effective 4/3/25, the Director of Nursing, Nurse Consultant, and Nursing Administration initiated education with all facility and contracted licensed nurses and Certified Nursing Assistants on the facility Notification of Changes in Condition and Fall Prevention Policies. Education includes the licensed nurse's responsibility to immediately notify the Medical Provider of any resident's change in condition, especially post-fall, with a history of stoke and pulmonary embolism on an anticoagulant. Certified Nursing Assistants will immediately communicate to the licensed nurses any change in Residents condition. The Director of Nursing will ensure all newly hired licensed nurses and Certified Nursing Assistants will be educated during orientation and contracted staff educated prior to taking their assignment.
Effective 4/3/25, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 04/05/25

On 04/08/25 the credible allegation of Immediate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 14 Jeopardy removal with a removal date of 04/05/25 was validated by onsite verification through staff interviews, record reviews, and education reviews. The staff interviewed included members of administration, licensed nurses and nursing assistants. The staff interviews were related to the facility's policy and procedures for notification of changes in condition, specifically how to identify changes in conditions and notification the providers upon changes in conditions. The management team reported new procedures in monitoring for changes in conditions in order to notify the providers. The licensed nurses reported their responsibility to assess residents when changes in conditions occur so that timely notification can be made to the providers, and the nurse aides voiced their responsibility in notifying the nurses of changes in the residents' conditions as soon as possible. The education of Notification provided for the staff was evident through staff interviews and education attendance records. The Immediate Jeopardy removal date of 04/05/25 was validated.	F 580		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 15 §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, and record reviews, the facility failed to protect a resident's right to be free from physical abuse when a Nursing Assistant woke a resident from his sleep to provide incontinent care against his will and held the resident's arms while the resident was fighting for 1 of 3 sampled residents (Resident #2). A skin tear to the resident's left lower forearm was noted after this incident. The findings included: Resident #2 was admitted to the facility on 07/09/2024 with diagnoses of chronic obstructive pulmonary disease, pacemaker, type II diabetes mellitus with chronic kidney disease, and major depressive disorder. A review of the 09/26/2024 provider progress notes on Resident #2 revealed major depression with psychosis with psychiatric features, moderate depression with psychosis, intermittent unfounded accusations toward staff and facility with paranoid ideations, and that ISIS wanted to kill him. Psychotherapy and evaluation and aggression with paranoid ideations were pending official notes. Lamictal (a drug used for bipolar I disorder maintenance) and trazodone (a drug used for depression) were reviewed. Lamictal dosing was switched to nighttime dosing due to daytime fatigue.	F 600	The facility failed to protect a resident's right to be free from abuse on 10/21/2024 when NA #8 awakened Resident #2 to provide incontinence care against his will and held the resident's arms resulting in a skin tear to resident's left lower arm. The facility completed an initial report to the state agency complaint intake department, notified local law enforcement and adult protective services (APS). On 10/21/24, the licensed nurse completed a comprehensive assessment including skin assessment, notified the resident's representative and the medical provider. New orders were received and implemented for Resident #2 skin tear to left lower arm. On 10/23/24, the physician assistant assessed Resident #2. On 10/28/24, the Administrator submitted a 5-Day investigation report to the state agency as appropriate. NA #8 is no longer an employee of the facility. Effective 4/29/25, the Social Worker completed abuse questionnaires with cognitively intact residents to ensure residents are free from abuse and only receive care as residents allow. No additional concerns reported. Effective 4/28/25, licensed nurses completed body audits on cognitively impaired residents to identify any signs of abuse or resistance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 16 A Discharge (end of Prospective Payment System [PPS] Part A Stay) Minimum Data Set (MDS) dated 10/19/2024 revealed that Resident #2 was cognitively intact and had skin tears. Resident #2 care plan dated 10/19/2024 stated that he had a skin tear to the right hand. A review of the physician orders revealed that the right hand had a skin tear on 10/09/2024 with orders renewed on 10/22/2024 to clean right hand with wound cleanser. Apply xeroform. Cover with dry dressing every day shift for wound healing. Then an order started on 10/22/2024 to Clean left wrist skin tear with wound cleanser and apply xeroform. Cover with dry dressing every day shift for wound healing. The initial psychiatric assessment dated 10/15/2024 denied a history of abuse without symptoms of Post Traumatic Stress Disorder. The report stated that Resident #2 denied recent abuse, history of traumatic events, no suicidal or homicidal ideations, no audio verbal hallucinations, or guilt. Diagnoses of bipolar and insomnia were documented by the Psychiatric Nurse Practitioner. A daily skilled assessment authored by Nurse #5 at 10:48 AM on 10/21/2024 revealed that Resident #2 did not have any unhealed pressure ulcers or injuries, yet he did have a skin tear. It was documented that there was no change in his skin integrity. Nursing Assistant (NA) #8's written statement on 10/22/2024 was reviewed and revealed that the employee entered Resident #2's room earlier that morning at approximately 5:45 AM, introduced	F 600	to care. No concerns observed. Effective 4/29/25, current facility and agency staff were in-serviced on the Abuse, Neglect and Exploitation Policy by the Director of Nursing (DON), Unit Managers, and Social Worker. Training topics included prohibiting, preventing and recognizing what constitutes abuse including refraining from providing care against a residents' will. Newly hired facility and agency staff will receive education during orientation and prior to taking their assignment. The DON will be responsible for ensuring all staff are trained by tracking daily nursing schedules and by reviewing the new hire and agency orientation packets for evidence of abuse training. The Social Worker and/or designee will complete ongoing monitoring by conducting abuse questionnaires with five (5) facility and/or agency staff and with five (5) cognitively intact residents to ensure understanding of the Abuse, Neglect and Exploitation Policy ensuring residents remain free from abuse to include receiving care as resident allows. The DON/Unit Managers/Designee will monitor staff during resident care for five (5) cognitively impaired residents to ensure residents remain free from abuse and care is provided as residents allow. Monitoring will be completed three times a week for four weeks, bi-weekly for four weeks, then weekly times four weeks. The Administrator will report audit findings during monthly Quality Assurance Process Improvement (QAPI) meetings monthly	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 17	F 600		

