STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345008	A. Building B. Wing	04/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Myers Park, LLC	300 Providence Road Charlotte, NC 28207

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43643 Based on record review, observations, staff and Psychiatric Nurse Practitioner, Nurse Practitioner interviews the facility failed to follow their abuse policy and procedure in the area of protection when they failed to implement measures to ensure residents were protected from Resident #2 who had known physically aggressive behaviors that included hitting Resident #1 in the eye resulting in a traumatic subdural hematoma, a serious condition where blood collects between the skull and the surface of the brain. This failure put 55 of the 89 residents who resided on the unsecured units at high likelihood of suffering serious physical and psychosocial harm enacted by Resident #2. Immediate Jeopardy began on 03/17/23, the date after the recertification exit date (3/16/23), when the facility failed to implement measures to ensure all residents on the unsecured units were protected from Resident #2. The immediate jeopardy was removed on 04/13/22 when the facility implemented a credible allegation of jeopardy removal. The facility will remain out of compliance at a lower scope and severity E (no actual harm with potential for harm) to ensure monitoring systems put into place are effective. The findings included: A review of the facility policy and procedure titled Abuse, Neglect, and Exploitation, with a revised date of 10/22/20, read in part, it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation, and misappropriation of resident property. The Protection of Resident: section specified, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to increased supervision of the alleged victim and resident. Resident #2 was admitted to the facility on [DATE] with diagnoses which included dementia, and schizoaffective disorder (bipolar type). Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact and was not coded for behaviors. He was assessed as requiring limited assistance with transfers and was independent with walking/locomotion. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #2's active care plan as of 03/17/23 revealed Resident #2 was physically aggressive and hits resident's secondary to agitation with the resident/situation. The care plan further revealed Resident #2 had a history of physical altercations with his roommates. The goal was for Resident #2 to have fewer episodes of hitting other residents through the review date. Interventions included separate residents having altercations, attempt to identify the cause of agitation, attempt to redirect and calm resident, assess and anticipate resident's needs, provide physical and verbal cues to alleviate anxiety; give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated, and monitor/document/report as needed (PRN) any signs and symptoms of resident posing danger to self and others. An interview conducted with Nurse #1 on 04/12/23 at 11:30 AM revealed she heard commotion in Resident #1 and Resident #2's room on 3/10/23 and went to the room and found Resident #2 had hit Resident #1 in the right eye. Nurse #1 further revealed Resident #2 admitted to hitting Resident #1 because he was trying to watch TV and Resident #1 would not be quiet. Nurse #1 indicated both residents were separated and sent to the hospital for evaluation. Nurse #1 stated Resident #2 required one-on-one supervision when he returned from the hospital (3/12/23) for a day or two but could not recall any other safety interventions put in place on his return. Nurse #1 indicated Resident #1 was moved to another floor when he returned from the hospital. Nurse #2 revealed she was not educated on any interventions to implement to protect other residents after Resident #2 was taken off of one-on-one supervision. Nurse #2 indicated Resident #2 was able to continue to be around residents without any supervision. An interview conducted with Nurse Aide (NA) #1 on 4/12/23 at 1:30 PM revealed she had worked on the same hall as Resident #2 and Resident #1 on 03/10/23. NA #1 further revealed she heard Resident #2 being loud and had entered the room after the incident had occurred and nursing staff were already present. NA #1 indicated she rarely had worked that floor but was never educated that Resident #2 had previous aggressive behaviors. NA #1 revealed after the incident she was not aware of any safety intervention in place for Resident #2. Review of the medical record revealed Resident #1 was admitted to the facility on the secured Memory Care Unit on 9/2/22 due to wandering behaviors. The record indicated Resident #1 was moderately cognitively impaired with diagnoses of atrial fibrillation, muscle weakness, and vascular dementia. Resident #1 did receive a blood thinning medication, Eliquis. Resident #1 was moved out of the secured Memory Care Unit due to no wandering behaviors and into a room with Resident #2 on 2/26/23. On 3/2/23 it was documented that nursing staff found Resident #2 standing over Resident #1 while he was in bed, threatening to whoop him. Nursing staff deescalated the situation by sitting with the resident. No interventions were put in place and there was not an incident report completed. On 3/11/23 the record revealed Resident #2 hit Resident #1 in the right eye. Both residents were sent to the hospital for evaluation and treatment. Resident #2 returned to the facility on [DATE], and staff completed one on one for a brief period of time. When Resident #1 returned to the facility he was moved to another room on a different floor from Resident #2. The incident report revealed Resident #2 was moved to a private room closer to the nurse's station. Adult Protective Services and Law Enforcement were notified by the facility. