DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

# POST-CERTIFICATION REVISIT REPORT

| PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER<br>345283     Y1 | MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing     Y2 | DATE OF REVISIT<br>5/15/2025     Y3 |
|---|---|---|
| NAME OF FACILITY<br>THE CITADEL MOORESVILLE | STREET ADDRESS, CITY, STATE, ZIP CODE<br>550 GLENWOOD DRIVE<br>MOORESVILLE, NC 28115 | |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 | ITEM<br>Y4 | DATE<br>Y5 |
|---|---|---|---|---|---|
| ID Prefix F0580<br>Reg. # 483.10(g)(14)(i)-(iv)(15)<br>LSC | Correction<br>Completed<br>05/15/2025 | ID Prefix F0600<br>Reg. # 483.12(a)(1)<br>LSC | Correction<br>Completed<br>05/15/2025 | ID Prefix F0684<br>Reg. # 483.25<br>LSC | Correction<br>Completed<br>05/15/2025 |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed | ID Prefix<br>Reg. #<br>LSC | Correction<br>Completed |

| REVIEWED BY STATE AGENCY ☐ | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF SURVEYOR | DATE |
|---|---|---|---|---|
| REVIEWED BY CMS RO ☐ | REVIEWED BY (INITIALS) | DATE | TITLE | DATE |

| FOLLOWUP TO SURVEY COMPLETED ON<br>4/8/2025 | ☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?    ☐ YES    ☐ NO |
|---|---|