himself and explained that he was going to change him. NA #8 explained that the resident was immediately aggressive and began throwing his hands. NA #8 stated that Resident #2 reportedly pulled back, and NA #8 left the room to allow the resident to cool down. He went back in 15 minutes, reintroduced himself, cleaned the resident and asked if Resident #2 needed anything else. Resident #2 reportedly thanked him and replied that he didn't think he needed anything more. NA #8 wrote that he told the resident he was welcome and exited the room.

At 2:16 PM on 04/02/2025, NA #8 was interviewed and stated that Resident #2 doesn't like to be woken from sleep. If he was awakened, he would become violent. Resident #2 tended to jump and get violent. NA #8 reported that when he awakened Resident #2 after NA #8 identified himself, Resident #2 refused care. NA #8 stated that when he touched Resident #8 to turn him, the resident started swinging his arms. NA #8 reported that Resident #8 could be aggressive and abusive both verbally and physically. NA #8 allowed the resident to cool down and reported to the nurse about Resident #2's refusal. NA #8 did not recall which nurse reportedly told him to go back and try to care for the resident again. NA #8 reported going back again to Resident #2 who seemed mildly cooperative.

NA #8 was interviewed by phone at 1:05 PM on 04/03/2025. He stated that he didn't know anything about Resident #2 having skin tears. NA #8 stated that he did not recall twisting his arms or doing anything to cause Resident #2 any harm. He explained that when he changed Resident #2 around 6:00 AM, the resident was wet and soiled with bowel movement (BM). NA #8 remembered

for continued compliance and/or revision.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 18	F 600		

the BM, because he recalled Resident #2 was on metformin, an antidiabetic drug, and was having issues with his bowels.

During an interview with Resident #2 at 1:55 PM on 04/02/2025, he reported that NA #8 was "trying to change me when I didn't need it. I resisted. He twisted my hands, and his long fingernails went into my skin. He nipped my skin with my fingernails. I told him he better not do that again. He didn't mean to hurt me. He was trying to get his job done. He changed me. I told them to keep him out of my room. It's better for us to stay apart. I didn't want to hurt him, and he didn't want to hurt me. Just the situation just gets out of hand."

An interview with Resident #2 at 4:23 PM on 04/02/2025 revealed that he didn't think the situation we talked about with NA #8 changing him was abuse. Resident #2 reported that he didn't think so, but "he should have stopped when I resisted. I didn't need changing."

Nurse #8's written statement dated 10/25/2024 revealed that no observations from NA #8 were reported to him on the night shift of 10/21/2024. Nurse #8 worked on the same hallway as NA #8 was assigned. Nurse #8 was not able to be interviewed.