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the hospital discharge summary dated 3/15/23 revealed Resident #1 was admitted to the Neuro Intensive Care Unit service on 3/12/23 for a traumatic subdural hematoma (SDH), and was receiving Eliquis, a blood thinner. He had a past medical history of atrial fibrillation, and vascular dementia and presented to the emergency department after being hit in the face by another resident at his skilled nursing facility. A head computed tomography (CT) was completed with results of a moderate sized right SDH. The resident was discharged back to the skilled nursing facility on 3/15/23. An interview conducted with the facility Nurse Practitioner (NP) on 04/12/23 at 11:45 AM revealed Resident #2 hit Resident #1 with his fist to the right eye on 3/10/23 and Resident #1 sustained a traumatic subdural hematoma injury. It was revealed after the incident Resident #1 was unable to feed himself and engage in conversation. The NP stated Resident #1 had passed and she believed it was possible Resident #1's head injury sustained from Resident #2 could have played part to Resident #1's death. The NP further revealed Resident #2 had other altercations with residents previously and it was unsafe for Resident #2 to be placed with other residents. She indicated she was unsure what the facility had done to ensure the safety of other residents. An interview conducted with Nurse #2 on 04/12/23 at 9:45 AM revealed Resident #2 had ongoing aggressive physical and verbal behavior towards residents and staff. Nurse #2 indicated Resident #2 had physically hit two other residents during his stay at the facility. He was unable to recall the dates of these incidents. Nurse #2 further revealed Resident #2 had threatened a roommate with a butter knife, threatened to hit Resident #1, and had recently assaulted Resident #1. Nurse #2 further revealed he did not recall previous safety interventions other than to re-direct him if he got agitated. Nurse #2 stated Resident #2 had ongoing physical behaviors and was a safety concern to other residents because he was allowed to go wherever in the unsecured area of the facility and was not supervised around other residents. Review of Resident #2's medical record revealed on 2/14/23 nursing staff found Resident #2 threatening his former roommate, before Resident #1 stating he could not come in the room and if he did, he was going to stab him. Staff retrieved a butter knife from Resident #2 and the resident stated his roommate was bothering him. Staff educated the resident about violent threats and consequences. Staff removed the roommate from the room. There was no incident report completed and law enforcement was not notified. No new interventions were put into place. An interview conducted with the facility Psychiatric Nurse Practitioner (NP) on 04/12/23 at 11:55 AM revealed she visited the facility after the altercation between Resident #1 and Resident #2. The Psychiatric NP indicated she had seen Resident #2 prior to the incident that occurred on 03/10/23 but nursing staff had failed to inform her of previous physical altercations between Resident #2 and other residents. She stated due to Resident #2's previous physical and verbal altercations he should not have been placed in a room with another resident. The Psychiatric NP revealed Resident #2 should not be in the facility because he was a safety concern to all residents and had access to other residents and staff and felt the facility could not ensure the safety of all the residents. The Psychiatric NP indicated Resident #2 was alert and knew he had caused harm to Resident #1. She reported that she believed Resident #2 was triggered easily. She explained this meant Resident #2 got agitated easily. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview conducted with Nurse Supervisor #1 on 04/12/23 at 1:15 PM revealed she was aware Resident #2 had previous physical altercations and had made verbal threats to Resident #1 and other residents. The Nurse Supervisor stated on 02/14/23 Resident #2 had a butter knife on his tray and threatened to stab his previous roommate. She reported the only interventions included the facility took the knife away and deescalated the situation. The Nurse Supervisor further revealed on 03/10/23 Resident #2 was put on one-to-one supervision for a short period of time after hitting Resident #1 and felt that Resident #2 would not be a safety concern to other residents due to being placed in a room by himself. It was revealed Resident #2 was no longer supervised and was able to be around other residents without any supervision. An interview conducted with the Director of Nursing (DON) and the Administrator on 04/12/23 at 2:45 PM revealed they were aware Resident #2 had physical altercations with other residents prior to the incident on 03/10/23. It was revealed it was known Resident #2 had made threats to Resident #1 and other residents prior. The Administrator and DON indicated on 02/14/23 Resident #2 had threatened his previous roommate with a butter knife and interventions included to de-escalate the situation and move Resident #2's roommate to another room. On 03/02/23 Resident #2 was observed by staff threatening to hit Resident #1 in his bed. Safety interventions included to de-escalate the situation. The Administrator further revealed when Resident #2 returned to the facility on [DATE] he was placed one-on-one for over a day, and he was moved closer to the nurses' station on 03/29/23. When asked why Resident #2 was taken off of one to one they reported the facility no longer had staff available to watch him, and they also felt like he no longer needed it. The Administrator reported before the incident with Resident #1 that the facility would de-escalate the situation by separating Resident #2 from others when Resident #2 became aggressive until he had calmed down. No other interventions were put in place. The Administrator revealed to ensure the safety of other residents Resident #2 was moved closer to the nurses' station so he could be heard. The Administrator stated Resident #2 had not shown any signs of physical aggression since he had been moved into a room by himself. The Administrator was notified of immediate jeopardy on 04/14/23 at 3:45 PM. The facility provided the following the following Immediate Jeopardy removal plan with completion date of 4/13/2023. 