A review of Nurse #7's written statement dated 10/24/2024 about her interview with Resident #2 revealed that the resident reported NA #8's grabbing him while he was sleeping thus startling him. The nurse observed 2 skin tears on Resident #2 at both the hand and wrist. The resident reported that he "jacked away" from him. Resident #2 reportedly told her that he felt his injuries were not intentional. Resident #2 thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 19 that NA #8 had a history of being rough with him. Nurse #7, a former Unit Manager who worked on dayshift, was unable to be interviewed. A review of a change in condition assessment on 10/22/2024 at 3:36 PM authored by Nurse #5 revealed that Resident #2 had a skin tear on the right hand and a skin tear on the left lower arm. Documentation revealed that the nurse was notified by Resident #2's family representative about an incident with the night NA. The Director of Nursing (DON) was interviewed at 3:55 PM on 04/03/2025 and stated she expected the NAs to provide care and communicate with the nurse. She revealed that a complete round must be done on every resident including a resident like Resident #2. During an interview at 2:34 PM on 04/03/2025 with the Administrator, she revealed that the NAs must explain to the nurse when a resident refuses care. Then the NA must report on why the resident was still resistant if applicable. A resident's history of behavior like Resident #2 is not a reason to not see about his care. She reported that the expectation has been set for every resident to be rounded on and clean. Each resident's brief must be opened and cleaned if needed. She expected the NAs to complete a round on every resident prior to leaving.	F 600		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to	F 684		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record reviews, Emergency Medical Services (EMS) records, facility staff, Emergency Department (ED) Physician, Physician Assistant (PA) and Medical Director interviews, the facility failed to recognize the severity of an acute change in condition after a fall for Resident #1. Resident #1 had a past medical history that included atrial fibrillation with anticoagulation, recent pulmonary embolism, recent COVID-19, history of traumatic brain injury (TBI), history of hemiplegia (paralysis on one side of body) following a cerebral infarction, and history of previous subdural hematoma. Resident #1 was prescribed an anticoagulant medication of apixaban 5 milligrams (mg) via gastrostomy tube twice a day for atrial fibrillation. On 03/25/25 between 2:00 PM to 2:30 PM Resident #1 had an unwitnessed fall from the bed and was assessed to have no visible injuries and transferred back to bed. Neurological checks were initiated. Resident #1 reported to staff that he did not hit his head. On 03/26/25 at approximately 8:30 AM Resident #1 was noted by staff to be hard to arouse, nonverbal, unresponsive, and lethargic. At 4:50 PM on 03/26/25 the Unit Manager (UM) notified the PA that Resident #1 was "lethargic" and received orders for bloodwork, urinalysis, culture and sensitivity, and a chest x-ray. On 03/27/25 at 9:58 AM Resident #1's family came to the facility and found him unresponsive and called Emergency Medical Services (EMS) and	F 684	The facility failed to recognize the severity of a change in condition for Resident #1 who sustained a fall from bed on 03/25/25 at approximately 2:00 PM. Resident #1 had a past medical history significant for history of stroke, recent pulmonary embolism, recent COVID-19, atrial fibrillation, and traumatic brain injury, who was prescribed Apixaban (anticoagulant) 5 milligram (mg) via gastrostomy tube twice a day for atrial fibrillation. In the morning hours of 03/26/25 at approximately 8:30 AM, Resident #1 was noted by staff with a change in condition as described by staff as having a decreased level of consciousness, not easily aroused, lethargic slow to respond, much different than his baseline. On 3/26/25 at approximately 4:50 PM the Unit Manager notified the Physician Assistant (PA) and orders obtained for blood work, urinalysis, and Chest Xray. Vital signs and neurological checks remained stable throughout the night. On 03/27/25 at approximately 9:58 AM Resident #1 became non-responsive and Emergency Medical Services (EMS) was called by the licensed nurse and family as ordered by the Physician Assistant. Resident #1 was diagnosed with sepsis and a left subdural hematoma and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21 Resident #1 was transported to the Emergency Department (ED) and diagnosed with a "huge left subdural hematoma with a midline shift" (shifting of brain past its center). Resident #1 was transitioned to Hospice services and passed away on 03/31/25. This affected 1 of 3 residents reviewed for change in condition. Immediate Jeopardy began on 03/26/25 when Resident #1 was noted to have had an acute significant change in condition and was not evaluated or transferred to a higher level of care until 03/27/25. Immediate Jeopardy was removed on 04/05/25 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity D (isolated with no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 02/28/25 with diagnoses that included atrial fibrillation, history of pulmonary embolism, history of cerebral infarction with hemiplegia and traumatic brain injury. Review of a physician order dated 02/28/25 read; Apixaban 5 milligrams (mg) via gastrostomy tube two times a day for atrial fibrillation. A review of Resident #1's care plan dated 02/28/25 indicated the Resident received an anticoagulant medication related to a diagnosis of atrial fibrillation. The goal that Resident #1 will be	F 684	transferred and placed on Hospice services where he passed away on 03/31/25. On 4/3/25, the DON and Nurse Consultant completed an audit of residents on anticoagulant therapy who have experienced a fall within the last 72 hours to ensure timely recognition and response occurred if the resident experienced a change in condition. Two residents were identified and no concerns identified. On 4/4/2025, the DON and Unit Managers reviewed all residents with changes in condition in 24 hours to ensure immediate notification to the Medical Provider occurred. Six residents were identified, assessed and the Medical Provider was notified. On 4/3/25, the Administrator, Director of Nursing (DON), Vice President of Risk and Quality Assurance (VPRQA), Nurse Consultant, PA and Medical Director held an Ad Hoc QAPI meeting to discuss the incident to determine root cause analysis of the facility's failure to recognize the severity of a change in condition for Resident #1. Root cause analysis determined that the facility failed to have effective systems in place and monitoring measures to ensure timely response and notification is made to a medical provider for proper intervention up to and including transfer to a higher level of care. On 4/3/2025, the Director of Risk and Quality Assurance, Nurse Consultant, Director of Nursing, Administrator, and Physician Assistant reviewed the change in condition and fall policy. No changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 22 free from adverse side effects of the anticoagulation medication would be attained by utilizing interventions such as administering the anticoagulation medication as ordered and monitoring for side effects specifically for bleeding since Resident #1 has a history of gastrointestinal bleed. Further Review of Resident #1's care plan revealed no active care plan for falls prior to the fall on 03/25/25. A review of Resident #1's admission Minimum Data Set assessment dated 03/07/25 revealed he was cognitively intact. The Resident was coded as requiring substantial to maximal assistance with most activities of daily living except eating. It was documented that he had no falls since admission and received an anticoagulant. A review of Resident #1's Medication Administration Record (MAR) for 02/2025 and 03/2025 indicated the Resident had received an anticoagulant medication apixaban 5 mg via gastrostomy tube twice a day for atrial fibrillation. The MARs indicated Resident #1 received the anticoagulant as ordered since his admission date of 02/28/25. An incident report dated 03/25/25 at 2:00 PM and written by Nurse #1 revealed Resident #1 was in bed after lunch when Nurse #1 was called to the Resident's room and upon arrival Resident #1 was lying on the floor next to his bed. Resident #1 stated he rolled over and he did not know what he was trying to do. A head-to-toe assessment was done, and Resident #1 was moving all extremities without any problems. The Resident complained of back pain which he does most of the time and	F 684	were made. Effective 4/3/25, the Director of Nursing, Nurse Consultant, and Nursing Administration initiated education with all facility and contracted licensed nurses and Certified Nursing Assistants on the facility Notification of Changes in Condition and Fall Prevention policies. Education includes recognizing the severity of a change in condition status post fall to include post fall assessment changes for 72 hours, changes in level of consciousness, and altered mental status away from baseline. Upon licensed nurse's assessment recognizing the severity of the residents change in condition away from baseline post fall, the Medical Provider will be immediately notified. Certified Nursing Assistants will communicate any residents change in condition away from baseline to the licensed nurses. The Director of Nursing and/or Unit Managers will ensure all newly hired facility and contracted licensed nurses and certified nursing assistants will receive education during orientation and prior to accepting their assignment. As of 4/5/25, the DON/Unit Manager/Nurse Supervisor will monitor using a Quality Assurance tool. The monitoring will ensure licensed nurses' assessment, timely notification to the medical provider, and follow-up interventions are implemented for residents with a change in condition post-fall on anticoagulation therapy. The QA monitoring will be conducted three times a week x 4 weeks, biweekly x 4 weeks, and then weekly x 4 weeks. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23	F 684	DON/Administrator will report the results of the QA monitoring monthly to the Quality Assurance Process Improvement (QAPI) committee for continued compliance and/or revision.	

was given some pain medication for pain. No injuries were noted, and Resident #1 was assisted back to bed using the total lift. Neurologic checks were initiated, and all vital signs were within the normal limits. Staff were to do frequent rounding and ensure correct positioning while in bed.

A nursing progress note written by Nurse #1 on 03/25/25 at 3:34 PM indicated Resident #1 was alert and able to make his needs known. The Resident was in bed after lunch when Nurse #1 was called to Resident #1's room (by Nurse Aide (NA) #1) and upon arrival the Resident was lying on the floor next to his bed. When Resident #1 was asked what he was trying to do, the Resident responded that he did not know what he was trying to do. A head-to-toe assessment was completed with Resident #1 being able to move all his extremities without any problems. No injuries noted. The Resident was transferred to bed via a total lift and 2 person assist (Nurse #1 and NA #1). Resident #1 complained of back pain and a pain medication was given and was effective. Neurologic checks were initiated, and the Resident's vital signs were within normal limits.

A review of the neurologic checks with vital signs indicated the checks were initiated on 03/25/25 at 2:00 PM and continued through 03/27/25 at 9:00 AM. One neurologic check assessment dated 03/26/25 at 7:45 PM was not documented. The documented neurologic checks indicated the vital signs were within normal limits and the grips were present and the upper and lower motor function of the extremities were present.

A review of the Physician Assistant progress note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 24	F 684		

dated 03/25/25 revealed Resident #1 was assessed after sustaining a fall earlier in the day of 03/25/25. No injuries or cognition changes were reported. The neurologic exam was at baseline and no acute distress was appreciated. The Resident was status post recent complicated hospitalization with a history of atrial fibrillation, cerebral vascular accident with residual left hemiparesis, pulmonary embolism and recent gastrointestinal bleed. Medications include apixaban 5 mg two times a day. Vital signs 119/76, 73, 18, 97.6 and oxygen saturation of 96%. Assessment Plan: continue post fall measures and neuro checks per the facility policy and continue to monitor for bleeding. Nursing will continue to monitor changes and inform the provider as needed.

During an interview with Nurse #1 on 04/02/25 at 2:40 PM the Nurse confirmed that she worked from 7:00 AM to 7:00 PM on 03/25/25. The Nurse explained that she was notified that Resident #1 was on the floor in his room by NA #1. Nurse #1 went to the Resident's room to find him lying on the floor and when the Nurse asked Resident #1 how he got on the floor, he stated that he guessed he turned over, but he could not remember. The Resident complained of back pain, and she gave him some pain medication that was effective. The Nurse continued to explain that they (Nurse #1 and NA #1) got Resident #1 back in the bed using the total lift. Nurse #1 stated she asked the Resident if he hit his head, and he made a remark of something funny which was his normal demeanor. She indicated she specifically looked for injuries on his head because it was an unwitnessed fall and there were no visible injuries. The Nurse reported she initiated neurologic checks, and they were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 25	F 684		

within normal limits. Nurse #1 explained that she continued the neurologic checks throughout the rest of the shift and the neurologic checks remained within normal limits and Resident #1 was alert and talkative, which was his normal demeanor. The Nurse indicated that she reported off to Nurse #3 at the change of shift. Nurse #1 continued to explain that when she returned to work on 03/27/25 for the 7:00 AM shift, Nurse #3 informed her that Resident #1 was lethargic, but she did not think to ask how long he had been lethargic. Nurse #1 explained that she went to assess Resident #1, and he was sleeping and when she tried to wake him up, the Resident would not wake up and he was lethargic. She stated she reviewed his progress notes which indicated he had labs drawn and a urine sample and a chest x-ray was due to be done. Nurse #1 reported that the UM asked her how Resident #1 was doing that day and Nurse #1 informed her that he was lethargic, and the UM stated that the Resident had labs drawn the day before. Nurse #1 reported that while she was passing her morning medications the radiology technician arrived to obtain a chest x-ray. Shortly after that, Resident #1's family came to visit and informed her that Resident #1 was not acting like himself and was aware that he had a fall on 03/25/25 and stated that Resident #1 had a history of two brain bleeds. The Nurse informed the family of the labs that were ordered, and the chest x-ray had been done but the family insisted that Resident #1 be transferred to the hospital, so Nurse #1 notified the PA and was given an order to transfer Resident #1 to the hospital.