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 put safety interventions in place to protect all residents from another resident known to have previously exhibited aggressive behaviors. After the incident on 3/11/23, Clonazepam was discontinued on 3/24/23 due to a fall. On 4/10/2023 a new order for Oxcarbazepine 150mg twice a day was obtained and on 4/13/2023 a new order for monthly ammonia levels was started. 03/21/2023: Nurse Practitioner completed med review and adjusted psych medications. 03/24/2023: Nurse Practitioner recommended to continue current plan of care and to continue to follow psych recommendations and adjust meds as needed. 03/28/2023: Physician assessed resident due to fall with no changes. (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	04/07/2023: Nurse Practitioner from psych assessed and ordered new medication. On 3/29/23 the perpetrator was moved to the room beside the Nurses station and remains in a private room. On 4/12/23 the Administrator placed the perpetrator on one-on-one supervision. On 4/12/23 the Administrator assigned a Nurse Aide to provide one on one supervision to the Resident with aggressive behaviors to ensure safety to all other residents. The Director of Nursing will be responsible for ensuring the resident has a 1:1 aide 24 hours a day. On 4/12/23 the Director of Nursing educated all Nurse Aides and Licensed Nurse regarding monitoring behaviors that include agitation, yelling, physical aggression and notifying the Director of Nursing and Nurse Manager in the event behavior escalation occurs. On 4/12/23 the Administrator, Director of Nursing and Nurse Managers completed an interview with all residents with BIMS greater than 10 to identify any allegations of abuse related to the perpetrator. On 4/12/23 the Nurse Managers and Wound Nurse conducted a skin assessment for those residents unable to be interviewed to identify any injuries that could have been caused by the perpetrator. On 4/12/23 the Director of Nursing received a Dietary order for no knives on the resident ' s meal tray and educated the Dietary Manager, Dietary staff and Nursing staff on no knives on the meal tray. On 4/12/23 the Director of Nursing and Nurse Managers assessed the resident ' s room for other dangerous objects, and none were identified. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete On 4/12/23 the Administrator, Director of Nursing and Nurse Managers re-educated all facility staff, including agency staff, on the facility policy for preventing abuse, providing safety and protection to residents from perpetrators to prevent further abuse by providing one on one supervision. On 4/12/23 the Nursing staff were educated regarding monitoring and documenting behaviors in the electronic medical record and the requirement to report new or escalating behaviors to the Director of Nursing or Nurse Managers to prevent abuse. On 4/12/23 the Director of Nursing and Nurse Managers educated all staff regarding the requirement to immediately provide safety for any resident in an abusive situation including providing one on one supervision for the perpetrator to provide safety for other residents from abuse, and then immediately report any observation or allegation of abuse to the Administrator or Director of Nursing for further investigation and interventions prior to removing the increased supervision. On 4/12/23 the staff were notified that the contact information for the Administrator and Director of Nursing is posted at each Nurses station for after hours and weekend reporting (continued on next page)

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F 0607 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 4/12/23 the Administrator notified the Director of Nursing of her responsibility to provide the education and maintain the tracking tool to ensure no staff are allowed to work without receiving training. The Director of Nursing will ensure any newly hired staff and agency staff receive this training during orientation. The Director of Nursing will be responsible for maintaining the one-on-one schedules. On 4/12/23 the Director of Nursing will ensure Behavior monitoring, including any residents with one-on-one supervision is reviewed during the morning Clinical meeting to identify escalating behaviors and ensure interventions are in place for prevention of abuse. On 4/12/23 the Administrator began reviewing all allegations of abuse with the Interdisciplinary team during the Morning Meeting and with the Regional Director of Operations and Regional Director of Clinical Services to include a review of safety measures put in place to prevent further abuse from perpetrators. On 4/12/23 the Regional Director of Operations and Regional Director of Clinical Services will begin a weekly review of all incidents to ensure interventions are in place to provide safety interventions to protect residents. Effective 4/12/23 the Administrator will be responsible for ensuring implementation of this immediate jeopardy removal for this alleged non-compliance. Alleged Date of IJ Removal: 4/13/2023 On 04/18/23, the facility's corrective action plan for immediate jeopardy removal effective 04/13/23 was validated by the following: Interviews with facility staff revealed in-service was completed and educated on policy for preventing abuse, providing safety and protection to residents from perpetrators to prevent further abuse by providing one on one supervision, nursing staff were educated regarding monitoring and documenting behaviors in the electronic medical record, to immediately provide safety for any resident in an abusive situation including providing one on one supervision for the perpetrator to provide safety for other residents from abuse, and then immediately report any observation or allegation of abuse to the Administrator or Director of Nursing for further investigation, and Resident #2 could not have a knife on his meal tray. It was observed Resident #2 was put on one-to-one supervision 24 hours a day to ensure the safety of the other residents. Interview with the dietary manager revealed Resident #2 was noted on his meal ticket and a sign was present on the meal line that Resident #2 could not receive a knife on his meal tray. The removal date of 04/13/23 was validated.