On 04/02/25 at 12:55 PM and 04/03/25 at 10:45 AM interviews were conducted with Nurse Aide (NA) #1 who confirmed she worked from 7:00 AM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 26	F 684		

to 3:00 PM on 03/25/25. The NA explained that after lunch she answered the call light for Resident #1's room and found Resident #1 lying on the floor on his left side between his bed and his roommate's bed. The roommate had pushed the call light for Resident #1. NA #1 continued to explain that she asked Resident #1 if he was hurt or if he hit his head during the fall and the Resident told her no and she saw no visible signs of injury or bleeding from Resident #1. NA #1 informed the Resident that she was going to get Nurse #1 which she did and after Nurse #1 assessed Resident #1 they used the total lift to put him back in bed. NA #1 reported that she checked on Resident #1 one more time before she went off shift and asked him what he was trying to do when he fell and the Resident responded, "I don't know, dancing I guess." The NA explained that it was Resident #1's usual demeanor to joke with the staff. NA #1 continued to explain that she worked from 7:00 AM to 3:00 PM on 03/26/25 but she worked on a different assignment, but she went to check on Resident #1 and found him to be lethargic and basically not responding as his usual self. The NA stated that she helped NA #2 get Resident #1 out of the bed for therapy around mid-morning and the Resident was limp like a rag doll and lethargic and that was a change in the Resident since the day before. NA #1 reported that she went and got the Physical Therapy Assistant (PTA) and reported how the Resident was acting since the fall on 03/25/25 and they both put Resident #1 back in the bed.

An interview was conducted with Nurse Aide #2 on 04/03/25 at 10:15 AM who confirmed she worked from 7:00 AM to 3:00 PM on 03/26/25. The NA explained that she had only worked with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

Resident #1 one time before 03/26/25, and he was alert and conversed with her about having a daughter with her name. NA #2 reported that when she went in to care for Resident #1 on that morning (03/26/25) around breakfast, she knew immediately that he was acting differently from their previous encounter because the Resident's response was slower, and he was not conversing with her like he normally did. NA #2 continued to explain that around 10:00 AM NA #1 helped her get Resident #1 out of bed for therapy and NA #1 went to inform therapy of how Resident #1 was acting and therapy and NA #1 put the Resident back to bed. NA #2 reported that she went to notify Nurse #2 of Resident #1's condition and Nurse #2 went to his room to assess him. NA #2 explained that Resident #1 acted the same throughout the rest of the shift when she went into care for him.

During an interview with the Physical Therapy Assistant (PTA) on 04/02/25 at 11:45 AM the PTA explained that she had worked with Resident #1 since his admission, and he was able to participate in therapy. She reported that on the morning of 03/26/25 NA #1 came and got her to go to Resident #1's room because the Resident had a fall out of bed the day before and they had gotten him out of bed for his therapy session, but he was not behaving like his normal behavior. The PTA stated she went into Resident #1's room and could see that he was lethargic and not responding to her as he normally did, and she and NA #1 put the Resident back to bed. The PTA explained that she reported her concern to Nurse #2 and the Nurse informed her that no one reported to her that Resident #1 had a fall. The PTA continued to explain that she periodically checked on Resident #1 throughout the rest of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 28	F 684		

the shift and he barely made eye contact with the PTA. She indicated the Resident made "groaning and moaning sounds" while he was sleeping.

Interviews were conducted with Nurse #3 on 04/02/25 at 9:20 PM and 04/04/25 6:55 AM. The Nurse confirmed that she worked with Resident #1 on 03/25/25 through 03/26/25 for the 7:00 PM to 7:00 AM shift and 7:00 PM to 7:00 AM for 03/26/25 through 03/27/25. Nurse #3 explained that she received in the report on 03/25/25 that Resident #1 sustained a fall from the bed and the neurologic checks were on going. When the Nurse went into assess Resident #1, he was alert and talkative and informed her that he had a fall before she asked the Resident about the fall. The Nurse indicated that every time she went into assess Resident #1, he spoke with her and his neurologic checks and vital signs were within normal limits and remained within normal limits throughout the rest of the shift. Nurse #3 continued to explain that she reported off to Nurse #2 the morning of 03/26/25 and informed the Nurse that Resident #1 had a fall and that his neurologic checks were on going and she documented it on the 24-hour report sheet. Nurse #3 stated when she came on duty at 7:00 PM on 03/26/25 she checked on the residents and found that Resident #1 was lethargic. Nurse #3 was then told by the Unit Manager (UM) that labs, urine and a chest x-ray had been ordered for Resident #1 and that she had to collect the urine and have it ready for the lab to pick up. The Nurse stated she obtained the urine, and the lab phlebotomist came in around 4:00 AM in the morning to obtain the Resident's labs so that just left the chest x-ray which she reported to Nurse #1 when she gave her report that morning. Nurse #3 continued to explain that Resident #1 slept all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29	F 684		

night, and she was able to perform the neurologic checks except the grips because he was sleeping. The Nurse indicated the Resident's vital signs were stable. Nurse #3 reported that she was able to connect his external tube feeding, medicate him through his gastrostomy tube, clean the gastrostomy tube site and disconnect the external tube feeding without waking him but that was not unusual for the Resident because he could be a "hard sleeper." Nurse #3 reported if it had been during the day she would have called the provider, but she knew the provider had already been informed of Resident #1's condition and his lab work was pending.

Interviews were conducted with Nurse #2 on 04/02/25 at 11:30 AM and 04/03/25 at 11:35 AM. Nurse #2 confirmed that she worked with Resident #1 on 03/26/25 from 7:00 AM to 3:00 PM and it was the first time she had worked with the Resident. Nurse #2 explained that she did not receive in report from Nurse #3 that Resident #1 had fallen but she did receive other information about the Resident. Nurse #2 stated after that between 8:00 AM and 8:30 AM a therapy staff (PTA) member informed her that Resident #1 had a fall and was not acting like himself and she went to assess him. Nurse #2 stated Resident #1 would open his eyes when she called his name, but he would not respond to her. The Nurse indicated that she obtained the Resident's vital signs which were within normal limits and completed a change in condition assessment and reported the change in condition to the UM after the UM got out of a meeting which was around 10:30 AM and the UM informed Nurse #2 that she would call the PA. The Nurse explained that they received orders for some blood work, urine and a chest x-ray and Nurse #2 called the Resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 30	F 684		

responsible party twice but had to leave a message on the cell phone and she did not know if the responsible party called back because she left off shift around 3:00 PM. When Nurse #2 was asked why she did not call the PA herself the Nurse indicated that she was not familiar with Resident and wanted to report the Resident's condition to her Unit Manager.

A review of a Change in Condition Assessment completed by Nurse #2 on 03/26/25 at 2:35 PM revealed Resident #1 was drowsy, lethargic and very less responsive. Blood Pressure 115/62, Pulse 64, Respirations 18 and Temperature 97.7 via forehead and recent oxygenation 95%. Decreased level of consciousness (sleepy, lethargic). The assessment indicated the PA, and the responsible party were notified.

A review of Resident #1's physician orders on 03/26/25 written around 5:40 PM indicated orders for a Complete Blood Count with Differential (CBC/Diff) in AM, Urine for Urinalysis and Culture and Sensitivity (UA/C&S) if indicated and a Chest X-Ray (CXR) for cough were obtained. The orders were written by the Unit Manager.

Interviews were conducted with the Unit Manager on 04/02/25 at 5:00 PM and 04/03/25 at 10:45 AM. The UM explained that she was notified of Resident #1's fall by Nurse #1 on 03/25/25 shortly after the fall happened and was told that the Resident did not sustain any injuries from the fall. Nurse #1 initiated the neurologic checks which included vital signs as per protocol for post falls. The UM continued to explain that the next day on 03/26/25 at approximately 4:30 PM after she got out of the Risk Management meeting, Nurse #2 informed her that Resident #1 had a change in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 31	F 684		

condition and was lethargic and she was going to document a change in condition and call the responsible party. The UM stated that she stepped into Resident #1's room and laid eyes on him but the Resident did not appear to her to be lethargic. She indicated that she did not complete an assessment on Resident #1. The UM continued to explain that since she had to call the PA about other residents, she decided to call the PA at that time and reported that Resident #1 had a change in condition and was lethargic. The UM stated she received orders for lab work, urine for culture and sensitivity and a chest x-ray which she put in the computer. The UM reported that Nurse #3 was to collect the urine, and the phlebotomist was to obtain the blood when they made their next round to the facility. The UM indicated Resident #1's vital signs were stable, and they were trying to rule out infection.

During an interview with NA #3 on 04/04/25 at 11:40 AM the NA confirmed that she worked with Resident #1 on 3:00 PM to 11:00 PM on 03/26/25. The NA explained that she remembered Resident #1 being quiet and refusing his supper. She indicated that he would only answer her questions with one-word responses and slept most of the shift. NA #3 stated she had not worked with Resident #1 enough to determine if it was his normal demeanor, so she did not think it was abnormal to report his behavior.

An interview was conducted with Nurse #4 on 04/03/25 at 8:15 AM who confirmed that she worked with Resident #1 on 03/26/25 from 3:00 PM to 7:00 PM. The Nurse explained that she only worked with the Resident that day and was unfamiliar with his usual demeanor. The Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 32	F 684		

stated she did not get in report that he had a fall, or she would have completed the neurologic checks. Nurse #4 reported that the Resident would answer her questions and allowed her to give him his enteral feeding. The Nurse stated if she had known or suspected that Resident #1 had a change in condition she would have notified the provider on call.

An interview was conducted with Nurse Aide #5 on 04/03/25 at 10:30 AM. The NA confirmed that she worked with Resident #1 on 03/26/25 3:00 PM through 03/27/25 to 7:00 AM. The NA explained that she noticed that Resident #1 was not acting like his normal self on the evening of 03/26/25 and reported it to Nurse #3 who was working with her that night. The Nurse informed her that Resident #1 had a fall the day before and they had notified the PA and were given orders for lab work. NA #5 stated that she was able to check and reposition Resident #1 throughout the night and basically sleep through it all which was unusual because the Resident would normally grunt and moan when she turned him.

Review of a progress note made by Nurse #1 on 03/27/25 at 10:52 AM indicated Resident #1 continued to appear lethargic, family at the facility at the time, requested Resident #1 to be sent out to ED for more evaluation. The PA was notified, and an order was received. Resident #1 left with EMS at around 10:19 AM. Vital Signs: 133/94, T97.3, R18, P112, 02 saturation 97% on room air.

A review of the EMS records dated 03/27/25 revealed they were dispatched to the facility at 10:01 AM and arrived at the facility at 10:10 AM to find Resident #1 lying in the bed unresponsive, hot to touch and breathing approximately 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 33	F 684		

times a minute. They were advised by facility staff that he had fallen 2 days prior but could not indicate how the Resident fell as it was noted that the Resident was paralyzed from previous cerebral vascular accidents. The family was also at bedside and advised that the Resident was normally alert and verbal and could carry a conversation, so they called EMS because the Resident was unresponsive. His temperature was obtained at 100.6 axillary, and intravenous access was established, and a fluid bolus was given. The Resident remained unresponsive throughout the transport.

A review of Resident #1's hospital records dated 03/27/25 revealed Resident #1 arrived at the ED with a history of intracranial hemorrhage, altered mental status and subdural hematoma. The Resident received apixaban 5 mg twice a day. Resident #1's vital signs rose to 212/108, 124, 40 but remained negative for fever. The Glasco Coma Scale (GCS) (a neurological assessment tool used to measure a person's level of conscientious especially in traumatic brain injury) was a 3 meaning the lowest possible level of consciousness and is usually associated with the deep coma or death meaning the person is wholly unresponsive. The computed tomography (CT) results of the brain revealed a huge left subdural hematoma measuring 15.1 centimeters (cm) in length, thickness of 3.4 cm and height of 9.7 cm. This results in severe compression of the left hemisphere with 1.5 cm midline shift. There is developing right side hydrocephalus (a buildup of fluid deep within the cavities of the brain). The report indicated the Resident's family was consulted on his condition and because of his condition the family opted to provide comfort measures only and to consult Hospice services.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 34	F 684		

An interview was conducted with the ED Physician on 04/04/25 at 10:20 PM. The ED Physician explained Resident #1 was brought to the ED by EMS who reported he had a fall one to one and a half days prior and had a decreased level of consciousness. He stated the Resident's vital signs were not terrible, but his blood pressure was 208/100 and his pulse was 124. The ED Physician continued to explain that the CT results showed a huge intracranial hemorrhage of a subdural hematoma that had a midline shift and after discussion with the family about the probable prognosis the family opted for Hospice services where he was sent that same day. The ED Physician reported that he saw no signs of injuries to account for the subdural hematoma, but it would not be uncommon for there not to be visible signs. He stated his opinion was that the hematoma was acute, but he could not be sure when it started because everyone was different and it could have even been before the fall. He indicated it could have been a slow bleed and when it crossed the midline shift was when Resident #1 started having a decreased level of consciousness. The ED Physician was asked if he thought Resident #1's recent diagnosis of COVID-19 affected his outcome and the ED Physician stated probably not.

Interviews were conducted with the Physician Assistant on 04/02/25 at 2:15 PM and 04/03/25 at 12:45 PM. The PA explained that she was at the facility on 03/25/25 and was informed that the Resident sustained a fall and assessed Resident #1 late that same night. She reported that Resident #1 had an extensive complicated history with multiple comorbidities and recently contracted COVID-19 which made his condition

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 35	F 684		

worse since he had a neurological condition. The PA continued to explain that when she assessed the Resident, she did not order anything but to continue the facility's protocol for post fall neurologic checks. The PA reported that the UM called her the next day on 03/26/25 around 4:50 PM when the Resident had a change in condition. When the PA was asked if she was notified that Resident #1 was lethargic, the PA stated she could not remember the exact verbiage that the UM used in describing the Resident's change in condition, but she felt that she needed to obtain labs, urine and a chest x-ray to diagnose the issue. The PA reported that the next morning on 03/27/25 she was notified by Nurse #1 that Resident #1's family was at the facility and wanted him sent to the hospital and she gave the Nurse an order to send Resident #1 out to the hospital. The PA stated she now knew that Resident #1 had a subdural hematoma which could show up in 72 hours after a fall with head injury and as soon as the facility noticed a change in condition, they called the PA for guidance. The PA stated it was possible that Resident #1 could have had a slow hemorrhage from a previous bleed.

During an interview was conducted with the Director of Nursing (DON) on 04/03/25 at 2:40 PM. The DON explained that she was notified of Resident #1's fall shortly after it happened but could not remember who notified her, but they told her that there were no injuries, and he did not hit his head. The DON reported that they talked about Resident #1 in the Risk Management meeting, and she specifically looked at his neurologic checks that were being done and there were no problems that she could determine. The DON stated that she always tried to follow up

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 36	F 684		

with the residents after falls and on Wednesday 03/26/25 she went into see Resident #1 who was in bed and asked him how he fell, and the Resident told her that he did not know how he fell and that he was not having any pain that he did not usually have. The DON reported that the next thing she knew was that Resident #1 was being sent to the emergency department on 03/27/25 at the family's request. The DON stated she did not know that Resident #1 had a change in condition on 03/26/25.

On 04/03/25 at 3:10 PM an interview was conducted with the Administrator. The Administrator explained that the facility followed the fall protocol and conducted neurologic checks with vital signs and the neurologic checks were stable until Resident #1 had a change in condition on 03/26/25. At that time the Physician Assistant was notified, and orders were received for labs, urine and a chest x-ray which were pending when the family insisted that Resident #1 be sent to the hospital. She indicated that when families insist on the residents to be sent to the hospital the facility accommodated the request. The Administrator acknowledged Resident #1's hospital admission diagnosis of a huge left subdural hematoma with a midline shift and indicated it could have been growing since the Resident's last traumatic brain injury.

An interview was conducted with the Medical Director on 04/04/25 at 4:15 PM. The Medical Director stated that he was notified of Resident #1's situation by the PA and was aware of the events that led to the Resident being sent to the hospital. The Medical Director stated that given Resident #1's complex medical history, the facility should have sent Resident #1 to the hospital

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 37	F 684		

when they noticed a change in his condition. He indicated that the outcome might not have changed but the facility should have sent him out.

The Administrator was notified of Immediate Jeopardy on 04/03/25 at 4:40 PM.

The facility implemented the following Credible Allegation of Immediate Jeopardy removal.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility failed to recognize the severity of a change in condition for Resident #1 who sustained a fall from bed on 03/25/25 at approximately 2:00 PM. Resident #1 had a past medical history significant for history of stroke, recent pulmonary embolism, recent COVID-19, atrial fibrillation, and traumatic brain injury, who was prescribed Apixaban (anticoagulant) 5 milligram (mg) via gastrostomy tube twice a day for atrial fibrillation. In the morning hours of 03/26/25 at approximately 8:30 AM, Resident #1 was noted by staff with a change in condition as described by staff as having a decreased level of consciousness, not easily aroused, lethargic slow to respond, much different than his baseline. On 3/26/25 at approximately 4:50 PM the Unit Manager notified the Physician Assistant (PA), and orders obtained for blood work, urinalysis, and Chest Xray. Vital signs and neurological checks remained stable throughout the night.

On 03/27/25 at approximately 9:58 AM Resident #1 became non-responsive and Emergency Medical Services (EMS) was called by the licensed nurse and family as ordered by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 38	F 684		

Physician Assistant. Resident #1 was diagnosed with sepsis and a left subdural hematoma and transferred and placed on Hospice services where he passed away on 03/31/25.

On 4/3/25, the DON and Nurse Consultant completed an audit of residents on anticoagulant therapy who have experienced a fall within the last 72 hours to ensure timely recognition and response occurred if the resident experienced a change in condition. Two residents were identified and no concerns identified.

On 4/4/2025, the DON and Unit Managers reviewed all residents with changes in condition in 24 hours to ensure immediate notification to the Medical Provider occurred. Six residents were identified and assessed, and the Medical Provider was notified.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring, and when the action will be complete.

On 4/3/25, the Administrator, Director of Nursing (DON), Vice President of Risk and Quality Assurance (VPRQA), Nurse Consultant, PA and Medical Director held an Ad Hoc QAPI meeting to discuss the incident to determine root cause analysis of the facility's failure to recognize the severity of a change in condition for Resident #1. Root cause analysis determined that the facility failed to have effective systems in place and monitoring measures to ensure timely response and notification is made to a medical provider for proper intervention up to and including transfer to a higher level of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 39	F 684		

On 4/3/2025, the Director of Risk and Quality Assurance, Nurse Consultant, Director of Nursing, Administrator, and Physician Assistant reviewed the change in condition and fall policy. No changes were made.

Effective 4/3/25, the Director of Nursing, Nurse Consultant, and Nursing Administration initiated education with all facility and contracted licensed nurses and Certified Nursing Assistants on the facility Notification of Changes in Condition and Fall Prevention policies. Education includes recognizing the severity of a change in condition status post fall to include post fall assessment changes for 72 hours, changes in level of consciousness, and altered mental status away from baseline. Upon licensed nurse's assessment recognizing the severity of the residents change in condition away from baseline post fall, the Medical Provider will be immediately notified. Certified Nursing Assistants will communicate any residents change in condition away from baseline to the licensed nurses. The Director of Nursing and/or Unit Managers will ensure all newly hired licensed nurses and Certified Nursing Assistants will be educated during orientation and contracted staff educated prior to taking their assignment.

Effective 4/3/25, the Administrator is ultimately responsible for the implementation and completion of this removal plan.

Alleged Date of IJ Removal: 04/05/2025

On 04/08/25 the credible allegation of Immediate Jeopardy removal with a removal date of 04/05/25 was validated by onsite verification through staff interviews, record reviews, and education reviews. The staff interviewed included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345283	A. BUILDING _____ B. WING _____	C 04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CITADEL MOORESVILLE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 40 members of administration, licensed nurses and nursing assistants. The staff interviews were related to the facility's policy and procedures for changes in condition specifically how to identify changes in conditions and notification upon changes in conditions. The management team reported new procedures in monitoring for changes in conditions, the licensed nurses reported their responsibility to assess residents when changes in conditions occur and the nurse aides voiced their responsibility in reporting changes in the residents' conditions as soon as it was noticed to the nurse responsible for the residents. The education provided for the staff was evident through staff interviews and education attendance records. The Immediate Jeopardy removal date of 04/05/25 was validated.	F 684		